# HB 99

<TARGET><BILL>HB  99</BILL><SUBJECT>HB 99</SUBJECT><COMM>HHSS29</COMM></TARGET>

29-LS0112\H
Bannister
4/16/15

# CS FOR HOUSE BILL NO. 99( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - FIRST SESSION

**BY**

**Offered:**
**Referred:**

**Sponsor(s): REPRESENTATIVES DRUMMOND, Josephson, Gruenberg**

## A BILL

## FOR AN ACT ENTITLED

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

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

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

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

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

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

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

### Chapter 55. Voluntary Termination of Life.

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

qualified, an individual shall

(1) be a resident of this state;

(2) be 21 years of age or older;

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

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

(5) have voluntarily expressed the wish to die.

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

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

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

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

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

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

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

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

**Sec. 13.55.040. Right to rescind request.** When a qualified individual makes the second oral request under AS 13.55.030, the attending physician shall offer the qualified individual an opportunity to rescind the initial oral request and the written 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. Written request requirements.** (a) A written request for medication under this chapter must be in substantially the form described in AS 13.55.060, signed and dated by the qualified individual, and witnessed by at least two other individuals. The attending physician may not witness the request. The witnesses shall, in the presence of the qualified individual, attest that, to the best of their knowledge and belief, the qualified individual is capable, acting voluntarily, and not under undue influence to sign the request.

(b) Only one witness may be

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

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

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

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

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

REQUEST FOR MEDICATION TO END MY LIFE

I, ________________, am 21 years of age or older and of sound mind.

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

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

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

INITIAL ONE OF THE FOLLOWING:

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

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

_____ I have no family to inform of my decision.

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

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

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

Signed: ____________________

Dated: _____________________

DECLARATION OF WITNESSES

We declare that the person signing this request

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

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

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

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

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

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

_______________________ Witness 1 Date: _____

_______________________ Witness 2 Date: _____

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

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

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

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

(3) inform the individual of the

(A) individual's medical diagnosis;

(B) individual's prognosis;

(C) potential risks associated with taking the medication;

(D) probable result of taking the medication; and

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

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

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

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

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

(8) inform the qualified individual that the qualified individual has an opportunity to rescind the request at any time and in any manner and offer the qualified 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 qualified individual is making an informed decision;

(10) fulfill the requirements of AS 13.55.130 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 written consent,

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

(B) deliver the written prescription personally or by mail 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. 13.55.080. 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. 13.55.090. 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 causing impaired judgment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) In this section,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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 40.25.100, 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.

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

(b) 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. 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.

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

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

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

(1) "attending physician" means the physician who has primary responsibility for the care of the individual and treatment of the individual's terminal

disease;

(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 if the individual is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment;

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

(6) "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; private, municipal, or state facility employing one or more public health nurses; and long-term care facility;

(7) "health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession; in this paragraph, "person" includes a state correctional facility as defined in AS 33.30.901 and a health care facility;

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

(A) qualified individual's medical diagnosis;

(B) qualified individual's prognosis;

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

prescribed;

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

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

(9) "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;

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

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

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

(13) "qualified individual" means an individual who is qualified under AS 13.55.010 to end the individual's life under this chapter;

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

(15) "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;

(16) "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.

* **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, 2016.

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

* **Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect January 1, 2016.

29-LS0112\W.1
Bannister
4/11/15

# AMENDMENT

OFFERED IN THE HOUSE

TO: HB 99

Page 2, line 3:

Delete "an adult"

Insert "21 years of age or older"

Page 4, line 2:

Delete "an adult"

Insert "21 years of age or older and"

Page 12, line 30:

Delete all material.

Renumber the following paragraphs accordingly.

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29-LS0112\W.2
Bannister
4/11/15

# AMENDMENT

OFFERED IN THE HOUSE
TO: HB 99

Page 2, line 4:
Delete "a court,"

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29-LS0112\W.3
Bannister
4/13/15

# AMENDMENT

OFFERED IN THE HOUSE

TO: HB 99

Page 13, lines 19 - 20:

Delete "correctional facility owned or administered by the state;"

Page 13, line 25, following "includes":

Insert "a state correctional facility as defined in AS 33.30.901 and"

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29-LS0112\W

# HOUSE BILL NO. 99

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - FIRST SESSION

**BY REPRESENTATIVE DRUMMOND**

**Introduced: 2/9/15**
**Referred:**

## A BILL

## FOR AN ACT ENTITLED

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

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

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

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### Chapter 55. Voluntary Termination of Life.

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

qualified, an individual shall

(1) be a resident of this state;

(2) be an adult;

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

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

(5) have voluntarily expressed the wish to die.

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

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

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

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

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

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

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

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

**Sec. 13.55.040. Right to rescind request.** When a qualified individual makes the second oral request under AS 13.55.030, the attending physician shall offer the qualified individual an opportunity to rescind the initial oral request and the written 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. Written request requirements.** (a) A written request for medication under this chapter must be in substantially the form described in AS 13.55.060, signed and dated by the qualified individual, and witnessed by at least two other individuals. The attending physician may not witness the request. The witnesses shall, in the presence of the qualified individual, attest that, to the best of their knowledge and belief, the qualified individual is capable, acting voluntarily, and not under undue influence to sign the request.

(b) Only one witness may be

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

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

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

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

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

## REQUEST FOR MEDICATION TO END MY LIFE

I, _______________, am an adult of sound mind.

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

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

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

INITIAL ONE OF THE FOLLOWING:

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

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

_____ I have no family to inform of my decision.

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

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

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

Signed: ____________________

Dated: _____________________

## DECLARATION OF WITNESSES

We declare that the person signing this request

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

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

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

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

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

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

______________________ Witness 1 Date: _____

______________________ Witness 2 Date: _____

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

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

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

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

(3) inform the individual of the

(A) individual's medical diagnosis;

(B) individual's prognosis;

(C) potential risks associated with taking the medication;

(D) probable result of taking the medication; and

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

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

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

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

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

(8) inform the qualified individual that the qualified individual has an opportunity to rescind the request at any time and in any manner and offer the qualified 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 qualified individual is making an informed decision;

(10) fulfill the requirements of AS 13.55.130 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 written consent,

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

(B) deliver the written prescription personally or by mail 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. 13.55.080. 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. 13.55.090. 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 causing impaired judgment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) In this section,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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 40.25.100, 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.

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

(b) 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. 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.

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

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

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

(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 individual and treatment of the individual's terminal disease;

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

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

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

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

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

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

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

(A) qualified individual's medical diagnosis;

(B) qualified individual's prognosis;

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

prescribed;

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

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

(10) "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;

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

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

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

(14) "qualified individual" means an individual who is qualified under AS 13.55.010 to end the individual's life under this chapter;

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

(16) "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;

(17) "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.

* **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, 2016.

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

* **Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect January 1, 2016.

# Fiscal Note

State of Alaska
2015 Legislative Session

| | |
|---|---|
| Bill Version: | HB 99 |
| Fiscal Note Number: | |
| () Publish Date: | |

| | | | |
|---|---|---|---|
| Identifier: | HB099-DHSS-BVS-04-05-15 | Department: | Department of Health and Social Services |
| Title: | VOLUNTARY TERMINATION OF LIFE | Appropriation: | Public Health |
| Sponsor: | DRUMMOND | Allocation: | Bureau of Vital Statistics |
| Requester: | House Health & Social Services Committee | OMB Component Number: | 961 |

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

| | FY2016 Appropriation Requested | Included in Governor's FY2016 Request | Out-Year Cost Estimates | | | | |
|---|---|---|---|---|---|---|---|
| **OPERATING EXPENDITURES** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2018** | **FY 2019** | **FY 2020** | **FY 2021** |
| Personal Services | | | | | | | |
| Travel | | | | | | | |
| Services | 75.0 | | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 |
| Commodities | | | | | | | |
| Capital Outlay | | | | | | | |
| Grants & Benefits | | | | | | | |
| Miscellaneous | | | | | | | |
| **Total Operating** | **75.0** | **0.0** | **5.0** | **5.0** | **5.0** | **5.0** | **5.0** |

**Fund Source (Operating Only)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1004 Gen Fund | 75.0 | | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 |
| **Total** | **75.0** | **0.0** | **5.0** | **5.0** | **5.0** | **5.0** | **5.0** |

**Positions**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Full-time | | | | | | | |
| Part-time | | | | | | | |
| Temporary | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Change in Revenues** | | | | | | | |

**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 125.0 *(separate capital appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/16

**Why this fiscal note differs from previous version:**

Not applicable, initial version.

| | | | |
|---|---|---|---|
| Prepared By: | Jay C. Butler, MD, Director/Chief Medical Officer | Phone: | (907)269-6680 |
| Division: | Public Health | Date: | 03/09/2015 12:00 AM |
| Approved By: | Sarah Woods, Deputy Director Finance & Management Services | Date: | 04/05/15 |
| Agency: | Health & Social Services | | |

## Analysis

This bill adds a new chapter Sec. 13.55 that allows terminally ill Alaska residents age 18 or older to use prescribed medications to voluntarily terminate their own life. The bill requires a health care provider to file with the Department of Health and Social Services a copy of the record of dispensing the medication.

Among the requirements of this bill the Department would be tasked to:
- Annually review a sample of the records required under this chapter.
- Develop and adopt regulations to facilitate the collection of information about compliance with this chapter.
- Develop and distribute the forms necessary to implement the new law.
- Collect and track the forms required by the new law.
- Generate a statistical report of the information collected under this chapter.

Alaska could expect between 10 and 19 voluntary termination-of-life deaths per year based on the experience of Oregon. Oregon is one of 5 states that allow voluntary termination of life. Oregon, Vermont and Washington have a "death with dignity act" similar to this bill. In Montana and New Mexico it was allowed by the courts (NM is under appeal). In the 2014 Oregon Death with Dignity Act report there were 155 death with dignity act prescriptions issued in Oregon. Of those, 105 or about two-thirds of the individuals died from ingesting the prescribed medication. For Oregon this corresponds to 31 death with dignity act deaths per 10,000 total deaths. If Alaska experienced about the same rate of participation, then we could expect about 29 applications per year and about 10 to 19 persons who died ingesting the prescribed medication.

The Bureau of Vital Statistics would be responsible for implementing the duties of the Department under a voluntary termination of life law. The bill allows the Department to adopt regulations after the effective date of January 1, 2016. Bureau staff do not have the capacity or expertise required to develop complex regulations and do extensive outreach. Therefore, a one-time contract for professional services would be needed in year one. Based on Washington's and Oregon's experience with their death with dignity laws, it is expected it will take six months to develop the preliminary draft regulations and forms required by this new chapter followed by a series of public meetings to get input from stakeholders, with a target of regulations being in place by July 1, 2016.

The Bureau would require a one-time capital appropriation to add a custom module to its existing electronic vital records database application. The module will store electronic copies, track the forms required by this law and produce the statistical report. Although only a small number of applications and deaths are anticipated annually, a simple spreadsheet will not be sufficient to collect, track and analyze forms. Washington State initially tried implementing their death with dignity act without a data base application, but that turned out to be an unwieldy solution.

The Department will have ongoing costs for training materials and travel to work with and train funeral homes, health care providers, and the State Medical Examiner's Office on the completion of death certificates for voluntary termination of life patients. The Bureau would also need to work with State Troopers, local law enforcement agencies, and the Medical Examiner's office on death investigations that appeared to be an accidental overdose, suicide, or attempted suicide since they may be voluntary termination of life events.

# Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 99
Fiscal Note Number:
() Publish Date:

Identifier: HB099-LAW-CRIM-04-03-15
Title: VOLUNTARY TERMINATION OF LIFE
Sponsor: DRUMMOND
Requester: House Health and Social Services

Department: Department of Law
Appropriation: Criminal Division
Allocation: Criminal Justice Litigation
OMB Component Number: 2202

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

| | FY2016 Appropriation Requested | Included in Governor's FY2016 Request | Out-Year Cost Estimates | | | | |
|---|---|---|---|---|---|---|---|
| **OPERATING EXPENDITURES** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2018** | **FY 2019** | **FY 2020** | **FY 2021** |
| Personal Services | | | | | | | |
| Travel | | | | | | | |
| Services | | | | | | | |
| Commodities | | | | | | | |
| Capital Outlay | | | | | | | |
| Grants & Benefits | | | | | | | |
| Miscellaneous | | | | | | | |
| **Total Operating** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Fund Source (Operating Only)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| None | | | | | | | |
| **Total** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Positions**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Full-time | | | | | | | |
| Part-time | | | | | | | |
| Temporary | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Change in Revenues** | | | | | | | |

**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(separate capital appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

**Why this fiscal note differs from previous version:**

Initial version; not applicable.

| | | | |
|---|---|---|---|
| Prepared By: | Valerie Rose, Budget Analyst | Phone: | (907)465-3674 |
| Division: | Administrative Services Division | Date: | 04/03/2015 03:07 PM |
| Approved By: | Craig W. Richards, Attorney General | Date: | 04/03/15 |
| Agency: | Department of Law | | |

## FISCAL NOTE ANALYSIS

**STATE OF ALASKA**
**2015 LEGISLATIVE SESSION**

**BILL NO.** HB 99

### Analysis

This legislation allows a person to voluntarily end their life if they are suffering from a terminal disease and have been determined by a court, physician, psychiatrist or psychologist to be capable of making that decision. It also allows an attending physician to prescribe medication which will enable the person to end their life and establishes a protocol that the attending physician must follow before doing so.

