


MEMORANDUM

TO:  Alaska House Health & Social Services Committee
FROM: Margaret Dore, Esq., MBA
RE: Vote "No" on HB 99. (No Assisted Suicide/Euthanasia)
HEARING: April 9, 2015, 3:00 p.m.

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APPENDIX

I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.¹ Our law is modeled on Oregon's law. Both laws are similar to the proposed bill, HB 99.²

HB 99 seeks to legalize assisted suicide and euthanasia in Alaska. The sponsor says that the bill applies to terminally ill patients with an "inevitable and certain death."³ Eligible persons, however, may have years, even decades, to live. The bill is, regardless, a recipe for elder abuse, especially for people with money.

Other problems if the bill passes, include: steerage to suicide by health care providers; trauma to patients; trauma to family members; and the risk of suicide contagion. I urge you to vote "NO" on HB 99. Do not make Washington's mistake.

II. FACTUAL AND LEGAL BACKGROUND

A. Financial Exploitation is a Large and Uncontrolled Problem.

The Alaska Office of Public Advocacy defines financial

¹ I have been licensed to practice law in Washington state since 1986. I am a former Law Clerk to the Washington State Supreme Court. I am a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. I am also President of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide. For more information, please see www.margarettdore.com, www.choiceillusion.org and www.margarettdore.org.

² A copy of HB 99 is attached hereto at A-1 through A-15.

³ Sponsor Statement, House Bill 99.

exploitation as the "illegal or improper use of an elder's funds, property or assets."⁴ Moreover, perpetrators are often the adult children of the victim.⁵ In 2009, the MetLife Mature Market Institute released a study, which estimated the financial loss by victims in the United States at \$2.6 billion per year.⁶

Consider also, *People v. Stuart*, which states:

Financial considerations [are] an all too common motivation for killing someone.⁷

In *Stuart*, a defendant who had killed her mother argued for leniency because the homicide had been prompted by care and concern.⁸ *Stuart* disagreed, stating:

[T]o do so would potentially expose some of the most vulnerable in our society to the grave danger of being killed by "loved ones," however compassionate they may be, who are unable to resist a temptation that dovetails with their financial self-interest, as the record suggests may have been the case here.⁹

B. Physician-assisted Suicide, Assisted Suicide and Euthanasia.

The American Medical Association defines "physician-assisted suicide" as occurring when "a physician facilitates a patient's

⁴ <http://doa.alaska.gov/opa/oefa/fin.html>

⁵ *Id.*

⁶ <https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf>, page 4.

⁷ *People v. Stuart*, 67 Cal.Rptr.3d 129, 143 (2007), excerpt at A-53.

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death by providing the necessary means and/or information to enable the patient to perform the life-ending act."¹⁰ "Assisted suicide" is a general term in which the aiding 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.¹¹

The American Medical Association rejects physician-assisted suicide and euthanasia, stating they are:

fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.¹²

C. Withholding or Withdrawing Treatment.

Withholding or withdrawing treatment ("pulling the plug") is not assisted suicide or euthanasia. This is because the intent is to remove treatment, not 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.¹³

¹⁰ The AMA Code of Medical Ethics, Opinion 2.211 - Physician-Assisted Suicide. (Attached at A-17).

¹¹ Cf. AMA Code of Ethics, Opinion 2.21 - Euthanasia. (Attached at A-18).

¹² AMA Code of Ethics, Opinions 2.211 and 2.21, *supra* at footnotes 9 & 10.

¹³ 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*

**D. Most States Have Rejected Assisted Suicide
and Euthanasia.**

The vast majority of states to consider legalizing assisted suicide and/or euthanasia have rejected it.¹⁴ Just two months ago, a bill similar to HB 99 was summarily defeated in Colorado.¹⁵

In the last four years, four states have strengthened their laws against assisted suicide. These states are: Arizona, Idaho, Georgia and Louisiana.¹⁶

III. THE BILL

**A. "Eligible" Patients May Have Years, Even
Decades, to Live.**

HB 99 applies to "terminal" patients, meaning those predicted to have less than six months to live.¹⁷ Such persons may, however, actually have years, even decades, to live, *i.e.*, unless the bill passes and they commit suicide or are euthanized thereunder. This is true for at least three reasons:

wrong?, Seattle Weekly, January 14, 2009. (Attached at A-19, quote at A-21).

¹⁴ See tabulation at http://epcdocuments.files.wordpress.com/2011/10/attempts_to_legalize_001.pdf

¹⁵ See article at A-25.

¹⁶ See materials at A-26 to A-29.

¹⁷ HB 99, §§ 13.55.010(a)(4) & 13.55.900(16). (Attached at A-2 & A-14).

1. If Alaska follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for persons with chronic conditions such as diabetes.

HB 99 states:

"Terminal disease" means an incurable and irreversible illness that has been medically confirmed and that will, within reasonable medical judgment, produce death within six months.¹⁸

Oregon's law has a nearly identical definition, as follows:

"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.¹⁹

In Oregon, this nearly identical definition is interpreted to include chronic conditions such as insulin dependent diabetes.²⁰ Oregon doctor, William Toffler, explains:

Our law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live.²¹

¹⁸ *Id.*

¹⁹ Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-30.

²⁰ See Oregon's annual assisted suicide report for 2014, attached hereto at A-31 to A-36. "Chronic lower respiratory disease" and "diabetes" are listed at A-35 & A-36, respectively.

²¹ Letter to the Editor, William Toffler MD, New Haven Register, February 24, 2014, ¶2. (Attached at A-37). (I verified the content with him).

If Alaska enacts HB 99 and follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for young adults with chronic conditions such as diabetes. Dr. Toffler states:

Such persons, with treatment, could otherwise have years or even decades to live.²²

2. Predictions of life expectancy can be wrong.

Patients may also have years to live because predicting life expectancy is not an exact science.²³ Consider John Norton who was diagnosed with ALS. 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.

Affidavit of John Norton, attached at A-39, ¶ 5.

3. Treatment can lead to recovery.

Consider also Oregon resident, Jeanette Hall, who was diagnosed with cancer in 2000 and wanted to do assisted suicide.²⁴

²² *Id.*

²³ Compare *Terminal Uncertainty*. (Attached hereto at A-19).

²⁴ Affidavit of Kenneth Stevens, MD ¶¶ 3-7. (Attached hereto at A-41 to A-49).

Her doctor convinced her to be treated instead.²⁵ In a 2013 affidavit, she states:

This last July, it was 13 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.²⁶

B. If HB 99 Is Enacted, There Will be Pressure to Expand Eligibility.

In Washington State, our law went into effect in 2009. Since then, we have had informal proposals to expand our law to non-terminal people. For me, most disturbing, was a column suggesting euthanasia for people without funds.²⁷ This was in the *Seattle Times*, which is our largest paper.²⁸ Meanwhile, in Oregon, there is an actual bill to expand eligibility.²⁹

If HB 99 is enacted in Alaska, it's not unlikely that there will be a similar pressure to expand.

C. How the Bill Works.

HB 99 has an application process to obtain the lethal dose, which includes a written lethal dose request form with two

²⁵ *Id.*

²⁶ Affidavit of Jeanette Hall, ¶ 4, attached hereto at A-50 to A-51. Jeanette is still alive today, nearly 15 years later.

²⁷ See Jerry Large, "Planning for old age at a premium," *The Seattle Times*, March 8, 2012 ("After Monday's column, . . . a few [readers] suggested that if you couldn't save enough money to see you through your old age, you shouldn't expect society to bail you out. At least a couple mentioned euthanasia as a solution.") (Emphasis added). (Attached at A-52).

²⁸ *Id.*

²⁹ Oregon House Bill 3337.

required witnesses.³⁰ One of the witnesses is allowed to be the patient's heir, who will benefit financially from the patient's death.³¹

Once the lethal dose is issued by the pharmacy, there is no oversight.³² The doctor is not required to be present at the death.³³ No one, not even a witness is required when the lethal dose is administered.³⁴

D. A Comparison to Probate Law.

When signing a will, an heir's acting as a witness supports a finding of undue influence. Consider, for example, Washington State's probate statute, which provides that when one of two required witnesses is a taker under a will, there is a rebuttable presumption that the taker/witness "procured the gift by duress, menace, fraud, or undue influence."³⁵

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

³⁰ The lethal dose request form can be viewed at HB 99, § 13.55.060. (Attached at A-3 to A-5)

³¹ See HB 99, §13.55.060 (providing that one of two witnesses on the lethal dose request form may be entitled to a portion of the individual's estate upon death).

³² See HB 99 in its entirety. (Attached at A-1 through A-15).

³³ Id.

³⁴ Id.

³⁵ RCW 11.88.160(2).

E. Patient Control is not Assured.

1. No witnesses at the death.

As noted above, HB 99 does not require witnesses at the death.³⁶ Without disinterested witnesses, the opportunity is created for someone else to administer the lethal dose to the patient without his consent.³⁷ Even if he struggled, who would know?

Without disinterested witnesses, the patient's control over the time, place and manner of his death is not guaranteed.

2. Adding witnesses will not fix the problem.

Requiring witnesses at the death would protect against overt murder. Generally, however, witnesses are not much of a safeguard. Many wills are properly witnessed and nonetheless set aside for undue influence, fraud, etc.

3. Someone else is allowed to speak for the patient, including a stranger, as long as the speaking person is "familiar with the patient's manner of communicating."

Patients signing the lethal dose request form are required

³⁶ See HB 99 in its entirety, attached hereto at A-1 to A-15.

³⁷ The drugs used for assisted suicide in Oregon and Washington, Secobarbital and Pentobarbital (Nembutal), are water and alcohol soluble, which allows injection without consent, for example, to a sleeping person. See "Secobarbital Sodium Capsules, Drugs.Com, at <http://www.drugs.com/pro/seconal-sodium.html> and <http://www.drugs.com/pro/nembutal.html> See also Oregon's report, page 5, attached at A-35 (listing these drugs).

to be "capable."³⁸ This term is, however, specially defined to allow someone else to speak for the patient during the lethal dose request process, *i.e.*, as long as the speaking person is "familiar with the individual's manner of communicating." HB 99 states:

"Capable" means that an individual has the ability to make and communicate health care decisions to health care providers; in this paragraph, "communicate" includes communication through a person familiar with the individual's manner of communicating . . . (Emphasis added)³⁹

Being familiar with an individual's "manner of communicating" is a very minimal standard. Consider, for example, a doctor's assistant who is familiar with a patient's "manner of communicating" in Spanish, but does not herself understand Spanish. That, however, would be good enough for the assistant to speak for the patient during the lethal dose request process. Indeed, the speaking person could be the doctor's janitor or practically anyone at all. The patient's control over the situation is not assured.

4. Individual "opt outs" are not allowed.

HB 99 does not allow people to opt out of its provisions. § 13.55.140 states:

A provision in a will or contract, whether

³⁸ HB 99 § 13.55.010(a)(3). ("Qualified" patients are required to be "capable"). (Attached at A-2).

³⁹ HB 99, § 13.55.900(3). (Attached at A-13).

written or oral, is not valid to the extent that the provision requires, prohibits, imposes a condition on, or otherwise addresses whether an individual may make or rescind a request for medication under this chapter. (Emphasis added).

So much for the patient's choice and control.

5. There is no requirement that a doctor or anyone else comply with a patient's "rescission."

HB 99 says that a patient may, at any time, rescind her request for the lethal dose.⁴⁰ There is, however, no provision, i.e., anywhere, that a doctor or anyone else is obligated to follow that request.⁴¹ This purported protection is illusory.

6. HB 99 legalizes euthanasia.

HB 99 appears to prohibit "euthanasia," which is another name for mercy killing.⁴² HB 99 states:

This chapter may not be construed to authorize a physician or another person to end an individual's life by lethal injection, mercy killing, or active euthanasia.⁴³

This prohibition is, however, defined away in the next sentence. HB 99 states:

⁴⁰ HB 99, § 13.55.040, states:

A qualified individual may rescind a request at any time and in any manner without regard to the qualified individual's mental state.

⁴¹ See HB 99 in its entirety, at A-1 though A-15.

⁴² See <http://medical-dictionary.thefreedictionary.com/mercy+killing> (defining "mercy killing" as euthanasia).

⁴³ § 13.55.220(b), at A-12.

An action allowed by this chapter is an affirmative defense to a criminal charge of homicide, murder, manslaughter, criminally negligent homicide, suicide, assisted suicide, mercy killing, or euthanasia under the law of this state.⁴⁴

The bottom line, HB 99 legalizes euthanasia.

IV. PUBLIC POLICY, SAFETY AND WELFARE

A. Legalization of Assisted Suicide and Euthanasia will Create New Paths of Elder Abuse.

In Alaska, preventing elder abuse is official state policy.⁴⁵ If assisted suicide and euthanasia are legalized pursuant to HB 99, new paths of abuse will be created against the elderly, which is contrary to that policy. Alex Schadenberg, chair for the Euthanasia Prevention Coalition, International, states:

With assisted suicide laws in Washington and Oregon [and with HB 99], perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. . . . [E]ven if a patient struggled, "who would know?"⁴⁶

Consider also, the Thomas Middleton case in which physician-assisted suicide was part of an elder abuse fraud. (See A-54).

⁴⁴ Id.

⁴⁵ http://doa.alaska.gov/opa/oefa/contact_us.html

⁴⁶ Alex Schadenberg, Letter to the Editor, *Elder abuse a growing problem*, *The Advocate*, October 2010, page 14, available at http://www.margarettdore.com/info/October_Letters.pdf

B. Any Study Claiming that Oregon's Law is Safe, is Invalid.

In 2011, the lack of oversight over administration of the lethal dose in Oregon, prompted State Senator Jeff Essmann to make this observation: the Oregon studies claiming that assisted suicide 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.⁴⁷

C. Oregon's Annual Report for 2014 is Consistent with Financial Elder Abuse

According to Oregon's most recent annual assisted suicide report, most of the people who died from a lethal dose were white, aged 65 or older, and well-educated.⁴⁸ People with these attributes are typically well off, i.e., the middle class and above.

The report implies that these deaths were voluntary, stating

⁴⁷ See link to hearing transcript for SB 167, February 10, 2011, http://www.margaretdore.com/pdf/senator_essmann_sb_167_001.pdf

⁴⁸ Report, page 2, attached hereto at A-32.

that Oregon's act "allows" residents to obtain a lethal dose.⁴⁹ There is nothing in the report, however, that actually says that the deaths were voluntary. Older well-off people are, regardless, in a vulnerable demographic for abuse and exploitation. This includes murder. The 2009 MetLife Mature Market Institute Study states:

Elders' vulnerabilities and larger net worth make them a prime target for financial abuse . . . Victims may even be murdered by perpetrators who just want their funds and see them as an easy mark.⁵⁰

D. Assisted Suicide and Euthanasia can be Traumatic for Family Members as well as Patients.

1. The Swiss study.

In 2012, a study was released in Switzerland, addressing trauma suffered by persons who witnessed an assisted suicide.⁵¹ The study found that 1 out of 5 family members or friends present at an assisted suicide were traumatized.⁵² These persons:

[E]xperienced full or sub-threshold PTSD [Post Traumatic Stress Disorder] related to the loss of a close person through assisted

⁴⁹ Id., page 1, attached hereto at A-31.

