TO: The Alaska House Health & Social Services Committee

FROM: Margaret Dore, Esq., MBA, President
Choice is an Illusion, a nonprofit corporation[1]

RE: Reject HB 54, Sponsor Substitute Version
(No Assisted Suicide/No Euthanasia)

- Prevent People With Years to Live From Throwing Away Their Lives
- Preserve Informed Consent
- Stop Legal Elder Abuse
- Stop Legal Murder
- Don't Put Older People in the Crosshairs of Their Heirs and Other Predators

HEARING: **Tuesday, March 28, 2017 at 3 p.m.**
120 East 4th Street, Room 106
Juneau, Alaska

MEMO DATE: March 28, 2017

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I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.[1] Our law is based on a similar law in Oregon. Both laws are similar to HB 54.[2]

HB 54 legalizes physician-assisted suicide and euthanasia as those terms are traditionally defined. The bill is sold as a promotion of patient choice and control, which is not true: The bill is stacked against the patient and a recipe for elder abuse.

HB 54 applies to persons with years or decades to live. Passage will encourage people with years to live to throw away their lives. I urge you to vote "No" on HB 54.

II. DEFINITIONS

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

The American Medical Association (AMA) defines physician-assisted suicide as occurring when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."[3] For example:

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[1] I am an elder law and appellate attorney licensed to practice law in Washington State since 1986. I am also a former Law Clerk to the Washington State Supreme Court. I am president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. My CV is attached hereto in the appendix, at A-1 to A-4. See also www.margaretdore.com, www.choiceillusion.org

[2] A copy of the proposed bill, HB 54 (sponsor substitute version) is attached hereto in the appendix, at A-101 to A-112.

[3] The AMA Code of Medical Ethics, 2016, Opinion 5.7, "Physician-Assisted Suicide. (Attached hereto at A-5).

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

Assisted suicide is a general term in which an assisting person is not necessarily a physician. Euthanasia is the administration of a lethal agent to cause another person's death.[5]

B. Withholding or Withdrawing Treatment

Withholding or withdrawing treatment ("pulling the plug") is not euthanasia if the purpose is to remove burdensome treatment, as opposed to an intent to kill the patient. More importantly, the patient will not necessarily die. Consider this quote from Washington State regarding a man removed from a ventilator:

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

III. ELDER ABUSE

A. Elder Abuse Is a Widespread Problem That Includes the Financial Exploitation and Murder of Older Adults

Elder abuse is a widespread problem in Alaska and throughout

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[4] Id.

[5] AMA Code of Medical Ethics, 2016, Opinion 5.8, "Euthanasia," attached hereto at A-5 (lower half of the page).

[6] Nina Shapiro, "Terminal Uncertainty – Washington's new 'Death with Dignity' law allows doctors to help people commit suicide – once they've determined that the patient has only six months to live. But what if they're wrong?," *The Seattle Weekly*, 01/14/09; article at A-6, quote at A-8.

the United States.[7] Perpetrators are often family members who start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or to coercing victims to change their wills or to liquidate their assets.[8]

Perpetrators are also calculating criminals. Consider, for example, Melissa Ann Shepard, a "Black Widow," who preyed on lonely men. A 2016 article states:

> [These men] sought companionship and found instead someone who siphoned their savings, slipped drugs into their food and, in the case of one man, ran him over with a car and left him dead on a dirt road.[9]

B. Victims Rarely Report

Elder abuse is a largely hidden problem, in part, because victims do not report it. It is estimated that only 1 in 14 cases ever comes to the attention of the authorities.[10] In another study, it was 1 out of 25 cases.[11] Reasons for the lack of reporting, include that many elders:

- Fear they will not be believed

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[7] See: State of Alaska Department of Administration, Office of Public Advocacy, "Elder Fraud Assistance Education" and "Financial Exploitation Explained," attached hereto at A-54 through A-56; and Met Life Mature Market Institute, Broken Trust: Elders, Family and Finances," March 2009, at https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

[8] Met Life Mature Market Institute, supra.

[9] Yanan Wang, "This 80-year-old 'Black Widow,' who lured lonesome old men to horrible fates, is out of prison again," *The Washington Post*, March 21, 2016. (Attached hereto at A-11 through A-13; quote at A-12).

[10] Nat'l Center on Elder Abuse, http://www.ncea.aoa.gov/Library/Data/

[11] Id.

- Associate a stigma with being labeled a victim
- Are dependant on their perpetrator
- Fear retaliation from their perpetrator
- Fear the loss of their independence.[12]

IV. ASSISTED SUICIDE AND EUTHANASIA

A. Thomas Middleton

Persons who assist a suicide or euthanasia can have their own agendas. For an Oregon example, there is the Thomas Middleton case. Two days after he died of physician-assisted suicide, his trustee sold his home and deposited the proceeds into bank accounts for her own benefit.[13] She was charged with fraud, but the case did not go forward.[14] Middleton's son was dismayed with the outcome.[15]

B. Few States Allow Assisted Suicide

Oregon and Washington legalized physician-assisted suicide by ballot measures in 1997 and 2008, respectively. Since then, just three states and the District of Columbia have passed similar laws (Vermont, California and Colorado). These laws also

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[12] State of Alaska, Financial Exploitation Explained, attached at A-56.

[13] KTVZ.com, "Sawyer Arraigned on State Fraud Charges," updated July 14, 2011. (Attached hereto at A-14).

[14] KTVZ.com, "State dropping Tami Sawyer fraud case: DOJ says prosecution likely would not add time behind bars," updated October 30, 2013. (Attached hereto at A-15).

[15] Id.

allow euthanasia.[16]

C. Other States Push Back

In the last six years, five states have strengthened their laws against assisted suicide: Arizona, Louisiana, Georgia, Idaho and Ohio.[17]

Last year, the New Mexico Supreme Court overturned a lower court case recognizing a right to physician aid in dying, meaning physician assisted suicide.[18] Physician-assisted suicide is no longer legal in New Mexico.

V. THE BILL

The bill provides a process to legally terminate an individual's life via a lethal drug. Once the drug is issued by the pharmacy, there is no supervision over its administration. No witness, not even a doctor, is required to be present at the death.[19]

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[16] Consider, for example, Washington's law, which was sold to voters as limited to assisted suicide in which a patient would "self-administer" a lethal drug. In Washington's law, the term, "self-administer," is specially defined to allow someone else to administer the drug to the patient, which is euthanasia. Cf. Margaret K. Dore, "'Death with Dignity': What Do We Advise Our Clients?," at A-16 to A-18.

[17] See: Associated Press, "Brewer signs law targeting assisted suicide," *Arizona Capitol Times*, 04/30/14, attached at A-19; Associated Press, "La. assisted-suicide ban strengthened," *The Daily Comet*, 04/24/12, attached at A-20); Georgia HB 1114 (attached hereto at A-21); Margaret Dore, "Idaho Strengthens Law Against Assisted Suicide," Choice is an Illusion, 07/04/11, at A-22 ("Governor Butch Otto signed Senate law 1070 into law. The law explicitly provides that causing or aiding a suicide is a felony"); and Ohio HB 470, at https://choiceisanillusion.files.wordpress

[18] *Morris v. Brandenburg*, 376 P.3d 836 (2016). (Excerpt attached at A-23).

[19] A copy of the bill is attached hereto at A-101 to A-112.

VI. DECADES TO LIVE

The bill applies to persons with a "terminal disease" who are predicted to have less than six months to live.[20] Such persons may, in fact, have decades to live. This is true for three reasons:

A. The Six Months to Live Is Determined Without Treatment

The bill states:

> "[T]erminal disease" means an incurable and irreversible disease that has been medically confirmed and that will, within reasonable medical judgment, produce death within six months . . . .[21]

Oregon's law has a nearly identical definition:

> "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.[22]

In Oregon, this nearly identical definition is interpreted to include chronic conditions such as "diabetes mellitus," better

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[20] Id., §§ 13.55.010(4) and 13.55.900(16), attached at A-102 & A-114.

[21] The bill states:

> "[T]erminal disease" means an incurable and irreversible disease that has been medically confirmed and that will, within reasonable medical judgment, produce death within six months; in this paragraph, "medically confirmed" means that a consulting physician who has examined the individual's relevant medical records has confirmed the medical opinion of the attending physician. (Emphasis added).

HB 54, Sec. 3, § 13.55.900(14), p. 11, lines 17 to 21, attached hereto at A-111.

[22] Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-28.

known as diabetes.[23] Oregon doctor, William Toffler, explains:

> [P]eople with chronic conditions are "terminal" [for the purpose of Oregon's law] if without their medications, they have less than six months to live. This is significant when you consider that a typical insulin-dependent 20 year-old . . . will live less than a month without insulin. Such persons, with insulin, are likely to have decades to live . . . . (Emphasis changed).[24]

If Alaska enacts the proposed bill and follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for people with chronic conditions such as insulin dependent diabetes. People who, with their medications, can have decades to live.

B. Predictions of Life Expectancy Can Be Wrong

Eligible persons may also have years to live because doctor predictions of life expectancy can be wrong. This is due to misdiagnosis and the fact that predicting life expectancy is not an exact science.[25] Consider John Norton, who was diagnosed with ALS (Lou Gehrig's disease) at age 18.[26] He was told that he would get progressively worse (be paralyzed) and die in three to

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[23] Declaration of William Toffler, MD, ¶3, attached hereto at A-26. See also Oregon's annual report for 2015, attached hereto at A-34 & A-35 (listing chronic conditions, such as "chronic lower respiratory disease" and "diabetes mellitus" as underlying illnesses sufficient to justify death under Oregon's act).

[24] Toffler, supra, ¶4, attached hereto at A-26 & A-27.

[25] See Jessica Firger, "12 million Americans misdiagnosed each year," CBS NEWS, 4/17/14 (attached at A-36); and Nina Shapiro, supra, attached at A-6.

[26] Affidavit of John Norton, ¶ 1 (Attached hereto at A-37).

five years.[27] Instead, the disease progression stopped on its own.[28] 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.[29]

C. Treatment Can Lead to Recovery

Consider also Oregon resident, Jeanette Hall, who was diagnosed with cancer in 2000 and made a settled decision to use Oregon's law.[30] Her doctor convinced her to be treated instead.[31] In a 2016 declaration, she states:

> This July, it will be 16 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.[32]

VII. "CHOICE" IS A BIG FAT FIB

A. Other People Are Allowed to Speak for the Patient as Long as They Are "Familiar With the Patient's Manner of Communicating"

A patient obtaining the lethal dose is required to be "capable."[33] This is a relaxed standard in which someone else is

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[27] Id., ¶ 1.

[28] Id., ¶ 4, attached hereto at A-38.

[29] Id., ¶ 5.

[30] Affidavit of Kenneth Stevens, MD, attached at A-40 to A-46, Jeanette Hall discussed at A-40 to A-41. See also the Declaration of Jeanette Hall, attached hereto at A-47.

[31] Id.

[32] Declaration of Jeanette Hall, ¶4, at A-47.

[33] HB 54, Sec. 3, § 13.55.010(3), pp. 1-2, attached at A-101 to A-102.

allowed to speak for the patient as long as he or she is familiar with the patient's "manner of communicating." The bill states:

> "Capable" means that an individual [patient] 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. (Emphasis added).[34]

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 she, herself, does not understand Spanish. That, however, would be good enough for her to speak for the patient during the lethal dose request process. With this situation, patient choice and control is far from guaranteed.

B. Patients Will Lose the Right to Informed Consent; They Will Lose the Right to Be Told About Alternatives For Cure

1. Present law

Under present law, a person making a health care decision has the right to "informed consent." This includes the right to be told about "reasonable alternatives to the proposed treatment," for example, regarding a new drug to cure cancer.[35]

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[34] Id., § 13.55.900(3), page 13, lines 3-6, attached hereto at A-110.

[35] AS 09.55.556(a) states:

> A health care provider is liable for failure to obtain

2. The bill

Under the bill, a person considering the lethal dose instead has the right to an "informed decision." HB 54 states:

> "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 . . .
>
> (E) feasible alternatives, including comfort care, hospice care, and pain control; (Emphasis added).[36]

With this language, the patient no longer has the right to be told of "reasonable alternatives to the proposed treatment," such as a new drug to cure cancer. This is due to the rule of statutory construction, *ejusdem generis*.

Per the rule, a general reference in a statute only applies to the same kind of things specifically listed.[37] As set forth above, the bill has a general reference to "feasible alternatives" and also refers to a list of specific alternatives: "comfort care, hospice care, and pain control."

> the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure. (Emphasis added).

Attached hereto at A-82.

[36] HB 54, Sec. 3, § 13.55.900(9), p. 10, line 24 through p. 11, line 3. (Attached hereto at A-110 and A-111).

[37] See http://dictionary.law.com/Default.aspx?selected=607

Per the rule, these specific alternatives, all having to do with death and dying, limit "feasible alternatives" to those involving death and dying. Patients will no longer have the right to be told of "reasonable alternatives to the proposed treatment," such as a cure for cancer. With the bill, they will lose that right. So much for empowering patient choice and control.

C. There Is No Requirement of Voluntariness, Consent or Capability When the Lethal Dose is Administered

HB 54 does not require administration of the lethal dose to be voluntary.[38] Similarly, there is no requirement of patient consent to administration.[39] There is no requirement that the patient be capable or even aware when the lethal dose is

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[38] HB 54 uses the word, "voluntarily," solely in relation to a <u>request</u> for the lethal dose, not administration. See HB 54, attached hereto at A-101 through A-112.

[39] HB 54 uses the word, "consent" just once, in the context of the obtaining the lethal dose from a pharmacist (not with regard to administration of the lethal dose). The bill, Sec. 3. § 13.55.050(a), p.3, starting at line 5, states:

> The attending provider shall: . . .
>
> (12) if the attending physician has a current federal Drug Enforcement Administration registration number and complies with applicable regulations, dispense medication directly, including ancillary medications intended to facilitate the desired effect or minimize the qualified individual's discomfort, <u>or, with the qualified individual's written consent</u>,
>
> (A) contact a pharmacist and inform the pharmacist of a prescription for the medication . . . . (Emphasis added).

Attached hereto at A-103 to A-104.

administered.[40] Without these requirements, patient choice and control is an illusion.

D. Someone Else Is Allowed to Administer the Lethal Dose to the Patient

Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer medication to a patient.[41]

Common examples of persons who administer medication under the direction of a doctor, include: nurses who administer prescription drugs to patients in a hospital setting; parents who administer prescription drugs to their children in a home setting; and adult children who administer prescription drugs to their parents in a home setting.[42]

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[40] HB 54 defines the term, "capable," to only be relevant during the lethal dose request process when a patient is to "make and communicate" health care decisions. The bill states:

> "capable" means that an individual has the ability to make and communicate health care decisions to health care providers . . . .

HB 54, Sec. 3, § 13.55.900(3), p. 10, lines 3 to 4, attached hereto at A-110.

[41] See Declaration of Kenneth Stevens, MD, 01/06/16, at A-51, ¶ 10, which states:

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

[42] Id.