If a person decides to end their life, the legislation requires them to make both an oral and written request to the attending physician. The oral request must be repeated to the attending physician more than 15 days after the initial request. A person may rescind their request at any time.

The legislation creates an affirmative defense to murder and manslaughter if the person is performing an act permitted by the legislation. It also establishes a new crime of abuse of life termination process if a person intends to cause another person's death and falsely makes or alters a request for medication or destroys a rescission of a request for medication. A person may also be guilty of this crime if they exert undue influence on another person to request medication for the purpose of ending that person's life. Abuse of life termination process is a class A felony.

The Department of Law does not anticipate a fiscal impact.

THE SEAL OF THE STATE OF ALASKA

# Representative Harriet Drummond
# Sponsor Statement

## House Bill 99 "Voluntary Termination of Life"

House Bill 99 allows terminally ill patients to ease their suffering and hasten an inevitable and certain death. This bill preserves dignity and a person's right to live, and die, on their own terms according to they own desires and beliefs.

Oregon enacted the first "death with dignity" law in 1994 through a citizens approved ballot initiative. The Supreme Court upheld the law in 2006. Washington followed with another ballot vote in 2008. Vermont passed the first death with dignity law passed by a state legislature. Similar legislation has now sprung up in twenty-five other states.

Death is a natural part of life. Providing dignity, control and peace of mind during a patient's final days with family and loved ones places a much greater focus on a person's life than on the often painful and agonizing process of dying.

This bill specifically requires the request process to stop immediately if there is any evidence of coercion. The laws further require the two physicians who work regularly and closely with terminally ill patients to be involved throughout the request process. These two qualified and independent diagnoses ensure against coercion.

This bill allows patients to have important end-of-life discussions with the doctors they already know and trust. Without this discussion, well-meaning doctors are faced with prescribing painful procedures even when the patient does not want them and there is little or no hope for success. People in these conditions have already lost their health and often much, much more. This bill at least lets them control the last and most important decision they have left.

Representative Harriet Drummond

# House Bill 99 Sectional Analysis
"Voluntary Termination of Life"

## Section 1:
*Page 1: Lines 4-7*

Amends AS 11.41.115 (defenses to murder) to allow an affirmative defense for acting under 13.55.

## Section 2:
*Page 1: Lines 8-10*

Adds a new subsection to AS 11.41.120 (manslaughter) to establish an affirmative defense to a prosecution for manslaughter for performing any action allowed in AS 13.55.

## Section 3:
*Pages 1-14: Lines 11-24*

Adds a new chapter AS 13.55, which provides the process in which terminally ill individuals may request medication to terminate their life.

**Sec. 13.55.010:** Describes which individuals may terminate their life under the new chapter. Lists the criteria for being a qualified individual. Includes state residency, being an adult, being capable, having a terminal disease, and having voluntarily expressed the wish to die. States that age or disability is not sufficient by itself to qualify.

**Sec. 13.55.020:** Authorizes a qualified individual's attending physician to dispense or write a prescription for the necessary medication if the physician complies with the chapter. Authorizes a pharmacist to dispense the prescribed medication to the qualified individual, the attending physician, or an agent of the qualified individual.

**Sec. 13.55.030:** Requires a qualified individual to make an oral request and a written request to their attending physician to receive the necessary medication. Requires the qualified individual to repeat the oral request 15 days after the initial request. Provides alternative request methods for qualified individuals who are not able to speak or not able to sign the request.

**Sec. 13.55.040:** Directs the attending physician to offer the qualified individual the opportunity to rescind the initial oral request and the written request when the qualified individual makes the second oral request. Allows a qualified individual to rescind a request at any time. Prohibits an attending physician from dispensing or prescribing medication unless the physician offers the qualified individual an opportunity to rescind the request.

**Sec. 13.55.050:** Sets up the requirements for the written request. Prohibits the attending physician from being a witness. Requires the witnesses to attest that the qualified individual is capable, acting voluntarily, and not under undue influence to sign. Sets limits on who may be witness.

**Sec. 13.55.060:** Lays out a form for the written request to be signed by the qualified individual.

**Sec. 13.55.070:** Lays out the duties of the attending physician. Includes determining whether the individual has a terminal disease, is capable, and has made the medication request voluntarily. Also includes providing certain listed information to the individual about the medical diagnosis and prognosis, the risks and probable result of taking the medication, and feasible alternatives. Requires the physician to refer the individual to a consulting physician to confirm the diagnosis and to determine that the individual is capable and acting voluntarily. Requires the physician to refer the individual for counseling if appropriate under Sec. 13.55.090. Lists other duties of the attending physician. Allows the attending physician to sign the death certificate.

**Sec. 13.55.080:** Before an individual can qualify under the chapter, it requires a consulting physician to examine the individual and confirm the attending physician's diagnosis of a terminal disease, and to verify that the individual is capable, acting voluntarily, and has made an informed decision.

**Sec. 13.55.090:** Requires the attending or consulting physician to refer the individual for counseling and prohibits the dispensing or prescribing of the necessary medicine until the counselor determines that the individual is not suffering from depression causing impaired judgment.

**Sec. 13.55.100:** Prohibits the attending physician from dispensing or prescribing medication unless the qualified individual has made an informed decision.

**Sec. 13.55.110:** Prohibits the attending physician from denying the medication request because the individual declines or cannot notify next of kin.

**Sec. 13.55.120:** Requires certain waiting periods before medication can be dispensed or prescribed.

**Sec. 13.55.130:** Requires that the medical record of the qualified individual contains the items listed in the section before the individual receives the medication.

**Sec. 13.55.140:** Invalidates will or contractual terms that require, prohibit, impose conditions on, or otherwise addresses whether an individual may make or rescind a request under this chapter.

**Sec. 13.55.150:** Provides a person with immunity from civil and criminal liability or professional disciplinary action for participating in good faith compliance with the chapter. States that a medication request by an individual or an attending physician providing medication in good faith compliance with this chapter may not provide the sole basis for the appointment of a guardian or conservator.

**Sec. 13.55.160:** States that a health care provider has no duty to participate.

**Sec. 13.55.170:** Under certain conditions allows a health care provider to prohibit another health care provider from participating in this chapter.

**Sec. 13.55.180:** Establishes the crime of abuse for certain activities. Makes the crime a class A felony.

**Sec. 13.55.190:** States that the chapter does not limit liability for civil damages resulting from a person's negligent conduct or intentional misconduct.

**Sec. 13.55.200:** Allows a governmental entity to file a claim against an individual's estate to recover expenses incurred by the entity resulting from the individual's termination of life under this chapter.

**Sec. 13.55.210:** Directs the Department of Health and Social Services to review a sample of the records maintained under the chapter every year. Requires a health care provider to file a record of dispensing medication under this chapter with the department. Directs the department to adopt regulations to facilitate the collection of information about compliance with the chapter. Makes the information confidential but requires the department to provide the public an annual statistical report about the information collected.

**Sec. 13.55.220:** Prohibits construing the chapter to authorize or require health care contrary to applicable generally accepted health care standards. Prohibits construing the chapter as authorizing the ending of life by certain methods, including lethal injection. Establishes that an action allowed by this chapter is an affirmative defense to certain crimes, including murder, manslaughter, and euthanasia.

**Sec. 13.55.230:** Prohibits a person from conditioning the sale, procurement, issuance, rate, delivery, or another aspect of a life, health, or accident insurance or annuity policy, on the making or rescission of a request for medication under the chapter.

Sec. 13.55.240: States that a request for medication under this chapter is not an advance health care directive under AS 13.52 and that AS 13.52 (Health Care Decision Act) does not apply to an activity allowed by the chapter.

Sec. 13.55.900: Defines the terms used in the new chapter.

## **Section 4:**

*Page 14: Lines 25-29*

Indicates that the chapter applies to contracts, wills, and life, health, or accident insurance or annuity policies delivered or issued for delivery on or after the effective date.

## **Section 5:**

*Pages 14-15: Lines 30-3*

Allows the Department of Health and Social Services to adopt regulations for the new chapter.

## **Section 6:**

*Page 15: Line 4*

Makes the regulation authority given under Bill Section 5 take effect immediately.

## **Section 7:**

*Page 15: Line 5*

Makes the Act (except Bill Section 5) effective January 1. 2016.

Representative Harriet Drummond

**MEMORANDUM**

**DATE:** 2/16/15

**TO:** Rep. Paul Seaton, Chair, House Health and Social Services Committee

**FROM:** Representative Harriet Drummond HD

**SUBJ:** House Bill 99 Hearing Request

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I would like to respectfully request a hearing for House Bill 99 before House Health and Social Services at your earliest convenience.

HB99 would allow terminally ill patients to ease suffering and hasten an inevitable and certain death. There are also safeguards in place to protect against coercion for those who are vulnerable.

Included with this request you will find:

1. The current version of the bill
2. A copy of the sponsor statement
3. A sectional analysis
4. Supporting documents
5. Letters of support

Please contact my staff, Kristin Kranendonk at 465-3875 for any additional information. My office will submit names of testifiers as soon as possible.

I appreciate your time and look forward to working with you on this issue.

# LEGISLATIVE RESEARCH SERVICES

Alaska State Legislature
Division of Legal and Research Services
State Capitol, Juneau, AK 99801

(907) 465-3991 phone
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*research@akleg.gov*

## Research Brief

TO: Representative Harriet Drummond
FROM: Tim Spengler, Legislative Analyst
DATE: February 18, 2015
RE: Cost of End-of-Life Care in Alaska
*LRS Report 15.200*

***You asked for information on costs related to end-of-life care in Alaska. Specifically, you asked for any cost estimates available for care given in the final three months of life to terminally ill individuals. Additionally, you wished to know if there is a cost discrepancy between the insured and uninsured.***

The Department of Health and Social Services (DHSS) provided us with information regarding the cost of end-of-life care in the state, which we provide, verbatim, in the paragraph below.[1] The department's response pertains to the cost for hospice care, which centers on making a dying patient as comfortable as possible, as opposed to medical (curative) treatment. You will note that hospice care averages around $175 a day. Where care includes pharmacy, medical equipment, and physician services, average costs are around $293 a day.[2] Medicaid pays for hospice services in the state.

Following DHSS' response, we provide information on end-of-life hospitalization costs in the United States, and on the cost discrepancy between the insured and uninsured. Finally, we include fiscal notes and other legislative information for a few states that have codified death with dignity laws or considered related bills.

### DHSS Response

> A Medicaid recipient is eligible to receive hospice services if his or her medical prognosis is a life expectancy of six months or less. Hospice services include routine and continuous home care, inpatient respite care, and general inpatient care and are paid at the Medicare hospice payment rate established under 42 CFR 418.306. Medicaid will also pay for hospice-related physician services and for room and board provided in a nursing facility for an individual who qualifies for hospice and who has an intellectual disability or related condition.
>
> Hospice services do not include curative treatment, but instead focus on palliation of pain and symptoms and quality of life.
>
> During FY2013 and FY2014, the average total cost of care per Alaska Medicaid hospice patient, was $174.39 per day for hospice services only. The average total cost of care, including all services (hospice, pharmacy, waiver, durable medical equipment, physician services, etc.) was $293.15 per day. Note: These figures do not reflect the significantly higher costs of care for terminally ill individuals who decline hospice services and choose to continue curative treatment.

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[1] Tony Newman is legislative liaison for the Department of Health and Social Services. Mr. Newman can be reached at (907) 465-1611.

[2] These figures do not include the much higher cost for patients who decline hospice services and continue curative treatment.

## End-of-Life Hospitalization in the United States

A ten-page brief from the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) provides information about end-of-life hospitalizations in the United States for the year 2007.[3] Below we highlight some of the document's findings. The brief can be accessed at *http://www.hcup-us.ahrq.gov/reports/statbriefs/sb81.pdf*.