⁵⁰ The MetLife Study can be viewed at this link: <https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf>

⁵¹ "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," B. Wagner, J. Muller, A. Maercker; European Psychiatry 27 (2012) 542-546, available at <http://choiceisanillusion.files.wordpress.com/2012/10/family-members-traumatized-eur-psych-2012.pdf> (First page attached at A-79).

⁵² Id.

suicide.⁵³

2. My cases involving the Oregon and Washington assisted suicide laws.

I have had two clients whose fathers signed up for the lethal dose.⁵⁴ In the first case, one side of the family wanted the father to take the lethal dose, while the other did not. The father spent the last months of his life caught in the middle and traumatized over whether or not he should kill himself. My client, his adult daughter, was also traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it's not clear that administration of the lethal dose was voluntary. A man who was present told my client that his father refused to take the lethal dose when it was delivered ("You're not killing me. I'm going to bed"), but then he took it the next night when he was high on alcohol. The man who told this to my client later recanted. My client did not want to pursue the matter further.

E. Enacting HB 99 Will Allow Health Care Providers to Implement Formal Steerage to Suicide.

If HB 99 is enacted, health care providers in Alaska will be

⁵³ *Id.*

⁵⁴ Cf. Margaret Dore, "Preventing Abuse and Exploitation: A Personal Shift in Focus" (An article about elder abuse, guardianship abuse and assisted suicide), The Voice of Experience, ABA Senior Lawyers Division Newsletter, Vol. 25, No. 4, Winter 2014, available at http://www.americanbar.org/publications/voice_of_experience/2014/winter/preventing_abuse_and_exploitationa_personal_shift_focus.html

able to follow the lead of Oregon's Medicaid program to steer patients to suicide, i.e., through institutionalized coverage incentives. To learn more, see the affidavit of Oregon doctor, Kenneth Stevens. (Attached hereto at A-41 through A-49). Do you want this to happen to you or your family?

V. PAIN IS NOT THE ISSUE.

The current Oregon report lists "concerns" as to why people who ingested the lethal dose signed up to do so.⁵⁵ Per the report, there were 33 patients who had a concern about: "inadequate pain control."⁵⁶ This is 33 people out of 33,931 total deaths in Oregon.⁵⁷ Regardless, there was no claim that any one of these 33 patients was actually in pain.⁵⁸ Pain is not the issue.

VI. COMPASSION & CHOICES, THE RISK OF SUICIDE CONTAGION AND A MISSION TO REDUCE PATIENT ACCESS TO CURES.

A. Compassion & Choices is a Successor Organization to the Hemlock Society.

Passage of HB 99 is being spearheaded by the suicide/euthanasia advocacy group, Compassion & Choices ("C & C"). C & C was formed in 2004 as the result of a merger/takeover

⁵⁵ Oregon Report, page 5, attached hereto at A-35.

⁵⁶ *Id.*

⁵⁷ Report, p.1, at A-31, fn 1 (total Oregon deaths in 2013 was 33,931).

⁵⁸ See entire Oregon report at A-31 et seq.

of two other organizations.⁵⁹ One of these organizations was the former Hemlock Society, originally formed by Derek Humphry.⁶⁰

In 2011, Humphry was in the news as a promoter of mail-order suicide kits.⁶¹ This was after one of the kits was used by the depressed son of a federal judge, to kill himself.⁶² Later that year, C & C celebrated Humphry as the keynote speaker for its annual meeting.⁶³

B. C & C's Media Campaign Presents a Risk of Suicide Contagion.

It is well known that media reporting of suicide can encourage other suicides, for example, a "copycat suicide" or a "suicide contagion." A famous example is Marilyn Monroe. Her widely reported suicide was followed by a increase in other suicides.

This encouragement phenomenon also occurs when the inspiring death is not a suicide. An example is the televised hanging of Saddam Hussein, which led to suicide deaths of children worldwide. An NBC News article begins:

⁵⁹ See 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").

⁶⁰ *Id.*

⁶¹ Randi Bjornstad, "Suicide Kits Sell Death by Mail," *The Register-Guard*, March 20, 2011 ("For \$60, they blew his life apart"). (Attached at A-55 to A-56).

⁶² *Id.*

⁶³ See Compassion & Choices newsletter at A-57.

The boys' deaths - scattered in the United States, in Yemen, in Turkey and elsewhere in seemingly isolated horror - had one thing in common: They hanged themselves after watching televised images of Saddam Husseins' execution.⁶⁴

Groups such as the National Institute of Health have developed guidelines for reporting suicide. Key points include that the risk of additional suicides increases "when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage."⁶⁵

The media campaign by C & C, to promote the assisted suicide of Brittany Maynard, violated and continues to violate all of these guidelines. We were told of the planned method, when and where it would take place and who would be there. There was, and continues to be, repeated extensive coverage in multiple media.

I have a physician friend, who recently committed a young man to mental health treatment. The man had become actively suicidal after reading about Ms. Maynard.⁶⁶

The risk of suicide contagion associated with C & C's media

⁶⁴ NBC News, Associated Press, "Children around the world kill themselves after watching televised images," January 14, 2007, attached at A-94. See also http://www.nbcnews.com/id/16624940/ns/world_news-mideast_n_africa/t/copycat-hangings-follow-saddam-execution/#.VDr5AfldWS0

⁶⁵ The National Institute of Mental Health, "Recommendations for Reporting on Suicide," <http://www.nimh.nih.gov/health/topics/suicide-prevention/recommendations-for-reporting-on-suicide.shtml> (A-96) See also: "Preventing Suicide: A Resource for Media Professionals," http://www.who.int/mental_health/prevention/suicide/resource_media.pdf

⁶⁶ Will Johnston, MD, Vancouver Canada.

campaign is real. The persons at risk include children.

C. In Oregon, Other (Conventional) Suicides Have Increased with Legalization of Physician-Assisted Suicide; the Financial Cost is "Enormous."

Government reports from Oregon show a positive statistical correlation between the legalization of physician-assisted suicide and an increase in other (conventional) suicides. The statistical correlation is consistent with a suicide contagion in which legalizing and normalizing physician-assisted suicide encouraged other suicides. Please consider the following:

Oregon's assisted suicide act went into effect "in late 1997."⁶⁷

By 2000, Oregon's conventional suicide rate was "increasing significantly."⁶⁸

By 2007, Oregon's conventional suicide rate was 35% above the national average.⁶⁹

By 2010, Oregon's conventional suicide rate was 41% above the national average.⁷⁰

The financial cost of these other suicides is huge. The 2010 report, page 3, elaborates:

The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization

⁶⁷ Oregon's assisted suicide report for 2014, attached at A-31.

⁶⁸ See Oregon Health Authority News Release, September 9, 2010, at <http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf> ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached at A-72)

⁶⁹ *Id.*

⁷⁰ Attached at A-77.

charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.⁷¹

Oregon is the only state where there has been legalization of assisted suicide long enough to have statistics over time. The enormous cost of increased (conventional) suicides in Oregon, positively correlated to physician-assisted suicide legalization, is a significant factor for this body to consider regarding HB 99, which seeks to legalize physician-assisted suicide in Alaska.

D. C & C Seeks to Reduce Choice in Health Care.

In 2008, Oregon's Medicaid program sent a letter to Oregon resident, Barbara Wagner, offering to cover her suicide instead of a drug to possibly cure her cancer.⁷² The drug's manufacturer subsequently provided her with the drug.⁷³ She nonetheless died a short time later.

After her death, C & C stepped forward to reveal its true mission. Specifically, its president, Barbara Coombs Lee, published an opinion piece defending Oregon's Medicaid program.⁷⁴ Coombs Lee also argued for a public policy change to discourage people from seeking cures. She said:

⁷¹ Attached at A-78.

⁷² See: Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (Excerpt attached at A-66).

⁷³ "Letter noting assisted suicide raises questions," KATU TV, July 30, 2008. (Attached at A-70 & 71)

⁷⁴ Barbara Coombs Lee, "Sensationalizing a sad case cheats the public of sound debate," *The Oregonian*, November 29, 2008. (Attached at A-81 to A-83)

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.⁷⁵

C & C's' president, Barbara Coombs Lee, is a former "managed care executive."⁷⁶

For more insight into C & C's true mission, see: Margaret Dore, "Compassion & Choices has a New Campaign to Reduce Patient Choice: Be Careful What You Sign," December 1, 2014 (attached at A-85); and Montana State Senator Jennifer Fielder, "Beware of Vultures," which states:

I found myself wondering, . . . why was more money spent on promoting assisted suicide than any other issue in Montana?

Attached at A-87 to A-88.

VII. CONCLUSION

HB 99's promise of patient control is an illusion. The bill is instead a recipe for elder abuse, especially for people with money. The most obvious gap is the lack of witnesses at the death. Even if the patient struggled, who would know?

Don't make Washington's mistake. I urge you to reject SB 128.


Respectfully submitted April 9, 2015

⁷⁵ *Id.*

⁷⁶ See Coombs Lee bio, attached at A-84.

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HOUSE BILL NO. 99

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES DRUMMOND, Josephson, Gruenberg

Introduced: 2/9/15

Referred: Health and Social Services, Judiciary

A BILL**FOR AN ACT ENTITLED**

1 "An Act relating to the voluntary termination of life by terminally ill individuals; and
 2 providing for an effective date."

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 11.41.115 is amended by adding a new subsection to read:

5 (g) In a prosecution under AS 11.41.100(a)(1) or 11.41.110(a)(1) or (2), it is an
 6 affirmative defense that the defendant was performing an action allowed under
 7 AS 13.55.

8 * **Sec. 2.** AS 11.41.120 is amended by adding a new subsection to read:

9 (c) In a prosecution under this section, it is an affirmative defense that the
 10 defendant was performing an action allowed under AS 13.55.

11 * **Sec. 3.** AS 13 is amended by adding a new chapter to read:

12 **Chapter 55. Voluntary Termination of Life.**

13 **Sec. 13.55.010. Individuals allowed to terminate life.** (a) A qualified
 14 individual may terminate the qualified individual's life under this chapter. To be

1 qualified, an individual shall

2 (1) be a resident of this state;

3 (2) be an adult;

4 (3) have been determined by a court, the individual's attending
5 physician, the individual's consulting physician, the individual's psychiatrist, or the
6 individual's psychologist to be capable;

7 (4) have been determined by the individual's attending physician and
8 consulting physician to be suffering from a terminal disease; and

9 (5) have voluntarily expressed the wish to die.

10 (b) An individual does not qualify under (a) of this section solely because of
11 the individual's age or disability.

12 **Sec. 13.55.020. Attending physician and pharmacist authority.** If a
13 qualified individual's attending physician complies with this chapter, the attending
14 physician may

15 (1) dispense medication directly to the qualified individual, including
16 ancillary medications intended to facilitate the desired effect or minimize the qualified
17 individual's discomfort; or

18 (2) write a prescription for the medication for the qualified individual
19 and personally or by mail deliver the prescription for the medication to a pharmacist,
20 who may dispense the medication to the qualified individual, the attending physician,
21 or an expressly identified agent of the qualified individual.

22 **Sec. 13.55.030. Requests for medication.** (a) To receive medication under this
23 chapter, a qualified individual shall make an oral request and a written request to the
24 qualified individual's attending physician. The qualified individual shall repeat the oral
25 request to the qualified individual's attending physician more than 15 days after
26 making the initial oral request.

27 (b) Notwithstanding (a) of this section, if a qualified individual is not
28 physically able to speak, a qualified individual may make an oral request by whatever
29 means the qualified individual can use to make the request, including electronic
30 means, as long as the request is made in person.

31 (c) Notwithstanding (a) of this section, if a qualified individual is not

1 physically able to sign a written request, the qualified individual may direct another
2 individual to sign for the qualified individual.

3 **Sec. 13.55.040. Right to rescind request.** When a qualified individual makes
4 the second oral request under AS 13.55.030, the attending physician shall offer the
5 qualified individual an opportunity to rescind the initial oral request and the written
6 request. A qualified individual may rescind a request at any time and in any manner
7 without regard to the qualified individual's mental state. An attending physician may
8 not dispense or prescribe medication under this chapter unless the attending physician
9 offers the qualified individual an opportunity to rescind the request.

10 **Sec. 13.55.050. Written request requirements.** (a) A written request for
11 medication under this chapter must be in substantially the form described in
12 AS 13.55.060, signed and dated by the qualified individual, and witnessed by at least
13 two other individuals. The attending physician may not witness the request. The
14 witnesses shall, in the presence of the qualified individual, attest that, to the best of
15 their knowledge and belief, the qualified individual is capable, acting voluntarily, and
16 not under undue influence to sign the request.

17 (b) Only one witness may be

18 (1) a relative of the qualified individual by blood, marriage, or
19 adoption;

20 (2) an individual who, at the time the qualified individual signs the
21 request, would be entitled to a portion of the estate of the qualified individual at death
22 under a will or by operation of law; or

23 (3) an owner, operator, or employee of a health care facility where the
24 qualified individual is receiving medical treatment or is a resident.

25 (c) If the qualified individual is an inpatient in a long-term care facility when
26 the qualified individual signs the request, one of the witnesses shall be an individual
27 designated by the facility who has the qualifications established by the department by
28 regulation. In this subsection, "long-term care facility" includes an assisted living
29 home as defined in AS 47.32.900 and a nursing facility as defined in AS 47.32.900.

30 **Sec. 13.55.060. Form for written request.** A request for a medication under
31 this chapter must be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

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

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE OF THE FOLLOWING:

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

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

 I have no family to inform of my decision.

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

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

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request

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

(2) in our presence signed or directed another person to sign this request;

(3) is not an individual for whom either of us is the attending physician; and

(4) to the best of our knowledge and belief,

(A) has the ability to make and communicate health care decisions to health care providers; and

(B) is acting voluntarily and not under undue influence.