HB 54 describes the lethal dose as a "medication" and allows a doctor to prescribe it.[43] The bill also describes a patient's life as being terminated by the patient. The bill states:

> [A] qualified individual may use medication obtained from the qualified individual's attending physician to end the qualified individual's life.[44]

There is, however, no language that a patient's life must be terminated by the patient.[45]

With self-termination not mandatory, generally accepted medical practice allow a doctor or a person acting under the direction of a doctor to administer medication (the lethal dose). Someone else is allowed to administer the lethal dose to the patient.

E. Allowing Someone Else to Administer the Lethal Dose is Euthanasia

Allowing someone else to administer the lethal dose to a patient is euthanasia under generally accepted medical terminology. Again, the AMA Code of Ethics, states:

> Euthanasia is the administration of a lethal agent <u>by another person to a patient</u> . . . . (Emphasis added.)[46]

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[43] The act defines "medication" as a "medication to end a qualified individual's life." See: HB 54, Sec. 3, § 13.55.900(11), page 11, lines 4-5, attached hereto at A-111.

[44] HB 54, Sec. 3, § 13.55.010(a), p.1, lines 13-14, attached at A-101.

[45] See HB 54 in its entirety, attached hereto at A-101 to A-112.

[46] Attached hereto at A-5 (lower half of the page).

F. The Bill Does Not Prohibit Euthanasia

HB 54 appears to prohibit euthanasia, which is also known as lethal injection and mercy killing.[47] The bill 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.[48]

This prohibition is defined away in the next sentence:

> 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. (Emphasis added).[49]

G. "Even If the Patient Struggled, Who Would Know?"

If for the purpose of argument, the bill does not allow euthanasia, patients are nonetheless at risk to the actions of other people. This is due to the complete lack of oversight at the death.

Without oversight, the opportunity is created for someone else to administer the lethal dose to the patient. The drugs used are water and alcohol soluble, such that they can be injected into a sleeping or restrained person.[50] Even if the

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[47] For definitions of "lethal injection" & "mercy killing," see A-52, A-53.

[48] HB 54, Sec. 3, § 13.55.230(b), page 9, lines 15-17, attached at A-109.

[49] Id., lines 17 to 19.

[50] The drugs used for assisted suicide in Oregon and Washington include Secobarbital and Pentobarbital (Nembutal). See "Secobarbital Sodium Capsules, Drugs.Com, at http://www.drugs.com/pr/seconal-sodium.html and

patient struggled, who would know?

Alex Schadenberg, Executive Director for the Euthanasia Prevention Coalition, puts it this way:

> With assisted suicide laws in Washington and Oregon [and with the proposed act], 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. . . . [I]f a patient struggled, "who would know?" (Emphasis added).[51]

VII. OREGON IS NOT A VALID CASE STUDY

Oregon is not a valid case study due to a near complete lack of transparency regarding its law.[52] Even law enforcement does not have access to the information collected.[53] Source documentation is destroyed.[54] The bottom line, Oregon's official

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http://www.drugs.com/pro/nembutal.html See also Oregon's government report, page 5, attached at A-34 (listing these drugs).

[51] Alex Schadenberg, Letter to the Editor, "Elder abuse a growing problem," *The Advocate*, Official Publication of the Idaho State Bar, October 2010, page 14, available at http://www.margaretdore.com/info/October_Letters.pdf

[52] See: "Declaration of Testimony" by Oregon attorney Isaac Jackson, dated September 18, 2012, attached hereto at A-57 to A-62 (regarding the run-around he got when he attempted to learn whether his client's father had died under Oregon's law - the Oregon Health Authority would neither confirm nor deny whether the father had died under the law); E-mail from Alicia Parkman, Oregon Mortality Research Analyst, to Margaret Dore, dated January 4, 2012, attached at A-63-A-64 (law enforcement cannot get access to information); Excerpt from Oregon's website at A-67 (patient identities "not recorded in any manner"); E-mail from Parkman to Dore, January 4, 2012, attached at A-65 to A-66 ("all source documentation" destroyed after one year); and the "Confidentiality of Death Certificates" policy issued by the Oregon Department of Human Resources Health Division, December 12, 1997, attached at A-68 to A-69 (clarifying that employees failing to comply with confidentiality rules "will immediately be terminated"), as published in the *Issues in Law & Medicine*, Volume 14, Number 3, 1998. See also documents attached at A-70 to A-72.

[53] Id.

[54] Id.

data cannot be verified.

VIII. OTHER CONSIDERATIONS

A. Compassion & Choices' Mission is to Promote Suicide

The bill's passage is being spearheaded by the suicide advocacy group, Compassion & Choices.

Compassion & Choices was formed in 2004 as the result of a merger/takeover of two other organizations.[55] One of these organizations was the former Hemlock Society, originally formed by Derek Humphry.[56]

In 2011, Humphry was the keynote speaker at Compassion & Choices' annual meeting in Washington State.[57] He was also in the news as a promoter of mail-order suicide kits.[58] This was after a depressed 29 year old man used one of the kits to kill himself.[59] Compassion & Choices' newsletter, promoting Humphry's

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[55] Ian Dowbiggin, A Concise History of Euthanasia 146 (2007)("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices."). Accord. Compassion & Choices Newsletter attached at A-73 ("Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion in Dying to become Compassion & Choices").

[56] Id.

[57] Compassion & Choices Newsletter, regarding Humphry's October 22, 2011 speaking date. (Attached hereto at A-73.)

[58] See Jack Moran, "Police kick in door in confusion over suicide kit," *The Register-Guard*, September 21, 2011 (""A spotlight was cast on the mail-order suicide kit business after a 29-year-old Eugene man committed suicide in December using a helium hood kit. The Register-Guard traced the $60 kit to [the company, which] has no website and does no advertising; clients find [the] address through the writings of Humphry.") (Attached hereto at A-74 to 75)(Emphasis added)

[59] Id.

presentation, references him as "the father of the modern movement for choice."[60] Compassion & Choices' mission is to promote suicide.

B. In Oregon, Other 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. This statistical correlation is consistent with a suicide contagion in which legalizing physician-assisted suicide encouraged other suicides. Consider the following:

> Oregon's assisted suicide act went into effect "in late 1997."[61]
>
> By 2000, Oregon's conventional suicide rate was "increasing significantly."[62]
>
> By 2007, Oregon's conventional suicide rate was 35% above the national average.[63]
>
> By 2010, Oregon's conventional suicide rate was 41% above the national average.[64]

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[60] Compassion & Choices Newsletter, at A-73.

[61] Oregon's assisted suicide report for 2014, first line, at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf

[62] *See* Oregon Health Authority News Release, 09/09/10. ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached at A-76)

[63] *Id.*

[64] Oregon Health Authority Report, Suicides in Oregon, Trends and Risk Factors (2012 Report), at A-78.

There is a significant financial cost associated with these other suicides. One reason is that people who attempt suicide (and fail) can injure themselves or become disabled by the attempt. A government report from Oregon states:

> [T]he estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.[65]

C. The Swiss Study: Physician-Assisted Suicide Can Be Traumatic for Family Members

In 2012, a European research study addressed trauma suffered by persons who witnessed legal physician-assisted suicide in Switzerland.[66] The study found that one out of five family members or friends present at an assisted suicide was traumatized. These people,

> experienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.[67]

D. My Clients Suffered Trauma in Oregon and Washington State

In Washington State and Oregon, I have had two cases where my clients suffered trauma due to legal assisted suicide. In the first case, one side of the family wanted the father to take the

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[65] See report at A-78.

[66] "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 (Cover page attached hereto at A-80)

[67] Id., at A-80.

lethal dose, while the other side did not. The father spent the last months of his life caught in the middle and torn over whether or not he should kill himself. My client, his adult daughter, was severely traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it's not clear that administration of the lethal dose was voluntary. A man who was present told my client that my client's father had refused to take the lethal dose when it was delivered, stating, "You're not killing me. I'm going to bed," but then he (the father) took it the next night when he was intoxicated on alcohol. The man who told this to my client subsequently changed his story.

My client, although he was not present, was traumatized over the incident, and also by the sudden loss of his father.

IX. CONCLUSION

Passing HB 54 will encourage people with years or decades to live to throw away their lives. The bill is sold as completely voluntary, but does not even have a provision requiring administration of the lethal dose to be voluntary. Administration of the lethal dose is allowed to occur in private without a doctor or witness present. If the patient objected or struggled, who would know? The bill allows legal murder. I urge you to vote "No" on HB 54.

Respectfully Submitted and Dated This 28th Day of March, 2017

Margaret Dore, Esq., MBA
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Appendix

Margaret Dore Memo

Reject HB 54

(Sponsor Substitute Version)

as of

March 28, 2017

CURRICULUM VITAE

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ATTORNEY EXPERIENCE:

Law Offices of Margaret K. Dore, P.S., Seattle, Washington USA.
Attorney/President. Work has included litigation, civil appeals, probate, guardianship and bankruptcy. Also participate in legislation and court cases involving assisted suicide and euthanasia in the US, Canada, Australia, South Africa and other jurisdictions. (October 1994 to present).

Lanz & Danielson, Seattle, Washington USA.
Attorney: Private practice emphasizing real estate litigation, bankruptcy, guardianship and appeals. (December 1990 to October 1994).

Self-Employed Attorney, Seattle, Washington USA.
Worked for other attorneys and private clients. Work emphasized appeals and litigation generally. (September 1989 to December 1990).

The United States Department of Justice, Office of the United States Trustee, Seattle, Washington USA.
Attorney: Government practice, emphasizing bankruptcy. (September 1988 to August 1989)

JUDICIAL CLERKSHIPS:

The Washington State Supreme Court, Olympia, Washington USA.
Law Clerk to Chief Justice Vernon R. Pearson. (August 1987 to August 1988).

The Washington State Court of Appeals, Tacoma, Washington USA.
Law Clerk to Judge John A. Petrich. (August 1986 to August 1987).

ADMITTED TO PRACTICE:

- Supreme Court of the United States, 2000-present.
- United States Court of Appeals for the Ninth Circuit, 1988-present.
- United States District Court, Western District of Washington 1988-present.
- Washington State Bar Association, 1986-present.

PROFESSIONAL MEMBERSHIPS:

- American Bar Association, 2001 to present.
- American Bar Association, Elder Law Committee of the Family Law Section, Chair 2007.
- Choice is an Illusion, President, 2010 to present.
- Fellows of the American Bar Foundation, Life Fellow, 2007 to present.
- King County Bar Association, 1989 to present.
- King County Bar Elder Law Section, Chair,1995-96.
- National Association of Elder Law Attorneys, 1996, 2001, present.
- Vision Awareness of Washington, President, 1993-2001.
- Washington State Trial Lawyers Association, 1996, other years.

PUBLICATIONS:

Assisted Suicide and Euthanasia

Margaret Dore, "California's New Assisted Suicide Law: Whose Choice Will it Be?," *JURIST* - Professional Commentary, October 24, 2015;

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, Winter 2014;

Margaret K. Dore, "Physician-Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice," *The Vermont Bar Journal*, Winter 2011;

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Margaret K. Dore, "Death with Dignity: What Do We Tell Our Clients?," Washington State Bar Association, *Bar News*, July 2009; and

Margaret K. Dore, "'Death with Dignity': What Do We Advise Our Clients?," King County Bar Association, *Bar Bulletin*, May 2009.

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Margaret K. Dore, Ten Reasons People Get Railroaded into Guardianship, 21 *American Journal of Family Law* 148, Winter 2008;

Margaret K. Dore, The Time is Now: Guardians Should be Licensed and Regulated Under the Executive Branch, Not the Courts, Washington State Bar Association, *Bar News*, March 2007;

Margaret K. Dore, A Call for Executive Oversight of Guardians, King County Bar Association, *Bar Bulletin*, March 2007;

Margaret K. Dore, The Case Against Court Certification of Guardians: The Case for Licensing and Regulation, National Academy of Elder Law Attorneys, *NAELA News*, Vol. 18, No. 1, February/March 2006;

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Margaret K. Dore, The "Friendly Parent" Concept: A Flawed Factor for Child Custody, 6 *Loyola Journal of Public Interest Law* 41 (2004);

Margaret K. Dore and J. Mark Weiss, "Washington Rejects 'Friendly Parent' Presumption in Child Custody Cases," Washington State Bar Association, *Bar News*, August 2001;

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Margaret K. Dore, "The Friendly Parent Concept (Access to Justice denied)," Washington State Trial Lawyers Association, *Trial News*, Volume 36, No. 9, May 2001;

Margaret K. Dore, "Parenting Evaluators and GALs: Practical Realities," King County Bar Association, *Bar Bulletin*, December 1999; and

Margaret K. Dore, "The Friendly Parent Concept--A Construct Fundamentally at Odds With The Parenting Act, RCW 26.09," Washington State Bar Association, *Family Law Section Newsletter*, Spring 1999.

AWARDS/RECOGNITIONS:

- Butch Blum Award of Excellence in the Legal Arena, for 2005, in association with *Law & Politics Magazine* (One of nine nominees, only solo practitioner).

- Wendy N. Davis, "Family Values in Flux: Some Lawyers are growing hostile to the 'friendly parent' idea in custody fights," *ABA Journal*, Vol. 87, p. 26, October 2001 (featuring Margaret Dore after victory in Washington State).

PUBLISHED DECISIONS:

- *In re Guardianship of Stamm*, 121 Wn. App. 830, 91 P.3d 126 (2004) (3-0 opinion limiting the admissibility of guardian ad litem testimony);

- *Lawrence v. Lawrence*, 105 Wn. App.683, 20 P.3d 972 (2001) (3-0 opinion re: the "friendly parent" concept, that its use in a child custody determination would be an abuse of discretion);

- *Kelly-Hansen v. Kelly-Hansen*, 87 Wn. App. 320, 941 P.2d 1108 (1997) (3-0 opinion re: post-dissolution dispute);

- *Jain v. State Farm*, 130 Wn.2d 688, 926 P.2d 923 (1996), (7-2 opinion re: insurance coverage and retroactive application of decisional law); and

- *In Re Alpine Group, Inc.*, 151 B.R. 931 (9th Cir. BAP 1993) (3-0 opinion re: attorney fees in bankruptcy).

EDUCATION:

University of Washington School of Law, Seattle, Washington USA.
Juris Doctorate, 1986.

University of Washington Foster School of Business, Seattle, Washington USA.
Masters of Business Administration, 1983; Concentration: Finance.

University of Washington Foster School of Business, Seattle, Washington USA.
Bachelor of Arts, Business Administration, 1979; Concentration: Accounting.
Honors: Graduated Cum Laude; Phi Beta Kappa.

Passed the C.P.A. examination in 1982.

Physicians may offer palliative sedation to unconsciousness to address refractory clinical symptoms, not to respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control. Existential suffering should be addressed through appropriate social, psychological or spiritual support.

AMA Principles of Medical Ethics: I,VII

5.7 Physician-Assisted Suicide

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

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately 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 engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I,IV

5.8 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. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

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.

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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.

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

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

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

Every morning when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.

The Washington Post

Morning Mix

This 80-year-old 'Black Widow,' who lured lonesome old men to horrible fates, is out of prison again

By Yanan Wang March 21, 2016

Like the men before him, Melissa Ann Shepard's last victim fell for her in more than one sense of the word.

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

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

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

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

Chambers told the CBC investigative program "The Fifth Estate" that only one of them appeared to be sick.