- Thirty-two percent of all deaths in the U.S. in 2007 were inpatient hospital deaths;
- The inpatient death rate in 2007 was 1.9 percent. However, these hospital stays ending in death were responsible for 5.1 percent ($17.6 billion) of all hospital inpatient costs;
- Average hospital costs for a stay ending in death were $23,000, about 2.7 times higher than for a patient discharged alive;
- Medicaid had the highest costs for a hospital stay ending in death at $35,000, which is nearly 5.5 times higher than for a Medicaid patient discharged alive. However, Medicaid had the lowest death rate among payers, 0.8 percent; and
- Medicare covered 67 percent of all inpatient deaths, with a total cost of over $10 billion, which accounted for 6.9 percent of all Medicare inpatient costs.

Another document, while somewhat dated, may also be of interest to you. The 2001 article from the journal *Health Affairs* entitled "Medicare Beneficiaries' Costs of Care in the Last Year of Life" can be accessed at *http://content.healthaffairs.org/content/20/4/188.full.* The document includes the following information.

- The typical Medicare decedent averaged roughly four significant diseases in the last year of life, while the average for survivors was slightly more than one in the typical calendar year. Decedents' high end-of-life costs are largely a consequence of this substantial disease burden.
- The share of Medicare spending for persons in the last year of life has been stable for two decades. For the mid-1990s decedents' per capita Medicare program outlays were about six times higher than that for survivors. This ratio is slightly lower than a similar estimate for 1979.
- Based on data for the calendar year of death, Medicare paid 61 percent of decedents' costs, Medicaid paid ten percent, and other payers 12 percent. Out-of-pocket costs accounted for 18 percent.

## Insured and Uninsured Costs

While perhaps counterintuitive, it is a truth universally acknowledged that uninsured individuals nationwide are often required to pay a higher rate for health services than those with insurance; this is especially true of hospital charges.[4] This occurs for two main reasons:

1. Health insurers typically negotiate discounted provider rates, based on their large volume of enrolled members, often 30 to 50 percent less than "charged" rates. Similarly public programs–Medicaid, Medicare, and state employee health–also negotiate significant discounts. These "provider rates" do not apply to those with no insurance coverage.

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[3] The Agency for Healthcare Research and Quality's (AHRQ) stated mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used (*http://www.ahrq.gov/*).

[4] For information on this section of the report, we contacted policy specialists at the National Conference of State Legislatures, as well as reviewing other sources.

2. Those with insurance also have a wide range of consumer protection laws including provisions of the Patient Protection and Affordable Care Act (ACA), which allow (or require) a review of charges.

Of course, a number of individuals without insurance ultimately do not pay their medical provider or hospital bills. There are myriad reasons why this occurs, not the least of which is the high cost of medical care. The below paragraph from an NCSL program specialist outlines this phenomena, called uncompensated care.[5] [Emphasis added.]

> Uncompensated care is an umbrella term used to refer [to] all health services rendered for which there is no usual source of payment, such as insurance, Medicaid/Medicare and the patient does not have the financial means to pay out of pocket. However, there are streams of funding available to hospitals and providers to pay for a portion of this care, such a Disproportional Hospital Share (DSH) payments and, in some cases, state/municipality–specific funding. **On average, a person who is uninsured has considerably lower annual health care expenses than a person who is insured.** This difference reflects the uninsured population's lower health services utilization rate and lower intensity of service use compared to the insured population. Compared to nonelderly people who had insurance for a full year, for whom average per capita medical expenditures were $4,876, nonelderly people who were without insurance for a full year used health care services valued at about half that amount, or just $2,443 per capita per year in 2013. Nonelderly people who were uninsured for part of the year had annual medical expenditures about 30% lower than people who were insured for the full year, spending an average of $3,439 annually per capita. Part-year uninsured individuals spent more per capita than full-year uninsured individuals largely due to higher spending in the months that they had coverage.

A 2013 report from the Kaiser Family Foundation "Uncompensated Care for the Uninsured in 2013: A Detailed Examination" provides further information on the topic (*http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/*).

## Death with Dignity Fiscal Notes and other Information

Below you will find links to fiscal notes and measures in four states with Death with Dignity laws or bills.[6]

- **Colorado House Bill 15-1135:**
  *http://www.leg.state.co.us/clics/clics2015a/csl.nsf/fsbillcont3/7D2B561E0A83252487257D9000776DB8?open&file=1135_01.pdf*
  Fiscal Note:
  *http://www.leg.state.co.us/clics/clics2015a/csl.nsf/fsbillcont3/7D2B561E0A83252487257D9000776DB8?Open&file=HB1135_00.pdf*
  Note: Bill introduced this year; pending.

- **Kansas House Bill 2108 (2013):** *http://www.kslegislature.org/li_2014/b2013_14/measures/hb2108/*
  Fiscal Note: *http://www.kslegislature.org/li_2014/b2013_14/measures/documents/fisc_note_hb2108_00_0000.pdf*
  Note: Bill died in committee.

- **Vermont Senate Bill 77:** *http://www.leg.state.vt.us/docs/2014/Bills/Intro/S-077.pdf*
  Fiscal note: *http://www.leg.state.vt.us/jfo/fiscal_notes/2013_S_77_as_amended_by_HHS.pdf*
  Note: Enacted in 2013.

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[5] Provided by Melissa Hansen, program principal, NCSL. Ms. Hansen can be reached at (303) 364-7700.

[6] Please note that we did not conduct a comprehensive search for such measures. Three states have enacted Death with Dignity laws: Oregon, Vermont, and Washington.

- **Washington Ballot Initiative (2008):** *www.wsha.org/files/i1000 text.pdf*
  Fiscal Impact:
  *http://ballotpedia.org/Washington_%22Death_with_Dignity_Act%22,_Initiative_1000_(2008)#Fiscal_note*
  Note: Law went into effect in 2009.
  More information on death with in Washington is available at
  *http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct.*

We hope this is helpful. If you have questions or need additional information, please let us know.

# Capitol Journal How we die should be a personal choice, not the government's

**George Skelton**
LOS ANGELES TIMES
*george.skelton@latimes.com*

FEBRUARY 22, 2015, 8:45 PM

Many terminally ill patients fear dying slowly in pain. They'd like to cut short the agony.

But some with disabilities worry about being pressured into suicide.

Still others believe their god insists they die naturally even if suffering.

Me, I'd like to make my own decision, thank you. No government or religion telling me what I can or cannot do with my own body.

It all adds up to potentially the most emotional issue of the new California legislative session.

Politicians and interest groups can't even agree on what we should call this. Everyone's playing word games trying to subtly tilt the debate.

Advocates of changing the law to allow for expedited, voluntary, doctor-aided death call it the End of Life Option Act. In Oregon, it's referred to as "death with dignity." Opponents just brand it "assisted suicide." It's all the same.

But "there are emotionally charged connotations with the word 'suicide,' " notes Assemblywoman Susan Talamantes Eggman (D-Stockton), a coauthor of the new legislation. "That's what the opposition wants you to use."

The bill is SB 128, also coauthored by Sens. Lois Wolk (D-Davis) and Bill Monning (D-Carmel). It would allow mentally competent California residents with less than six months to live obtain physician-prescribed lethal drugs that they'd administer themselves.

A patient would need two doctors to confirm the illness was terminal. Also required: two oral requests 15 days apart and a written version witnessed by two people. Physicians, pharmacists and healthcare facilities could opt out. Those participating would be protected against lawsuits. Coercing a patient would be a felony.

The first committee hearing is set for March 25. Sponsors hope for a Senate floor vote by June.

Very likely this will be one of those rare "you could hear a pin drop" debates. "People have intense feelings," Wolk says.

"But everybody has a personal story. My mother died when I was 17 from cancer and it was pretty brutal. It's a rare person who hasn't had an experience with death of a loved one, a family member or a very good friend. And at the end of the story, everyone says there must be a better way.

"People should have the right to a peaceful death and not go through suffering."

If it passes the Senate, the bill will face a tougher hurdle in the Assembly. There, many Latinos represent heavily Catholic constituencies and are leery because of church opposition.

Gov. Jerry Brown, a former Jesuit seminarian, hasn't taken a position.

"California is ready for this," Eggman says. "I'm not sure the Assembly is ready. But if it doesn't go through the Legislature, there'll probably be a ballot initiative."

Better to filter the proposal through the checks and balances of the state Capitol. Too many initiatives have been clumsily written with unintended consequences.

The last significant California polling was nine years ago by the nonpartisan Field Poll. It found 70% support for terminal patients being allowed to take life-ending medication.

But the next year, such a proposal was shelved in the Assembly for lack of support. The Catholic Church had played nasty.

Then-Cardinal Roger M. Mahony, speaking to worshipers at the cathedral in Los Angeles, charged that then-Assembly Speaker Fabian Nunez was part of "the culture of death" because he supported the legislation.

The Catholic Church also opposes the new bill, but is taking a back seat.

It's letting disability-rights activists do most of the heavy fighting. They fear the legislation would become an easy tool that inconvenienced family members and greedy insurance companies could use to rid themselves of burdensome and costly patients with disabilities.

"There's a deadly mix when you combine our broken, profit-driven healthcare system and legal assisted suicide, which would instantly become the cheapest treatment," says Marilyn Golden, a senior policy analyst for the Disability Rights Education and Defense Fund.

She adds: "There's a prejudice in society that a disabled person's life is not worth living."

Catherine Campisi, former director of the state Department of Rehabilitation and a disabilities activist, points out there already are options for the terminally ill. They can stop treatment, go into hospice care and be administered palliative sedation, "which keeps them comfortable while the dying takes place."

Well, not always, according to many who have watched someone close die while suffering in a medicated fog.

Dr. Robert Olvera of Santa Ana, a family physician, watched his 25-year-old daughter Emily die from a rare type of leukemia last year. "During the final four months," he says, "she suffered a stroke, went blind, was unable to feed herself, used Depends. It was basically a dark world.

"Pain medicine wouldn't do it. She wanted me to give her something to put her to sleep permanently. I didn't want to do that. If we had known it was legal in Oregon, we would have taken that option. She finally elected to starve herself."

Starve yourself. Pull the plug. Or take a drug. Same result. You should be allowed to choose the least painful, quickest route that fits your beliefs.

Doctors take an oath to "do no harm." That's why the California Medical Assn. has opposed similar proposals previously, although it hasn't taken a position on the latest bill.

"I don't feel that helping with end-of-life decisions is harming anyone," Olvera says.

There's no universal right or wrong in any of this. It's only right or wrong for yourself.

george.skelton@latimes.com
Twitter: @LATimesSkelton

I am terminally ill, and writing in support of HB99. This is difficult, but I think necessary.

After gathering research and articles regarding "Death With Dignity", I've come to the conclusion that the opposition consists mainly of radical religious fanatics. I believe in God, always have. I live by the 10 Commandments. But, after suffering for 20 years with excruciating pain, I believe I have the right to die my way, in peace, with compassion. Since I am already dying, it isn't murder in my eyes. Only those who are experiencing near death, and the pain involved, can say without reservation that they would rather pass away peacefully before inhumane pain and lack of dignity takes over their body. I live every day in fear of those days I have to look forward to.

I would love for someone to do for me what I have done for my pets when it was their time. I helped them to pass painlessly and peacefully, with lots of love. I don't understand those who don't have compassion for the dying, whether it be a human or an animal. Do they enjoy watching the suffering? Or, do they just stay away from the dying during those days/months so they don't have to watch? I think you would have to be a cold, cold person to not feel for that person who is in pain and dying.

Death with Dignity should be a "choice"! I am not for "forcing" another to choose it. But, it should be a person's "right" to have that choice. It is not intended for suicide, murder, or depression. There's a big difference. I would like to see it in a person's Will and "Advanced Health Directive" so there would be no doubt as to the individual's decisions for their death. I would have it in my Will if I could.

Please consider my letter. This is for a person's right of choice, it is not a mandate that everyone has to "Die with Dignity". If you want to die miserably and in pain, leaving thousands of dollars in medical bills, among other bills, be my guest, but I should also have the choice to "Die with Dignity".

Patricia Pattee

**From:** Anne Kilkenny <annekilkenny@hotmail.com>
**Sent:** Monday, April 06, 2015 7:12 PM
**To:** Rep. Harriet Drummond; Rep. Andy Josephson; Rep. Max Gruenberg
**Subject:** HB 99

Representatives Drummond, Josephson & Gruenberg,

re: HB 99

Thank you for having the courage to begin the discussion of this very difficult topic!

A couple of weeks ago I spent 2 days with a friend at the bedside of her dying 98 yr old semi-comatose mom. Ten days after "Mom" stopped talking, eating or drinking, she died a peaceful death, her body so emaciated that her head was a skull with skin stretched over it.