Witness 1 Date: _____

Witness 2 Date: _____

NOTE: One witness may not be a relative (by blood, marriage, or adoption) of the individual signing this request, may not be entitled to a portion of the individual's estate on death, and may not own, operate, or be employed at a health care facility where the person is an individual or resident. If the individual is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

Sec. 13.55.070. Attending physician duties and authority. (a) The attending physician shall

(1) make the initial determination of whether an individual has a terminal disease, is capable, and has made the request for medication voluntarily;

(2) request that the individual demonstrate that the individual is a resident of this state;

(3) inform the individual of the

(A) individual's medical diagnosis;

(B) individual's prognosis;

(C) potential risks associated with taking the medication;

(D) probable result of taking the medication; and

(E) feasible alternatives, including comfort care, hospice care, and pain control;

(4) refer the individual to a consulting physician for medical confirmation of the diagnosis and for a determination that the individual is capable and acting voluntarily;

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1 (5) refer the individual for counseling if appropriate under
2 AS 13.55.090;

3 (6) recommend that the qualified individual notify the qualified
4 individual's next of kin;

5 (7) counsel the qualified individual about the importance of having
6 another person present when the qualified individual takes the medication prescribed
7 under this chapter and of not taking the medication in a public place;

8 (8) inform the qualified individual that the qualified individual has an
9 opportunity to rescind the request at any time and in any manner and offer the
10 qualified individual an opportunity to rescind the request at the end of the 15-day
11 waiting period under AS 13.55.030;

12 (9) immediately before dispensing or prescribing medication under this
13 chapter, verify that the qualified individual is making an informed decision;

14 (10) fulfill the requirements of AS 13.55.130 for medical record
15 documentation;

16 (11) ensure that all appropriate steps are carried out under this chapter
17 before dispensing or prescribing medication to enable a qualified individual to end the
18 qualified individual's life under this chapter; and

19 (12) if the attending physician has a current federal Drug Enforcement
20 Administration registration number and complies with applicable regulations, dispense
21 medication directly, including ancillary medications intended to facilitate the desired
22 effect or minimize the qualified individual's discomfort, or, with the qualified
23 individual's written consent,

24 (A) contact a pharmacist and inform the pharmacist of a
25 prescription for the medication; and

26 (B) deliver the written prescription personally or by mail to the
27 pharmacist who will dispense the medication to the qualified individual, the
28 attending physician, or an agent of the qualified individual who is expressly
29 identified as an agent by the qualified individual.

30 (b) Notwithstanding any other provision of law to the contrary, the attending
31 physician may sign the qualified individual's death certificate.

1 **Sec. 13.55.080. Confirmation by consulting physician.** Before an individual
 2 becomes a qualified individual under this chapter, a consulting physician shall
 3 examine the individual and the individual's relevant medical records, confirm in
 4 writing the attending physician's diagnosis that the individual is suffering from a
 5 terminal disease, and verify that the individual is capable, is acting voluntarily, and
 6 has made an informed decision.

7 **Sec. 13.55.090. Counseling referral.** If the attending physician or the
 8 consulting physician determines that an individual may be suffering from a psychiatric
 9 or psychological disorder or depression causing impaired judgment, either physician
 10 shall refer the individual for counseling, and the attending physician may not dispense
 11 or prescribe medication until the person performing the counseling determines that the
 12 individual is not suffering from depression or a psychiatric or psychological disorder
 13 causing impaired judgment.

14 **Sec. 13.55.100. Informed decision.** An attending physician may not dispense
 15 or prescribe medication unless the qualified individual has made an informed decision.
 16 Immediately before dispensing or prescribing medication under this chapter, the
 17 attending physician shall verify that the qualified individual is making an informed
 18 decision.

19 **Sec. 13.55.110. Family notification.** The attending physician may not deny a
 20 qualified individual's request for medication if the qualified individual declines or is
 21 unable to notify the qualified individual's next of kin.

22 **Sec. 13.55.120. Waiting periods.** An attending physician may not dispense
 23 medication or write a prescription for medication for a qualified individual unless
 24 more than 15 days have elapsed between the qualified individual's initial oral request
 25 and the writing of the prescription and more than 48 hours have elapsed between the
 26 qualified individual's written request and the writing of the prescription.

27 **Sec. 13.55.130. Medical record documentation requirements.** Before a
 28 qualified individual receives medication under this chapter, the medical record of the
 29 qualified individual must contain

30 (1) all oral requests by a qualified individual for medication under this
 31 chapter;

1 (2) all written requests by a qualified individual for medication under
2 this chapter;

3 (3) the attending physician's diagnosis, prognosis, and determination
4 that the individual is capable, is acting voluntarily, and has made an informed
5 decision;

6 (4) the consulting physician's diagnosis, prognosis, and verification that
7 the individual is capable, is acting voluntarily, and has made an informed decision;

8 (5) if counseling is performed, a report of the determinations made
9 during counseling and the outcome;

10 (6) the attending physician's offer to the qualified individual to rescind
11 the qualified individual's request at the time of the qualified individual's second oral
12 request under AS 13.55.030;

13 (7) a note by the attending physician indicating that all requirements
14 under this chapter have been met and indicating the steps taken to carry out the
15 request, including a statement describing the medication prescribed.

16 **Sec. 13.55.140. Effect on construction of wills and contracts.** A provision in
17 a will or a contract, whether written or oral, is not valid to the extent that the provision
18 requires, prohibits, imposes a condition on, or otherwise addresses whether an
19 individual may make or rescind a request for medication under this chapter.

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20 **Sec. 13.55.150. Immunity.** (a) A person is not subject to civil or criminal
21 liability or professional disciplinary action, including disciplinary action by a licensing
22 authority, for participating in good faith compliance with this chapter, including being
23 present when a qualified individual takes the prescribed medication to end the
24 qualified individual's life under this chapter.

25 (b) A professional organization or association or health care provider may not
26 subject a person to censure, discipline, suspension, loss of license, loss of privileges,
27 loss of membership, or other penalty for participating in or refusing to participate in
28 good faith compliance with this chapter.

29 (c) A request by an individual for, or provision by an attending physician of,
30 medication in good faith compliance with this chapter does not provide the sole basis
31 for the appointment of a guardian or conservator of the individual.

1 **Sec. 13.55.160. No duty to participate.** A health care provider is not under a
 2 duty, whether by contract, statute, or other legal requirement, to dispense medication,
 3 prescribe medication, or otherwise participate in the provision of medication to a
 4 qualified individual under this chapter. If a health care provider is unable or unwilling
 5 to carry out a qualified individual's request under AS 13.55.030 and the qualified
 6 individual transfers the qualified individual's care to another health care provider, the
 7 transferring health care provider shall provide to the other health care provider, at the
 8 qualified individual's request, a copy of the qualified individual's relevant medical
 9 records.

10 **Sec. 13.55.170. Prohibition against participation; sanctions.** (a)
 11 Notwithstanding another provision of law to the contrary, a health care provider may
 12 prohibit another health care provider from participating in this chapter on the premises
 13 of the prohibiting health care provider if the prohibiting health care provider notifies
 14 the other health care provider of the prohibiting health care provider's policy regarding
 15 not participating in this chapter. This subsection does not prevent a health care
 16 provider from providing health care services to an individual if the health care services
 17 do not constitute participating in this chapter.

18 (b) Notwithstanding AS 13.55.150 and 13.55.160, a health care provider may
 19 sanction another health care provider as follows if the sanctioning health care provider
 20 notifies the sanctioned health care provider before participating under this chapter that
 21 the sanctioning health care provider prohibits participating in this chapter:

22 (1) loss of privileges, loss of membership, or other sanction provided
 23 under the bylaws, policies, or procedures of the sanctioning health care provider if the
 24 sanctioned health care provider is a member of the sanctioning health care provider's
 25 medical staff and is participating in this chapter while on the health care facility
 26 premises of the sanctioning health care provider; in this paragraph, "health care
 27 facility premises" does not include the private medical office of the sanctioned health
 28 care provider even if located on the health care facility premises of the sanctioning
 29 health care provider;

30 (2) termination of lease or other contract or imposition of nonmonetary
 31 remedies provided by the lease or other contract if the sanctioned health care provider

1 is participating in this chapter while on the premises of the sanctioning health care
 2 provider or on property that is owned by or under the direct control of the sanctioning
 3 health care provider; in this paragraph, "remedies" does not include the loss or
 4 restriction of medical staff privileges or exclusion from a provider panel; or

5 (3) termination of a contract or imposing other nonmonetary remedies
 6 provided by a contract if the sanctioned health care provider is participating in this
 7 chapter while acting in the course and scope of the sanctioned health care provider's
 8 capacity as an employee, except as a member of the sanctioning health care provider's
 9 medical staff, or independent contractor of the sanctioning health care provider; this
 10 paragraph does not prevent

11 (A) a health care provider from participating in this chapter
 12 while acting outside the course and scope of the health care provider's capacity
 13 as an employee or independent contractor; or

14 (B) an individual from contracting with the individual's
 15 attending physician or consulting physician to act outside the course and scope
 16 of the physician's capacity as an employee or independent contractor of the
 17 sanctioning health care provider.

18 (c) A health care provider who imposes sanctions under (b) of this section shall
 19 follow all procedures that are provided under an applicable contract, the applicable
 20 terms of employment, or law for imposing the sanctions.

21 (d) Suspension or termination of staff membership or privileges under (b) of
 22 this section is not reportable under AS 08.64.336.

23 (e) In this section,

24 (1) "notifies" means delivers a written statement to the health care
 25 provider specifically informing the health care provider before the health care
 26 provider's participation in this chapter of the sanctioning health care provider's policy
 27 about participation in activities covered by this chapter;

28 (2) "participating in this chapter" means performing the duties of an
 29 attending physician under AS 13.55.070, the function of a consulting physician under
 30 AS 13.55.080, or the counseling function under AS 13.55.090; in this paragraph,
 31 "performing the duties" does not include

(A) making an initial determination that an individual has a terminal disease and informing the individual of the medical prognosis;

(B) providing information about this chapter to an individual at the request of the individual;

(C) providing an individual with a referral to another physician at the request of the individual; or

(D) contracting with the individual's attending physician or consulting physician to act outside the course and scope of the health care provider's capacity as an employee or independent contractor of a sanctioning health care provider.

Sec. 13.55.180. Criminal penalties. (a) A person commits the crime of abuse of life termination process if the person, with the intent to cause the individual's death or knowing that the death of the individual is substantially certain to result,

(1) without the authorization of the individual, falsely makes, completes, or alters a request for medication or conceals or destroys a rescission of the individual's request; or

(2) exerts undue influence on an individual to request medication for the purpose of ending the individual's life or to destroy a rescission of the individual's request.

(b) Abuse of life termination process is a class A felony and may be punished as provided in AS 12.55.

(c) This chapter does not prevent the imposition of criminal penalties that apply under another law for conduct that is inconsistent with this chapter.

Sec. 13.55.190. Civil penalties. This chapter does not limit liability for civil damages resulting from a person's negligent conduct or intentional misconduct.

Sec. 13.55.200. Claims for costs incurred. A governmental entity that incurs expenses that result from the termination by a qualified individual of the qualified individual's life under this chapter in a public place may file a claim against the estate of the individual to recover the costs and attorney fees related to enforcing the claim.

Sec. 13.55.210. Duties of department. (a) The department shall annually review a sample of records maintained under this chapter.

1 (b) After dispensing medication under this chapter, a health care provider shall
2 file with the department a copy of the record of dispensing the medication.

3 (c) The department shall adopt regulations under AS 44.62 (Administrative
4 Procedure Act) to facilitate the collection of information about compliance with this
5 chapter. The information collected is not a public record under AS 40.25.100, and the
6 department may not make the information available for inspection by the public.

7 (d) The department shall generate and make available to the public an annual
8 statistical report of the information collected under (c) of this section. The statistical
9 report may not disclose information that is confidential under (c) of this section, but
10 shall present the information in a manner that prevents the identification of particular
11 persons.

12 **Sec. 13.55.220. Construction of chapter.** (a) This chapter may not be
13 construed to authorize or require a health care provider to provide health care contrary
14 to generally accepted health care standards applicable to the health care provider.

15 (b) This chapter may not be construed to authorize a physician or another
16 person to end an individual's life by lethal injection, mercy killing, or active
17 euthanasia. An action allowed by this chapter is an affirmative defense to a criminal
18 charge of homicide, murder, manslaughter, criminally negligent homicide, suicide,
19 assisted suicide, mercy killing, or euthanasia under the law of this state.

20 **Sec. 13.55.230. Insurance or annuity policies; contracts.** Notwithstanding
21 AS 21.45.250 or another provision to the contrary, a person may not condition the
22 sale, procurement, issuance, rate, delivery, issuance for delivery, or other aspect of a
23 life, health, or accident insurance or annuity policy or another contract on the making
24 or rescission of a request by a qualified individual for medication under this chapter.

25 **Sec. 13.55.240. Coordination with other law.** A written or oral request for
26 medication under this chapter is not an advance health care directive under AS 13.52,
27 and AS 13.52 does not apply to an activity allowed by this chapter.

28 **Sec. 13.55.900. Definitions.** In this chapter, unless the context indicates
29 otherwise,

30 (1) "adult" means an individual who is 18 years of age or older;

31 (2) "attending physician" means the physician who has primary

responsibility for the care of the individual and treatment of the individual's terminal disease;

(3) "capable" means that an individual has the ability to make and communicate health care decisions to health care providers; in this paragraph, "communicate" includes communication through a person familiar with the individual's manner of communicating if the person is available;

(4) "consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis about the individual's disease;

(5) "counseling" means consultation as necessary between a psychiatrist or psychologist and an individual to determine if the individual is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment;

(6) "department" means the Department of Health and Social Services;

(7) "health care facility" means a private, municipal, or state hospital; independent diagnostic testing facility; primary care outpatient facility; skilled nursing facility; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility; ambulatory surgical facility; Alaska Pioneers' Home or Alaska Veterans' Home administered by the department under AS 47.55; correctional facility owned or administered by the state; private, municipal, or state facility employing one or more public health nurses; and long-term care facility;

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

(9) "informed decision" means a decision that is based on an appreciation of the relevant facts and that is made after the attending physician fully informs a qualified individual of the

(A) qualified individual's medical diagnosis;

(B) qualified individual's prognosis;

(C) potential risks associated with taking the medication to be

- 1 prescribed;
- 2 (D) probable result of taking the medication to be prescribed;
- 3 and
- 4 (E) feasible alternatives, including comfort care, hospice care,
- 5 and pain control;
- 6 (10) "medically confirmed" means that a consulting physician who has
- 7 examined the individual's relevant medical records has confirmed the medical opinion
- 8 of the attending physician;
- 9 (11) "medication" means medication to end a qualified individual's life
- 10 under this chapter;
- 11 (12) "physician" means a doctor of medicine or osteopathy who is
- 12 licensed under AS 08.64 to practice medicine or osteopathy;
- 13 (13) "prescription" means a prescription for medication to end a
- 14 qualified individual's life under this chapter;
- 15 (14) "qualified individual" means an individual who is qualified under
- 16 AS 13.55.010 to end the individual's life under this chapter;
- 17 (15) "request" means a request under AS 13.55.030;
- 18 (16) "terminal disease" means an incurable and irreversible disease
- 19 that has been medically confirmed and that will, within reasonable medical judgment,
- 20 produce death within six months;
- 21 (17) "undue influence" means the control of an individual by a person
- 22 who stands in a position of trust or confidence to exploit wrongfully the trust,
- 23 dependency, or fear of the individual to gain control over the decision making of the
- 24 individual.

25 * **Sec. 4.** The uncoded law of the State of Alaska is amended by adding a new section to

26 read:

27 **APPLICABILITY.** AS 13.55, enacted by sec. 3 of this Act, applies to a contract, will,

28 or life, health, or accident insurance or annuity policy if the contract, will, or policy is

29 delivered or issued for delivery on or after the effective date of sec. 3 of this Act.