ADVERTISING

"Mr. Weeks didn't look well at all. He looked a little green, very gaunt-looking," she recounted. "Mrs. Weeks, on the other hand, she was beautifully groomed, in a lovely red suit."

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

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

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

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

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

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

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

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

The Halifax Regional Police advised Friday, upon Shepard's release, that "a high risk offender is residing in our community." Authorities have ordered her not to use the Internet, to report any changes to her appearance and to abide by an

11 p.m. curfew. Any romantic relationships must also be reported to the police, so that prospective partners can be informed of her history.

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

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

Strategos, a Florida man, learned this the hard way after meeting Shepard on an online dating site. "I was just lonely, and I figured this was a good chance for me to find somebody and get together, and start a perfect life," Strategos told the CBC.

But from the start, Strategos's relationship with her was far from idyllic. Shepard drove down from Canada in a white Cadillac to meet Strategos for their first date, and spent the night in his bed. While she slept, he awoke to go to the bathroom and felt dizzy, his vision blurred.

The nausea continued night after night, and Strategos started to regularly fall and pass out. He eventually surmised that she was spiking the ice cream that she fed to him every night. By the time Shepard was sentenced to five years in prison for stealing $20,000 from Strategos, his savings were depleted, but he was still alive. The same couldn't be said for Shepard's prior two male companions.

Before Strategos and Weeks, there was Robert Friedrich, a successful engineer whom Shepard met at church in 2001.

"The Holy Spirit told me that this man would be my next husband," Shepard explained to the CBC in 2005, in a rare interview from prison. Three days after meeting, the pair was engaged and soon embarked on a five-month honeymoon across North America, paid for by Friedrich's life savings of approximately $250,000.

Friedrich's deteriorating health during that period would be a harbinger of Shepard's later experiences with Strategos and Weeks: He started falling constantly and was often in the hospital.

After the honeymoon, Shepard left Friedrich's son Bob a menacing voice mail, the CBC reported, announcing that he and his two brothers were being taken out of Friedrich's will.

"I have something to share with you this morning," Shepard said to Bob, according to the CBC, which broadcast her voice mail on television. "Your father is going to change his will. ... You guys are getting nothing, a big fat zero. So try that on for size, and have a nice day."

No more than a year after Shepard was supposedly moved to make Friedrich her husband, he passed away, leaving her some $100,000. Shepard has never been charged for anything in connection with that marriage.

KTVZ.COM
CENTRAL OREGON'S NEWS LEADER

Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

News sources
POSTED: 11:35 PM PDT September 7, 2011 UPDATED: 4:36 AM PDT July 14, 2011
BEND, Ore. -

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

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

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

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

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

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

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

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

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

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

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

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

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

Sawyer and her husband, a former Bend police captain, face trial scheduled for December in Eugene on federal charges of money laundering, wire fraud and conspiracy to commit wire fraud. They are accused of using investor money to pay for personal property, causing investors to lose $4.4 million.

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Sunday, July 10, 2016 10:49 pm

State dropping Tami Sawyer fraud case

DOJ says prosecution likely would not add time behind bars

Barney Larten

POSTED: 10:59 AM PST December 24, 2013
UPDATED: 2:21 PM PDT October 30, 2013

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Lane County Jail

Tami and Kevin Sawyer were booked into the Lane County Jail in Eugene last spring after their federal sentencing on fraud charges

BEND, Ore. - With former Bend real estate broker Tami Sawyer already serving a nine-year federal prison term on fraud and money-laundering convictions, the Oregon Department of Justice said Wednesday it has moved to dismiss another fraud case against her.

MORE FROM KTVZ.COM

- Sawyers' tenants still will pay the couple in prison
- Sawyers go to prison; victims see justice - but money?
- Tami Sawyer Back in Bend Court; Plea Delayed
- Tami Sawyer in Court; Plea Hearing Reset
- Failure to Show Up for Court Not Uncommon
- Sawyers Agree To $809,000 Lawsuit Settlement

Sawyer and her husband, Kevin, a former Bend police captain, were sentenced last spring to years in prison – two for him – for fraud, money-laundering and other crimes. They also were ordered by the federal judge to pay nearly $6 million to their victims.

Another fraud case brought by the Oregon Department of Justice has been pending, involving Tami Sawyer's handling of the Thomas Middleton Trust. The state accused her of pocketing part of the proceeds when she sold Middleton's home in 2008, after his death, putting proceeds into her now-defunct firm, Starboard LLC, then transferring $90,000 to two of her other companies.

One of Middleton's sons, David Middleton of Redmond, expressed dismay at learning the state was dropping its case. But state Department of Justice spokesman Michael Kron told NewsChannel 21 they had to take a "hard look" at the costs vs. likely outcome of continuing to pursue a case that likely would not add to her time behind bars.

"We understand, of course, their preference would be to get the conviction," Kron said. "In taking a hard look at it, our sense of it was that there was no additional money to go after, and it's very unlikely we'd get additional jail time for Mrs. Sawyer, given the fact they (the Middleton heirs) were victims in both cases."

"It's unlikely the court would add jail time on top of the existing (federal) sentence, so they would be

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May 2009 Bar Bulletin

'Death with Dignity':

What Do We Advise Our Clients?

By Margaret Dore

A client wants to know about the new Death with Dignity Act, which legalizes physician-assisted suicide in Washington.[1] Do you take the politically correct path and agree that it's the best thing since sliced bread? Or do you do your job as a lawyer and tell him that the Act has problems and that he may want to take steps to protect himself?

Patient "Control" is an Illusion

The new act was passed by the voters as Initiative 1000 and has now been codified as Chapter 70.245 RCW.

During the election, proponents touted it as providing "choice" for end-of-life decisions. A glossy brochure declared, "Only the patient — and no one else — may administer the [lethal dose]."[2] The Act, however, does not say this — anywhere. The Act also contains coercive provisions. For example, it allows an heir who will benefit from the patient's death to help the patient sign up for the lethal dose.

How the Act Works

The Act requires an application process to obtain the lethal dose, which includes a written request form with two required witnesses.[3] The Act allows one of these witnesses to be the patient's heir.[4] The Act also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient's heir.[5] This does not promote patient choice; it invites coercion.

Interested witness

By comparison, when a will is signed, having an heir as one of witnesses creates a presumption of undue influence. The probate statute provides that when one of the two required witnesses is a taker under the will, there is a

Originally published in the May 2009 issue of the King County Bar Association Bar Bulletin. Reprinted with permission of the King County Bar Association.

rebuttable presumption that the taker/witness "procured the gift by duress, menace, fraud, or undue influence."[6]

Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons. Indeed, no one is required to be present. The Act does not state that "only" the patient may administer the lethal dose; it provides that the patient "self-administer" the dose.

"Self-administer"

In an Orwellian twist, the term "self-administer" does not mean that administration will necessarily be by the patient. "Self-administer" is instead defined as the act of ingesting. The Act states, "'Self-administer' means a qualified patient's act of ingesting medication to end his or her life."[7]

In other words, someone else putting the lethal dose in the patient's mouth qualifies as "self-administration." Someone else putting the lethal dose in a feeding tube or IV nutrition bag also would qualify. "Self-administer" means that someone else can administer the lethal dose to the patient.

No witnesses at the death

If, for the purpose of argument, "self-administer" means that only the patient can administer the lethal dose himself, the patient still is vulnerable to the actions of other people, due to the lack of required witnesses at the death.

With no witnesses present, someone else can administer the lethal dose without the patient's consent. Indeed, someone could use an alternate method, such as suffocation. Even if the patient struggled, who would know? The lethal dose request would provide an alibi.

This situation is especially significant for patients with money. A California case states, "Financial reasons [are] an all too common motivation for killing someone."[8] Without disinterested witnesses, the patient's control over the "time, place and manner" of his death, is not guaranteed.

If one of your clients is considering a "Death with Dignity" decision, it is prudent to be sure that they are aware of the Act's gaps.

What to Tell Clients

1. Signing the form will lead to a loss of control

By signing the form, the client is taking an official position that if he dies suddenly, no questions should be asked. The client will be unprotected against others in the event he changes his mind after the lethal prescription is filled and decides that he wants to live. This would seem especially important for clients with money. There is, regardless, a loss of control.

2. Reality check

The Act applies to adults determined by an "attending physician" and a "consulting physician" to have a disease expected to produce death within six months.[9] But what if the doctors are wrong? This is the point of a recent article in The Seattle Weekly: Even patients with cancer can live years beyond expectations[10]. The article states:

> Since the day [the patient] was given two to four months to live, [she] has gone with her children on a series of vacations . . . .

"We almost lost her because she was having too much fun, not from cancer," [her son chuckles].[11]

Conclusion

As lawyers, we often advise our clients of worst-case scenarios. This is our obligation regardless of whether it is politically correct to do so. The Death with Dignity Act is not necessarily about dignity or choice. It also can enable people to pressure others to an early death or even cause it. The Act also may encourage patients with years to live to give up hope. We should advise our clients accordingly.

Margaret Dore is a Seattle attorney admitted to practice in 1986. She is the immediate past chair of the Elder Law Committee of the ABA Family Law Section. She is a former chair of what is now the King County Bar Association Guardianship and Elder Law Section. For more information, visit her website at www.margaretdore.com.

1 The Act was passed by the voters in November as Initiative 1000 and has now been codified as RCW chapter 70.245.

2 I-1000 color pamphlet, "Paid for by Yes! on 1000."

3 RCW 70.245.030 and .220 state that one of two required witnesses to the lethal-dose request form cannot be the patient's heir or other person who will benefit from the patient's death; the other may be.

4 id.

5 RCW 70.245.010(3) allows someone else to talk for the patient during the lethal-dose request process; for example, there is no prohibition against this person being the patient's heir or other person who will benefit from the patient's death. The only requirement is that the person doing the talking be "familiar with the patient's manner of communicating."

6 RCW 11.88.160(2).

7 RCW 70.245.010(12).

8 People v. Stuart, 67 Cal. Rptr. 3rd 129, 143 (2007).

9 RCW 70.245.010(11) & (13).

10 Nina Shapiro, "Terminal Uncertainty," Washington's new "Death with Dignity" law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong? The Seattle Weekly, January 14, 2009. http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty.

11 id.

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ARIZONA CAPITOL TIMES
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OCTOBER 13, 2016
5:30 - 7:30 PM
LEADERS OF THE YEAR

Brewer signs bill targeting assisted suicide

By: The Associated Press April 30, 2014 , 5:32 pm

Rep. Justin Pierce, R-Mesa. (Cronkite News Service Photo by Laura Dickerson)

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.

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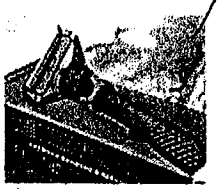

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La. assisted-suicide ban strengthened

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.

Georgia General Assembly

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

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First Reader Summary

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

Status History

May/01/2012 - Effective Date
May/01/2012 - Act 639
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

Votes

Mar/29/2012 - Senate Vote #888	Yea(38)	Nay(11)	NV(7)	Exc(0)

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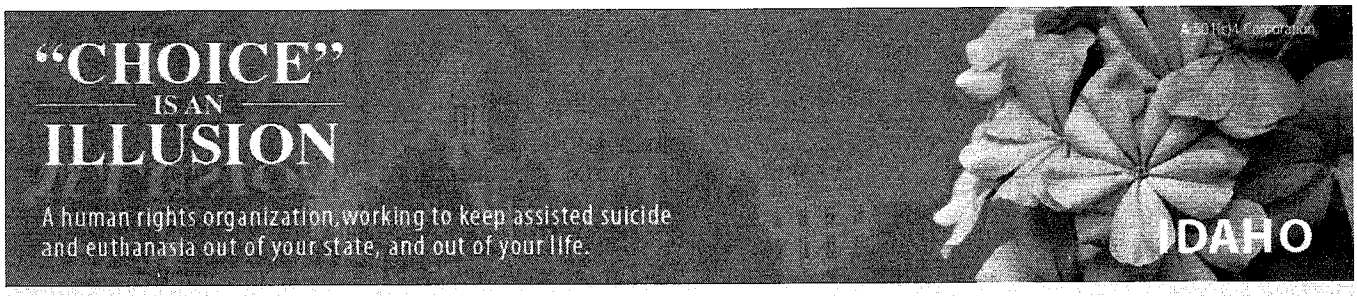

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VOICES AGAINST ASSISTED SUICIDE AND EUTHANASIA

- "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"

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- Idaho Strengthens its Law Against Assisted Suicide
- 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
- What People Mean When They Say They Want to Die
- Who is at Risk?
- Definitions

BAR ARTICLES

- Idaho: The Advocate

MONDAY, JULY 4, 2011

Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

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]

* * *

[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,

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LABELS

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- assisted suicide (1)
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- Kathryn Tucker (1)
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- Robert E. Bakes (1)
- S1070 (1)

IDAHO ARCHIVE

- 2011 (1)
  - July (1)
    - Idaho Strengthens Law Against Assisted-Suicide

A-22

by the protections outlined in the UHCDA and the Pain Relief Act, and therefore the government interests we have identified, similar to those in *Glucksberg*, are supported by a firm legal rationale. Applying this to Petitioners' challenge, we conclude that there is a firm legal rationale behind (1) the interest in protecting the integrity and ethics of the medical profession; (2) the interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes due to the real risk of subtle coercion and undue influence in end-of-life situations or the desire of some to resort to physician aid in dying to spare their families the substantial financial burden of end-of-life health care costs; and (3) the legitimate concern that recognizing a right to physician aid in dying will lead to voluntary or involuntary euthanasia because if it is a right, it must be made available to everyone, even when a duly appointed surrogate makes the decision, and even when the patient is unable to self-administer the life-ending medication. *See* 521 U.S. at 731–33, 117 S.Ct. 2258; Part III, ¶ 27, *supra*. Petitioners nonetheless maintain that the *Glucksberg* Court either did not have the same evidence before it that we do today, including data from several states and established practices in those states, and therefore concerns addressed in *Glucksberg* are no longer valid, or never came to fruition. However, in New Mexico these very concerns are addressed in the UHCDA, which was most recently amended in 2015, indicating not only the desirability of legislation in areas such as aid in dying, but also reflecting legitimate and ongoing legal rationales that *Glucksberg* raised nearly twenty years ago which endure today. Although it is unlawful in New Mexico to assist someone in committing suicide, the exceptions contained within the UHCDA and the Pain Relief Act narrow the statute's application, provided that physicians comply with the rigorous requirements of each act. Therefore, when the relevant legislation is read as a whole, Section 30–2–4 is rationally related to the aforementioned legitimate government interests. If we were to recognize an absolute, fundamental right to physician aid in dying, constitutional questions would abound regarding legislation that defined terminal illness or provided for protective procedures to assure that a patient was making an informed and independent decision. Regulation in this area is essential, given that if a patient carries out his or her end-of-life decision it cannot be reversed, even if it turns out that the patient did not make the decision of his or her own free will.

VIII. CONCLUSION

{58} Pursuant to New Mexico's heightened rational basis analysis, and based on the record before us and the arguments of the parties, we conclude that although physician aid in dying falls within the proscription of Section 30–2–4, this statute is neither unconstitutional on its face nor as it is applied to Petitioners. For the foregoing reasons, we reverse the district court's contrary conclusion and remand to the district court for proceedings consistent with this opinion.