This was not the first time I've spent days at the bedside of a dying person. Each experience has opened for me a Pandora's box of questions, most of which I have found no answers to, even though I am a life-long, practicing Catholic.

A couple of things, however, ARE clear to me:
1) people should have the maximum control over their lives,
2) death is a natural part of life, and
3) it should not be illegal for anyone to assist another person in their effort to exercise control over their life.

Thank you for your courage and service,

Anne Kilkenny
P. O. Box 870163
Wasilla, Alaska USA
99687-0163

907-376-6225

Live Simply. Love Generously. Care Deeply. Speak Kindly. Leave the rest to God.

**Kristin Kranendonk**

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**From:** Walter Benesch <wbenesch@alaska.edu>
**Sent:** Tuesday, April 07, 2015 11:53 AM
**To:** Kristin Kranendonk
**Subject:** HB 99 support

Kristin Kranendonk, I would like to add my support for HB99. It is time that we come to terms with the "right to die with dignity" and get the vested theological interests out of this decisions making
process. Walter Benesch, Prof of Philosophy Emeritus UAF.

| | |
|---|---|
| **From:** | dixalaska@aol.com |
| **Sent:** | Tuesday, April 07, 2015 1:54 PM |
| **To:** | Rep. Harriet Drummond |
| **Subject:** | HB 99 - a note from dixie hood - |

I am 81 years old and a member of the Juneau Commission on Aging. With the increasing population of Seniors in Juneau and all of Alaska, there are many issues and important needs facing us. This is a letter in support of HB 99 Death with Dignity. This Legislation empowers Elders and others suffering with life-threatening medical conditions to access Physician prescribed medication and would facilitate thoughtful end-of-life choice.

As a Senior myself and a Licensed Marriage and Family Therapist, I have seen friends and clients move to Oregon to access this opportunity for a peaceful passing.

Going through all the preparation and expense of moving to another state complicates lives of patients and their caretakers in extremely negative ways. Most of these folks want to stay in Alaska within their familiar communities. Passage of HB 99 would enable this. There is no apparent fiscal note required, please take positive action to pass this Legislation as soon as possible.

Thank you.

Dixie A. Hood
9350 View Drive
Juneau AK 99801

(907) 789-2068 (H)
(907)586-2200 (24 hr mess.#)

**Kristin Kranendonk**

**From:** Mary Ann Borchert <maborche@gmail.com>
**Sent:** Tuesday, April 07, 2015 2:10 AM
**To:** Kristin Kranendonk
**Subject:** Re: HB99

I am in favor of HB 99. Please convey this support to HSS committee members. I don't think my previous message came through correctly.
Thank you.
Mary Ann Borchert

Sent from my iPhone
Mary Ann Borchert
2450 Locksley Ct.
Fairbanks, AK. 99709
maborchert@alaska.net
907-479-2087
Cell 907-888-2972

On Apr 7, 2015, at 9:58 AM, Mary Ann Borchert <maborche@gmail.com> wrote:

**Kristin Kranendonk**

**From:** Robert Churchill <rock4@gci.net>
**Sent:** Sunday, April 05, 2015 10:50 AM
**To:** Kristin Kranendonk
**Subject:** HB99

Unfortunately I'll be out of town on the date for public testimony. However I fully support the passage of this bill. I have had two very close friends who have been terminal with cancer that I've spend a significant amount of time with in the last 6 months of their lives. Based on my conversations with them, I know they would have appreciated having this as an option.

Given the criterion I don't believe this either encourages or leads to "suicide" in the context we most often think of it.

I hope this passes and gives Alaskans another option when it comes to end of life decisions.

Bob Churchill

Representative Paul Seaton
270 W Pioneer, #B
Homer, AK 99603

RE: HB 99

Dear Rep Seaton:

I am writing in support of HB 99 by Rep. Drummond. I believe it is referred to by many as the "the right to die bill" although I personally consider it the "death with dignity" bill.

My fervent belief is that every person has a right to die with dignity when suffering a terminal illness and as painlessly as his/her medical provider and family can arrange. This conviction is the result of my experiences with the end of life.

As a hospice volunteer I have watched people progress towards their death. No doubt, many would not want to end their lives sooner. All are given significant doses of pain relieving medication, some to the degree that they are not aware of the family or friends that may be at their bedside. Others may welcome the choice of when and how the end of their life would take place. The choice to be conscious of their surrounding and the ability to say goodbye.

My Father died a painful cancer death in 1965 two days before his 52nd birthday and on my 22nd birthday. Of course, he was deeply medicated that last night that I sat in his hospital room therefore oblivious to my presence. Perhaps he would have chosen a different end, I don't know but the operative word is "choice".

We have many protections for our right to choose how to live our lives, to be free to make choices yet such freedoms are denied when dying. As has been pointed out by many, our pets and other animals are allowed more privilege than us. Four months ago I was able to ask the kind veterinarian to put my 16 year old cat down when his kidneys gave out rather than try to keep him alive for an unknown but likely short period of time. I wish for, ask for the same option - to be "put down" at my request when my body is giving out.

Please bring this bill up for a hearing so all views can be discussed.

You may wish to review this site: deathwithdignity.org

Thank you,

*Monte*

Ms Monte L. Jordan
P.O. Box 73941
Fairbanks, AK 99707

cc: Representatives Harriet Drummond

**Subject:** Support for HB 99 voluntary termination of life by terminally ill individuals

Representative Drummond,

I would like to extend my appreciation for your support of HB 99.

My father, age 90, has been an Alaska resident since 1948 (67 years). He was until December 2014, very independent – living in his own home, driving, shopping, out visiting with friends, going to family functions, fishing, fixing his own meals and taking care of all his own needs. In December he was diagnosed with a terminal illness and is now confined to a wheel chair, unable to support his own weight and requires a 24 hour caregiver. The changes basically seemed to happen overnight. As a family we are able to provide for his physical needs. But this is not the quality of life that he had experience all his life.

Both my parents have had health care directives for many years. Their choice for health care is allowed by law.

After reading a recent Alaska Dispatch article on HB 99, my father has several times expressed that he wished the law was available now. He has mentioned it to several family members.

I took the time to go online to Oregon's website http://www.deathwithdignity.org/in-oregon . I wanted to understand and make certain that the ability to choose was only the patients. Which it is. In Oregon the patient must be able to administer the pill themselves.

As a family, I don't think that we are ever ready to experience our parent's passing. But who are we to decide that our parents have to remain alive for our emotional wellbeing.

I now watch a man, whom I love, unable to continue to live life as he had experienced in the past. I see a man that knows how he must spend the rest of his life because he currently has no ability to choose.

I would support my father's choice for death with dignity.

Would it be difficult? Of course it would. But harder still is to know he is going to die; watch the changes in his body as he wastes away; seeing how very tired he is.

What makes it bearable? Knowing that the choice was his; that this was both the quantity & most importantly the quality of life that he chose.

I know that I may have rambled on, but this bill is important to Alaskans. I was aware that other states have had the ability to choose death with dignity, but never thought I would one day wish that I was a resident of one of those states.

Please feel free to share this e-mail.

Respectfully,

My Father's Daughter

Cynthia Kimbley

From: Robyn Lauster <robynkcl@gmail.com>
Subject: HB 99

Message Body:
Dear Harriet:

I appreciate your sponsoring this bill making voluntary termination of life legal. My experience with my sister's death convinces me that this is a needed option in a compassionate society. In the 1980's, my sister, then 45 and suffering from cancer which had metastasized to her brain, chose to take medication at home, retaining control over her time and method of departure. She had undergone all the recommended surgeries and chemo, and was under a doctor's care for pain control. However, she was bedridden and given only a matter of days to live. She talked to me, to our father, and to a close cousin before deciding, collecting our opinions and support. I know she prepared her son, who was 16, her partner, her best friend, and others. I don't believe anyone tried to change her mind, but offered support. Although it was not legal in her state at the time, she had a close friend who was a medical doctor who made sure she had medication which would be appropriate. Her partner and best friend sat by her bedside until she had passed. Under the circumstances, it was the kindest, most loving thing anyone could do for her at that point. It should be an option available to everyone in similar circumstances. Thank you again for sponsoring this bill, and please feel free to use this email in any way to help support HB 99.

# Emails in Support of HB 99

*Included emails from:*

- *Neil McArthur- Homer*
- *Richard Seifert- Fairbanks*
- *Janet Girt*
- *Donna Rae Faulkner and Don McNamara – Homer*
- *Ron Johnson – Fairbanks*
- *Carol Griswold – Seward*
- *Laurinda Marcello – Sitka*

Please accept the following as written comment on HB 99 Voluntary Termination of Life.

If the time comes when I can no longer live with dignity and relative comfort, I want the opportunity to die with dignity, and to have some guidance in the matter if needed. After watching my wife spend nine years in a nursing home on Medicaid, I commend the dedication and kindness of the staff, but do not personally want to go there. Nor did she. Such a law would not have applied in her case, but perhaps it might in some scenario of mine, and my getting my way might save the system quite a lot of money besides.

Thank you -- Neil McArthur, Homer

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**From:** Richard Seifert [redacted]
**Sent:** Thursday, March 12, 2015 1:18 PM
**To:** Rep. David Guttenberg; Powers, Mike; Shelley Ebenal
**Subject:** Message in Strong support of House Bill 99 and legal standing for Death with Dignity

I will place in this message a letter I have sent to the three sponsors of the very needed House Bill 99, which addresses the unmet need for allowing Alaskans the choice of dying with dignity. My letter further elaborates the case and my suggestions for supporting this legislation. Please urge its further hearing and support it.

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Honorable Representatives Drummond, Josephson, and Gruenberg, and all Representatives: A Message regarding HB 99

March 11, 2015

I wish to commend the sponsors (listed first above) for submitting courageously and with compassion, House Bill 99, regarding voluntary termination of life by terminally ill individuals. It is my long-standing concern and a very crucial concept: the release of those afflicted with terminal illness and suffering, that they be given their due legal authority and fulfill their great need to end their lives with dignity and as they wish. While there are some details of the bill which are complex and difficult to follow, I believe this bill is on the right track for affording Alaskans this clarity and option for determining their own life choices, and end-of-life choices. The present form of the law is very careful and well-formulated to ensure against abuse and yet provide for several options in the case of inabilities for the afflicted to communicate.

My few comments, which now I will add, are not intended to be criticism, rather they are questions which I have, or statements in the present suggested legislation which to me are not clear or are over-complicated.

1. First, I am not sure why a 15 day waiting period is needed. Aren't five days enough? If a person is suffering a fatal illness and in serious pain, why make them wait for more than two weeks for fulfilling their choice? Surely this is not needed.

2. On page 8 of the bill, the section detailing due diligence by professionals in the health care area is a bit dense and difficult to follow. It will be crucial that all necessary diligence be followed and may require additional education to professionals (doctors, pharmacists, nursing care staff) upon passage of this important bill to ensure full comprehension of all the compliance rules and records required.

3. As a 27-year board member of the Fairbanks Memorial Hospital Foundation, I will bring this law to the attention of the board and Banner Health staff, as the section 13.55.170 on sanctioning such end-of-life options, has strong implications for hospital participation, or non-participation. (I am writing this as a private citizen however, and only mention my hospital involvement because I want to be sure the hospitals are engaged by the legislature.) I expect you are letting all the hospitals and hospital associations know about this, as well as doctors. That being said, it is difficult to get any public dialog on this matter. Please advise me as soon as possible if there are any hearings on this bill.

4. From March 4 through March 25, each Wednesday in Fairbanks, Mr. Dick Farris is conducting an Osher Life-Long Learning class on the topic of "Death with Dignity", and this law is incredibly timely for promoting discussion of that topic and public action to allow for the dignity of life's end to be afforded. We shall be discussing this law throughout the course and will be advocating for its passage. It is at least one public event where this legislation is being reviewed, discussed and endorsed.

Thank you all, profoundly, for attempting to bring this important issue to legal acceptance through your legislative bill. I again commend you for courage and foresight. I have long supported such law and have watched Oregon's process and experience in this area with approval. You may wish to review that experience as well.

Thank you for the opportunity to comment.

Respectfully,

Richard D. Seifert

[redacted]
Fairbanks, AK 99712

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**From:** Janet Girt [redacted]
**Sent:** Saturday, February 21, 2015 1:16 AM
**To:** Rep. Paul Seaton
**Subject:** PASS HB 99

I implore you to support this bill. I have been waiting to see this state make some progressive moves to enable people to have the right to make some choices in their life and in their death. There is no harm done when we just give someone a choice to live their life out as they think right when their choice does not harm anyone or anything. If you are against this law because you think it enables or encourages suicide then your soul must tell you that guns should be eliminated as we know they enable more successful suicides than other means and with guns so many innocent lives are also taken.