30 * **Sec. 5.** The uncoded law of the State of Alaska is amended by adding a new section to

31 read:

- 1 TRANSITION: REGULATIONS. The Department of Health and Social Services may
2 adopt regulations authorized by AS 13.55, enacted by sec. 3 of this Act. The regulations take
3 effect under AS 44.62 (Administrative Procedure Act), but not before January 1, 2016.
- 4 * **Sec. 6.** Section 5 of this Act takes effect immediately under AS 01.10.070(c).
- 5 * **Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect January 1, 2016.



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Alaska Statutes.

Title 11. Criminal Law

Chapter 41. Offenses Against the Person

Section 100. Murder in the First Degree.

previous: [Chapter 41.](#) Offenses Against the Person

next: [Section 110.](#) Murder in the Second Degree.

AS 11.41.100. Murder in the First Degree.

(a) A person commits the crime of murder in the first degree if

(1) with intent to cause the death of another person, the person

(A) causes the death of any person; or

(B) compels or induces any person to commit suicide through duress or deception;

(2) the person knowingly engages in conduct directed toward a child under the age of 16 and the person with criminal negligence inflicts serious physical injury on the child by at least two separate acts, and one of the acts results in the death of the child;

(3) acting alone or with one or more persons, the person commits or attempts to commit a sexual offense against or kidnapping of a child under 16 years of age and, in the course of or in furtherance of the offense or in immediate flight from that offense, any person causes the death of the child; in this paragraph, "sexual offense" means an offense defined in AS [11.41.410](#) - [11.41.470](#);

(4) acting alone or with one or more persons, the person commits or attempts to commit criminal mischief in the first degree under AS [11.46.475](#) and, in the course of or in furtherance of the offense or in immediate flight from that offense, any person causes the death of a person other than one of the participants; or

(5) acting alone or with one or more persons, the person commits terroristic threatening in the first degree under AS [11.56.807](#) and, in the course of or in furtherance of the offense or in immediate flight from that offense, any person causes the death of a person other than one of the participants.

(b) Murder in the first degree is an unclassified felony and is punishable as provided in AS [12.55](#).

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Note to HTML Version:

This version of the Alaska Statutes is current through December, 2007. The Alaska Statutes were automatically converted to HTML from a plain text format. Every effort has been made to ensure their accuracy, but this can not be guaranteed. *If it is critical that the precise terms of the Alaska Statutes be known, it is recommended that more formal sources be consulted.* For statutes adopted after the effective date of these statutes, see, [Alaska State Legislature](#) If any errors are found, please e-mail Touch N' Go systems at [E-mail](#). We hope you find this information useful.

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[Resources](#) » [Medical Ethics](#) » [AMA Code of Medical Ethics](#) » [Opinion 2.211](#)

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 (eg, 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)

Issued June 1994 based on the reports "[Decisions Near the End of Life](#)," adopted June 1991, and "[Physician-Assisted Suicide](#)," adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.

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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)

Issued June 1994 based on the report "[Decisions Near the End of Life](#)," adopted June 1991 (JAMA. 1992; 267: 2229-2233); Updated June 1996



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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

Nina Shapiro



Maryanne Clayton with her son, Eric, in the Fred Hutch waiting room: "I just kept going."

Details:

- Study: [Why Now?](#) Timing and Circumstances of Hastened Deaths
- [Dilemmas by caretakers](#) and other Oregon studies
- [Stats on people](#) who have used Oregon's Death with Dignity law.
- [Harvard professor Nicholas Christakis](#) looking at the accuracy of prognosis.
- [JAMA study](#) examining the accuracy of prognosis.

UPDATE: ["It Felt Like the Big One"](#)

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

That was almost four years ago.

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

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

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

Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

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

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

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

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

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

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

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

Sadly, Christakis' research has shown that his mother was an exception. In 2000, Christakis published a study in the *British Medical Journal* that followed 500 patients admitted to hospice programs in Chicago. He found that only 20 percent of the patients died approximately when their doctors had predicted. Unfortunately, most died *sooner*. "By and large, the physicians were overly optimistic," says Christakis.

In the world of hospice care, this finding is disturbing because it indicates that many patients aren't being referred early enough to take full advantage of services that might ease their final months. "That's what has frustrated hospices for decades," says Wayne McCormick, medical director of Providence Hospice of Seattle, explaining that hospice staff frequently don't get enough time with patients to do their best work.

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

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

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

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

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

X 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.

"There's always a little triumph," Bud chimes in. "I made it for another day."

It's been like this for years. A decade ago, after clearing a jungle of blackberries off a lot he had bought adjacent to his secluded ranch house south of Tacoma, Bud came down with a case of pneumonia. "Well, no wonder he's so sick," Heidi recalls the chief of medicine saying at the hospital where he was brought. "He's in congestive heart failure."

Then 75, "he became old almost overnight," Heidi says. Still, Bud was put on medications that kept him going—long enough to have a stroke five years later, kidney failure the year after that, and then the onset of severe chest pain known as angina. "It was scary," says Heidi, who found herself struggling at 3 a.m. to find Bud's veins so she could inject the morphine that the doctor had given Bud for the pain. Heidi is a petite blond nurse with a raucous laugh. She's 20 years younger than her husband, whom she met at a military hospital, and shares his cigar-smoking habit. Bud was a high-flying psychiatrist in the '80s when he became the U.S. Assistant Secretary of Defense, responsible for all Armed Forces health activities.

After his onslaught of illnesses, Bud says, his own prognosis for himself was grim. "Looking at a patient who had what I had, I would have been absolutely convinced that my chance of surviving more than a few months was very slim indeed."

Bud's doctor eventually agreed, referring him to hospice with a prognosis of six months. That was a year and a half ago. Bud, who receives visits from hospice staff at home, has since not gotten much worse or much better. Although he has trouble walking and freely speaks of himself as "dying," he looks like any elderly grandfather, sitting in a living room decorated with mounted animal heads, stuffing tobacco into his pipe and chatting about his renewed love of nature and the letter he plans to write to Barack Obama with his ideas for improving medical care. Despite his ill health, he says the past few years have been a wonderful, peaceful period for him—one that physician-assisted suicide, which he opposes, would have cut short.

A year after he first began getting visits from the Franciscan Hospice, the organization sent Dr. Bruce Brazina to Mayer's home to certify that he was still really dying. It's something Brazina says he does two to four times a week as patients outlive their six-month prognoses. Sometimes, Brazina says, patients have improved so much he can no longer forecast their imminent death. In those cases, "we take them off service"—a polite way of saying that patients are kicked off hospice care, a standard procedure at all hospices due to Medicare rules. But Brazina found that Mayer's heart condition was still severe enough to warrant another six-month prognosis, which the retired doctor has just about outlived again.

"It's getting to the point where I'm a little embarrassed," Mayer says.

What's going on with him is a little different than what happened to Randall Curtis' patients or to Maryanne Clayton. Rather than reviving from near death or surviving a disease that normally kills quickly, Mayer is suffering from chronic diseases that typically follow an unpredictable course. "People can be very sick but go along fine and stable," Brazina explains. "But then they'll have an acute attack." The problem for prognosis is that doctors have no way of knowing when those attacks will be or whether patients will be able to survive them.

When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the *Journal of the American Medical Association*.

Given these two studies, it's no surprise that in Oregon some people who got a prescription for lethal medication on the basis of a six-month prognosis have lived longer. Of the 341 people who put themselves to death as of 2007 (the latest statistics available), 17 did so between six months and two years after getting their prescription, according to state epidemiologist Katrina Hedberg. Of course, there's no telling how long any of the 341 would have lived had they not killed themselves. The Department of Health does not record how long people have lived after getting prescriptions they do not use, so there's no telling, either, whether those 200 people outlived their prognosis. Compassion & Choices of Oregon, which independently keeps data on the people whom it helps navigate the law, says some have lived as long as eight years after first inquiring about the process (although it doesn't track whether they ever received the medication and a six-month prognosis).

The medical field's spotty track record with prognosis is one reason Harborview's Curtis says he is not comfortable participating in physician-assisted suicide. It's one thing to make a six-month prognosis that will allow patients access to hospice services, he says, and quite another to do so for the purpose of enabling patients to kill themselves. "The consequences of being wrong are pretty different," he says.

Under the law, doctors and institutions are free to opt out, and several Catholic institutions like Providence Hospice of Seattle have already said they will do so. Medical director McCormick finds the idea of patients killing themselves particularly troubling because "you can't predict what's going to happen or who's going to show up near the end of your life." He says he has watched people make peace with loved ones or form wonderful new connections. He's preparing a speech in case patients ask about the new law: "I will stop at nothing to ensure that you're comfortable. I won't shorten your life, but I will make it as high-quality as possible."

Thomas Preston, a retired cardiologist who serves as medical director of Compassion & Choices of Washington, says he has in mind a different kind of speech: "You have to understand that this prognosis could be wrong. You may have more than six months to live. You may be cutting off some useful life."

He also says he will advise doctors to be more conservative than the law allows. "If you think it's going to be six months, hold off on it [writing a prescription]—just to be sure." Instead, he'll suggest that doctors wait until they think a patient has only one or two months to live.

The UW's Farber leans toward a different approach. While he says he hasn't yet decided whether he himself will write fatal prescriptions, he plans at least to refer patients to others who will. Given that prognostic precision is impossible, he says, "I personally just let go of the six months." Instead, he says he would try to meet what he sees as the "spirit of the law" by assessing that someone is "near" the end of their life, so that he could say to them, "You're really sick and you're not going to get better."

Knowing exactly when someone is going to die, he continues, is not as important as knowing when someone "has reached the point where their life is filled with so much suffering that they don't want to be alive."

Randy Niedzielski reached that point in the summer of 2006, according to his wife Nancy. Diagnosed with brain cancer in 2000, the onetime Lynnwood property manager had been through several rounds of chemotherapy and had lived years longer than the norm. But the cancer cells had come back in an even more virulent form and had spread to his muscle system. "He would have these bizarre muscle contractions," Nancy recalls. "His feet would go into a cone shape. His arms would twist in weird angles." Or his chest would of its own volition go into what Nancy calls a "tent position," rising up from his arms. "He'd just be screaming in pain."

Randy would have liked to move to Oregon to take advantage of the Death With Dignity Act there, according to Nancy. But he didn't have time to establish residency as required. That was about six weeks before his death.

Nancy, who has become an advocate for physician-assisted suicide, says that typically people are only weeks or days away from death when they want to kill themselves. Oregon's experience with people hanging onto their medicine for so long, rather than rushing to use it as soon as they get a six-month prognosis, bears this out, she says: "A patient will know when he's at the very end of his life. Doctors don't need to tell you."

Sometimes, though, patients are not so near the end of their life when they're ready to die. University of Washington bioethics professor Helene Starks and Anthony Back, director of palliative care at the Seattle Cancer Care Alliance, are two of several researchers who in 2005 published a study that looked at 26 patients who "hastened" their death. A few were in Oregon, but most were in Washington, and they brought about their own demise mostly either by refusing to eat or drink or by obtaining medication illegally, according to Back and Starks. Three of these patients had "well over six months" of remaining life, Starks says, perhaps even years.

The paper, published in the *Journal of Pain and Symptom Management*, quotes from an interview with one of these patients before she took her life. Suffering from a congenital malformation of the spine, she said it had reached the point that her spine or neck could be injured even while sitting. "I'm in an invisible prison," she continued. "Every move I make is an effort. I can't live like this because of the constant stress, unbearable pain, and the knowledge that it will never be any better."

Under the law, she would not be eligible for lethal medication. Her case was not considered "terminal," according to the paper. But for patients like her, the present is still unbearable. Former governor Booth Gardner, the state's most visible champion of physician-assisted suicide, would have preferred a law that applied to everyone who viewed their suffering this way, regardless of how long they were expected to live. He told *The New York Times Magazine*, for a December 2007 story, that the six-month rule was a compromise meant to help insure the passage of Initiative 1000. Gardner has Parkinson's disease, and now can talk only haltingly by phone. In an interview he explained that he has been housebound of late due to several accidents related to his lack of balance.

Researchers who have interviewed patients, their families, and their doctors have found, however, that pain is not the central issue. Fear of future suffering looms larger, as does people's desire to control their own end.

"It comes down to more existential issues," says Back. For his study of Washington and Oregon patients, he interviewed one woman who had been a successful business owner. "That's what gave her her zest for life," Back says, and without it she was ready to die.

Maryanne Clayton says she has never reached that point. Still, she voted for the Death With Dignity Act. "Why force me to suffer?" she asks, adding that if she were today in as much pain as she was when first diagnosed with lung cancer, she might consider taking advantage of the new law. But for now, she still enjoys life. Her 35-year-old son Eric shares a duplex with her in the Tri-Cities. They like different food. But every night he cooks dinner on his side, she cooks dinner on her side, and they eat together. And one more day passes that proves her prognosis wrong.

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Colorado rejects right-to-die legislation

AP By IVAN MORENO
February 7, 2015 12:03 AM

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option to seek
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ending their lives,
concluding a long
day of emotional
testimony from
more than 100 people.

For one lawmaker who voted no, the issue was personal.
Tearfully telling her colleagues she was a cancer survivor,
Democratic Rep. Dianne Primavera recalled how a doctor told
her she wouldn't live more than five years.

But she found a doctor who gave her a different opinion.

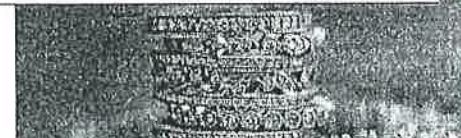
"And he took me in his care, and I am here today 28 years later,"
she said.

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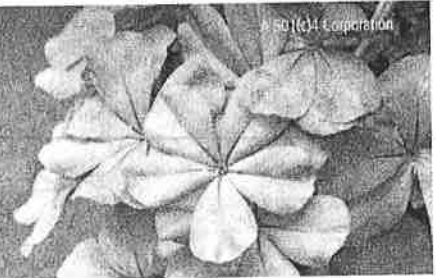
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ASSISTED SUICIDE BATTLE IN COURT



Click on the photo to find out more about the battle to prevent assisted suicide from becoming legal in Montana

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Margaret Dore
Washington State: Vote "Yes" on SB 5919

VOICES AGAINST ASSISTED SUICIDE AND EUTHANASIA

- "I was afraid to leave my husband alone"
- "This is how society will pay you back? With non-voluntary or involuntary euthanasia?"
- "It wasn't the father saying that he wanted to die"
- "He made the mistake of asking for information about assisted suicide"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "Mild stroke led to mother's forced starvation"

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MAJOR TOPICS

MONDAY, MAY 5, 2014

Arizona Strengthens its Law Against Assisted Suicide

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

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

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

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

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

Brewer signed the bill on Wednesday.