{59} **IT IS SO ORDERED.**

WE CONCUR:

CHARLES W. DANIELS, Chief Justice

PETRA JIMENEZ MAES, Justice

BARBARA J. VIGIL, Justice

JAMES M. HUDSON, District Judge, Sitting by designation

All Citations

376 P.3d 836, 2016 -NMSC- 027

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Morris v. Brandenburg
376 P.3d 836

Oregon Revised Statute

Chapter 127

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

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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

IN THE STATE OF COLORADO

IN RE PROPOSED INITIATIVE #124	**DECLARATION OF WILLIAM TOFFLER, MD**

I, WILLIAM TOFFLER, declare the following under penalty of perjury.

1. 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 physician-assisted suicide, which is legal in Oregon, and which I understand has been proposed for legalization in Colorado.

2. Oregon's law applies to "terminal" patients who are predicted to have less than six months to live. Our law defines terminal as follow:

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

Exhibit A, attached hereto.

3. In practice, this definition is interpreted to include people with chronic conditions such as "chronic lower respiratory disease" and "diabetes mellitus," better known as "diabetes."

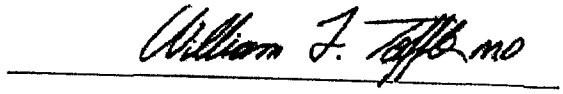
4. In Oregon, people with chronic conditions are "terminal," if

without their medications, they have less than six months of live. This is significant when you consider that a typical insulin-dependent 20 year-old-year *will live less than a month without insulin*. Such persons, with insulin, are likely to have decades to live; in fact, most diabetics have a normal life span given appropriate control of their blood sugar.

5. I am concerned that by labelling people with chronic conditions "terminal," there will be an excuse to deny such persons medical treatment so that they can continue to live healthy and productive lives. Oregon's Medicaid program is already denying treatment to some patients based on a statistical prognosis.

6. To read the most recent Oregon government report on our law, listing chronic conditions as an "underlying illness" to justify assisted-suicide, please see Exhibit B attached hereto.

Signed under penalty of perjury, this 11th day of April 2016



William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239

Oregon Revised Statute

Chapter 127

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(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.

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(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.

TOFFLER EXHIBIT A
A-28

OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY

Oregon Public Health Division
February 4, 2016

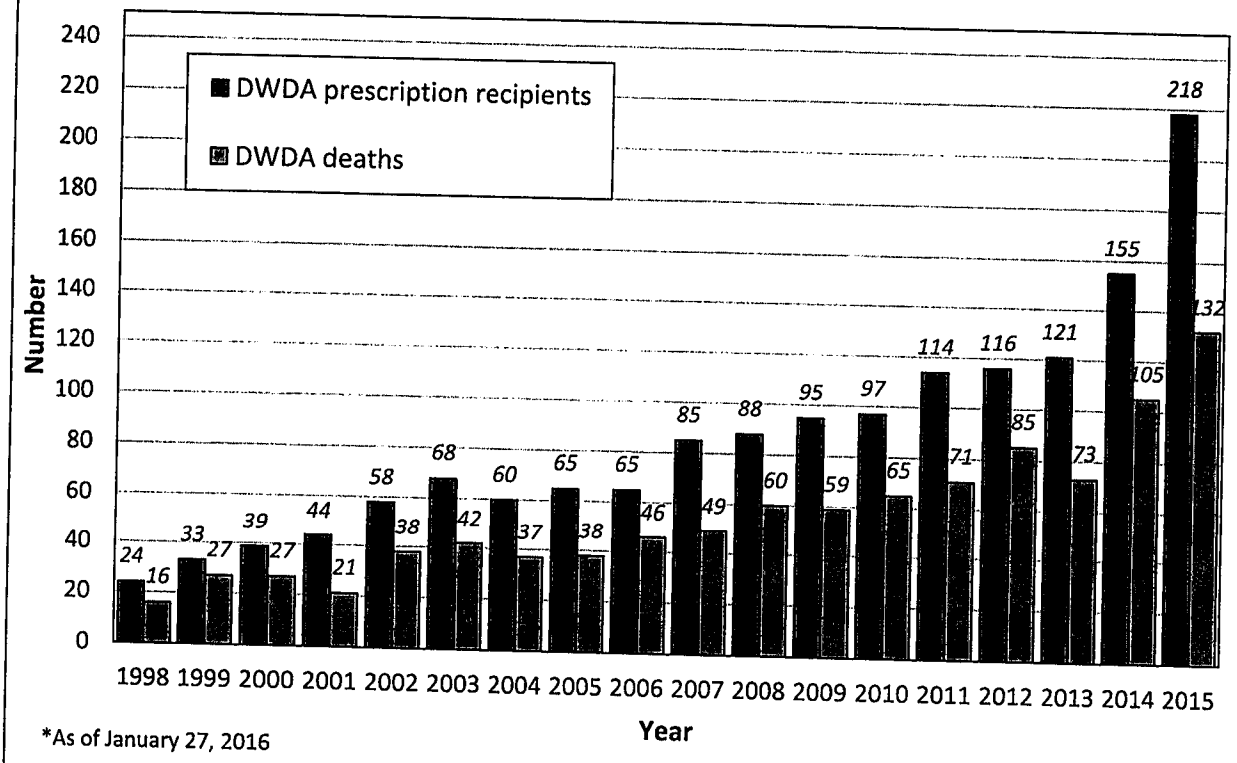
For more information:
http://www.healthoregon.org/dwd
Contact: DWDA.info@state.or.us

TOFFLER EXHIBIT B

Introduction

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. Data presented in this summary, including the number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of the medications (DWDA deaths), are based on required reporting forms and death certificates received by the Oregon Public Health Division as of January 27, 2016. More information on the reporting process, required forms, and annual reports is available at: http://www.healthoregon.org/dwd.

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



*As of January 27, 2016

Participation Summary and Trends

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

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

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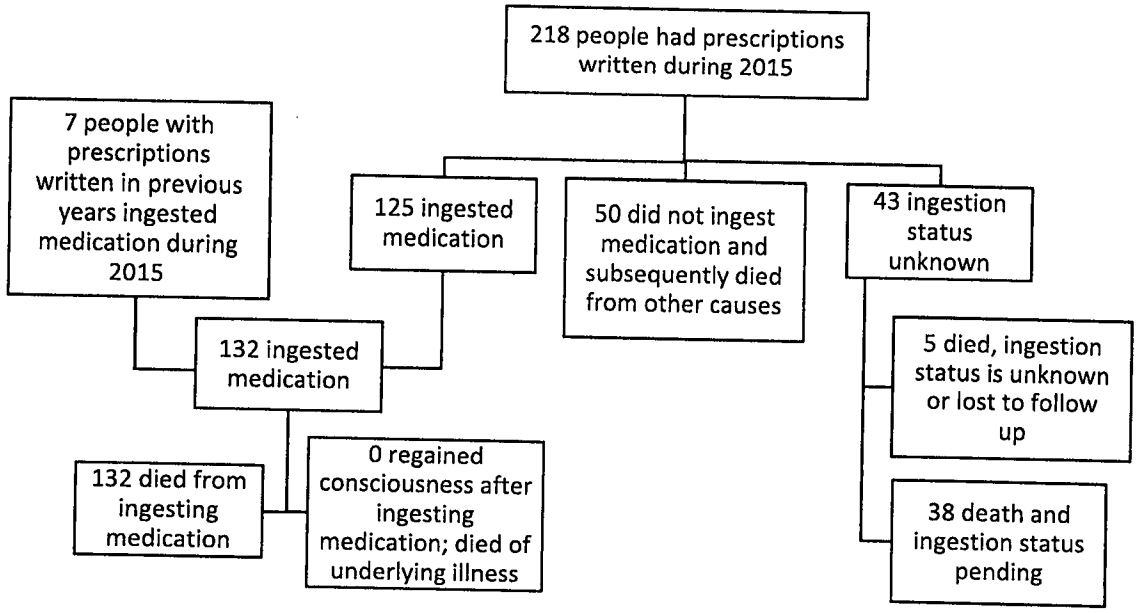
2015, the number of prescriptions written increased by an average of 24.4%. During 2015, the rate of DWDA deaths was 38.6 per 10,000 total deaths.[1]

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

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

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2015, as of January 27, 2016



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

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http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf

Patient Characteristics

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

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

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

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

DWDA Process

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

A procedure revision was made in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. For 27 patients, either the prescribing physician or another healthcare provider was present at the time of death. Prescribing physicians were present at time of death for 14 patients (10.8%) during 2015 compared to 15.7% in previous years; 13 additional cases had other health care providers present (e.g. hospice nurse). Data on time from ingestion to death is available for only 25 DWDA deaths during 2015. Among those 25 patients, time from ingestion until death ranged from five minutes to 34 hours. For the remaining two patients, the length of time between ingestion and death was unknown.

Table 1. Characteristics and end-of-life care of 991 DWDA patients who have died from ingesting DWDA medications, by year, Oregon, 1998-2015

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Sex	N (%)	N (%)	N (%)
Male (%)	56 (42.4)	453 (52.7)	509 (51.4)
Female (%)	76 (57.6)	406 (47.3)	482 (48.6)
Age at death (years)			
18-34 (%)	1 (0.8)	7 (0.8)	8 (0.8)
35-44 (%)	5 (3.8)	18 (2.1)	23 (2.3)
45-54 (%)	2 (1.5)	61 (7.1)	63 (6.4)
55-64 (%)	21 (15.9)	184 (21.4)	205 (20.7)
65-74 (%)	41 (31.1)	247 (28.8)	288 (29.1)
75-84 (%)	30 (22.7)	229 (26.7)	259 (26.1)
85+ (%)	32 (24.2)	113 (13.2)	145 (14.6)
Median years (range)	73 (30-102)	71 (25-96)	71 (25-102)
Race			
White (%)	122 (93.1)	831 (97.1)	953 (96.6)
African American (%)	0 (0.0)	1 (0.1)	1 (0.1)
American Indian (%)	0 (0.0)	2 (0.2)	2 (0.2)
Asian (%)	4 (3.1)	9 (1.1)	13 (1.3)
Pacific Islander (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	0 (0.0)	3 (0.4)	3 (0.3)
Two or more races (%)	1 (0.8)	3 (0.4)	4 (0.4)
Hispanic (%)	4 (3.1)	6 (0.7)	10 (1.0)
Unknown	*1*	*3*	*4*
Marital status			
Married (including Registered Domestic Partner) (%)	52 (39.7)	395 (46.1)	447 (45.3)
Widowed (%)	34 (26.0)	198 (23.1)	232 (23.5)
Never married (%)	9 (6.9)	69 (8.1)	78 (7.9)
Divorced (%)	36 (27.5)	194 (22.7)	230 (23.3)
Unknown	*1*	*3*	*4*
Education			
Less than high school (%)	7 (5.4)	51 (6.0)	58 (5.9)
High school graduate (%)	31 (23.8)	187 (21.9)	218 (22.2)
Some college (%)	36 (27.7)	224 (26.2)	260 (26.4)
Baccalaureate or higher (%)	56 (43.1)	392 (45.9)	448 (45.5)
Unknown	*2*	*5*	*7*
Residence			
Metro counties (Clackamas, Multnomah, Washington) (%)	64 (49.2)	361 (42.3)	425 (43.2)
Coastal counties (%)	7 (5.4)	63 (7.4)	70 (7.1)
Other western counties (%)	48 (36.9)	365 (42.7)	413 (42.0)
East of the Cascades (%)	11 (8.5)	65 (7.6)	76 (7.7)
Unknown	*2*	*5*	*7*
End-of-life care			
Hospice			
Enrolled (%)	118 (92.2)	747 (90.2)	865 (90.5)
Not enrolled (%)	10 (7.8)	81 (9.8)	91 (9.5)
Unknown	*4*	*31*	*35*
Insurance			
Private (alone or in combination) (%)	44 (36.7)	489 (60.2)	533 (57.2)
Medicare, Medicaid or other governmental (%)	75 (62.5)	311 (38.3)	386 (41.4)
None (%)	1 (0.8)	12 (1.5)	13 (1.4)
Unknown	*12*	*47*	*59*

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http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Underlying illness			
Malignant neoplasms (%)	**95 (72.0)**	**667 (77.9)**	**762 (77.1)**
Lung and bronchus (%)	23 (17.4)	154 (18.0)	177 (17.9)
Breast (%)	9 (6.8)	64 (7.5)	73 (7.4)
Colon (%)	7 (5.3)	54 (6.3)	61 (6.2)
Pancreas (%)	7 (5.3)	56 (6.5)	63 (6.4)
Prostate (%)	5 (3.8)	35 (4.1)	40 (4.0)
Ovary (%)	3 (2.3)	33 (3.9)	36 (3.6)
Other (%)	41 (31.1)	271 (31.7)	312 (31.6)
Amyotrophic lateral sclerosis (%)	**8 (6.1)**	**71 (8.3)**	**79 (8.0)**
Chronic lower respiratory disease (%)	**6 (4.5)**	**38 (4.4)**	**44 (4.5)**
Heart disease (%)	**9 (6.8)**	**17 (2.0)**	**26 (2.6)**
HIV/AIDS (%)	**0 (0.0)**	**9 (1.1)**	**9 (0.9)**
Other illnesses (%)[2]	**14 (10.6)**	**54 (6.3)**	**68 (6.9)**
Unknown	***0***	***3***	***3***
DWDA process			
Referred for psychiatric evaluation (%)	5 (3.8)	47 (5.5)	52 (5.3)
Patient informed family of decision (%)[3]	126 (95.5)	729 (93.2)	855 (93.5)
Patient died at			
Home (patient, family or friend) (%)	118 (90.1)	810 (94.6)	928 (94.0)
Long term care, assisted living or foster care facility (%)	9 (6.9)	37 (4.3)	46 (4.7)
Hospital (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	4 (3.1)	8 (0.9)	12 (1.2)
Unknown	*1*	*3*	*4*
Lethal medication			
Secobarbital (%)	114 (86.4)	466 (54.2)	580 (58.5)
Pentobarbital (%)	1 (0.8)	385 (44.8)	386 (39.0)
Phenobarbital/chloral hydrate/morphine sulfate mix (%)	16 (12.1)	0 (0.0)	16 (1.6)
Other (combination of above and/or morphine) (%)	1 (0.8)	8 (0.9)	9 (0.9)
End of life concerns[4]	**(N=132)**	**(N=859)**	**(N=991)**
Less able to engage in activities making life enjoyable (%)	127 (96.2)	758 (88.7)	885 (89.7)
Losing autonomy (%)	121 (92.4)	782 (91.5)	903 (91.6)
Loss of dignity (%)[5]	98 (75.4)	579 (79.3)	677 (78.7)
Losing control of bodily functions (%)	46 (35.7)	428 (50.1)	474 (48.2)
Burden on family, friends/caregivers (%)	63 (48.1)	342 (40.0)	405 (41.1)
Inadequate pain control or concern about it (%)	37 (28.7)	211 (24.7)	248 (25.2)
Financial implications of treatment (%)	3 (2.3)	27 (3.2)	30 (3.1)
Healthcare provider present (collected 2001-present)	**(N=132)**	**(N=789)**	**(N=921)**
When medication was ingested[6]			
Prescribing physician	15	133	148
Other provider, prescribing physician not present	13	243	256
No provider	6	81	87
Unknown	*98*	*332*	*430*
At time of death			
Prescribing physician (%)	14 (10.8)	121 (15.7)	135 (15.0)
Other provider, prescribing physician not present (%)	13 (10.0)	268 (34.7)	281 (31.2)
No provider (%)	103 (79.2)	383 (49.6)	486 (53.9)
Unknown	*2*	*17*	*19*

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Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Complications[6]	(N=132)	(N=859)	(N=991)
Regurgitated	2	22	24
Other	2	1	3
None	23	506	529
Unknown	*105*	*330*	*435*
Other outcomes			
Regained consciousness after ingesting DWDA medications[7]	0	6	6
Timing of DWDA event			
Duration (weeks) of patient-physician relationship			
Median	9	13	12
Range	1-1004	0-1905	0-1905
Number of patients with information available	*132*	*857*	*989*
Number of patients with information unknown	*0*	*2*	*2*
Duration (days) between 1st request and death			
Median	45	47	46
Range	15-517	15-1009	15-1009
Number of patients with information available	*131*	*859*	*990*
Number of patients with information unknown	*1*	*0*	*1*
Minutes between ingestion and unconsciousness[6]			
Median	5	5	5
Range	2-15	1-38	1-38
Number of patients with information available	*25*	*506*	*531*
Number of patients with information unknown	*107*	*353*	*460*
Minutes between ingestion and death[6]			
Median	25	25	25
Range (minutes - hours)	5mins-34hrs	1min-104hrs	1min-104hrs
Number of patients with information available	*25*	*511*	*536*
Number of patients with information unknown	*107*	*348*	*455*

1 Unknowns are excluded when calculating percentages.

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

3 First recorded beginning in 2001. Since then, 40 patients (4.4%) have chosen not to inform their families, and 19 patients (2.1%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.