Janet Girt

**From:** Donna Rae and Don [redacted]
**Sent:** Thursday, March 05, 2015 11:14 AM
**To:** Rep. Paul Seaton; Sen. Lesil McGuire; Sen. Peter Micciche; Rep. Harriet Drummond
**Cc:** Taneeka Hansen
**Subject:** Support of HB 99

Dear Honorable Senator Seaton, Honorable Senator McGuire and the Honorable Members of the Health and Social Services Committee, the Senate Judiciary Committee and your staff, as well as our Honorable Senator Micciche,

We request that our comments be entered into the public record and that they be read into the records. Thank you.

We very briefly want to let you know that we support and applaud HB99 Voluntary Termination of Life.

House Bill 99 allows terminally ill patients to ease their suffering and hasten an inevitable and certain death. This bill preserves dignity and a person's right to live, and die, on their own terms according to they own desires and beliefs. It makes common sense to us and we hope that Alaska passes this bill in to law. We want to thank Representative Drummond for sponsoring this bill that will hopefully come to be appreciated by many generations to come. We are proud that it is coming before you now. It is about time!

Feel free to contact us in the future if you would like more expansive comments.

Thank you all for your fine work on behalf of all Alaskans.

Sincerely,

*Donna Rae and Don*

Donna Rae Faulkner and Don McNamara
[redacted]
Homer, AK 99603
(907)235-SURF and Don's cell 299-SURF

**From:** Ronald Johnson [redacted]
**Sent:** Wednesday, February 18, 2015 11:47 AM
**To:** Rep. Paul Seaton
**Cc:** Monte Lynn Jordan
**Subject:** HB 99

Dear Rep Seaton,

I hope you can support HB 99 [right to die bill] by Rep Drummond. Similar legislation in Oregon has not been abused. By providing aid in dying, this bill can greatly reduce the terrible suffering that many now have to endure in their last days, weeks, or months of life. As a veterinarian said on a PBS show several years ago [paraphrasing], it is too bad that I don't have the choice that my dog has which is to die with dignity. The veterinarian was in terminal stages of ALS.

85 % of Canadian Health care professionals support a physicians ability to assist in dying should someone be terminally ill and suffering unbearably.
http://www.dyingwithdignity.ca/resources/first-release-poll-results/inner_articles/727.php

Whether you agree with my views or not, please schedule a hearing so all sides can have a say in this important discussion.

Thanks

--

Ron Johnson
Professor Emeritus
Mechanical and Environmental Engineering
Univ of Alaska Fairbanks

2113 Jack St
Fairbanks, AK 99709

**Sent:** Sunday, March 29, 2015 4:14 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool; Rep. Mike Chenault; Rep. Mike Chenault; Sen. Peter Micciche
**Subject:** Re: YES to HB 99 Voluntary Termination of Life

Honorable Representatives. and Senator Micciche,

I urge you to support HB 99, Voluntary Termination of Life. Please help to allow death with dignity.

Thank you for your consideration.

Carol Griswold
[redacted]
Seward, Alaska

**From:** Laurinda Marcello [redacted]
**Sent:** Wednesday, April 08, 2015 10:56 AM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool
**Cc:** Rep. Jonathan Kreiss-Tomkins; Sen. Bert Stedman
**Subject:** Support for HB-99 Voluntary Termination of Life

Dear House Health & Social Services Standing Committee:

I urge you to support HB 99 on Voluntary Termination of Life.

When I was just 18 years old my life changed drastically. During that short summer between my high school graduation and the start of college, my dad was both diagnosed with and died from stage IV colon cancer. Even with the relatively short time he spent in the hospital, I still saw that there comes a time when the maximum amount of pain medication allowed is insufficient to meet a patient's needs.

While I realize his disease progressed too quickly for him to have benefited from a Death with Dignity law, there are many others for whom HB 99 would be a true blessing. I've since seen loved ones and friends undergo much longer periods of suffering associated with terminal diagnoses such as a recurring breast cancer, pancreatic cancer, congestive heart failure, and ALS. Undoubtedly, some would opt to end their suffering and die on their own terms, if given the option.

Therefore, I ask each of you to support HB 99 so that terminally ill Alaskans can take charge of their own endings. I look forward to the passage of this legislation.

Thank you,

Laurinda Marcello

Sitka, AK

# Support for HB 99 – 04.13.2015

*Includes emails from:*

*Gary Newman – Fairbanks*

*Bernie and Donna Gareau – Homer*

*Joyanne Bloom - Juneau*

**From:** [redacted] **On Behalf Of** Gary Newman
**Sent:** Saturday, April 11, 2015 2:57 PM
**To:** Rep. Paul Seaton
**Cc:** Rep. David Guttenberg; Rep. Harriet Drummond; Rep. David Talerico
**Subject:** HB 99

Rep. Seaton,

Thank you for hearing HB 99 yesterday. I listened to a good deal of the committee hearing at the LIO in Fairbanks and was struck by the many heartfelt stories. I didn't hear any opposition that would not have been addressed by HB 99. I do have a few of my own family stories, but won't share them here.

It seems an inconsistent phenomenon to me that Alaskans, who pride themselves on their personal independence and not wanting more governmental interference than absolutely necessary, would not want to allow their fellow Alaskans to have the freedom to make the most existential decision of their lives with dignity.

I will say that HB 99 is far more stringent in its application than I would advocate. For example, people with incurable and excruciating pain that isn't life threatening within 6 months of expected death are not eligible. That being said, HB 99 would still be a good beginning.

While end of life shouldn't be a purely economic decision, I also recognize and have known individuals who want to avoid having their family's financed depleted from extraordinary means of preserving their lives at any cost.

You are welcome to share this with other members of the committee and I hope for continued progress.

Sincerely,

Gary Newman
Fairbanks, Alaska

From: Bernie Gareau [[redacted]
Sent: Friday, April 10, 2015 12:20 PM
To: Rep. Paul Seaton
Subject: Right to Die

We support your position on this pending legislation. Our personal experience with parents and grandparents who were fervent Catholics and who faced terminal conditions after fighting lengthy illnesses were assisted by courageous healthcare professionals to a dignified and peaceful death. We should all be so blessed to live long and productive lives and then pass peacefully and with dignity. Thank you again for your efforts on behalf of this type of initiative.

Bernie & Donna Gareau
PO Box 3526
Homer, AK 99603

**From:** Joyanne Bloom [redacted]
**Sent:** Sunday, April 12, 2015 11:38 AM
**To:** Rep. Paul Seaton
**Cc:** Rep. Harriet Drummond
**Subject:** HB99

Representative Seaton, I'm so grateful that you brought HB99 before your HSS Committee Thursday, 4/9/15. I was there on to testify but had to leave after an hour and three quarters without having my turn. Here's is what I would have said:

I'm representing myself. I've lived here for over 40 years. I've raised my children here. I'm now blessed with five grandchildren all here in Alaska. There's no getting me to leave the state - with one exception.

When my time comes, I will have to leave my family and leave Alaska so I can have the death I want, a death with dignity. Leaving home at that time terrifies me! With the passage of HB99, I can stay home in Alaska with my family and have the death I choose.

As far as hearing from the doctors that testified against the bill, there is a simple answer. The legislation doesn't make them do anything they don't want to do. The objections are noted and met.

Please share this with other members of the Committee.

Thank you again so much for honoring your mother, father and aunt with this bill,

Joyanne Bloom

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Joyanne Bloom
883 Basin Road
Juneau, Alaska 99801
Home: 907 463-3327

Cell: 907 723-3604

From: Steve McKinstry [mailto:smckinstry69@yahoo.com]
Sent: Thursday, April 09, 2015 11:18 AM
To: Rep. Paul Seaton
Subject: Support assisted suicide

Yes on assisted suicide

Cynthia Kimbley
Anchorage
907/240-9961

I am here in support of House Bill 99 on behalf of myself ~~and my father who is unable attend~~.

My father, age 90, has been an Alaska resident since 1948. He was until December 2014, very independent – living in his own home, driving, shopping, visiting friends, and taking care of all his own needs. Last fall he was diagnosed with a terminal illness and now confined to a wheel chair and is now receiving hospice care.

~~He is now on anxiety medication and morphine for what he calls "discomfort" as his body starts to shut down.~~
He is fully competent & able to make decisions for himself
This is not the **quality** of life that he had experience all his life.

Both my parents have had health care directives for many years. That choice is allowed by law.

My father has several times expressed to family members that he wished that Alaska had a Death with Dignity law.

I took the time to go online to Oregon's website. I wanted to understand and make certain that the ability to choose was **only** the patients. Which it is. In Oregon the patient must be able to administer the ~~pill~~ medication themselves.

As a family, I don't think that we are ever ready to experience a loved one's passing. But who are we to decide that they have to remain alive for our emotional wellbeing.

I now watch a man, whom I love, unable to continue to live life as he had experienced in the past. I see a man that knows how he must spend the rest of his life because he currently has no ability to choose.

My father recently told me that he would like to go to sleep & "be gone". He said he hoped that I wished the same thing for him.

I told him that it might be selfish, but we would never be ready.

He said "YES that was selfish".

I would support my father's choice for death with dignity.

Would it be difficult? Of course it would.
But harder still is to know that he aware that he is dying; watch the changes in his body as he wastes away; seeing how very tired and how sad he is because he is frustrated that the process of dying is taking so long.

What makes it bearable if he chose Death With Dignity?
It would be knowing that he made the choice that **he** wanted; he is at peace with dying; knowing that this was both the quantity & most importantly the quality of life that he chose.

Death with Dignity is specific to only terminal patients and their ability to choose quality & quantity of life.

I am respectful of your right to choose for yourself.

But please don't deny those who DO want the ability to choose for themselves.

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compassion
& choices

Care and Choice at the End of Life

Feb. 23, 2015

To Alaska Legislators:

Compassion & Choices is the nation's oldest and largest nonprofit organization working to improve care and expand choice at the end of life. Our priorities include making aid in dying an open and accessible medical practice in Alaska and throughout the country. We strongly support An Act Relating To The Voluntary Termination Of Life By Terminally Ill Individuals, (HB 99) to allow medical aid in dying as an end-of-life option and urge the Alaska legislature to pass this important law. This bill will improve the quality of end-of-life care for terminally ill Alaskans and their families, while protecting physicians who care for them.

Medical aid in dying provides peace of mind to terminally ill patients. It allows doctors to write a prescription for medication in response to a request from a terminally ill, mentally competent adult under their care. The individual must, if they choose, self-administer the medication to achieve a peaceful death.

Medical aid in dying is needed because:

- Too many suffer needlessly at the end of life;
- Too many endure unrelenting pain and other symptoms at the end of life;
- Too many turn to violent means at the end of life when medical aid could help them die peacefully.

We want people to be free to choose how they live – and when the time comes, how they die. All Alaskans should have the option, in consultation with their families and doctors, to make the end-of-life decisions that are right for them in the final stages of a terminal illness. These should include the option to request a prescription from their doctor to end their dying process painlessly and peacefully. The Act relating to the voluntary termination of life by terminally ill individuals would give dying Alaskans this important option.

The Alaska bill is modeled after legislation in Oregon and other states where aid in dying has been proven to be good policy and safe medical practice.

- It allows only qualified terminally ill, mentally competent adults to request and obtain a prescription from their physician for medication that they can self-administer to bring about a peaceful and humane death. Two physicians must confirm the diagnosis and terminal prognosis.
- It requires two witnesses to attest that the request is voluntary.
- It protects physicians from civil or criminal liability and from professional disciplinary action if they meet certain requirements in fulfilling an eligible individual's request. Physician participation is fully voluntary.
- It provides safeguards against coercion of patients by establishing felony penalties for coercing or forging a request, and it confirms a patient's right to rescind the request.

Besides Oregon, aid in dying is authorized in Washington, Montana, Vermont and New Mexico. In those five states, people report significant peace of mind, knowing the option is there if they need it.

Brittany Maynard - a California native who suffered severe headaches and debilitating seizures from her terminal brain cancer - had to move to Oregon to access its death-with-dignity law because California does not authorize this end-of-life option. In the final weeks of her life, Maynard partnered with Compassion & Choices to launch a campaign on www.TheBrittanyFund.org to make aid in dying an open and accessible medical practice in her home state and throughout the country. No Alaskan should be forced to move out of state to have a peaceful death. We need a law in Alaska that makes this healthcare option available to those who need and want it at the end of their lives.

National and state polls consistently show the vast majority of Americans across the demographic and political spectrum want to choose their own medical treatment at the end of life. Yet two decades after Oregon voters passed the nation's first death-with-dignity law in 1994, Alaska still has not authorized this end-of-life option.