Labels: assisted suicide

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MARGARET DORE BLOG



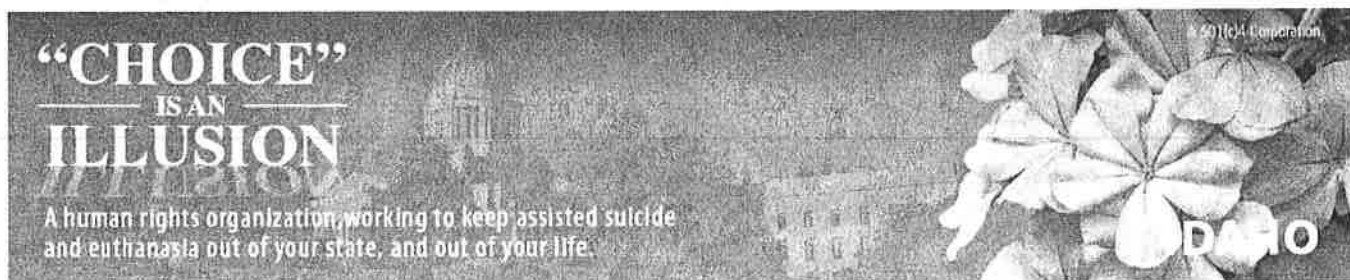
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WELCOME

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

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

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



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MONDAY, JULY 4, 2011

Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

VOICES AGAINST ASSISTED SUICIDE AND EUTHANASIA

- "I was afraid to leave my husband alone"
- "In Oregon, the only help my patient received was a lethal prescription, intended to kill him."
- "It wasn't the father saying that he wanted to die"
- "He made the mistake of asking for information about assisted suicide"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "Mild stroke led to mother's forced starvation"

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

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

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

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

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

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

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- New Hampshire Defeats Assisted Suicide Again
- Hawaii AG Rejects Claim That Assisted Suicide is "Already Legal"
- A Legal Analysis: The Oregon & Washington Physician-Assisted Suicide Laws
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- Idaho Strengthens Law Against Assisted-Suicide

[1] Bill Status S1070, entry for April 5, 2011.

[2] See here for bill text.

[3] Then existing civil law included *Cramer v. Slater*, 146 Idaho 868, 878, 204 P.3d 508 (2009), which states that doctors "can be held liable for [a] patient's suicide." Existing law also included a common law crime in which an "aider and abettor" of suicide is guilty of murder. Assisted suicide can also be statutorily charged as murder. See Margaret K. Dore, "Aid in Dying: Not Legal in Idaho; Not About Choice," *The Advocate*, official publication of the Idaho State Bar, Vol. 52, No. 9, pages 18-20, September 2010 (describing existing law prior to the new bill's enactment); and The Hon. Robert E. Bakes, Retired Chief Justice of the Idaho Supreme Court, Letter to the Editor, "Legislature rejected euthanasia," *The Advocate*, September 2010 ("In both the Idaho criminal statutes as well as I.C.6-1012, the Idaho legislature has rejected physician-assisted suicide"). Entire issue, available here:
<http://www.isb.idaho.gov/pdf/advocate/issues/adv10sep.pdf>

[4] Revised Statement of Purpose, RS20288.

[5] Ian Dowbiggin, A CONCISE HISTORY OF EUTHANASIA: LIFE, DEATH, GOD AND MEDICINE, Rowman & Littlefield Publishers,

Georgia General Assembly

2011-2012 Regular Session - HB 1114 Homicide; offering to assist in commission of suicide; repeal certain provisions

Sponsored By

(1) Setzler, Ed 35th	(2) Golick, Rich 34th	(3) Ramsey, Matt 72nd
(4) Pak, B.J. 102nd	(5) Lindsey, Edward 54th	(6) Rice, Tom 51st

Sponsored In Senate By

Ligon, Jr., William 3rd

Committees

HC: Judiciary Non-Civil

SC: Judiciary

First Reader Summary

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

Status History

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

Footnotes

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

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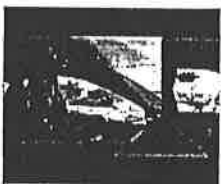
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La. assisted-suicide ban strengthened

The Associated Press

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

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

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

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

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

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Oregon Revised Statute

Chapter 127

Contact Us

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

dwda.info@state.or.us

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

127.800 s.1.01. Definitions.

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

- (1) "Adult" means an individual who is 18 years of age or older.
- (2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- (3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
- (4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- (5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- (6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.
- (7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
 - (a) His or her medical diagnosis;
 - (b) His or her prognosis;
 - (c) The potential risks associated with taking the medication to be prescribed;
 - (d) The probable result of taking the medication to be prescribed; and
 - (e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.
- (8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.
- (9) "Patient" means a person who is under the care of a physician.
- (10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.
- (11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.
- (12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

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

(Section 2)

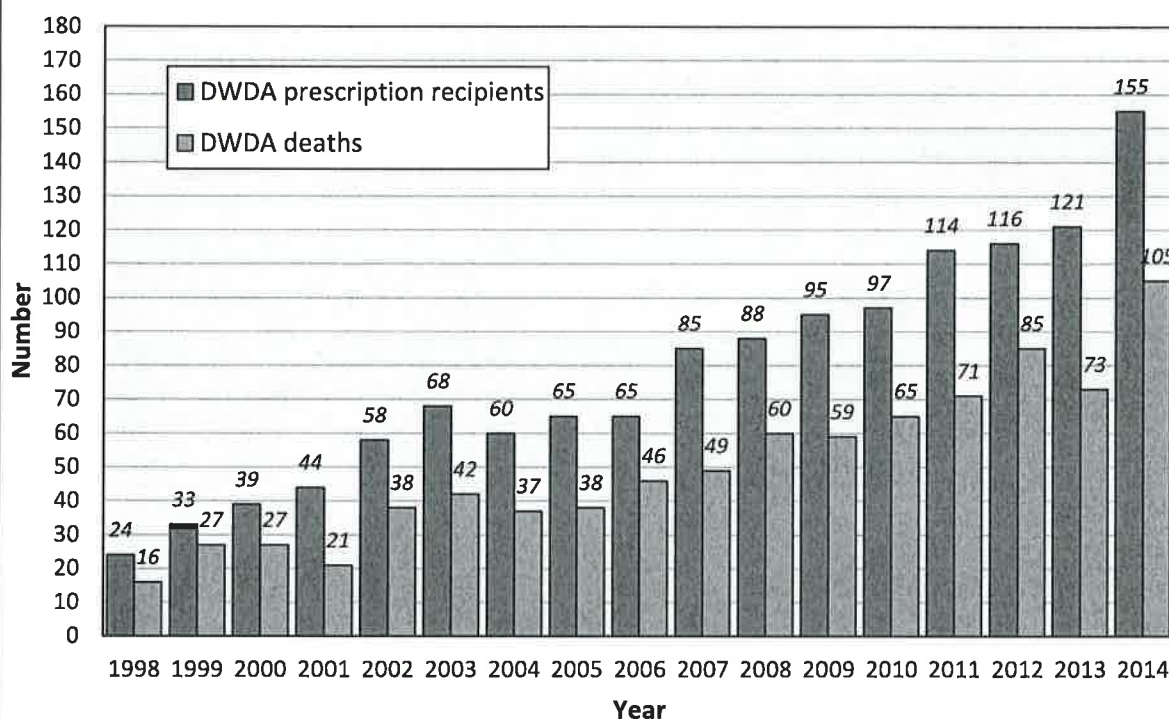
127.805 s.2.01. Who may initiate a written request for medication.

- (1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and

Oregon's Death with Dignity Act--2014

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. The key findings from 2014 are presented below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of February 2, 2015. For more detail, please view the figures and tables on our web site: <http://www.healthoregon.org/dwd>.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2014



*As of February 2, 2015

- As of February 2, 2015, prescriptions for lethal medications were written for 155 people during 2014 under the provisions of the DWDA, compared to 121 during 2013 (Figure 1). At the time of this report, 105 people had died from ingesting the medications prescribed during 2014 under DWDA. This corresponds to 31.0 DWDA deaths per 10,000 total deaths.¹

¹ Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2013 (33,931), the most recent year for which final death data are available.

- Since the law was passed in 1997, a total of 1,327 people have had DWDA prescriptions written and 859 patients have died from ingesting medications prescribed under the DWDA.
- Of the 155 patients for whom DWDA prescriptions were written during 2014, 94 (60.6%) ingested the medication; all 94 patients died from ingesting the medication. No patients that ingested the medication regained consciousness.
- Eleven patients with prescriptions written during the previous years (2012 and 2013) died after ingesting the medication during 2014.
- Thirty-seven of the 155 patients who received DWDA prescriptions during 2014 did not take the medications and subsequently died of other causes.
- Ingestion status is unknown for 24 patients who were prescribed DWDA medications in 2014. For all of the 24 patients, both death and ingestion status are pending (Figure 2).
- Of the 105 DWDA deaths during 2014, most (67.6%) were aged 65 years or older. The median age at death was 72 years. As in previous years, decedents were commonly white (95.2%) and well-educated (47.6% had a least a baccalaureate degree).
- While most patients had cancer, the percent of patients with cancer in 2014 (68.6%) was lower than in previous years (79.4%), and the percent with amyotrophic lateral sclerosis (ALS) was higher (16.2% in 2014, compared to 7.2% in previous years).
- While similar to previous years that most patients had cancer (68.6%), this percent was lower than the average for previous years (79.4%); in contrast, the percent of patients with ALS was higher in 2014 (16.2%) than in previous years (7.2%).
- Most (89.5%) patients died at home, and most (93.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, all (100.0%) had some form of health care insurance, although the number of patients who had private insurance (39.8%) was lower in 2014 than in previous years (62.9%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (60.2% compared to 35.5%).
- As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (86.7%), and loss of dignity (71.4%).
- Three of the 105 DWDA patients who died during 2014 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for 14 patients (13.9%) during 2014 compared to 15.9% in previous years.

- A procedure revision was made in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 20 of the 105 DWDA deaths during 2014. Among those 20 patients, time from ingestion until death ranged from eleven minutes to one hour.
- Eighty-three physicians wrote 155 prescriptions during 2014 (1-12 prescriptions per physician).
- During 2014, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

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

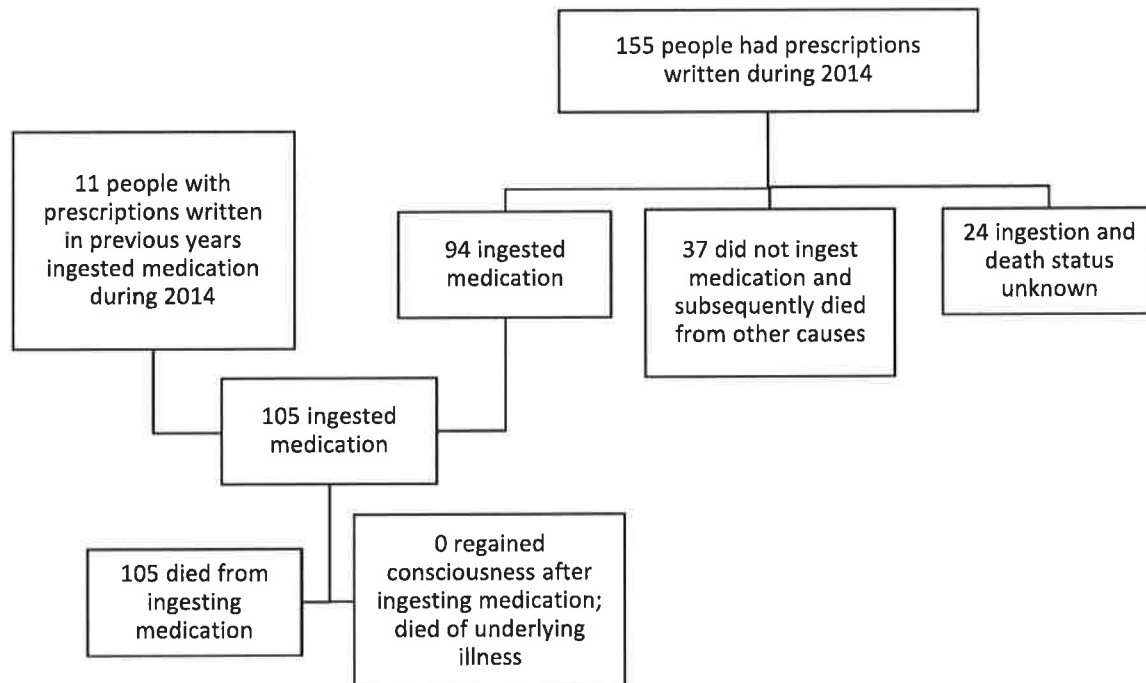


Table 1. Characteristics and end-of-life care of 857 DWDA patients who have died from ingesting a lethal dose of medication as of February 2, 2015, by year, Oregon, 1998-2014

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Sex	N (%) ¹	N (%) ¹	N (%) ¹
Male (%)	56 (53.3)	397 (52.7)	453 (52.7)
Female (%)	49 (46.7)	357 (47.3)	406 (47.3)
Age at death (years)			
18-34 (%)	1 (1.0)	6 (0.8)	7 (0.8)
35-44 (%)	2 (1.9)	16 (2.1)	18 (2.1)
45-54 (%)	3 (2.9)	58 (7.7)	61 (7.1)
55-64 (%)	28 (26.7)	156 (20.7)	184 (21.4)
65-74 (%)	29 (27.6)	218 (28.9)	247 (28.8)
75-84 (%)	23 (21.9)	206 (27.3)	229 (26.7)
85+ (%)	19 (18.1)	94 (12.5)	113 (13.2)
Median years (range)	72 (29-96)	71 (25-96)	71 (25-96)
Race			
White (%)	100 (95.2)	731 (97.3)	831 (97.1)
African American (%)	0 (0.0)	1 (0.1)	1 (0.1)
American Indian (%)	0 (0.0)	2 (0.3)	2 (0.2)
Asian (%)	1 (1.0)	8 (1.1)	9 (1.1)
Pacific Islander (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	2 (1.9)	1 (0.1)	3 (0.4)
Two or more races (%)	1 (1.0)	2 (0.3)	3 (0.4)
Hispanic (%)	1 (1.0)	5 (0.7)	6 (0.7)
Unknown	0	3	3
Marital Status			
Married (%) ²	48 (45.7)	347 (46.2)	395 (46.1)
Widowed (%)	26 (24.8)	172 (22.9)	198 (23.1)
Never married (%)	6 (5.7)	63 (8.4)	69 (8.1)
Divorced (%)	25 (23.8)	169 (22.5)	194 (22.7)
Unknown	0	3	3
Education			
Less than high school (%)	6 (5.7)	45 (6.0)	51 (6.0)
High school graduate (%)	23 (21.9)	164 (21.9)	187 (21.9)
Some college (%)	26 (24.8)	198 (26.4)	224 (26.2)
Baccalaureate or higher (%)	50 (47.6)	342 (45.7)	392 (45.9)
Unknown	0	5	5
Residence			
Metro counties (%) ³	46 (44.7)	315 (41.9)	361 (42.3)
Coastal counties (%)	6 (5.8)	57 (7.6)	63 (7.4)
Other western counties (%)	40 (38.8)	325 (43.3)	365 (42.7)
East of the Cascades (%)	11 (10.7)	54 (7.2)	65 (7.6)
Unknown	2	3	5
End of life care			
Hospice			
Enrolled (%) ⁴	93 (93.0)	654 (90.0)	747 (90.3)
Not enrolled (%)	7 (7.0)	73 (10.0)	80 (9.7)
Unknown	5	27	32
Insurance			
Private (%) ⁵	37 (39.8)	452 (62.9)	489 (60.2)
Medicare, Medicaid or Other Governmental (%)	56 (60.2)	255 (35.5)	311 (38.3)
None (%)	0 (0.0)	12 (1.7)	12 (1.5)
Unknown	12	35	47