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

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

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

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

diabetes

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

12 million Americans misdiagnosed each year

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

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

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

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

→ More from Morning Rounds with Dr. LaPook

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

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

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A-36

CANADA C O U R S U P É R I E U R E

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

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 1st, 2012

NAME: Heidi Pruzynski

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:

HEIDI PRUZYNSKI
MY COMMISSION EXPIRES
JUNE 22, 2018
COMMONWEALTH OF MASSACHUSETTS
NOTARY PUBLIC

JOHN NORTON

CANADA

COUR SUPÉRIEURE

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 KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

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

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

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

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

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

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

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

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

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

Attached hereto at page SI-1.

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

10. The term, "less than 24 months median survival with treatment," means that statistically half the patients receiving treatment will live less than 24 months (two years) and the other half will live longer than two years.

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

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

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

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

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

NAME: Jessica Borgo

A notary in and for the
State of Oregon

ADDRESS: 16100 SW Tualatin-Sherwood Rd

EXPIRY OF COMMISSION: Aug, 30, 2015

PLACE SEAL HERE: Jessica Borgo

OFFICIAL SEAL
JESSICA R BORGO
NOTARY PUBLIC - OREGON
COMMISSION NO. 461438
MY COMMISSION EXPIRES AUGUST 30, 2015

Ken Stevens MD

Ken Stevens, MD

STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

A) without regard to a patient's expected length of life:
   - Inpatient palliative care consultation; and,
   - Outpatient palliative care consultation, office visits.

B) with an expected median survival of less than one year, as supported by the best available published evidence:
   - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.

C) with an expected median survival of six months or less, as supported by peer-reviewed literature:
   - Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

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

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

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

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 pegfilgrastrim) 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.

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

DECLARATION OF JEANETTE HALL

I, JEANETTE HALL, declare as follows:

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

2. In 2000, I was diagnosed with cancer and told that I had 6 months to a year to live. I knew that our law had passed, but I didn't know exactly how to go about doing it. I tried to ask my doctor, Kenneth 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 July, it will be 16 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 30 day of June 2016

Jeanette Hall

Jeanette Hall

E:\ASE 2016 +\Colorado Initiative\Jeanette Hall Declaration.wpd

WESTLAW

West's Hawai'i Revised Statutes Annotated
Division 4. Courts and Judicial Proceedings
Title 36. Civil Remedies and Defenses and Special Proceedings

§ 671-3. Informed consent
West's Hawai'i Revised Statutes Annotated Division 4. Courts and Judicial Proceedings *(Approx. 2 pages)*

HRS § 671-3

§ 671-3. Informed consent

Currentness

(a) The Hawaii medical board may establish standards for health care providers to follow in giving information to a patient, or to a patient's guardian or legal surrogate if the patient lacks the capacity to give an informed consent, to ensure that the patient's consent to treatment is an informed consent. The standards shall be consistent with subsection (b) and may include:

(1) The substantive content of the information to be given;

(2) The manner in which the information is to be given by the health care provider; and

(3) The manner in which consent is to be given by the patient or the patient's guardian or legal surrogate.

(b) The following information shall be supplied to the patient or the patient's guardian or legal surrogate prior to obtaining consent to a proposed medical or surgical treatment or a diagnostic or therapeutic procedure:

(1) The condition to be treated;

(2) A description of the proposed treatment or procedure;

(3) The intended and anticipated results of the proposed treatment or procedure;

(4) The recognized alternative treatments or procedures, including the option of not providing these treatments or procedures;

(5) The recognized material risks of serious complications or mortality associated with:

(A) The proposed treatment or procedure;

(B) The recognized alternative treatments or procedures; and

(C) Not undergoing any treatment or procedure; and

(6) The recognized benefits of the recognized alternative treatments or procedures.

(c) On or before January 1, 1984, the Hawaii medical board shall establish standards for health care providers to follow in giving information to a patient or a patient's guardian, to ensure that the patient's consent to the performance of a mastectomy is an informed consent. The standards shall include the substantive content of the information to be given, the manner in which the information is to be given by the health care provider and the manner in which consent is to be given by the patient or the patient's guardian. The substantive content of the information to be given shall include information on the recognized alternative forms of treatment.

(d) Nothing in this section shall require informed consent from a patient or a patient's guardian or legal surrogate when emergency treatment or an emergency procedure is rendered by a health care provider and the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of the patient's health.

(e) For purposes of this section, "legal surrogate" means an agent designated in a power of attorney for health care or surrogate designated or selected in accordance with chapter 327E.

Credits

Laws 1976, ch. 219, § 2; Laws 1982, ch. 95, § 1; Laws 1983, ch. 223, § 2; Laws 1983, ch. 284, § 1; Laws 2003, ch. 114, § 2; Laws 2008, ch. 9, § 3, eff. April 11, 2008.

NOTES OF DECISIONS (97)

Breach of duty to inform
Consent forms
Consulting and referring physicians
Contributory negligence
Duty to inform patient
Elements and standards of informed consent
Full disclosure
Incompetent persons
Informed consent, generally
Instructions
Preservation of issues
Presumptions and burden of proof
Review
Risks to patient and alternatives
Testimony of experts
Therapeutic privilege exception
Verdicts
Waiver
Weight and sufficiency of evidence

BEFORE THE LEGISLATURE OF THE STATE OF NEW YORK

IN RE NEW YORK BILLS	**DECLARATION OF KENNETH STEVENS, MD**

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

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

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

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

cancer. I understand that he had referred her to me.

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

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

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

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

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

9. Finally, I have been asked to comment on generally accepted medical practice regarding the administration of prescription drugs to a patient.

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

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

Kenneth Stevens Jr. MD

Kenneth Stevens, Jr., MD
Sherwood, Oregon

Adult Asthma Symptoms?
Get Info On An Asthma Control Treatment For Adults Here.
www.Asthma-Control-Treatment.com

lethal injection

noun

the act or instance of injecting a drug for purposes of capital punishment or euthanasia

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Examples from the Web for lethal injection

Contemporary Examples

Rangers caught the dingo and put it down with *lethal injection*.

(http://www.thedailybeast.com/?source=dictionary) Pets or Predators? 10 Things About Australia's Famous Dog, the Dingo (http://www.thedailybeast.com/articles/2012/06/13/pets-or-predators-10-things-on-australia-s-famous-dog-the-dingo.html?source=dictionary)

Meredith Kaufman (http://www.thedailybeast.com/contributors/meredith-kaufman.html?source=dictionary)

June 12, 2012

lethal injection is allowed as a form of execution in all thirty-two states that have the death penalty.

(http://www.thedailybeast.com/?source=dictionary) Arizona Botches Execution (http://www.thedailybeast.com/articles/2014/07/23/arizona-botches-execution.html?source=dictionary)

Ben Jacobs (http://www.thedailybeast.com/contributors/ben-jacobs.html?source=dictionary)

July 22, 2014

Death by pills or *lethal injection* might be unnatural, but she believes that declining nourishment and medications is not.

(http://www.thedailybeast.com/?source=dictionary) The Nurse Coaching People Through Death by Starvation (http://www.thedailybeast.com/articles/2014/11/17/the-nurse-coaching-people-through-suicide-by-starvation.html?source=dictionary)

Nick Tabor (http://www.thedailybeast.com/contributors/nick-tabor.html?source=dictionary)

awesome insults (http://www.dictionary.com/slideshows/12-insults-we-should-bring-back/?src=dcom-serp-tab)

Enterprise Communications Shouldn't Be Boring | The Enterprise Video Suite starts at $199/mo | START A FREE TRIAL

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A-52

Mercy killing - definition of mercy killing by The Free Dictionary

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mercy killing

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

mercy killing

n.

Euthanasia.

American Heritage® Dictionary of the English Language, Fifth Edition. Copyright © 2016 by Houghton Mifflin Harcourt Publishing Company. Published by Houghton Mifflin Harcourt Publishing Company. All rights reserved.

mercy killing

n

(Medicine) another term for **euthanasia**

Collins English Dictionary – Complete and Unabridged, 12th Edition 2014 © HarperCollins Publishers 1991, 1994, 1998, 2000, 2003, 2006, 2007, 2009, 2011, 2014

eu•tha•na•sia (ˌyu θəˈneɪ ʒə, -ʒi ə, -zi ə)

n.

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

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

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Thesaurus

Legend: ≡ Synonyms ↔ Related Words ≠ Antonyms

Switch to **new thesaurus**

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

≡ **euthanasia**

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

A-53

State of Alaska

Department of Administration

Division of Office of Public Advocacy

Elder Fraud Assistance Education

The office was created by statute in September of 2006.

Mission

The mission of the office is to investigate claims regarding the financial exploitation of Alaskans 60 and older, and seek civil remedies on behalf of elders unable to bring a complaint without assistance.

Vision

The Office of Elder Fraud & Assistance is charged with addressing all forms of financial exploitation and coordinating related services for the entire elder population of the state of Alaska. Our goal is to ensure that every elder victim of financial exploitation who wants assistance: 1) Receives it from existing sources, and 2) Where other assistance is unavailable, to provide individual civil representation.

Contact Us

If you believe that you are a victim of financial exploitation or that someone you know is a victim, please complete a Report of Harm Form (pdf).

or simply contact us at:

Office of Elder Fraud & Assistance
900 West 5th Avenue, Suite 525
Anchorage, AK 99501

A-54

State of Alaska

Department of Administration

Division of Office of Public Advocacy

Financial Exploitation Explained

What is Financial Exploitation?

Financial Exploitation takes many forms

Definitions:

- The National Elder Abuse Incidence Study:
  - "Illegal or improper use of an elder's funds, property, or assets."
- Alaska's New Statute:
  - Robbery, extortion, theft, and
  - "exploitation of another person or another person's resources for personal profit or advantage with no significant benefit accruing to the person who is exploited."

How much of this goes on?

A Widespread Problem:

- Estimated 5 million cases each year
- However, probably only 1 of every 25 cases reported

Why aren't more cases reported?

A-55

- Many Elders:
  - Have disabilities which inhibit their ability to report abuse.
  - Do not know they have been exploited or discover the exploitation after it has occurred and assume it is too late to seek help.
  - Fear they will not be believed
  - Associate a stigma with being labeled a victim.
  - Are dependant on their perpetrator
  - Fear retaliation from their perpetrator
  - Fear the loss of their independence

Who are the perpetrators?

- According to the 1998 National Elder Abuse Incidence Study:
  - 60.4% of perpetrators are the adult children of the victim.
  - Approximately 45% of perpetrators were 40 or younger, 39.5% were between 41 and 59.

General

- Financial Exploitation Explained
- Related Agencies
- Resources
- Make a Report

- Site Map
- Accessibility

Office of Public Advocacy
900 W 5th Ave. Ste. 525, Anchorage, Alaska 99501
Fax: 269-3535 • Phone: (907) 269-3500 • Toll-Free: 1-877-957-3500

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DECLARATION OF TESTIMONY

I, Isaac Jackson, declare under penalty of perjury the following:

1. I am a lawyer licensed to practice law in the State of Oregon, USA. I am in private practice with my own law firm specializing injury claims, including wrongful death cases. I previously served as a Law Clerk to Judge Charles Carlson of the Lane County Circuit Court. I was also an associate lawyer with a firm that specializes in insurance defense and civil litigation.

2. I write to inform the court regarding a lack of transparency under Oregon's assisted suicide act. Even law enforcement is denied access to information collected by the State of Oregon. Moreover, according to the current Oregon State website, this lack of access is official Oregon State Policy.

3. In 2010, I was retained by a client whose father had apparently died under Oregon's law. The client wanted to know whether that was true. I therefore made inquiry on his behalf. However and unlike other deaths I have investigated, it was difficult to get information.

4. I wrote Dr. Hedberg, the State epidemiologist. Attached hereto as Exhibit 1 is a true and correct copy of a letter I received back from the Office of the Attorney General of Oregon dated November 3, 2010. The letter describes that the Oregon Health Authority is only allowed to release annual statistical information about assisted suicide deaths. The letter states:

> ORS [Oregon Revised Statutes] 127.865 prevents OHA [Oregon Health Authority] from releasing any information to you or your client. OHA may only make public annual statistical information.

5. I also wrote the Oregon Medical Board. Attached hereto as Exhibit 2 is a true and correct redacted copy of a letter I received back, dated November 29, 2010, which states in part:

> While sympathetic to [your client's] concerns about the circumstances of his father's death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Health collects these documents for their purposes. Further, if the Board did have the documents as a part of an investigation, the Board would be prevented from releasing them by ORS 676.175. *See* Exhibit 2.

6. I also received a copy of the decedent's death certificate, which is the official death record in Oregon. A true and correct, but redacted copy, is attached hereto as Exhibit 3. The "immediate cause of death" is listed as "cancer." The "manner of death" is listed as "Natural."

///

7. Per my request, a police officer was assigned to the case. Per the officer's confidential report, he did not interview my client, but he did interview people who had witnessed the decedent's death.

8. The officer's report describes how he determined that the death was under Oregon's assisted suicide law act due to records other than from the State of Oregon. The officer's report also describes that he was unable to get this information from the Oregon Health Authority, which was not willing to confirm or deny whether the deceased had used the act. The officer closed the case.

9. Attached hereto as Exhibit 4 is a true and correct copy of the Oregon Health Authority's data release policy, as of September 18, 2012, which states in part:

> The Death with Dignity Act requires that the Oregon Health Authority collect information pertaining to compliance (ORS 127.865 (2)) and to make available to the public an annual statistical report (ORS 127.865 (3)).
>
> The Oregon Health Authority's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation. Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.
>
> The Oregon Health Authority will NOT confirm on a case-by-case basis whether an individual has used, or a provider has been involved with, Death with Dignity. We will not release a report when the first case occurs and we will not respond to questions regarding number of cases within a specific time period. (Emphasis in original).