Expanded options at the end of life would provide Alaska citizens the autonomy they deserve. Studies show patients who receive counseling about end-of-life choices score higher on quality of life and mood measures than patients who do not. Leading national professional medical associations support aid in dying because it empowers physicians to respect their patients' wishes.

The American College of Legal Medicine, the American Medical Women's Association, the American Medical Student Association, the Gay and Lesbian Medical Association and the American Public Health Association all support aid in dying. Each of these groups understands aid in dying is a legitimate end-of-life medical practice. That is, given the protracted dying process that medical technology now creates for Americans, authorizing this practice can spare certain patients from untreatable pain and unmanageable suffering that many now endure.

Courts have upheld this right. In 1997, the United States Court of Appeals for the Ninth Circuit upheld Oregon's first-in-the-nation Death With Dignity Act (passed by ballot initiative in 1994). The law establishes that eligible adults may receive a prescription for medication to end their suffering and advance the time of death.

On December 31, 2009, the Montana Supreme Court ruled in a 5-2 vote that terminally ill Montanans have the right to choose aid in dying under state law. In January 2014, New Mexico Second Judicial District Judge Nan Nash issued a landmark decision that terminally ill, mentally competent adults have a fundamental right to aid in dying under the substantive due process clause of the New Mexico State Constitution.

On February 6, 2014 the Canada Supreme Court ruled that prohibition of assisted dying violates the right to life, liberty and security of the person and is not in accordance with principles of fundamental justice.

We urge all Alaska legislators to support An Act Relating To The Voluntary Termination Of Life By Terminally Ill Individuals, (HB 99) so state residents with a terminal illness can be secure in the ability to achieve a peaceful death if they choose.

Sincerely,

Barbara Coombs L

Barbara Coombs Lee PA, FNP, JD
President

Mr. Chairman, Committee Members:

My name is Peter Bangs[1] and I would like to first disclose that I am a state employee, but I am taking leave today to share my personal opinions in support of House Bill 99.

I would like to briefly describe two contrasting experiences that have helped shaped my beliefs on this issue. Several years ago, my wife's grandmother, Helen, was severely injured in an accident. Her doctors told us in no uncertain terms that she was dying from her injuries, but that it could take a few weeks. Unfortunately, they were not able to keep her comfortable. Helen had always been a remarkably strong and tough woman, but she was in so much pain and suffering that she kept telling her care givers that it was time and that she begged them to let her go. In an effort to speed up the process, she refused to eat, drink, or take her medications.

In contrast, my wife and I recently lost two dogs – one to cancer and another to liver disease. For each of them, we made the decision to put them to sleep after exhausting treatment options and when they were no longer comfortable. As much as we hated to let them go, I am grateful that we had the option to end to their needless suffering. When it comes to people, I don't understand why we can't provide our loved ones with the same freedom to die with dignity and compassion as we do for our companion animals.

This is an issue about allowing people to make their own decisions according to their own desires and beliefs. To put this issue in perspective, consider that Alaska allows 19 year old kids to decide whether to use tobacco, even though tobacco products cause cancer and premature deaths for hundreds of thousands of people in the US each year. One of the main reasons that tobacco - and now marijuana - is legal is because Alaskans value the right to make their own decisions, even if you or I don't agree with their choices. That is exactly what HB 99 is all about – empowering terminally ill people with the right to die on their own terms according to their own desires and beliefs – not yours or mine. Thank you.

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[1] Address: 4257 Marion Dr, Juneau, AK 99801 – pbangs@gmail.com

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FAX: 907-465-3472

TO: Representative Paul Seaton

DATE: April 12. 2015

RE: House Committee, Health and Social Servicing hearing on House Bill 99

FROM: Karen Dechman Bond, 907-227-6717, karen@post.harvard.edu, 4620 Golden Spring, Circle, Anchorage, Alaska 99507

Dear Representative Seaton,

I am writing to express an apology to you and the members of your committee for my having left the hearing chamber during the testimonies of House Bill 99. I very much wanted to remain, but I found myself unable to continue hearing testimony as call after call reiterated the human suffering of my fellow Alaskans. As you may recall, my brother just died a very painful death four months ago, so House Bill 99 is very personal for me and my family. When one of our fellow Alaskans called in to read excerpts from her terminally ill husband's suicide note, it was so powerful and similar to my own brother's situation, that I found myself unable to remain without distracting the hearing with my emotional reaction. I am typically a very professional and controlled person, but the suffering of my brother is too fresh in my mind. I hope that you and the members of your committee will forgive me.

I deeply appreciated your sharing your own personal experiences regarding terminally ill family members. What you shared was powerful. I think it is challenging for those who have not witnessed the suffering of a terminally ill loved one to fully comprehend what you and I know. This is a very Alaskan piece of legislation and I agree with you that it is very Republican in its intent, emphasizing independence and liberty.

I thank you and your committee for your patience, kindness and consideration with these hearings. My family and our friends are grateful and will continue to closely follow House Bill 99.

House Bill 99, Health and Social Services Committee, April 9, 2015, Juneau, Alaska

Testimony of Karen Dechman Bond, Anchorage, Alaska

Having never been to Juneau, I felt this Bill was of such importance that I flew down here today to speak before this committee regarding the death of my brother, Mark, and how House Bill 99 would have spared him a tremendous amount of pain and suffering.

My brother died of esophageal cancer four months ago. Esophageal cancer is the fastest growing cancer in the United States with low survival rate. It is caused by acid reflux, or smoking, or consuming alcohol. My brother was very active, didn't smoke, occasionally drank, but did suffering from what many would consider normal acid indigestion from time to time. He went from being an active hiker, cave diver, guitarist, world traveler, devoted father, who was quick to laugh, to a grim, pain-wracked, human-being. He lost thirty pounds in two months, being unable to eat and then the cancer, as it slowly consumed his body from within, caused his body to swell and swell. The cancer caused a bowel obstruction, which is not uncommon, but was inoperable, and he was unable to have a bowel movement. My formerly happy, strong, independent, proud, brother, went from helping others, to needing others to give him suppository (he could not swallow) drugs to stop the many fevers that now plagued him daily. He had an IV of morphine that did not stop the pain and certainly did not stop his awareness of what was happening to him. He woke up day after day (he could barely sleep anyway, given the pain) in a living hell.

My brother asked me for my help to end his life. Instead of shopping for holiday presents, I found myself shopping for instruments of death. Instead of working on holiday cards, he worked on his suicide note. Mark had done a tremendous amount of research, but he was still afraid that whatever method he chose for his suicide, would not be successful. He was justifiably afraid of ending up hurting himself more, mangling his already broken body further and that I would be charged with murder, which would prevent me from protecting his daughter once he was gone. He ultimately planned to die by a poison gas and once having turned it on and he placed it over his face, he was going to handcuff himself to a rail, thus preventing himself from accidentally removing the mask during a death seizure and not succeeding in finding peace. My job was to get the heavy tank, because at this point he was too weak to lift or transport the tank. I was also going to be the one to find him after death and help him to die, if something went wrong and he was unable to die on his own. His body was in such a weakened condition that he suffered a heart attack during this time and because he was forced to go back into the hospital, he was unable to carry out his plans. On the recommendation of medical staff, he chose Hospice, believing that he would only be alive for a week, but because he was young, his death dragged on and on, full of pain and sorrow, with every day his begging me to make it happen sooner. "Please, Karen, make his happen today." He could not eat, could not drink, and was in significant pain and it got to the point where he was asking strangers, janitorial staff, to help him die.

Before my brother's cancer, I mistakenly thought we died peacefully. I had watched too many movies where a dying person smiled and closed their eyes, surrounded by loved ones as they quietly left this Earth. Walking the cancer ward at the hospital and watching my suffering brother, I learned that this is completely false. Many of us die in considerable pain, all dignity gone from us, and it is a process that can take weeks or even months, every day hoping and waiting while your body breaks down in front of you, that it will end.

I could not save my brother, but I know that this important legislation will save others from a horrible and agonizing death. My brother didn't die how he wanted or when he wanted. He died around 2 a.m. in the morning, without our elderly mother with him, because she had been sent home to sleep that night after having sat for weeks by Mark's beside.

I am begging this committee as my brother begged me, to please pass House Bill 99. This is a very Alaskan piece of legislation, about independence and control over one's own life; empowering the terminally ill with the ability for them to choose when and how they will die.

Thank you for your patience and consideration.

**HB 99 VOLUNTARY TERMINATION OF LIFE**

Do not pass HB99 it is a slippery slope in the the same path that Hitler went down. Unreal after history has proven this to be evil. With this legislation passed someone who is caring for a sick relative, who can no longer speak, can sign or speak for them. Sounds like a good way to bump off your sick relative that you don't want to take care of anymore. That is what will happen.

Turning doctors into murderers is not a good way to achieve quality health care. You legislators are now responsible and you should be held accountable for your decision. What will you do? Will you vote yes to Euthanasia and be responsible for murder or will you vote no and save lives?

The Nazi's practiced this sort of evil. Do you want to be called a bunch of Nazi's? I hope that you do the right thing and vote no to HB99.

Please respond to this email and let me know your intentions regarding this bill.

Sincerely,
Darcia Grace

Re: HB99 - Euthanasia

Dear Hospital Foundation Members and Legislators,

This dissent regarding HB99 was crafted with due respect for my Fairbanks Hospital Foundation colleague, Rich Seifert, who e-mailed all Foundation members and the State House March 12 with his general support and suggestions concerning HB99, a saccharine bill which would legalize euthanasia in Alaska. I know Juneau well enough to predict HB99 will go nowhere fast. Sadly, that does not mean euthanasia advocates will back off. They will hound the Legislature, use the Courts, or go the initiative route.

Although I choose to remain hopeful, it is my opinion that America in 2015 is in grave moral crisis. The sanctity of faith, traditional marriage and family, pillars of all civil and just societies and governments, is under relentless assault. The killing of our unborn young persists as a legal option, a privacy matter. Alaska just legalized marijuana despite irrefutable evidence of its multifaceted negative impacts on society – especially our young. Now sweetly comes so-called mercy killing to tempt our Legislature. The culture of death is bold and persistent.

And all it takes for Evil to prevail is for good folks to do nothing. Here is my personal, individual take in the matter of HB99 and Fairbanks Memorial Hospital:

Fairbanks Memorial Hospital (FMH) is celebrated and respected for its relentless focus on preserving and promoting life and health in our community. I for one, do not wish to sit down and reason together about how we might depart that sacred ground to improve and embrace HB99. When pre-born children are to be killed in our town – we decline that evil chore. Life is sacred here at FMH! If our older, sicker, and less efficient family members are ever to be killed in our town – let that evil chore also fall to others. Life is sacred here at FMH! The most vulnerable trust us with their very lives. Let us not confuse our mission – no mixing of healing and killing. Every day in the FMH medical family we provide excellent pain management combined with loving and compassionate End-of-Life Care. Kill our patients? – No, not on my watch, please God. Thank you all for listening.

Respectfully, Mike Kelly

cc: Alaska House members – please consider this as written testimony opposing HB99 in the committees of referral of both bodies

| | |
|---|---|
| **From:** | Joel M Potter <jmpotter3@uaa.alaska.edu> |
| **Sent:** | Monday, April 06, 2015 10:59 PM |
| **To:** | Rep. Harriet Drummond |
| **Subject:** | Regarding House Bill 99 |

Greetings,

I am writing regarding your sponsorship of House Bill 99, which would legalize physician-assisted suicide. I am a biomedical ethics professor at UAA. I appreciate your support for the expansion of Medicaid and other initiatives. While I do not doubt your good intentions in sponsoring House Bill 99, I think it is a serious mistake.

The medical profession has a responsibility both to respect the wishes of patients and to do what will benefit patients. If a medical procedure cannot be construed as a benefit to the patient, then it is inappropriate for a medical professional to perform the procedure (especially if it is something as irreversible as assisting in a person's death). Now, many people think that allowing a person to end their own life is an act of mercy that does benefit the person by ending their suffering. But this is not correct; in order for the patient to benefit, they must continue to exist. Unlike palliative care, which may benefit the patient by alleviating suffering, ending *the person* does not, since the patient no longer exists to benefit. People mistakenly think of suicide as allowing a patient to rest or be at peace, when in fact it ends the life of the patient. No one remains to enjoy rest or peace. Now if there is an afterlife, this line of reasoning would not apply, since the individual might continue to exist after death. But the State of Alaska is in no position to set policies based upon beliefs about life after death.