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Underlying illness			
Malignant neoplasms (%)	72 (68.6)	596 (79.4)	668 (78.0)
Lung and bronchus (%)	16 (15.2)	139 (18.5)	155 (18.1)
Breast (%)	7 (6.7)	57 (7.6)	64 (7.5)
Colon (%)	5 (4.8)	49 (6.5)	54 (6.3)
Pancreas (%)	9 (8.6)	47 (6.3)	56 (6.5)
Prostate (%)	2 (1.9)	33 (4.4)	35 (4.1)
Ovary (%)	5 (4.8)	28 (3.7)	33 (3.9)
Other (%)	28 (26.7)	243 (32.4)	271 (31.7)
Chronic lower respiratory disease (%)	4 (3.8)	34 (4.5)	38 (4.4)
Heart Disease (%)	3 (2.9)	14 (1.9)	17 (2.0)
HIV/AIDS (%)	0 (0.0)	9 (1.2)	9 (1.1)
Other illnesses (%)⁶	9 (8.6)	44 (5.9)	53 (6.2)
Unknown	0	3	3
DWDA process			
Referred for psychiatric evaluation (%)	3 (2.9)	44 (5.9)	47 (5.5)
Patient informed family of decision (%) ⁷	95 (90.5)	634 (93.6)	729 (93.2)
Patient died at			
Home (patient, family or friend) (%)	94 (89.5)	716 (95.3)	810 (94.6)
Long term care, assisted living or foster care facility (%)	8 (7.6)	29 (3.9)	37 (4.3)
Hospital (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	3 (2.9)	5 (0.7)	8 (0.9)
Unknown	0	3	3
Lethal medication			
• Secobarbital (%)	63 (60.0)	403 (53.4)	466 (54.2)
• Pentobarbital (%)	41 (39.0)	344 (45.6)	385 (44.8)
Other (%) ⁸	1 (1.0)	7 (0.9)	8 (0.9)
End of life concerns⁹			
	(N=105)	(N=754)	(N=859)
Losing autonomy (%)	96 (91.4)	686 (91.5)	782 (91.5)
Less able to engage in activities making life enjoyable (%)	91 (86.7)	667 (88.9)	758 (88.7)
Loss of dignity (%) ¹⁰	75 (71.4)	504 (80.6)	579 (79.3)
Losing control of bodily functions (%)	52 (49.5)	376 (50.1)	428 (50.1)
Burden on family, friends/caregivers (%)	42 (40.0)	300 (40.0)	342 (40.0)
Inadequate pain control or concern about it (%)	33 (31.4)	178 (23.7)	211 (24.7)
Financial implications of treatment (%)	5 (4.8)	22 (2.9)	27 (3.2)
Health-care provider present¹¹			
	(N=105)	(N=684)	(N=789)
When medication was ingested ¹²			
Prescribing physician	14	119	133
Other provider, prescribing physician not present	6	238	244
No provider	4	76	80
Unknown	81	251	332
At time of death			
Prescribing physician (%)	14 (13.9)	107 (15.9)	121 (15.7)
Other provider, prescribing physician not present (%)	6 (5.9)	263 (39.2)	269 (34.8)
No provider (%)	81 (80.2)	301 (44.9)	382 (49.5)
Unknown	4	13	17
Complications¹²			
	(N=105)	(N=754)	(N=859)
Regurgitated	0	22	22
Seizures	0	0	0
Other	0	1	1
None	20	487	507
Unknown	85	244	329
Other outcomes			
Regained consciousness after ingesting DWDA medications ¹³	0	6	6

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Timing of DWDA event			
Duration (weeks) of patient-physician relationship ¹⁴			
Median	19	12	13
Range	1-1312	0-1905	0-1905
Number of patients with information available	105	752	857
Number of patients with information unknown	0	2	2
Duration (days) between 1st request and death			
Median	43	48	47
Range	15-439	15-1009	15-1009
Number of patients with information available	105	754	859
Number of patients with information unknown	0	0	0
Minutes between ingestion and unconsciousness ^{11, 12}			
Median	5	5	5
Range	2-15	1-38	1-38
Number of patients with information available	20	487	507
Number of patients with information unknown	85	267	352
Minutes between ingestion and death ^{11, 12}			
Median	27	25	25
Range (minutes - hours)	11mins-1hr	1min-104hrs	1min-104hrs
Number of patients with information available	20	492	512
Number of patients with information unknown	85	262	347

¹ Unknowns are excluded when calculating percentages.

² Includes Oregon Registered Domestic Partnerships.

³ Clackamas, Multnomah, and Washington counties.

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

⁵ Private insurance category includes those with private insurance alone or in combination with other insurance.

⁶ Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.

⁷ First recorded beginning in 2001. Since then, 37 patients (4.7%) have chosen not to inform their families, and 16 patients (2.0%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.

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

⁹ Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

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

¹¹ The data shown are for 2001-2014 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.

¹² A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

¹³ There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (<http://www.healthoregon.org/dwd>) for more detail on these deaths.

¹⁴ Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.

Margaret K. Dore

Margaret Dore <margaretdore@margaretdore.com>

Letter to editor, New Haven Register

1 message

William Toffler <toffler@ohsu.edu>

Sun, Feb 23, 2014 at 7:23 PM

To: "letters@nhregister.com" <letters@nhregister.com>

Dear Editor,

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

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

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

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

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

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

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

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

William L. Toffler MD
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*I confirmed the
content with
Dr. Toffler.*

PROVINCE DE QUÉBEC

DISTRICT DE TROIS-RIVIÈRES

No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

**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

AFFIDAVIT OF JOHN NORTON- Page 1

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time. By then, I had twitching in both hands, which were also getting weaker. At some point, I lost the ability to grip in my hands. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor's prescription and support, I would have taken that opportunity.

4. Six years after my initial diagnosis, the disease progression stopped. Today, my condition is about the same. I still can't grip with my hands. Sometimes I need special help. But, I have a wonderful life. I am married to Susan. We have three children and one grandchild. I have a degree in Psychology and one year of graduate school. I am a retired bus driver (no gripping required). Prior to driving bus, I worked as a parole and probation officer. When I was much younger, I drove a school bus. We have wonderful friends. I enjoy singing tenor in amateur choruses. I help other people by working as a volunteer driver.

5. I will be 75 years old this coming September. If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come. I hope that Canada does not legalize these practices.

SWORN BEFORE ME at
MASSACHUSETTS, USA
on, August 18th, 2012

NAME: Heidi Pruzynski
Heidi

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:



JOHN NORTON

AFFIDAVIT OF JOHN NORTON- Page 3

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Attorneys for Petitioner

**MONTANA FIRST JUDICIAL DISTRICT COURT,
LEWIS AND CLARK COUNTY**

MONTANANS AGAINST ASSISTED
SUICIDE & FOR LIVING WITH
DIGNITY, a Montana Nonprofit
Public Benefit Corporation,

PETITIONER,

vs.

BOARD OF MEDICAL EXAMINERS,
MONTANA DEPARTMENT OF LABOR &
INDUSTRY,

RESPONDENT.

Cause No. ADV-2012-1057

**AFFIDAVIT OF KENNETH R.
STEVENS, JR., MD**

STATE OF OREGON)
) ss.
COUNTY OF CLACKAMAS) _____

KENNETH STEVENS, MD, being first duly sworn on oath, deposes
and says as follows:

1. I am a doctor in Oregon where physician-assisted suicide is
legal. I am also a Professor Emeritus and a former Chair of the
Department of Radiation Oncology, Oregon Health & Science
University, Portland, Oregon. I have treated thousands of

Affidavit of Kenneth Stevens, Jr., MD - page 1
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Appendix, Tab 6, Affidavit of Kenneth Stevens, MD
Page 1 of 10

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patients with cancer.

2. On December 5, 2011, I submitted a letter to the Board of Medical Examiners, which is attached hereto as Exhibit A.

3. The instant affidavit updates that letter to reflect current Oregon practice. Specifically, the "five year, five percent" rule described in my letter has been replaced with the prioritization scheme described below.

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

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

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

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

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

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

10. Today, for patients under the Oregon Health Plan (Medicaid), there are also financial incentives to commit suicide. One incentive is that the Plan covers the cost. The Plan's "Statements of Intent for the April 1, 2012 Prioritized List of Health Services," states:

It is the intent of the [Oregon Health Services] Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services.

Attached hereto as Exhibit B, page SI-1.

11. Under the Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient's treatment. As an example, patients with cancer are denied treatment if they have a "less than 24 months median survival with treatment" and fit other criteria. This is the Plan's "Guideline Note 12." (Attached hereto as Exhibit B, page GN-4).

12. The term, "less than 24 months median survival with treatment," means that statistically half the patients receiving

treatment will live less than 24 months (two years) and the other half will live longer than two years.

13. Some of the patients living longer than two years will likely live far longer than two years, as much as five, ten or twenty years depending on the type of cancer. This is because there are always some people who beat the odds.

14. All such persons who fit within "Guideline Note 12" will nonetheless be denied treatment. Their suicides under Oregon's assisted suicide act will be covered.

15. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.

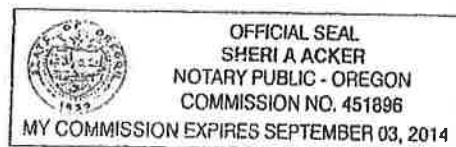
16. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Montana, your government health plan could follow a similar pattern. Private health plans could also follow this pattern. If so, these plans would pay for you and/or your family to die, but not to live.

FURTHER AFFIANT SAYETH NOT.

Kenneth Stevens Jr MD
KENNETH STEVENS, JR., MD.

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

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



12/5/11

From: Kenneth Stevens [mailto:kennethstevensjr@gmail.com]
Sent: Monday, December 05, 2011 10:52 PM
To: Marquand, Ian; Connor, Maggie; DLI BSD Medical Examiners; bdbdburke@gmail.com
Subject: Physician assisted suicide dangers

Re: Physician-Assisted Suicide: A Danger to Patients; Don't Let Patients be Steered to Suicide

Dear Montana Medical Examiner Board member:

I understand that the Montana Medical Examiner Board will be voting on physician-assisted suicide. I have been a cancer doctor in Oregon for more than 40 years. The combination of assisted-suicide legalization and prioritized medical care based on prognosis has created a danger for my patients on the Oregon Health Plan (Medicaid).

The Plan limits medical care and treatment for patients with a likelihood of a 5% or less 5-year survival. My patients in that category, who say, have a good chance of living another three years and who want to live, cannot receive surgery, chemotherapy or radiation therapy to obtain that goal. The Plan guidelines state that the Plan will not cover "chemotherapy or surgical interventions with the primary intent to prolong life or alter disease progression." The Plan WILL cover the cost of the patient's suicide.

Under our law, a patient is not supposed to be eligible for voluntary suicide until they are deemed to have six months or less to live. In the well publicized cases of Barbara Wagner and Randy Stroup, neither of them had such diagnoses, nor had they asked for suicide. The Plan, nonetheless, offered them suicide.

In Oregon, the mere presence of legal assisted-suicide steers patients to suicide even when there is not an issue of coverage. One of my patients was adamant she would use the law. I convinced her to be treated. Eleven years later she is thrilled to be alive. Please, don't let assisted suicide come to Montana.

[Support for this letter regarding Barbara Wagner and Randy Stroup can be found in these articles: <http://www.katu.com/news/26119539.html> & <http://abcnews.go.com/Health/story?id=5517492&page=1> My patient's letter in the Boston Globe describing her being alive 11 years later can be read here: http://articles.boston.com/2011-10-04/bostonglobe/30243525_1_suicide-doctor-ballot-initiative]

Kenneth R. Stevens, Jr., MD
13680 SW Morgan Rd Sherwood, OR 97140
Professor Emeritus and former Chair, Radiation Oncology Department, Oregon Health & Science University, Portland, Oregon
[503 625 5044](tel:5036255044) [503 481 8410](tel:5034818410)

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

STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

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

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

GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

Lines 79,102,103,105,123-125,131,144,159,165,166,168,170,181,197,198,206-208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,314,320,339-341,356,459,622

- A) CSF are not indicated for primary prophylaxis of febrile neutropenia unless the primary chemotherapeutic regimen is known to produce febrile neutropenia at least 20% of the time. CSF should be considered when the primary chemotherapeutic regimen is known to produce febrile neutropenia 10-20% of the time; however, if the risk is due to the chemotherapy regimen, other alternatives such as the use of less myelosuppressive chemotherapy or dose reduction should be explored in this situation.
- B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.
- C) CSF are not indicated in patients who are acutely neutropenic but afebrile.
- D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <100/mcl, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.
- E) CSF are not indicated to increase chemotherapy dose-intensity or schedule, except in cases where improved outcome from such increased intensity has been documented in a clinical trial.
- F) CSF (other than pegfilgrastim) are indicated in the setting of autologous progenitor cell transplantation, to mobilize peripheral blood progenitor cells, and after their infusion.
- G) CSF are NOT indicated in patients receiving concomitant chemotherapy and radiation therapy.
- H) There is no evidence of clinical benefit in the routine, continuous use of CSF in myelodysplastic syndromes. CSF may be indicated for some patients with severe neutropenia and recurrent infections, but should be used only if significant response is documented.
- I) CSF is indicated for treatment of cyclic, congenital and idiopathic neutropenia.

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

Lines 102,103,123-125,144,159,165,166,170,181,197,198,207,208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,320,339-341,356,459,586,622

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

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

Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.

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

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

4-16-2012

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

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

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

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

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

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

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

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

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

Ventricular assist devices are not covered for destination therapy.

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

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

PET Scans are covered for diagnosis of the following cancers only:

- Solitary pulmonary nodules and non-small cell lung cancer
- Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

PET scans are covered for the initial staging of the following cancers:

- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal

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Filed 2013 Dec 6 P 4:5

Attorneys for Petitioner

MONTANA FIRST JUDICIAL DISTRICT COURT,
LEWIS AND CLARK COUNTY

MONTANANS AGAINST ASSISTED
SUICIDE, a Montana Nonprofit
Public Benefit Corporation,

PETITIONER,

vs.

BOARD OF MEDICAL EXAMINERS,
MONTANA DEPARTMENT OF LABOR &
INDUSTRY,

RESPONDENT.