Pursuant to Oregon Rules of Civil Procedure 1E, I hereby declare that the above statement is true to the best of my knowledge and belief, and that I understand it is made for use as evidence in court and is subject to penalty for perjury.

Dated Sept. 18 2012

Isaac Jackson, OSB 055494
Jackson Law Office, LLC

Post Office Box 41240
Eugene, OR 97404
541.225.5061
Jackson@irjlaw.com

JOHN R. KROGER
Attorney General

MARY H. WILLIAMS
Deputy Attorney General

DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

RECEIVED
11/4/10

November 3, 2010

Isaac Jackson
Jackson Law Office, LLC
P.O. Box 279
Eugene, OR 97440

Re: Death with Dignity Act Records Request

Dear Mr. Jackson:

Dr. Hedberg, the state epidemiologist, received your letter dated October 27, 2010, requesting certain Death with Dignity Act records that may have been filed under OAR 333-009-0010. If records cannot be provided, you also ask Dr. Hedberg to investigate the existence of the documents and report findings to you, or lastly, to at least verify whether the Oregon Health Authority (OHA) has any record of contact with your client's deceased father. In sum, your client would like any information that might shed light on his father's death.

While Dr. Hedberg understands the difficult time your client must be going through, ORS 127.865 prevents OHA from releasing any information to you or your client. OHA may only make public annual statistical information. Please be assured that if irregularities are found on paperwork submitted to the OHA under OAR 333-009-0010, OHA can and has reported information to the Oregon Medical Board who can then investigate the matter.

I understand that you are in the process of getting the death certificate for your client's father and that may shed some light on the matter for your client. If your client believes that some nefarious actions have taken place he certainly could contact law enforcement.

Please contact me if you have additional questions.

Sincerely,

Shannon K. O'Fallon
Senior Assistant Attorney General
Health and Human Services Section

SKO:vdc/Justice# 2345752
cc: Katrina Hedberg, M.D, DHS

1515 SW Fifth Ave, Suite 410, Portland, OR 97201
Telephone: (971) 673-1880 Fax: (971) 673-18868 TTY: (503) 378-5938 www.doj.state.or.us

11/29/10

Oregon

Theodore R. Kulongoski, Governor

Medical Board
1500 SW 1st Ave Ste 620
Portland, OR 97201-5847
(971) 673-2700
FAX (971) 673-2670
www.oregon.gov/omb

November 29, 2010

Isaac Jackson
Jackson Law Office
PO Box 279
Eugene, OR 97440

Dear Mr. Jackson:

The Oregon Medical Board has received your letter regarding .... and his death, apparently under the Oregon Death with Dignity Act. In order for the Board to proceed with a formal investigation, a medical and/or legal basis must exist to support an allegation that a physician licensed by the Board may have violated Oregon law. In our review of the information that you presented we did not find a physician identified nor was there a specific allegation of misconduct on the part of a physician. As such, the board is not able to initiate a formal investigation.

While sympathetic to concerns about the circumstances of his father's death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Human Services collects these documents for their purposes. Further, if the Board did have the documents as a part of an investigation, the Board would be prevented from releasing them by ORS 676.175.

Thank you for bringing your concerns to the attention of the Oregon Medical Board. If you have any further questions regarding this matter, you may contact me at 971-673-2702.

Sincerely,

Randy H. Day
Complaint Resource Officer
Investigations/Compliance Unit

Exhibit 2

CERTIFICATION OF VITAL RECORD

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

[redacted] I.D. TAG NO. [redacted] STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY

Legal Name First [redacted] Middle [redacted] Last [redacted] Suffix			Death Date [redacted] 2010
Sex Male	Age [redacted]	Social Security Number [redacted]	County of Death [redacted]
Birthdate [redacted]	Birthplace [redacted]		Was Decedent Ever in U.S. Armed Forces? [redacted]
Residence [redacted]		City/Town [redacted]	
Residence County [redacted]	State or Foreign Country Oregon	Zip Code + 4 [redacted]	Inside City Limits? [redacted]
Marital Status at Time of Death [redacted]	Spouse's Name Prior to First Marriage [redacted]		
Father's Name [redacted]		Mother's Name Prior to First Marriage [redacted]	
Informant's Name [redacted]	Telephone Number Not Available	Relationship to Decedent [redacted]	Mailing Address [redacted]
Place of Death Decedent's Residence	Facility Name [redacted]		
Location of Death [redacted]	City/Town or Location of Death [redacted]	State Oregon	Zip Code + 4 [redacted]
Method of Disposition Donation and cremation	Place of Disposition [redacted] Cremation Center	Location (City/Town and State) [redacted] Oregon	
Name and Complete Address of Funeral Facility [redacted]			
Date of Disposition TBD	Funeral Director's Signature /S/ [redacted]		OR License Number [redacted]
Registrar's Signature /S/ [redacted]		Date Received [redacted] 2010	Local File Number [redacted]
Amendment			

TO BE COMPLETED BY MEDICAL CERTIFIER

Was case referred to Medical Examiner? No	Autopsy? No	Were autopsy findings available to complete the cause of death?	Time of Death [redacted]
CAUSE OF DEATH			Approximate Interval: Onset to Death
IMMEDIATE CAUSE ↓ a. [redacted] cancer			[redacted] years
Due to (or as a consequence of) ↓ b. [redacted]			years
Due to (or as a consequence of) ↓ c.			
Due to (or as a consequence of) ↓ d.			
Other significant conditions contributing to death [redacted] Disease;			
Manner of Death Natural	If Female		Did tobacco use contribute to death? [redacted]
Date of Injury	Time of Injury	Place of Injury	Injury at Work?
Location of Injury			
Describe how injury occurred			If transportation injury, specify.
Name and Address of Certifier [redacted]			
Name and Title of Attending Physician if Other than Certifier			Date Signed [redacted] 2010
Medical Certifier /S/ [redacted]		Title of Certifier M.D.	License Number [redacted]
Amendment			

[redacted]

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STATE OF OREGON 1859

Exhibit 3

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Learn about air quality and health issues related to the 2012 Oregon wildfires.

Oregon Health Authority

Data Release Policy

Release of Information Regarding the Death with Dignity Act

The Death with Dignity Act requires that the Oregon Health Authority collect information pertaining to compliance (ORS 127.865 (2)) and to make available to the public an annual statistical report (ORS 127.865 (3)).

The Oregon Health Authority's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation.

Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.

The Oregon Health Authority will **NOT** confirm on a case-by-case basis whether an individual has used, or a provider has been involved with, Death with Dignity. We will not release a report when the first case occurs and we will not respond to questions regarding number of cases within a specific time period.

Within the principles of confidentiality, the Oregon Health Authority will publish an annual report which will include information on how many prescriptions are written, and how many people actually take the prescribed medication. The specificity of any data released will depend upon whether we can ensure that confidentiality will not be breached.

To reiterate, the Oregon Health Authority's role in reporting on the Death with Dignity Act is similar to other public health data we collect. The data are population-based and our charge is to maintain surveillance of the overall effect of the Act. The data are to be presented in an annual report, but the information collected is required to be confidential. Therefore, case-by-case information will not be provided, and specificity of data released will depend on having adequate numbers to ensure that confidentiality will be maintained.

Frequently Asked Questions Related to Additional Data Requests

Exhibit 4

Margaret K. Dore

Margaret Dore <margaretdore@margaretdore.com>

RE: Death with Dignity Act

1 message

Parkman Alicia A <alicia.a.parkman@state.or.us>
To: Margaret Dore <margaretdore@margaretdore.com>
Cc: BURKOVSKAIA Tamara V <tamara.v.burkovskaia@state.or.us>

Wed, Jan 4, 2012 at 7:57 AM

Thank you for your email regarding Oregon's Death with Dignity Act. For all of your questions, the answer is no. Since our office is charged with maintaining absolute confidentiality, our policy is to never release identifying information. We can neither confirm nor deny participation of any individual patient or physician. We have been contacted by law enforcement and legal representatives in the past, but have not provided identfying information of any type. To ensure confidentiality, our office does not maintain source documentation on participants.

Please let me know if you have further questions.

Thank you,

Alicia

Alicia Parkman

Mortality Research Analyst

Center for Health Statistics

Oregon Health Authority

Ph: 971-673-1150

Fax: 971-673-1201

From: Margaret Dore [mailto:margaretdore@margaretdore.com]
Sent: Monday, January 02, 2012 5:48 PM
To: alicia.a.parkman@state.or.us
Subject: Death with Dignity Act

Thank you for answering my prior questions about Oregon's death with dignity act.

I have these follow up questions:

1. Would your office release copies of completed reporting forms, e.g., a doctor's completed "Oregon Death with Dignity Act Attending Physician Follow-up Form," in response to a civil subpoena?

X 2. Would your office release copies of completed reporting forms in answer to a request by law enforcement?

X 3. Would your office confirm to law enforcement whether a person had in fact died under Oregon's Death with Dignity Act?

Margaret Dore
Law Offices of Margaret K. Dore, P.S.
www.margaretdore.com
1001 4th Avenue, 44th Floor
Seattle, WA 98154
206 389 1754

Margaret K. Dore

[illegible]

Re: Record Retention Policy

1 message

DWDA INFO <dwda.info@state.or.us>
To: Margaret Dore <margaretdore@margaretdore.com>

Mon, Jun 27, 2011 at 4:18 PM

Hello Ms. Dore,

Thank you for your email regarding Oregon's Death with Dignity Act (DWDA). To answer your question, no, we would not have that information on file. Because the DWDA forms and data are not public records, they do not fall under the retention schedule. We (the Public Health Division) compile the data we need for our reports and then destroy all source documentation after one year.

More information can be found in our "Frequently Asked Questions" document, available on our website (http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf).

The FAQ does contain a question specific to how data are collected, used and maintained by the agency:

Q: Are participating patients reported to the State of Oregon by name?

A: The State does collect the names of patients in order to cross-check death certificates. However, the law guarantees the confidentiality of all participating patients (as well as physicians) and the Department of Human Services does not release this information to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed.

Please let me know if you have further questions.

Thank you,

Alicia

Alicia Parkman
Mortality Research Analyst
Center for Health Statistics
Oregon Health Authority
971-673-1150
alicia.a.parkman@state.or.us

>>> "Margaret Dore" <margaretdore@margaretdore.com> 6/25/2011 11:04 AM >>>

Hi. I am an attorney in Washington State.

I would like to know what is Oregon's document retention policy regarding DWDA reporting.

For example, if there were a question about a death occurring five years ago, would the original doctor after-death report still be on file with your office?

Thanks.

Margaret Dore
Law Offices of Margaret K. Dore, P.S.
www.margaretdore.com
1001 4th Avenue, 44th Floor
Seattle, WA 98154
206 389 1754

There is no state "program" for participation in the Act. People do not "make application" to the State of Oregon or the Oregon Health Authority. It is up to qualified patients and licensed physicians to implement the Act on an individual basis. The Act requires the Oregon Health Authority to collect information about patients who participate each year and to issue an annual report.

Q: Are there any other states that have similar legislation?

A: Yes. The Death with Dignity National Center, which advocates for the passage of death with dignity laws, tracks the status of these laws around the country (see: https://www.deathwithdignity.org/take-action).

Q: Who can participate in the Act?

A: The law states that, in order to participate, a patient must be: 1) 18 years of age or older, 2) a resident of Oregon, 3) capable of making and communicating health care decisions for him/herself, and 4) diagnosed with a terminal illness that will lead to death within six (6) months. It is up to the attending physician to determine whether these criteria have been met.

Q: Can someone who doesn't live in Oregon participate in the Act?

A: No. Only patients who establish that they are residents of Oregon can participate if they meet certain criteria.

Q: How does a patient demonstrate residency?

A: A patient must provide adequate documentation to the attending physician to verify that s/he is a current resident of Oregon. Factors demonstrating residency include, but are not limited to: an Oregon Driver License, a lease agreement or property ownership document showing that the patient rents or owns property in Oregon, an Oregon voter registration, a recent Oregon tax return, etc. It is up to the attending physician to determine whether or not the patient has adequately established residency.

Q: How long does someone have to be a resident of Oregon to participate in the Act?

A: There is no minimum residency requirement. A patient must be able to establish that s/he is currently a resident of Oregon.

Q: Can a non-resident move to Oregon in order to participate in the Act?

A: There is nothing in the law that prevents someone from doing this. However, the patient must be able to prove to the attending doctor that s/he is currently a resident of Oregon.

Q: Are participating patients reported to the State of Oregon by name?

A: The State does collect the names of patients in order to cross-check death certificates. However, the law guarantees the confidentiality of all participating patients (as well as physicians) and the Oregon Health Authority does not release this information to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed.

Q: Who can give a patient a prescription under the Act?

A: Patients who meet certain criteria can request a prescription for lethal medication from a licensed Oregon physician. The physician must be a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) licensed to practice medicine by the Board of Medical Examiners for the State of Oregon. The physician must also be willing to participate in the Act. Physicians are not required to provide prescriptions to patients and participation is voluntary. Additionally, some health care systems (for example, a Catholic hospital or the Veterans Administration) have prohibitions against practicing the Act that physicians must abide by as terms of their employment.

Q: If a patient's doctor does not participate in the Act, how can s/he get a prescription?

A: The patient must find another M.D. or D.O. licensed to practice medicine in Oregon who is willing to participate. The Oregon Health Authority does not recommend doctors, nor can we provide the names of participating physicians or patients due to the need to protect confidentiality.

Q: If a patient's primary care doctor is located in another state, can that doctor write a prescription for the patient?

A: No. Only M.D.s or D.O.s licensed to practice medicine by the Board of Medical Examiners for the State of Oregon can write a valid prescription for lethal medication under the Act.

Q: How does a patient get a prescription from a participating physician?

A: The patient must meet certain criteria to be able to request to participate in the Act. Then, the following steps must be fulfilled:

1. The patient must make two oral requests to the attending physician, separated by at least 15 days;
2. The patient must provide a written request to the attending physician, signed in the presence of two witnesses, at least one of whom is not related to the patient;
3. The attending physician and a consulting physician must confirm the patient's diagnosis and prognosis;
4. The attending physician and a consulting physician must determine whether the patient is capable of making and communicating health care decisions for him/herself;
5. If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder (such as depression), the patient must be referred for a psychological examination;
6. The attending physician must inform the patient of feasible alternatives to the Act including comfort care, hospice care, and pain control;
7. The attending physician must request, but may not require, the patient to notify their next-of-kin of the prescription request. A patient can rescind a request at any time and in any manner. The attending physician

Confidentiality of Death Certificates

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION

(503) 731-4412 Center for Health Statistics
FAX (503) 731-4084 P.O. Box 14050
TDD-Nonvoice (503) 731-4031 Portland, OR 97293-0050

December 12, 1997

TO: County Vital Records Registrars and Deputies
FROM: Sharon Rice, Manager, Registration Unit Center for Health Statistics

SUBJECT: CONFIDENTIALITY—DEATH WITH DIGNITY

This memo is to insure your continued support of the Vital Records strict code of confidentiality on all birth and death certificates.