Some argue that even if, strictly speaking, suicide is not a benefit to the patient, physician assisted suicide is a way of respecting a patient's final wishes. But such respect is misplaced. We do not really respect an individual's capacity to make decisions when we support an action that will permanently end that individual's ability to make decisions. Instead, by supporting such actions we fail to respect the dignity that the individual possesses as a rational decision maker. Out of respect for a person's capacity to make decisions, we would not agree to administer an addictive drug like heroine that would compromise their ability to make decisions even if a person asked us to do this with full understanding of the consequences. The reason we wouldn't do this is because we respect a person's capacity to make decisions too much to give in to requests that would impair that very capacity. The same should hold for requests of assistance in committing suicide.

One might think that it is up to each individual to judge whether his or her life is good on the whole and that supporting physician assisted suicide allows individuals to make this judgment for themselves. But by allowing physician-assisted suicide the state does not remain neutral on the value of persons' lives. Rather, since it is necessary for the state to set criteria for when a person might choose to end his or her life, the state makes an implicit judgment about which lives are too valuable to permit assistance and which lives are not. Thus, under the guise of personal autonomy and choice, the state supports the death of individuals deemed sufficiently unfit to remain alive.

Thank for your time considering the reasons I have addressed above. Life is not a right that can be waived; it is something that we must live up to.

Respectfully,

Joel Potter

Joel M. Potter, Ph.D.

Term Assistant Professor of Philosophy

University of Alaska Anchorage

Philosophy Department

3211 Providence Drive

ADM/Humanities - 278

Anchorage, AK 99508

3/9/15

Honorable Paul Seaton
Committee on House Health and Social Services
State Capitol, Room 102. Juneau, AK 99801-1182

Dear Chairman Seaton,

Physicians, in their care of patients, must establish a physician-patient relationship based on mutual trust and respect to be able to render the best care to their patients. Centuries ago the physician Hippocrates wrote the Hippocratic Oath, which many of us took when we became physicians and guides us in the ethical practice of medicine. It states that when treating patients, physicians will "First do no harm." It goes on to state "I will give no deadly medicine to anyone if asked nor suggest any such counsel."

Alaska HB 99, The Voluntary Termination of Life Law, is in direct conflict with the Hippocratic oath I took in 1984. When that oath is followed, it has protected the patient, physician, society and the family, and at the same time has committed doctors to compassion and human dignity. As a practicing Neurologist, I have cared for many patients throughout their lives, extending through to their last days of life. Their needs must be honored and their dignity preserved, which might require alleviation of pain, treatment of depression if it exists, as well as support for them and their families. Palliative or hospice care must be offered when appropriate.

Simply put, HB 99 is in direct opposition to the pledge physicians take to devote their lives to healing and to life. We believe laws sanctioning voluntary physician assisted suicide serves to undermine the foundation of the patient-physician relationship, which is grounded in the patient's trust that the physician is working wholeheartedly for the patient's health and welfare. Please do not allow HB 99 to leave your committee.

Sincerely,

Brian A Trimble

Dr. Brian Trimble
19430 Upper Skyline Dr.
Eagle River, AK 99577
(907) 696-2578

THE STATE
of ALASKA
GOVERNOR BILL WALKER

**Department of
Health and Social Services**

Senior and Disabilities Services
Governor's Council on Disabilities & Special Education
Patrick J. Reinhart, Executive Director

3601 C Street, Suite 740
Anchorage, Alaska 99503
Main: 907.269.8990
Fax: 907.269.8995

April 9, 2015

To: Members of the Alaska House Health & Social Services Committee

RE: HB 99: Voluntary Termination of Life

Dear Representative Seaton, Representative Vazquez, and Members of the Committee:

The Governor's Council on Disabilities and Special Education (the Council) fills a variety of federal and state roles, including serving as the State Council on Developmental Disabilities (SCDD) under the Developmental Disabilities Assistance and Bill of Rights Act. As the state DD Council, we works with Senior and Disabilities Services and other state agencies to ensure that people with intellectual and developmental disabilities (I/DD) and their families receive the services and supports that they need, as well as participate in the planning and design of those services. Our council membership is composed of self-advocates and family members of individuals with intellectual and development disabilities (60%), as well as agency and partner representatives (40%). One of the duties of the state DD Council is providing comments on proposed recommendations that may have an impact on individuals with intellectual and/or developmental disabilities and their families.

The Council is in opposition to HB 99, the Voluntary Termination of Life bill, introduced by Representative Drummond. The Council feels strongly that legalizing physician-assisted suicide has the distinct potential to result in discrimination against those with physical and developmental disabilities. There is public perception that individuals with significant disabilities do not have a high quality of life. As a substantially vulnerable population, individuals with disabilities could be put at risk for coercion, that choosing death over life is a viable option for them. There is real concern that individuals with disabilities may feel pressured into such a choice for fear of burdening their families.

In addition, many individuals with disabilities have family members as their guardians, which presents yet another concern regarding this legislation and its potentially deleterious results. This bill could create a conflict of interest if the guardian stands to benefit in any way from the death of the individual with disabilities. It may be construed as a cost-saving decision if the individual with disabilities required significant costs of care. This is important to remember in a state with high child abuse, domestic violence, and elder abuse rates; not everyone lives in loving, supportive families. It is the job of the Council and other advocacy groups to safeguard this vulnerable population.

There is also the potential that patients could be misdiagnosed as terminally ill and thus make a truly tragic choice based on inaccurate information. With a government-funded or profit-driven health care system, this legislation should also present some apprehension regarding the potential of patients being denied or delayed life-saving treatments. For example, in Oregon where assisted suicide is legal, some terminally-ill patients have been prescribed expensive treatments by their doctors that are not covered by their insurance. However, these insurance companies offer to cover less expensive treatments, including physician-assisted suicide. This effectively encourages suicide by classifying it as a covered "treatment." How many of those Oregonians who chose assisted suicide did so after receiving notice that potentially life-saving treatments were prohibitively expensive?

People with disabilities already face many obstacles in their daily lives. They do not have full access to appropriate health care, affordable and accessible housing, public transportation, full integration into communities, the list goes on. If this bill passes, people with significant disabilities may feel that their only choice is to end their lives. The Council would rather see a legislative push to improve services and end-of-life care over an assisted suicide bill.

Many other national organizations also stand with the Council in opposition to legalizing physician-assisted suicide, including American Disabled for Attendant Programs Today (ADAPT), Association of Programs for Rural Independent Living (APRIL), Autistic Self-Advocacy Network (ASAN), Disability Rights Education and Defense Fund (DREDF), Disability Section of the American Public Health Association, Justice for All (JFA), National Council on Disability (NCD), National Council on Independent Living (NCIL), National Spinal Cord Injury Association, Not Dead Yet (NDY), TASH, World Association of Persons with Disabilities (WAPD), and World Institute on Disability (WID).

The Council respectfully opposes this bill and the potentially disastrous consequences that could impact Alaskans with disabilities.

Sincerely,

Ric Nelson, Chair

Dean Gates, Legislative Committee Chair

CC.
Representative Charisse Millett, Majority Leader and GCDSE Legislative Member
Valerie Davidson, Commissioner, DHSS
Duane Mayes, Director, Senior and Disability Services
Jeff Jessee, CEO, Alaska Mental Health Trust Authority
GCDSE Members

**From:** Pam Albrecht [redacted]
**Sent:** Wednesday, April 08, 2015 8:37 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; presentative.Dave.Talerico@akleg.gov; Rep. Geran Tarr; Rep. Adam Wool; Rep. Louise Stutes; Rep. Neal Foster
**Subject:** HB99 Physician-Assisted Suicide

Dear Representative: April 8, 2015

As I am unable to be at the hearing on HB99 tomorrow in Anchorage I'm attaching a letter received from Ms. Margaret Dore, Esq., Choice is an Illusion, of Seattle. She has carefully compared the Physician-Assisted laws in Oregon, Washington and Alaska and lists in her letter difficulties that have arisen in Oregon and Washington with similar laws. Please read this carefully. Perhaps a staff person can print the links that support her concerns. These issues were not considered or known when the bills passed in Oregon or Washington.

A common problem, other than pain, for those seriously ill is depression. Can we not treat the depression with anti-depressants rather than killing the patient. Hospice care, good medication and personal concern for the person are the kindest, most humane way for us to treat the suffering of the very ill.

This cannot be a good example for young people—what are we thinking. We are very concerned about their suicide rate and how to lower it. Is this bill going to be helpful for that purpose?

You may remember in the recent past there was a slogan "We don't give a damn how they do it Outside". That was jettisoned at some time; now we look to Washington, Oregon, Colorado as our shining stars. Maybe we need to set the higher example.

I am appalled that killing would be our first response to those needing our compassionate care and ask that you vote 'No" on this unfortunate bill.

Thank you for your consideration of this request.

Pamela Albrecht

Anchorage, AK Constituent

To: <alertagainst1000@googlegroups.com>
Sent: Wednesday, February 25, 2015 5:14 PM
Subject: [alert] Dore post against Alaska bill (HB 99)

I am a lawyer in Washington State where assisted suicide is legal. Our law is similar to a law in Oregon. The proposed bill to legalize assisted suicide in Alaska is similar to both laws.

Problems with legalization include the following:

1. The proposed bill legalizes assisted suicide for persons with a "terminal disease," which is defined as having less than six months to live. In Oregon, which uses the same definition, young adults with chronic conditions such as diabetes are "eligible" for assisted suicide. Such persons can have years, even decades, to live. Consider also, Jeanette Hall, who was adamant that she would do assisted suicide, but was convinced to be treated instead. Today, nearly 15 years later, she is "thrilled to be alive." See http://www.montanansagainstassistedsuicide.org/2013/04/if-kress-had-been-my-doctor-in-2000-i_27.html

2. In Oregon, that state's Medicaid Plan steers people to suicide through coverage incentives. For more information, see the affidavit of Kenneth Stevens, MD, at this link: https://maasdocuments.files.wordpress.com/2014/08/dr-stevens-affidavit_001.pdf

3. Legalization is a recipe for elder abuse. Your bill, like Washington's law, allows one of two witnesses on the lethal dose request to be an heir who will benefit from the patient's death. Once the lethal dose is issued by the pharmacy, there is no oversight. Even if the patient struggled, who would know?

4. In Oregon, other conventional "violent" suicides have increased significantly with the legalization of physician-assisted suicide. In Oregon, conventional suicides are a $41 million problem due to hospitalization costs, etc. See http://www.choiceillusion.org/2014/03/the-high-financial-cost-of-regular.html Legalization, regardless, sends the wrong message to young people that suicide is an acceptable solution to life's problems. Alaska already has highest suicide rate in the nation. See http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs_sspc/AKSuicideStatistics.pdf

For a short article about Washington's similar law, please go here (non-lawyers tell me they like it): https://www.kcba.org/newsevents/barbulletin/BView.aspx?Month=05&Year=2009&AID=article5.htm

Don't make Washington's mistake. Tell your legislators to say "NO" to assisted suicide.

Margaret Dore, Esq., MBA
Law Offices of Margaret K. Dore, P.S.
Choice is an Illusion, a nonprofit corporation www.choiceillusion.org
1001 4th Avenue, 44th Floor
Seattle, WA 98154
206-389-1754

April 9, 2015

40899 Waterman Rd.

Homer, Alaska 99603

Representative Seaton:

I tried to be at the office here for the start of the public comments but boat work kept me from it. Therefore I'll write out my objection to HB 99.

Have you ever read the 1993 novel by Velma Wallis entitled, "Two Old Women?" It's a story about two elderly Gwich'in women who were abandoned by their tribe because they were considered to be a burden to them. The two not only survived a harsh artic winter alone but did so in better health then their younger tribesman. When it was discovered that the two were still alive, the tribe began the policy of never abandoning their old again.

The story sends a positive message about the need for society to value the elderly or those who are less capable. It's a story about the need to value life.

Bills like HB 99 do the opposite.

I know that this isn't an easy issue. My father died only last July and I understand the emotional pain of watching him slowly pass away. I'm blessed that he was the kind of person who allowed the process of death to take its own route though it was hard to watch.

I'd be honored if you thoughtfully considered my objection as you work through this issue.

Thank-you

Leonard Miller llmiller@ptialaska.net

Leonard

**From:** [redacted]
**Sent:** Thursday, April 09, 2015 4:34 PM
**To:** Rep. Louise Stutes; Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool
**Subject:** Oppose HB 99

Dear Committee Members

I appreciate the hearing you held today on HB 99. I agree with Rep. Stutes' caution to the committee. I have also seen disagreement over how quickly an elderly loved one should die. The elderly person wanted to manage his symptoms and live longer while certain influential family members pressured him and other relatives to change treatment so he would die sooner. Advocates for the dying family member were forced to strongly intervene on the patient's behalf to make sure his care progressed as he wished. I think HB 99 would provide another avenue for this kind of selfish maneuvering.

I oppose HB 99.