Cause No. ADV-2012-1057

AFFIDAVIT OF JEANETTE HALL

STATE OF OREGON)
) ss.
COUNTY OF Washington)

JEANETTE HALL, being first duly sworn on oath, deposes and
says as follows:

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

2. In 2000, I was diagnosed with cancer and told that I had 6
months to a year to live. I knew that our law had passed, but I

Affidavit of Jeanette Hall - page 1
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Appendix, Tab 7, Affidavit of Jeanette Hall
Page 1 of 3

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didn't know exactly how to go about doing it. I tried to ask my doctor, Ken Stevens MD, but he didn't really answer me. In hindsight, he was stalling me.

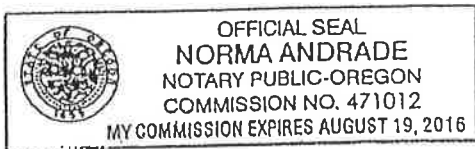
3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!

4. This last July, it was 13 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

FURTHER AFFIANT SAYETH NOT.

Jeanette Hall
JEANETTE HALL

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



N. Andrade
Norma Andrade
Printed Name
Notary Public for the State
of Oregon
Residing at Tigard
My Commission Expires August 19, 2016

The Seattle Times

Winner of Nine Pulitzer Prizes

Columnists

Originally published Wednesday, March 7, 2012 at 6:46 PM

Planning for old age at a premium

Preparing for longterm care is difficult — even for those who can afford insurance plans.



Jerry Large

Seattle Times staff columnist

Monday, I suggested exploring long-term health insurance as a way to deal with the cost of assisted living.

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

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

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

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

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

The only certainty is that nothing is universally true.

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

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

At least a couple mentioned euthanasia as a solution.

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

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

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

Insurance for long-term care is supposed to provide some security for people who are not quite

Three years after
our assisted suicide
law went into effect
here in Washington
State, this article
came out in our
largest paper,
suggesting euthanasia
for people who
didn't save enough
money for their
old age.

— So if
you work
hard all
your life,
pay taxes
and your
pension
plan
goes
broke —

this is
how
society
pays
you
back?

— No one talked
like this
before
our
assisted
suicide
law
went
into effect

— Margaret Dove

consented to defendant's acts, we are satisfied from our independent research that defendant's actions should not be treated in effect as assisting a suicide. Our Supreme Court rejected an "assisted suicide" argument in *People v. Matlock* (1959) 51 Cal.2d 682, 336 P.2d 505 (*Matlock*), stating " 'where a person actually performs, or actively assists in performing, the overt act resulting in death, such as shooting or stabbing the victim, administering the poison, or holding one under water until death takes place by drowning, his act constitutes murder, and it is wholly immaterial whether this act is committed pursuant to an agreement with the victim....' " (*Id.* at p. 694, 336 P.2d 505, followed in *People v. Cleaves* (1991) 229 Cal.App.3d 367, 376-377, 280 Cal.Rptr. 146; but see *In re Joseph G.* (1983) 34 Cal.3d 429, 194 Cal.Rptr. 163, 667 P.2d 1176 [making an exception to *Matlock's* murder rule when one of two people engaged in a simultaneous suicide effort actively employs the single instrumentality involved].)

B. Defendant's "Unusual Case" Argument

[10] Defendant argues that she plainly overcame the presumption against probation because "this was extremely unusual in the most basic, fundamental way central to the statutory bar: Ms. Stuart inflicted great bodily injury or death upon her mother out of a felt love for and duty to her. However misdirected those laudable impulses were, she acted 'from a heartfelt place,' which can rarely if ever be said about the willful infliction of death or great bodily injury." Defendant also asserts that "[t]he homicide of one's beloved parent prompted by care and concern for that aged parent and filial obedience to and honor of that parent's apparent wishes is a most peculiar manslaughter indeed, and one that is at the lowest end of the spectrum**143 of moral opprobrium when

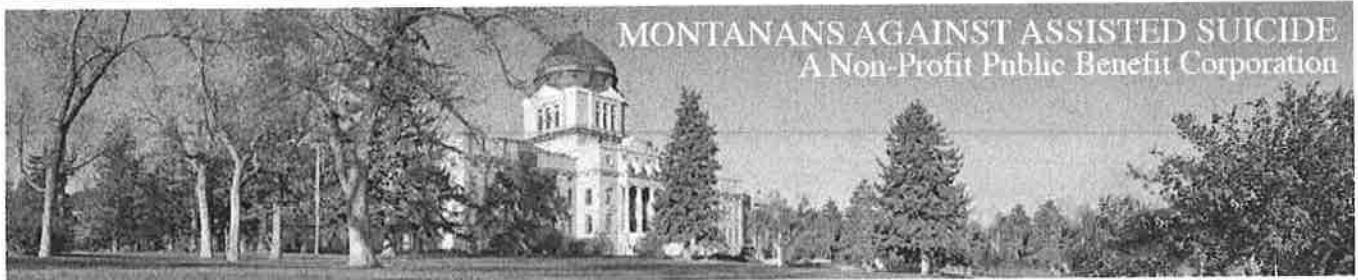
examining the motives of those who willfully inflict great bodily injury or death." We disagree.

As we have already discussed, a reasonable person could conclude that defendant acted at least in part out of financial considerations, an all too common motivation for killing someone, and without Isabel's knowledge or consent. This undermines defendant's argument that she acted with a reduced moral culpability.

Furthermore, a killer's subjective belief about the reason for a crime, including that he or she acted out of the "compassion and empathy" that *183 defendant contends she acted upon here, does not necessarily mean the case is "unusual." It is not particularly unusual for a killer to believe his or her action was justified; it is, for example, the root of any vigilantism. Moreover, that defendant believes she acted out of good intentions has little, if any, bearing on an objective view of her legal and moral culpability under the circumstances. It is reasonable to conclude an adult child who takes it upon herself to commit the "mercy killing" of a very elderly parent based only on that parent's "apparent wishes" has abused a position of trust and committed a very serious crime. A court is not required to conclude such an act rests on a higher moral plane than any other killing. Indeed, to do so would potentially expose some of the most vulnerable in our society to the grave danger of being killed by "loved ones," however compassionate they may be, who are unable to resist a temptation that dovetails with their financial self-interest, as the record suggests may have been the case here. The trial court acted within its discretion in rejecting any arguments that defendant's motivations reduced her moral culpability, including because, as the trial court stated, defendant's killing of her mother was "perhaps the most extreme form that elder abuse can take."

C. Defendant's "Provocation and Duress" Argument

[11] Regarding rule 4.413(c)(2)(A), defendant



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[Laws Against Assisted Suicide are Constitutional](#) [The Oregon Studies are Invalid](#) [Charlton Letter to Physicians](#) [About Us](#) [Donate](#)
[Quick Facts About Assisted Suicide](#) [MAAS lawsuit will keep assisted suicide illegal](#) [What People Mean When They Say They Want to Die](#)
[MAAS appeals Medical Examiner Board Lawsuit](#) [Compassion & Choices is the Hemlock Society](#) [A Message to our Supporters](#)
[Bradley Williams Takes on Compassion & Choices](#) [Increased Reports of Involuntary Deaths](#) [Rapist charged with "aiding or soliciting suicide"](#)

It's great to be alive! Don't let assisted suicide become legal in Montana!



Jeanette Hall, 12 years after her doctor talked her out of physician-assisted suicide in Oregon - Click photo to read her story

Voices From Oregon and Washington Where Assisted Suicide is Legal

- "I was afraid to leave my husband alone"
- "This is how society will pay you back? With non-voluntary or involuntary euthanasia?"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "It wasn't the father saying that he wanted to die"
- "He made the mistake of asking about assisted suicide"

Law Enforcement Viewpoint Against Assisted Suicide

Friday, March 29, 2013

Physician-Assisted Suicide Part of Elder Abuse Fraud

On March 26, 2013, Philip Tummarello, a retired police Sergeant Inspector, testified before the Montana Senate Judiciary Committee on behalf of HB 505. His testimony included the Thomas Middleton case in which physician-assisted suicide had facilitated the defrauding of an elderly man. An article from KTVZ.com states:

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

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

To read the entire article, go here:

<http://www.ktvz.com/news/Sawyer-Arraigned-on-State-Fraud-Charges/-/413192/619440/-/view/print/-/1w9ly3z/-/index.html>

Posted by Admin at 7:32 PM

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Labels: Elder abuse, HB 505, Physician-assisted suicide

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WHY WE CARE

To learn more about problems with legal assisted suicide, go to Quick Facts About Assisted Suicide.

Some healthcare providers already misuse and/or abuse palliative care. If assisted suicide is made legal, providers will have even more power to abuse patients and/or take away patient choice. To learn more, click here.

Choice is an Illusion



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- "Aid in Dying" Whose Choice?
- Why do so many disability groups oppose assisted suicide?
- US Overview (Idaho article)
- Terminal

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SUICIDE KITS SELL DEATH BY MAIL.



Title Annotation: *Health; Legislation is being prepared to outlaw sale of helium hoods*

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Date: Mar 20, 2011

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Byline: Randi Bjornstad The Register-Guard

His mind was keen, his grin infectious. His passions were politics and sports. He read voraciously. His humor was prankish, his wit razor-sharp.

Born and raised in Eugene, he adored his parents and four brothers. He graduated from South Eugene High School and the University of Michigan.

For years, he struggled through bouts of pain and fatigue that defied medical diagnosis and left him depressed about his inability to carry on normal daily activities and fearful that he would never regain normal health.

He had dreams, ambitions, accomplishments and, say many who knew him, vast potential.

But three months ago, in the throes of a flu that upended a period of relatively good health, Nick Klonoski took his own life.

He had just turned 29.

Klonoski did not use any of the commonly known methods of suicide. Instead, he employed a "helium hood kit" that he ordered by mail from a two-person company in Southern California.

The small, white box, measuring 10 by 7 by 3 inches and decorated with a butterfly, holds a brown paper packet, its edges zigzagged with pinking shears and stitched shut on a sewing machine. Inside the packet is a clear plastic bag with an elasticized band sewn to the open end, to slip over the head and fit snugly around the neck. The box also contains clear plastic tubing, for hooking up tanks of lethal helium gas.

Manufactured and sold by The Gladd Group, the helium hood kit has no other use than to assist a person contemplating suicide. It costs \$60, payable only by cash or check. According to Manta, an online business networking site where small-business owners can share information, The Gladd Group has two employees and estimated annual sales of \$98,000 - equal to the price of 1,633 kits.

Selling a "suicide kit" - coupled with detailed instructions from another right-to-suicide organization on where to buy it and how to use it - raises complex legal, ethical and emotional questions about what constitutes helping another person to take his or her own life. Assis

another person's suicide via the law in most states, including Oregon. But definitions of aiding, promoting, encouraging or assisting are not legally precise.

No one to date has been prosecuted for selling a helium hood kit in the United States. Many police agencies, medical examiners, district attorneys and legislators know little or nothing about the kits, although now that he is aware of them, state Sen. Floyd Prozanski, D-Eugene, says he's drafting a bill to outlaw their sale.

The right-to-suicide movement argues that disseminating how-to information about suicide and selling the kits that facilitate the act are protected by the free speech clause of the First Amendment in the U.S. Constitution.

On the afternoon he died, Klonoski drove to a party goods store not far from his family's Eugene home. A store receipt police found in his room shows that at 2:16 p.m., he signed for rental of a large tank of helium. Returning home, with the rest of his family out of the house for the afternoon - all five brothers had gathered at the family home for the holidays - he followed the instructions for using the helium hood kit as detailed in "Final Exit," a book written by longtime pro-suicide activist and longtime Lane County resident, Derek Humphry. He died in his bedroom before his family returned.

Jake Klonoski, at 30 the oldest of the Klonoski brothers, found his next-younger brother's body after Nick didn't respond to attempts to call him to dinner.

"I know Nick was vulnerable because of the health issues he had been dealing with for years, but he wasn't terminally ill, and he seemed to have been getting better until the flu thing happened," Jake Klonoski said. "He had family and many friends to help him through the bad times and then enjoy the good times with him. Now I know there also are people out there ready to persuade people like Nick to give up."

Nearly 1,000 people, including a former governor and a busload of colleagues from one of his many political projects, packed Temple Beth Israel's huge sanctuary - the only place large enough to accommodate the crowd on a cold sunny afternoon in early January - to honor Nick Klonoski's life. Although the family is not Jewish, his brothers wore yarmulkes, bright yellow imprinted with the blue emblem of the University of Michigan, in his honor. Speakers laughed and cried as they chronicled his intellectual brilliance and mischievous nature, and mourned the loss of his immense possibilities.

Overwhelmed by his death, his mother, U.S. District Court Judge Ann Aiken, declines to speak publicly about it. His father, retired University of Oregon political science professor James Klonoski, died two years ago. But two of his brothers, Jake and Zach Klonoski, are determined to speak out, to stop what they consider illegal and immoral assisted suicide.

"The company that sells this kit obviously is purposely targeting a vulnerable group," said Jake Klonoski, a law student at Stanford University. "They made money off my brother, they gave him the tools to take his own life without knowing him, without knowing anything about him. For \$60, they blew his life apart. It breaks my heart."

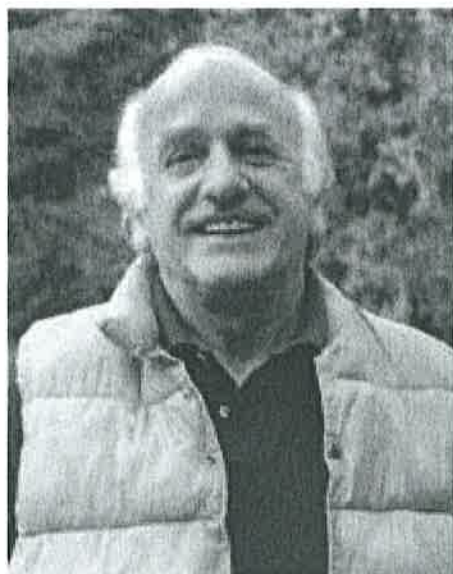
When it comes to promoting an American's right to die by suicide, all roads lead to Derek Humphry. He describes himself in an online autobiography as "a journalist and author who has spent the last 30 years campaigning for lawful physician-assisted dying to be an option for the

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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.

Save the Date!
Sat., October 22, 2011, 1-3 p.m.
University Unitarian Church
6556 35th Ave NE
Seattle, WA 98115-7393

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.

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Death Drugs Cause Uproar in Oregon

Terminally Ill Denied Drugs for Life, But Can Opt for Suicide

By **SUSAN DONALDSON JAMES**

Aug. 6, 2008 —

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

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

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

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

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

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

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

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

Letter's Impact 'Devastating'

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

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

"I'm not too good today," said Wagner, a Springfield great-grandmother. "But I'm opposed to the

A-66

[assisted suicide] law. I haven't considered it, even at my lowest point.