You received a memo dated November 18, 1997 from Edward Johnson, II, State Registrar. In this memo he discussed the necessity of protecting the privacy of all parties when a death occurs by means of Oregon's death with dignity law.

I have received several calls from different counties asking for more information. After discussing these concerns with the Registrar and physicians within the Health Division the following rules will apply to all physician assisted deaths.

You will neither confirm nor deny if a death has occurred in your county. If this question is asked by employees within your own Health Department, those calls should be referred to Edward Johnson, II, State Registrar (503) 731-4109 or Katrina Hedberg, M.D. (503) 731-4024. If you are asked for information from any other source on this specific topic, those callers will be referred to Katrina Hedberg, M.D., Oregon Health Division, (503) 731-4024. Do not refer callers to me as I am not at liberty to discuss this topic, and I would only have to refer the caller again.

We will begin asking funeral directors to direct report all physicians assisted death certificates to this office thus eliminating the registration through the county office. This will assist in maintaining the confidentiality in your office. Only limited staff in records will be aware of this type of death, as these records will not be handled through regular channels. We will also be controlling the issuance of certified copies making sure the family is aware of the new abbreviated copies and recommending they receive this type of certified copy.

If the funeral home chooses to forward the death record to your office, you may forward it to this office for registration. You should not maintain a white copy of the death record for six months nor should you issue certified copies.

If you do register the death locally then you may not maintain a six-month copy of the death record. Before issuing any certified copies of the death record you will need to contact this office for special permission to do so. There are three people in this office that can grant that permission:

Edward Johnson, II—State Registrar (503) 731-4109
Carol Sanders, Manager, Certification Unit 731-4416
Sharon Rice, Manager, Registration Unit 731-4412

Since we do not anticipate a large number of these cases, the different rules for the handling, these deaths should not adversely affect your work. You may never have this type of death occur within your county.

If you haven't by now determined the seriousness of this, let me add one additional statement so you will know how seriously this matter is being taken by the State Health Division. Any staff within the Center for Health Statistics that reveals any information they are not authorized to release, will immediately be terminated. Any county vital records staff, releasing information will have their registrar-deputy registrar commissions immediately revoked, thus eliminating you from having any contact with vital records within your county.

Remember if you are asked if any physician assisted deaths have occurred in your county you may neither confirm nor deny their occurrence. This may put you in a difficult position if you are being asked from Personnel within your own health department. Again, you will need to explain that you have been told you are not to discuss this topic with anyone, and refer the caller as mentioned earlier in this memo.

The Oregon Death with Dignity Act:

A Guidebook for Health Care Professionals

Developed by
The Task Force to Improve the Care of Terminally-Ill Oregonians

Convened by
The Center for Ethics in Health Care, Oregon Health & Science University

Patrick Dunn, M.D., Task Force Chair and Co-Editor
Bonnie Reagan, M.D., R.N., Co-Editor
Susan W. Tolle, M.D., Reviewer and Major Contributor
Sarah Foreman, Manuscript Preparation

Initial writing of the Guidebook was supported in part by
The Greenwall Foundation

First Edition (print): March 1998

Current Edition (2008): Published on this website
Updated as information becomes available

Registrar, Center for Health Statistics, 800 NE Oregon St., Suite 205, Portland, OR 97232; or by facsimile to (971) 673-1201. Information to be reported to the Department shall include: (a) Patient's name and date of birth; (b) Prescribing physician's name and phone number; (c) Dispensing health care provider's name, address and phone number; (d) Medication dispensed and quantity; (e) Date the prescription was written; and (f) Date the medication was dispensed.

Attending physicians are encouraged to inform patients of the requirement that the Department of Human Services have access to data regarding implementation of the Oregon Act. They may wish to have the patient's written request for enacting the provisions of the statute include a statement of consent for release of medical records to the Department of Human Services. The patient and attending physician should discuss post-death arrangements as part of the overall plans. As discussed in the chapter, *Attending Physician and Consulting Physician*, the attending physician may want to be present at the time of death or make arrangements to be notified by the family immediately following the death. The attending physician could then notify the funeral home that this is an expected death and that he/she will be signing the death certificate. The death certificate will then be filed and processed according to routine procedures and the death will not go into the medical examiner's system. The Medical Examiner is required to investigate any death that is suspicious (i.e., not natural or expected).[6] In addition, if Emergency Medical Services (EMS) are present at the time of death the Medical Examiner will be called. Because medical examiner investigations allow for limited public disclosure,[7] the confidentiality of the patient cannot be assured in these instances. Additionally, family members may be questioned regarding the circumstances surrounding these deaths.

The death certificate originates in the mortician's office, and is sent to the physician to complete the cause of death information. The death certificate is then sent back to the mortician's office, which files it with the local health department. Finally, the death certificate is forwarded to the Department of Human Services, State Registrar for Vital Records. While the confidentiality of the death certificate can be assured once it has reached the local health department and the Department of Human Services, physicians must ensure confidentiality in the clinical setting. Because death certificates have multiple purposes, including settling the estate as well as for public health information, the Department of Human Services suggests physicians record the underlying terminal conditions as the cause of death and mark the manner of death "natural", rather than recording that the patient ingested a lethal dose of medication prescribed under the Oregon Death with Dignity Act. Death certificates should not be left on desktops or at nurses' stations. Health care professionals and institutions might consider implementing a policy of keeping all death certificates in envelopes marked "confidential" until they are formally filed.

Confidentiality is of paramount importance in ensuring compliance with this Oregon Act. The Oregon Act ensures that "information collected shall not be a public record and may not be made available for inspection by the public" (see *Liability and Negligence*). Thus, information regarding the identity of patients, health care professionals, and health care facilities obtained by the Department of Human Services with respect to compliance with the Oregon Act shall be confidential. Summary information released in Department of Human Services' annual reports will be aggregated to prevent identification of individuals, physicians, or health care professionals complying with the Oregon Act. Death certificates are also confidential: OAR 333-11-096 (1) states that the Department of Human Services "... shall not permit inspection of, or

Don't follow Oregon's lead: Say no to assisted suicide

Dear Editor:

I am an internal medicine doctor, practicing in Oregon where assisted suicide is legal. I write in support of Margaret Dore's article, Aid in Dying: Not Legal in Idaho; Not About Choice. I would also like to share a story about one of my patients.

I was caring for a 76 year-old man who came in with a sore on his arm. The sore was ultimately diagnosed as a malignant melanoma, and I referred him to two cancer specialists for evaluation and therapy. I had known this patient and his wife for over a decade. He was an avid hiker, a popular hobby here in Oregon. As he went through his therapy, he became less able to do this activity, becoming depressed, which was documented in his chart.

During this time, my patient expressed a wish for doctor-assisted suicide to one of the cancer specialists. Rather than taking the time and effort to address the question of depression, or ask me to talk with him as his primary care physician and as someone who knew him, the specialist called me and asked me to be the "second opinion" for his suicide. She told me that barbiturate overdoses "work very well" for patients like this, and that she had done this many times before.

I told her that assisted-suicide was not appropriate for this patient and that I did NOT concur. I was very concerned about my patient's mental state, and I told her that addressing his underlying issues would be better than simply giving him a lethal prescription. Unfortunately, my concerns were ignored, and approximately two weeks later my patient was dead from an overdose prescribed by this doctor. His death certificate, filled out by this doctor, listed the cause of death as melanoma.

The public record is not accurate. My patient did not die from his cancer, but at the hands of a once-trusted colleague. This experience has affected me, my practice, and my understanding of what it means to be a physician.

What happened to this patient, who was weak and vulnerable, raises several important questions that I have had to answer, and that the citizens of Idaho should also consider:

- If assisted suicide is made legal in Idaho, will you be able to trust your doctors, insurers and HMOs to give you and your family members the best care? I referred my patient to specialty care, to a doctor I trusted, and the outcome turned out to be fatal.
- How will financial issues affect your choices? In Oregon, patients under the Oregon Health Plan have been denied coverage for treatment and offered coverage for suicide instead. See e.g. KATU TV story and video at http://www.katu.com/home/video/26119539.html (about Barbara Wagner). Do you want this to be your choice?
- If your doctor and/or HMO favors assisted suicide, will they let you know about all possible options or will they simply encourage you to kill yourself? The latter option will often involve often less actual work for the doctor and save the HMO money.

In most states, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient received was a lethal prescription, intended to kill him.

Is this where you want to go? Please learn the real lesson from Oregon.

Despite all of the so-called safeguards in our assisted suicide law, numerous instances of coercion, inappropriate selection, botched attempts, and active euthanasia have been documented in the public record.

Protect yourselves and your families. Don't let legalized assisted suicide come to Idaho.

Charles J. Bentz MD
Oregon Health & Sciences University
Portland, OR

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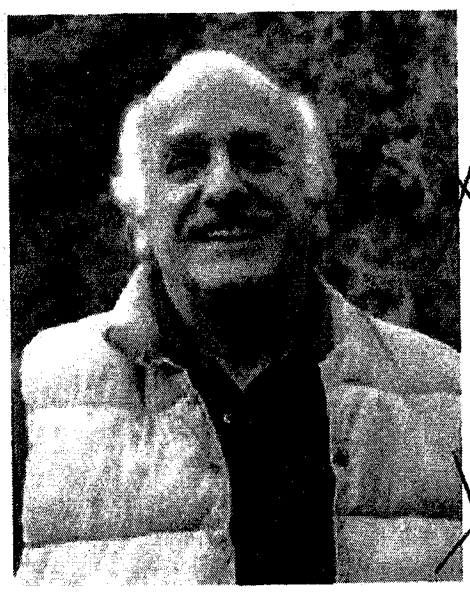
Derek Humphry to be Keynote Speaker at 2011 Annual Meeting



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 A

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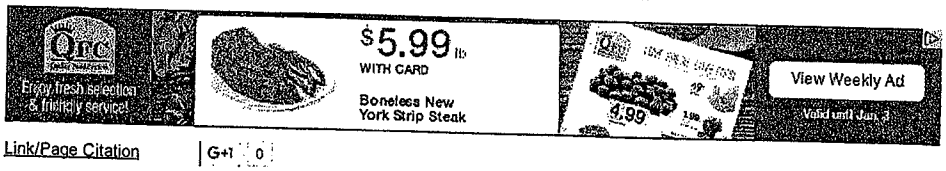
Police kick in door in confusion over suicide kit.



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Byline: Jack Moran The Register-Guard

SPRINGFIELD - The teletype message came Tuesday from the FBI, and it sounded urgent: A Springfield man had purchased a mail-order suicide kit and could be in danger.

Springfield police responded immediately to the man's Harlow Road home. They spoke with the condominium complex's manager, who told officers that he had seen the man carry a bag into his house earlier in the day, police Sgt. Richard Jones said.

Officers knocked on the man's front door, but received no response. After conferring with a police captain who urged them to force their way into the home in case the man needed immediate help, officers kicked in the front door, Jones said.

They soon learned the man was not home.

He was at work - in The Register-Guard's newsroom. And he said he's not at all suicidal.

Furthermore, he's not angry at Springfield police for kicking in his front door and damaging an interior door that had been shut.

"I'm going to put it all down as a misunderstanding," he said. "I thanked (the police officer who spoke with me on the phone about the incident) for taking it seriously and making sure that I was OK."

The Register-Guard employee - who said the complex manager must have seen him toting his gym bag home on Tuesday - agreed to be interviewed on the condition that his name not be used, citing privacy concerns. He said he purchased by mail a helium-hood suicide kit in February from a Southern California company that is now the focus of an ongoing FBI investigation.

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He didn't buy the kit for personal reasons. He mailed a check to The Gladd Group in order to get a suicide kit for reporter Randi Bjornstad, who at the time was researching the sale of the suicide kits for a story that was published March 20.

Bjornstad said she asked her colleague to order one of the kits by following instructions on a website maintained by Derek Humphry, a longtime Junction City resident and pro-suicide advocate whom she had interviewed as part of her research.

Although he claims complete separation from The Gladd Group, which manufactured and sold the devices until the FBI raided the business in late May, Humphry was the sole source, via his books, blog and online videos, for the company's address and the instructions for using the kit to commit suicide.

Bjornstad said she didn't want to raise any red flags that could prevent her from obtaining a kit if someone with The Gladd Group identified her as a reporter who had been researching the device.

The FBI's investigation involving The Gladd Group is ongoing. Since the May raid on the home of the company's owner, 91-year-old Sharlotte Hydorn, the FBI has asked local law enforcement agencies throughout the country to carry out "welfare checks" on people whose names are apparently listed on client lists gleaned from Hydorn's computers.

Jones, the Springfield police sergeant, said the FBI teletype his office received on Tuesday did not state when the Springfield man purchased the suicide kit.

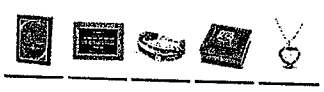
"Nowhere in this teletype does it say that this happened (seven) months ago," Jones said. "It was interpreted by us that they're suggesting that we need to go out now and conduct a welfare assessment."

While Jones said he hopes to follow up with the FBI to ask why they didn't share more detailed information with police, he realizes that many of The Gladd Group's customers have probably bought the kits while contemplating end-of-life decisions.

"Most of them aren't going to be newspaper reporters looking to buy one for a story," Jones said.

In response to the same teletype, a Lane County sheriff's sergeant contacted a local woman who had purchased a kit from Hydorn's company.

"She advised that she bought it as an option in the future, but had no immediate plans" of suicide, sheriff's Lt. Byron Trapp said. He did not know when she bought the kit.



quote

The sheriff's office will notify the FBI that they spoke with the woman about her purchase, Trapp said.

Responding Tuesday to a Register-Guard reporter's questions about the situation involving the Springfield Register-Guard employee, FBI Special Agent Darrell Foxworth, who works in the agency's San Diego office, issued a brief statement in which he said "that when the FBI receives information that a person may cause harm to themselves or others, we appropriate agency so that agency, at their discretion, and within their own guidelines, may take whatever action they deem appropriate. The FBI does this out of an abundance of caution for the safety of the individual and the public."

A spotlight was cast on the mail-order suicide kit business after a 29-year-old Eugene man committed suicide in December using a helium hood kit. The Register-Guard traced the $60 kit to Hydom, who has no website and does no advertising; clients find her address through the writings of Humphry.

State lawmakers this year approved a bill that makes it a felony to sell suicide kits to Oregonians. Gov. John Kitzhaber signed the bill into law in July.

The Register-Guard employee who purchased the kit in February said that Springfield police apologized and assured him that they would pay for damages to his home. He said the kit is no longer at his residence. Rather, the newspaper has it.

He also pointed out that officers could have simply opened the front door, had they checked underneath his door mat and seen the house key that he had left there earlier in the day for his wife, who had forgotten hers when she went to town.

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Article Details

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Title Annotation: Local News; The FBI message to police about the purchase of the gear failed to mention it was bought seven months ago
Publication: The Register-Guard (Eugene, OR)
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Words: 936
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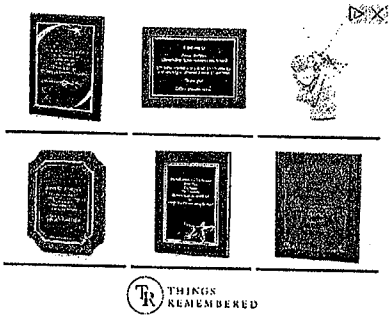
Next Article: Local man pleads guilty to federal gun charge.
Topics: Suicide



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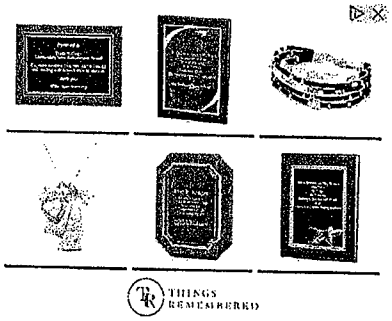

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OREGON HEALTH AUTHORITY

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.
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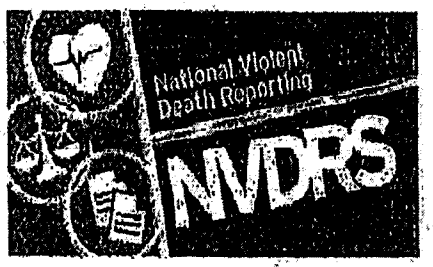


OREGON

Public Health Division

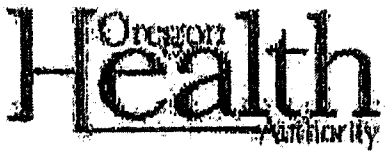
Suicides in Oregon: Trends and Risk Factors

-2012 Report-

Oregon Violent Death Reporting System

Injury and Violence Prevention Program

Center for Prevention and Health Promotion



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

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

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

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

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

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

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

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

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

Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year[1,2]. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts[3,4]. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon[3]. 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.

The cost $

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

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Original article

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

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ABSTRACT

Background: Despite continuing political, legal and moral debate on the subject, assisted suicide is permitted in only a few countries worldwide. However, few studies have examined the impact that witnessing assisted suicide has on the mental health of family members or close friends.
Methods: A cross-sectional survey of 85 family members or close friends who were present at an assisted suicide was conducted in December 2007. Full or partial Post-Traumatic Distress Disorder (PTSD; Impact of Event Scale–Revised), depression and anxiety symptoms (Brief Symptom Inventory) and complicated grief (Inventory of Complicated Grief) were assessed at 14 to 24 months post-loss.
Results: Of the 85 participants, 13% met the criteria for full PTSD (cut-off ≥ 35), 6.5% met the criteria for subthreshold PTSD (cut-off ≥ 25), and 4.9% met the criteria for complicated grief. The prevalence of depression was 16%; the prevalence of anxiety was 6%.
Conclusion: A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although there seemed to be no complications in the grief process, about 20% of respondents experienced full or subthreshold PTSD related to the loss of a close person through assisted suicide.
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1. Introduction

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

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 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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http://www.legis.state.ak.us/basis/statutes.asp#09.55.556

Sec. 09.55.556. Informed consent.

(a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for medical malpractice based upon an alleged failure to obtain informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that the patient would undergo the treatment or procedure regardless of the risk involved or that the patient did not want to be informed of the matters to which the patient would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider after considering all of the attendant facts and circumstances used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to the patient because the health care provider reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 54

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTIETH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE DRUMMOND

Introduced: 3/27/17
Referred: Health and Social Services, Judiciary

A BILL

FOR AN ACT ENTITLED

1 **"An Act providing an end-of-life option for terminally ill individuals; and providing for**
2 **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 a
6 defense that the defendant was performing an action allowed under AS 13.55.
7 * **Sec. 2.** AS 11.41.120 is amended by adding a new subsection to read:
8 (c) In a prosecution under this section, it is a defense that the defendant was
9 performing an action allowed under AS 13.55.
10 * **Sec. 3.** AS 13 is amended by adding a new chapter to read:
11 **Chapter 55. Voluntary Ending of Life.**
12 **Sec. 13.55.010. Individuals allowed to end life.** (a) As provided in this
13 chapter, a qualified individual may use medicine obtained from the qualified
14 individual's attending physician to end the qualified individual's life.

1 (b) To be a qualified individual under (a) of this section, an individual must
2 (1) be a resident of this state;
3 (2) be 18 years of age or older;
4 (3) have been determined to be capable;
5 (4) have been determined to be suffering from a terminal disease; and
6 (5) have voluntarily expressed the wish to die.
7 (c) An individual does not qualify under (b) of this section solely because of
8 the individual's age or disability.
9 **Sec. 13.55.020. Attending physician and pharmacist authority.** If a
10 qualified individual's attending physician complies with this chapter, the attending
11 physician may
12 (1) dispense medication directly to the qualified individual, including
13 ancillary medications intended to facilitate the desired effect or minimize the qualified
14 individual's discomfort; or
15 (2) write a prescription for the medication for the qualified individual
16 and in person, by mail, or by electronic transmission deliver the prescription for the
17 medication to a pharmacist, who may dispense the medication to the qualified
18 individual, the attending physician, or an expressly identified agent of the qualified
19 individual.
20 **Sec. 13.55.030. Requests for medication.** (a) To receive medication under this
21 chapter, a qualified individual shall make an oral request to the qualified individual's
22 attending physician. The qualified individual shall repeat the oral request to the
23 qualified individual's attending physician not sooner than 15 days after making the
24 initial oral request.
25 (b) Notwithstanding (a) of this section, if a qualified individual is not
26 physically able to speak, a qualified individual may make an oral request by whatever
27 means the qualified individual can use to make the request, including electronic
28 means, as long as the request is made in person.
29 **Sec. 13.55.040. Right to rescind request.** When a qualified individual makes
30 the second oral request under AS 13.55.030, the attending physician shall offer the
31 qualified individual an opportunity to rescind the initial oral request. A qualified

individual may rescind a request at any time and in any manner without regard to the qualified individual's mental state. An attending physician may not dispense or prescribe medication under this chapter unless the attending physician offers the qualified individual an opportunity to rescind the request.

Sec. 13.55.050. 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;

(5) refer the individual for counseling if appropriate under AS 13.55.070;

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

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

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

(9) immediately before dispensing or prescribing medication under this

chapter, verify that the individual is making an informed decision;

(10) fulfill the requirements of AS 13.55.110 for medical record documentation;

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

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

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

(B) deliver the written prescription in person, by mail, or by electronic transmission to the pharmacist who will dispense the medication to the qualified individual, the attending physician, or an agent of the qualified individual who is expressly identified as an agent by the qualified individual.

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

Sec. 13.55.060. Confirmation by consulting physician. Before an individual becomes a qualified individual under this chapter, a consulting physician shall examine the individual and the individual's relevant medical records, confirm in writing the attending physician's diagnosis that the individual is suffering from a terminal disease, and verify that the individual is capable, is acting voluntarily, and has made an informed decision.

Sec. 13.55.070. Counseling referral. If the attending physician or the consulting physician determines that an individual may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the individual for counseling, and the attending physician may not dispense or prescribe medication until the person performing the counseling determines that the individual is not suffering from depression or a psychiatric or psychological disorder

1 causing impaired judgment.

2 **Sec. 13.55.080. Informed decision.** An attending physician may not dispense
3 or prescribe medication unless the qualified individual has made an informed decision.
4 Immediately before dispensing or prescribing medication under this chapter, the
5 attending physician shall verify that the qualified individual is making an informed
6 decision.

7 **Sec. 13.55.090. Family notification.** The attending physician may not deny a
8 qualified individual's request for medication if the qualified individual declines or is
9 unable to notify the qualified individual's next of kin.

10 **Sec. 13.55.100. Waiting periods.** An attending physician may not dispense
11 medication or write a prescription for medication for a qualified individual unless at
12 least 15 days have elapsed between the qualified individual's initial oral request and
13 the writing of the prescription.

14 **Sec. 13.55.110. Medical record documentation requirements.** Before a
15 qualified individual receives medication under this chapter, the medical record of the
16 qualified individual must contain

17 (1) a record of all oral requests by a qualified individual for medication
18 under this chapter;

19 (2) the attending physician's diagnosis, prognosis, and determination
20 that the individual is capable, is acting voluntarily, and has made an informed
21 decision;

22 (3) the consulting physician's diagnosis, prognosis, and verification
23 that the individual is capable, is acting voluntarily, and has made an informed
24 decision;

25 (4) if counseling is performed, a report of the determinations made
26 during counseling and the outcome;

27 (5) a record of the attending physician's offer to the qualified
28 individual to rescind the qualified individual's request at the time of the qualified
29 individual's second oral request under AS 13.55.030;

30 (6) a note by the attending physician indicating that all requirements
31 under this chapter have been met and indicating the steps taken to carry out the

1 request, including a statement describing the medication prescribed.

2 **Sec. 13.55.120. Effect on construction of wills and contracts.** A provision in
3 a will or a contract, whether written or oral, is not valid to the extent that the provision
4 requires, prohibits, imposes a condition on, or otherwise addresses whether an
5 individual may make or rescind a request for medication under this chapter.

6 **Sec. 13.55.130. Immunity; effect of action on status of individuals.** (a) A
7 person is not subject to civil or criminal liability or professional disciplinary action,
8 including disciplinary action by a licensing authority, for participating or otherwise
9 acting in good faith compliance with this chapter, including being present when a
10 qualified individual takes the prescribed medication to end the qualified individual's
11 life under this chapter.

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

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

19 **Sec. 13.55.140. No duty to participate.** A health care provider is not under a
20 duty, whether by contract, statute, or other legal requirement, to dispense medication,
21 prescribe medication, or otherwise participate in the provision of medication to a
22 qualified individual under this chapter. If a health care provider is unable or unwilling
23 to carry out a qualified individual's request under AS 13.55.030 and the qualified
24 individual transfers the qualified individual's care to another health care provider, the
25 transferring health care provider shall provide to the other health care provider, at the
26 qualified individual's request, a copy of the qualified individual's relevant medical
27 records.

28 **Sec. 13.55.150. Prohibitions.** Notwithstanding another provision of law to the
29 contrary, a health care provider may not prohibit another health care provider,
30 including an employee, contractor, or lessee of the prohibiting health care provider,
31 from participating in this chapter. However, a health care provider may prohibit

1 another health care provider, including an employee, contractor, or lessee of the
2 prohibiting health care provider, from allowing a patient of the prohibited health care
3 provider to administer medication on the premises of the prohibiting health care
4 provider if the medication was obtained under this chapter.

5 **Sec. 13.55.160. Prohibition notice.** To prohibit another health care provider
6 from allowing a patient to administer medication on the premises of the prohibiting
7 health care provider, the prohibiting health care provider shall notify the prohibited
8 health care provider in writing about the prohibition.

9 **Sec. 13.55.170. Sanctions.** (a) Notwithstanding AS 13.55.130 and 13.55.140,
10 if a health care provider violates a prohibition allowed under AS 13.55.150 after
11 receiving a written notice under AS 13.55.160, the prohibiting health care provider
12 may impose the following sanctions on the prohibited health care provider:

13 (1) loss of privileges, loss of membership, or other sanction provided
14 under the bylaws, policies, or procedures of the prohibiting health care provider if the
15 prohibited health care provider is a member of the prohibiting health care provider's
16 medical staff;

17 (2) termination of a lease or another contract between the prohibiting
18 health care provider and the prohibited health care provider, or an imposition of
19 nonmonetary remedies provided by the lease or other contract; in this paragraph,
20 "remedies" does not include the loss or restriction of medical staff privileges or
21 exclusion from a medical care provider panel.

22 (b) A prohibiting health care provider who imposes sanctions under (a) of this
23 section shall follow all procedures that are provided under an applicable contract, the
24 applicable terms of employment, or law for imposing the sanctions.

25 (c) Suspension or termination of staff membership or privileges under (a) of
26 this section is not reportable under AS 08.64.336.

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

30 (1) without the authorization of the individual, falsely makes,
31 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; in this paragraph, "undue influence" means the control of an individual by a person who stands in a position of trust or confidence to exploit wrongfully the trust, dependency, or fear of the individual to gain control over the decision making of the individual.

(b) Abuse of life-ending 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 a qualified individual's ending 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.

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

(c) The department shall adopt regulations under AS 44.62 (Administrative Procedure Act) to facilitate the collection of information about compliance with this chapter. The information collected is not a public record under AS 40.25.110, and the department may not make the information available for inspection by the public.

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

(e) In this section, "department" means the Department of Health and Social

1 Services.

2 **Sec. 13.55.220. Attending physician qualifications.** (a) To qualify as an
3 attending physician under this chapter, a physician must

4 (1) have primary responsibility for the patient's health care;

5 (2) have primary responsibility for the treatment of the patient's
6 terminal illness; and

7 (3) routinely provide medical care to patients with advanced and
8 terminal illnesses in the normal course of the physician's practice.

9 (b) Notwithstanding (a)(3) of this section, an attending physician's practice
10 may not be primarily or solely made up of individuals requesting medication under
11 this chapter.

12 **Sec. 13.55.230. 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. 13.55.240. Insurance or annuity policies; contracts.** Notwithstanding
21 AS 21.45.250 or another provision of law to the contrary, a person may not condition
22 the sale, procurement, issuance, rate, delivery, issuance for delivery, or other aspect of
23 a life insurance policy, health insurance policy, accident insurance policy, or annuity
24 policy, or another contract on the making or rescission of a request by a qualified
25 individual for medication under this chapter.

26 **Sec. 13.55.250. Coordination with other law.** A request for medication under
27 this chapter is not an advance health care directive under AS 13.52, and AS 13.52 does
28 not apply to an activity allowed by this chapter.

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

31 (1) "attending physician" means a physician who qualifies under

AS 13.55.220 as an attending physician;

(2) "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;

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

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

(5) "health care provider" means a person or health care facility 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, "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; state correctional facility as defined in AS 33.30.901; private, municipal, or state facility employing one or more public health nurses; and long-term care facility;

(6) "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 an individual of the

(A) individual's medical diagnosis;

(B) individual's prognosis;

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

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

and

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

(7) "medication" means medication to end a qualified individual's life under this chapter;

(8) "physician" means a doctor of medicine or osteopathy who is licensed under AS 08.64 to practice medicine or osteopathy;

(9) "prescription" means a prescription for medication to end a qualified individual's life under this chapter;

(10) "prohibited health care provider" means a health care provider that is prohibited by another health care provider under AS 13.55.150;

(11) "prohibiting health care provider" means a health care provider that prohibits another health care provider under AS 13.55.150;

(12) "qualified individual" means an individual who is qualified under AS 13.55.010(b);

(13) "request" means a request under AS 13.55.030;

(14) "terminal disease" means an incurable and irreversible disease that has been medically confirmed and that will, within reasonable medical judgment, produce death within six months; in this paragraph, "medically confirmed" means that a consulting physician who has examined the individual's relevant medical records has confirmed the medical opinion of the attending physician.

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 13.55, enacted by sec. 3 of this Act, applies to a contract, will, or life, health, or accident insurance or annuity policy if the contract, will, or policy is delivered or issued for delivery on or after the effective date of sec. 3 of this Act.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may adopt regulations authorized by AS 13.55, enacted by sec. 3 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before January 1, 2019.

1 * **Sec. 6.** Section 5 of this Act takes effect immediately under AS 01.10.070(c).

2 * **Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect January 1, 2019.