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

The cancer went into remission, but in May, Wagner found it had returned. Her oncologist prescribed the drug Tarceva to slow its growth, giving her another four to six months to live.

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

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

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

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

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

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

Playing With 'My Life'

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

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

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

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

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

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

Letter noting assisted suicide raises questions

By Susan Harding and KATU Web Staff | Published: Jul 30, 2008 at 6:30 PM PDT (2008-07-31T1:30:0Z) | Last Updated: Oct 30, 2013 at 7:35 AM PDT (2013-10-30T14:35:0Z)



Barbara Wagner

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

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

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

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

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

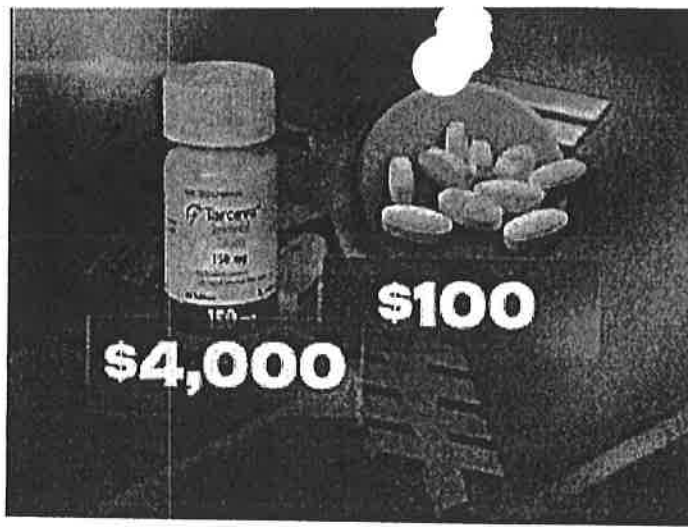
An unfortunate interpretation?

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

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

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

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



Saha said state health officials do not consider whether it is cheaper for someone in the health plan to die than live. But he admitted they must consider the state's limited dollars when dealing with a case such as Wagner's.

"If we invest thousands and thousands of dollars in one person's days to weeks, we are taking away those dollars from someone," Saha said.

But the medical director at the cancer center where Wagner gets her care said some people may have incredible responses to treatment.

Health plan hasn't evolved?

The Oregon Health Plan simply hasn't kept up with dramatic changes in chemotherapy, said Dr. David Fryefield of the Willamette Valley Cancer Center.

Even for those with advanced cancer, new chemotherapy drugs can extend life.

Yet the Oregon Health Plan only offers coverage for chemo that cures cancer - not if it can prolong a patient's life.

"We are looking at today's ... 2008 treatment, but we're using 1993 standards," Fryefield said.

"When the Oregon Health Plan was created, it was 15 years ago, and there were not all the chemotherapy drugs that there are today."

Patients like Wagner can appeal a decision if they are denied coverage. Wagner appealed twice but lost both times.

However, her doctors contacted the pharmaceutical company, Genentech, which agreed to give her the medication without charging her. But doctors told us, that is unusual for a company to give away such an expensive medication.

NEWS RELEASE



Date: Sept. 9, 2010

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

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

Oregon's suicide rate is 35 percent higher than the national average. The rate is 15.2 suicides per 100,000 people compared to the national rate of 11.3 per 100,000. (for 2007)

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

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

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

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

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

The report also included the following findings:

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

9/2010

OREGON DEPARTMENT OF HUMAN SERVICES

Public Health
Division (PHD)

Suicides in Oregon Trends and Risk Factors

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

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Oregon suicide report,
issued in September 2010. Data
through 2007. Excerpts attached.

Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the leading cause of injury death – there are more deaths due to suicide in Oregon than due to car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all Oregonians. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data of Oregon Violent Death Reporting System (ORVDRS). This report presents main findings of suicide trends and risk factors in Oregon.

Key Findings

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

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

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

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

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

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

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

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

Introduction

Suicide is an important public health problem in Oregon. Each year there are more than 350 Oregonians who died by suicide and more than 1800 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon with more deaths due to suicide among Oregonians than car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all ages in Oregon¹. The cost of suicide is enormous. In 2006 alone, self-inflicted hospitalization charges exceeded 24 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 570 million dollars^{1,2}. The loss to families and communities broadens the impact of each death.

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors"³. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Methods, data sources and limitations

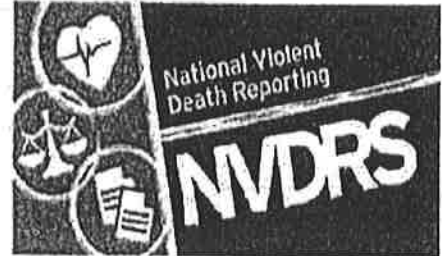
X 11
Suicide is a death resulting from the intentional use of force against oneself. In this report, suicide deaths are identified according to International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of deaths on death certificates. Suicide was considered with code of X60-84 and Y87.0.⁴ Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore are excluded from this report.

¹ Injury in Oregon, 2008 Annual Report. http://www.oregon.gov/DHS/ph/ine/docs/report2008v2_2.pdf. Accessed on March, 26, 2010.

² Phaedra S. Corso, James A. Mercy, Thomas R. Simon et al, Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States. *Am J Prev Med.* 2007;32(6):474-482.

³ Ronald W. Maris, Alan L. Berman, Morton M. Silverman. (2000). *Comprehensive Textbook of suicidology*. New York: The Guilford Press. (p378)

⁴ Pavlozzi LJ, Mercy J, Frazier Jr L, et al. CDC's National Violent Death Reporting System: Background and Methodology. *Injury Prevention*, 2004;10:47-52.



OREGON

Public Health Division

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

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

**Oregon
Health
Authority**

*Excerpt
printed
2/9/14*

Executive Summary

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

Key Findings

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

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

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

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

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

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

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

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

Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year^{1,2}. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts^{3,4}. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon³. The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars^{3,4,5}. The loss to families and communities broadens the impact of each death.

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cost
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“Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors”⁶. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

¹ Oregon Healthy Teens 2009 -11th Grade Results.

<http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2009/11/Documents/mental11.pdf>

² Crosby A.E., Han B., Ortega L.A.G., Park S.E., et al, Suicidal Thoughts and Behaviors Among Adults aged ≥ 18 Years – United States, 2008-2009. MMWR. 2011;60:13.

³ Oregon Vital Statistics Annual Report, Vol. 2, 2010. Oregon Health Authority.

⁴ Wright D., Millet L., et al, Oregon Injury and Violence Prevention Program Report for 2011 Data year. Oregon Health Authority.

⁵ Corso P.S., Mercy J.A., Simon T.R., et al, Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States. Am J Prev Med. 2007;32(6):474-482.

⁶ Maris R.W., Berman A.L., Silverman A.M. (2000). Comprehensive Textbook of suicidology. New York: The Guilford Press. (p378)



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Original article

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

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Depression

ABSTRACT

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

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

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

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

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1. Introduction

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

organisations offer personal guidance to members suffering diseases with "poor outcome" or experiencing "unbearable suffering" who wish to die.

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 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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Sensationalizing a sad case cheats the public of sound debate

Posted by rattig November 29, 2008 19:30PM

In the crucial period leading up to Washington State's vote on an Oregon-style Death with Dignity law, this newspaper published a story featuring Barbara Wagner. A sensational story, an easy media "gotcha" on Oregon's Medicaid program, it completely missed the deeper questions crucial to public understanding of end-of-life care and our national healthcare debate.



Barbara Coombs Lee

Readers will recall Wagner as a 64-year-old Springfield resident with end stage lung cancer, a life-long smoker enrolled in the Oregon Health Plan (OHP). Over several years the OHP had paid for extensive cancer treatment and it continued to pay for Wagner's healthcare until her death.

When it became clear that first and second-line therapies had failed and her prognosis was grim, Ms. Wagner's oncologist recommended a costly, third-line cancer drug called Tarceva. Research indicates that 8 percent of advanced lung cancers respond to Tarceva, with a chance to extend life from an average of 4 months to 6 months. The likelihood of no response to the drug is 92 percent, yet 19 percent of patients develop toxic side effects like diarrhea and rash. Based on the low indicators of effectiveness, Oregon Health Plan denied coverage.

The irresistible ingredients of sensationalism included a distraught patient, a doctor deeply opposed to Death with Dignity and an insensitive letter of payment denial. The media was called in and the rest is history.

As a publicly funded service, Oregon Health Plan aims to do the greatest good it can. It assigns a high priority to preventive care, health maintenance, and treatments that offer a near-certain cure. Elective, cosmetic or ineffective, "futile" care is not covered. Futile care is defined as any treatment without at least a 5 percent chance of 5 year survival. "We can't cover everything for everyone," said the medical director of OHP. "Taxpayer dollars are limited for publicly funded programs. We try to come up with policies that provide the most good for the most people."

The OHP letter denying one ineffective treatment did not close the door on all care. It included a long list of appropriate end-of-life care that OHP would pay for, including hospice, medical equipment, palliative services and state-of-the-art pain and symptom management. Yes, the list included medication prescribed under the Oregon Death with Dignity Act. The media juxtaposed denial of Tarceva with coverage for aid in dying in a sensational, emotional manner, suggesting the two were related. Many stories ensued about supposedly callous bureaucrats refusing to prolong life but agreeing to shorten it. It made for a catchy story ... but not truthful journalism.

Was it true that Ms. Wagner was harmed in any manner? Or that Tarceva was an efficacious option?

President of Choices
Compassion & Choices
criticizing Wagner's
"Choice"

Compassion &
Choices defends
Oregon's Medicaid
program against
an individual
patient.

Ms. Wagner received Tarceva, anyway, when the drug's manufacturer, Genentech, responding to the media firestorm and provided it at no cost. News stories never mentioned that when Wagner bet on the remote chance to prolong life, she probably turned her back on hospice care, widely recognized as the gold standard for end-of-life care. Sadly, it turned out Tarceva didn't help Wagner and she lived only a short time after starting the drug.

While the media widely reported OHP's denial of this expensive experimental treatment, we worry the media missed the important issues inherent in the story.

What do patients like Wagner really understand about the "last hope" treatments their doctors offer? Do doctors inform patients of the true statistical chance these therapies will prolong life, or the chance of toxic side effects that diminish the quality of the short life that remains? Might Wagner have been better served, and perhaps even lived longer, if her doctors had referred her to hospice instead of recommending a drug so toxic and so unlikely to extend her life? How many times do patients lose out on the real hope and comfort hospice offers because they are encouraged to grasp for the small hope of largely ineffective chemotherapy? Do financial incentives play a role in whether physicians recommend long-shot chemotherapy instead of comprehensive comfort care?

While the OHP decision was closely scrutinized, there was no scrutiny of realistic options considered or not considered and the decision-making process. The burning health 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 and the time for comfort care is at hand. Such encouragement serves neither patients, families, nor the public.

Barbara Roberts, Oregon's wise and gentle former governor, tells in her first book the story of how she and her husband Frank reacted to the news that he had entered the terminal stage of prostate cancer. She describes how immediately after disclosing the grim prognosis, the doctor announced he was setting up an appointment for chemotherapy! Frank asked two crucial questions, "Will this treatment extend my life?" and "For how long." And when the answers, balanced against the likely toxic side effects, didn't add up to how Frank envisioned his last days on earth, he declined the doctor's recommended treatment.

Roberts writes that chemotherapy seemed, "a medical misjudgment encouraged by a culture in denial and a medical profession equally in denial and unwilling to treat death as normal." Frank said "no" to treatment. But he said "yes" to life and began the "hard work of acceptance" of what it means to be mortal.

In order for society to overcome its collective denial of mortality, we desperately need a public dialogue that shuns superficial sensationalism and leads us to, and through, the hard questions. We're Oregonians. We can handle it.

Coombs Lee is president of the group Compassion & Choices.

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Comments

LetDocDecide says...

My wife was diagnosed with Stage IIb lung cancer (which really should have been stage IV) in April 2006. The diagnosing surgeon announced that there was no hope, and that my wife would only live a short time. In fact, the prognosis for my wife suggested she had a 1%-2% chance of surviving 2 years. Thankfully, we had an ambitious Oncologist that thought the surgeon's opinion was wrong.

While it is easy to armchair quarterback the appropriateness of health care treatments. You can be the one that tells my 8 and 10 year old sons that their mother should not receive Tarceva because it is an "experimental treatment". The efficacy of all chemotherapy treatments are ALL poor. The first line chemo treatment (carboplatin/Paclitaxel) that my wife received had only a 35% likelihood of a positive response. That was 2 years and 8 months ago and she is still kicking. Her response to Tarceva has been an exceptional one, resulting in a significant reduction of the size and number of tumors in her remaining right lung. After a 3rd tier chemo treatment failed 3 months ago, Tarceva is probably the only reason she is spending Christmas day with me and my boys. In fact, I expect that she will continue having a positive response to the Tarceva for at least a couple of months. Anyone with a loved one with a terminal disease would appreciate the added time.

On the topic of cost and side effects, the side-effects of Tarceva (rash and diarrhea) are nothing compared to the side effects of the Taxane or platinum chemotherapy drugs (severe anemia, reduced white blood counts and platelet levels, severe nausea, body PAIN, etc..).

In addition to these benefits, the cost of Tarceva (about \$4000/month) is NOT HIGHER than the cost of chemotherapy (about \$8000 per treatment every 3 weeks). It is expensive to treat cancer, period. It is unclear to me whether the author of this news story is appealing for the denial of all cancer treatments, or just Tarceva. If that is the case, they can tell the family of the next Stage IIIb/IV lung cancer patient that treatment is not worth the cost. What the hell, perhaps we should just Euthanize all cancer patients at the time of diagnosis to save a little money.

I believe that the spiralling costs of health care are not caused by the compassionate treatment of those with terminal diseases. The real culprits are 1) the fact that to many individuals that have no health insurance use emergency care at a huge cost premium over preventative care; 2) People have had no incentive to use healthy lifestyles as a preventative; 3) Many people with insurance are not smart shoppers when it comes to health care. This leads to people having expensive diagnostic procedures like MRI and CT scans inappropriately.

We need to wakeup, do a little research into the available treatments for our ailments, and determine if the increased public cost for not insuring everyone and using more preventative health care.

Respectfully
Bob

Posted on 12/25/08 at 12:16AM
Footer



Barbara Coombs Lee

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Barbara Coombs Lee is President of Compassion & Choices, a nonprofit organization dedicated to expanding and protecting the rights of the terminally ill. She practiced as a nurse and physician assistant for 25 years before beginning a career in law and health policy. Since then she has devoted her professional life to individual choice and empowerment in health care. As a private attorney, as counsel to the Oregon State Senate, as a managed care executive and finally as Chief Petitioner for Oregon's Death with Dignity Act, she has championed initiatives that enable individuals to consider a full range of choices and be full participants in their health care decisions.

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Posted September 27, 2010 | 11:33 AM (BST)

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[2 Comments](#) | Posted August 19, 2010 | 07:01 PM (EST)

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Posted July 14, 2010 | 03:15 PM (EST)

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