Sincerely,
Christine O'Connor
2800 N Park Dr.
Wasilla, AK 99654
(907) 373-5775

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From: Steve and Dorris Stevenson [redacted]
Sent: Thursday, April 09, 2015 12:43 PM
To: Rep. Paul Seaton
Subject: HB99

HB99
As you meet today, Please do not be persuaded to continue to promote or vote for house bill 99 for assisted killing of patients. Anyone who is terminal and wants to die can fine numerous ways to end their life-They do not need doctors to help them. What about the Hippocratic oath that says "I will neither give a deadly drug to anyone if asked for it, nor will I make a suggestion to this effect". It seems this bill would only validate Sarah Palin's death panels.
Please stand up for dignity of life not death with dignity.
Thank you.
Mrs Stevenson
Chugiak

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**From:** Charles & Carole Hart [redacted]
**Sent:** Thursday, April 09, 2015 12:19 PM
**To:** Rep. Paul Seaton
**Subject:** vote no on HB99

Rep. Seaton,
I urge you to vote no on HB 99. This is an example of a bill going too far…and what are we saying to young adults, who are tempted to suicide?
We must protect life, as our constitution does.
Thank you,
Carole Hart

<u>Emails in Opposition of HB 99</u>

*Includes emails from:*

- *Phyllis Shepherd*
- *Maureen Klump*
- *J.R. Myers*
- *Mary Ann Gilgallon –Anchorage*
- *Maureen Retzel*
- *Mike Kelly – Fairbanks*
- *Mary Anne Green*
- *Mary Beth Bragiel – Anchorage*
- *Richard Novcaski*
- *Shelley Withem – Anchorage*
- *Daniel Bramer –*
- *Janet B. McCoy – Anchorage*
- *Mary L. Barry - Anchorage*

**From:** [redacted]
**Sent:** Sunday, March 01, 2015 4:41 PM
**To:** Rep. Paul Seaton
**Subject:** HB 99 Doctor prescribed suicide

We do not need anymore intentional killings.

Alaska's population is small enough.

Fund better hospice care.

The elderly will be put under too much pressure to die to provide for younger people. We have enough pain killers to be able to help people as they transition to another plane of life. There will be a lot of guilty feelings in the survivors who have pressured the elderly to die.

There is wisdom in the elderly. Respect for life is a virtue.

Please vote against HB 99.

Thank you.

Phyllis Shepherd

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**From:** Phil and Maureen Klump [redacted]
**Sent:** Thursday, March 05, 2015 1:26 PM
**To:** Rep. Paul Seaton
**Subject:** HB99

Hello Representative Seaton, Please do not support HB99. Regardless of how the bill is written, individuals will feel pressured by their families and their doctors to choose and early death and relieve others of the financial, physical and emotional burdens of having to care for them during their illnesses. Also, I would not want doctors and nurses to have to participate in assisted suicide in any way. Thank you for your time, Maureen Klump RN

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**From:** Mr J.R.Myers [redacted]
**Sent:** Wednesday, February 18, 2015 10:21 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool
**Cc:** Alaska Constitution Party; ACP Officers
**Subject:** Testimony on HB 99

Dear Representatives,

The Alaska Constitution Party opposes House Bill 99 and any similar measures as an unacceptable affront to life.

Thank You,

J.R.Myers, Chairman, Alaska Constitution Party

**From:** MaryAnn Gilgallon [redacted]
**Sent:** Sunday, March 01, 2015 2:17 PM
**To:** Rep. Paul Seaton
**Subject:** Vote NO on HB 99

Dear REP Paul Seaton,

Please vote NO on HB 99. Suicide is NOT medical care and should not be used to prematurely end a person's life.

Thank you,

Mary Ann Gilgallon
[redacted]
Anchorage, AK 99516

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**From:** Maureen [redacted]
**Sent:** Wednesday, March 04, 2015 8:24 PM
**To:** Rep. Harriet Drummond
**Cc:** Rep. Les Gara; Rep. Paul Seaton; Sen. John Coghill; Sen. Kevin Meyer; Rep. Andy Josephson
**Subject:** HB 99
**Importance:** High

Ms. Drummond,

I am deeply appalled and sickened that you, a former member of the Anchorage School District who worked to elevate the well-being and education of Anchorage's youth, would introduce and co-sponsor a bill (HB 99) that promotes suicide and death. What message does this proposed legislation communicate to vulnerable teens or the disabled, the ill, the elderly, the depressed about their personal value or identity? It communicates that human life in all of it complexity has no intrinsic value and/or that the purpose for living is relative based on an individual's (Hitler, Machiavelli, Malthus, Marx) or society's judgment of a person's importance or value. Is not all life on earth terminal? Is not any and all suffering filled with pain and anguish?

Reconsider the opening of this Pandora's box and the deadly evil that has and will follow upon our state and the souls of our Nation. Please remove HB 99 for consideration.

What is needed are messages of hope and encouragement, messages that communicate that all life and living have beauty and worth regardless of condition. What is needed is community-wide outreach and public funding to provide more affordable, quality in-home care and much needed respite for exhausted families and friends so that the elderly, disabled and/or ill sufferers never feel less human or "burdensome", but instead, valued, needed and loved.

This is the true meaning of compassion—making it easier for others to endure, to live not to die.

Sincerely,

Maureen Retzel

From: **Mike Kelly** [redacted]
Date: Wed, Mar 18, 2015 at 11:35 AM
Subject: HB99 Euthanasia

Dear Hospital Foundation Members and Legislators,

This dissent regarding HB99 was crafted with due respect for my Fairbanks Hospital Foundation colleague, Rich Seifert, who e-mailed all Foundation members and the State House March 12 with his general support and suggestions concerning HB99, a saccharine bill which would legalize euthanasia in Alaska. I know Juneau well enough to predict HB99 will go nowhere fast. Sadly, that does not mean euthanasia advocates will back off. They will hound the Legislature, use the Courts, or go the initiative route.

Although I choose to remain hopeful, it is my opinion that America in 2015 is in grave moral crisis. The sanctity of faith, traditional marriage and family, pillars of all civil and just societies and governments, is under relentless assault. The killing of our unborn young persists as a legal option, a privacy matter. Alaska just legalized marijuana despite irrefutable evidence of its multifaceted negative impacts on society – especially our young. Now sweetly comes so-called mercy killing to tempt our Legislature. The culture of death is bold and persistent.

And all it takes for Evil to prevail is for good folks to do nothing. Here is my personal, individual take in the matter of HB99 and Fairbanks Memorial Hospital:

Fairbanks Memorial Hospital (FMH) is celebrated and respected for its relentless focus on preserving and promoting life and health in our community. I for one, do not wish to sit down and reason together about how we might depart that sacred ground to improve and embrace HB99. When pre-born children are to be killed in our town – we decline that evil chore. Life is sacred here at FMH! If our older, sicker, and less efficient family members are ever to be killed in our town – let that evil chore also fall to others. Life is sacred here at FMH! The most vulnerable trust us with their very lives. Let us not confuse our mission – no mixing of healing and killing. Every day in the FMH medical family we provide excellent pain management combined with loving and compassionate End-of-Life Care. Kill our patients? – No, not on my watch, please God. Thank you all for listening.

Respectfully, Mike Kelly

cc: Alaska House members – please consider this as written testimony opposing HB99 in the committees of referral of both bodies

Dear Rep. Seaton,

I urge you most strongly to oppose HB 99, which would legalize assisted suicide for people who have been determined to be terminally ill. Although advocates of assisted suicide claim both that it is compassionate and that it will be strictly limited to the terminally ill, the experience of countries and states, such as Holland, that have legalized assisted suicide prove otherwise.The criteria for assisted suicide in Holland have grow progressively looser, so that they now allow it for children and even infants. Elderly and disabled people report feeling pressured to "choose" suicide.

Disability rights groups, such as Not Dead Yet, strongly oppose assisted suicide.

I know that people with cancer (for example) experience horrible pain. We should promote greater knowledge and use of palliative care, including access to all helpful drugs and better methods of administering them.

Furthermore, diagnoses of terminal illness are not infallible. For example, eight-year-old Claudia Burkhill was diagnosed with an inoperable brain tumor in 2011. On four separate occasions, her doctors told her family that she had only days - sometimes only hours - to live. She was given an experimental cancer treatment called the Milan Protocol and is now cancer-free. If her family had accepted the terminal diagnoses as inevitable, she would be dead, and we would not have evidence that this treatment works - evidence that can help other people with this type of cancer. You can read her story here: http://www.mirror.co.uk/news/uk-news/terminally-ill-schoolgirl-makes-miracle-3665979 .

Please, DO NOT schedule hearings for HB 99. Let's stop it here.

Sincerely,

Mary Anne Green

**From:** Richard Novcaski [redacted]
**Sent:** Sunday, March 01, 2015 2:42 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool
**Subject:** HB99

Hello Representatives,

We are writing to respectfully encourage you to vote NO on HB99.

We like the quote from Justice Alex Bryner who wrote that the State "*insists that the terminally ill are a class of persons who need protection from family, social, and economic pressures, and who are often particularly vulnerable to such pressures because of chronic pain, depression, and the effects of medication.*" This clearly states one of our beliefs of why HB99 should not become law.

A basic principle of society is the protection of life, not the taking of a vulnerable life. We should be concerned with the care of a person in pain. To allow physician assisted suicide is "a public act that requires medicine, law and society approve a lethal prescription that crosses the line between caring and killing." (1)

This law is also not sustainable in regards to accountability. HB99 states that "if there is evidence ". We all know how hard and what kind of effort it takes to find "evidence of correction", so that's a weak safeguard.

There is also the problem of accountability once the prescription is handed over to the patient. How will it be known that the patient was the one that administered it? What if the patient changes their mind, but they have pressure not to?

Also, once we have a law like this on the books, it is inevitable that there will become a subtle underlying societal pressure on all those vulnerable patients where care costs money to quietly (and cheaply) end their life in a "peaceful way".

To ignore all these points, is to be incredibly naïve about human nature. And in fact, a job of those entrusted to writing laws to protect it's citizens would be to be aware of human nature and keep this is mind when writing law.

The bottom line is the depressed, vulnerable and suffering need our care and compassion, not a "quick fix" that appears to solve the suffering person's problem and appears to put the least strain on the care givers. It would be great if all the time and energy spent on this HB99 legislation, was instead spent on how structures could be put in place for society to help support the patients and caregivers.

Sincerely,

Mr. and Mrs. Rich Novcaski

**From:** Ronald & Shelley Withem [redacted]
**Sent:** Wednesday, February 11, 2015 8:38 AM
**To:** Rep. Paul Seaton
**Subject:** HB99

Dear Chairman Seaton,

I am writing this email to strongly urge you to NOT move HB99 - Right to Die - out of committee for a hearing. The bill should be completely dropped. it makes no sense that in a state with the highest suicide rates per capita, we would to pass legislation that would, in effect, encourage suicide.

With soaring healthcare costs and cutbacks, how much longer until the "right to die" becomes the "duty to die?" How much longer until those considered a "burden" on society are systematically denied healthcare and life-saving measures in order to cut costs? It is a very short step from assisted suicide to euthanasia for those who are a "burden" to the state and society. The right to life is one of our most precious freedoms.

Terminally ill patients in Alaska need love, care and <u>protection</u> from those around them. Instead of killing the pain that terminally ill patients are suffering, these "right to die" activists focus on killing the patient. Why not, instead, educate healthcare professionals about the amazing advances in palliative care?

Sincerely,

Shelley Withem

[redacted]
Anchorage AK 99504

**From:** Danny B [redacted]
**Sent:** Tuesday, February 24, 2015 9:14 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool
**Subject:** House Bill 99

Dear Representatives,

I want to start by thanking you for giving this issue the consideration it deserves. Physician-Assisted Suicide (PAS) is a slippery and dangerous slope on which to embark. Legalizing PAS is not about giving the patient the right to die, but about giving a physician the right to kill. There are many other alternatives to PAS available for end of life care which are compassionate, evidence based and ethically sound.

PAS will undoubtedly destroy the trust surrounding the doctor-patient relationship. Major medical associations oppose this legislation for this and other reasons. The physician should never have the power of judge, jury and executioner in ANY situation. PAS is an easy way out for a busy, litigation weary and stressed physician. PAS is fundamentally incompatible with the physician's role, would be very difficult to control once approved, and would pose serious, far-reaching societal risks.

PAS is dangerous for patients, families, physicians and society as a whole. As a physician, I took an oath that I will neither give a deadly drug to anyone who asks for it, nor make a suggestion for someone to take a drug that will end their life. There are many better alternatives including: training more palliative care physicians, modifying laws to allow adequate pain/symptom control at the end of life, better identification and treatment of depression, hospice promotion/funding, and mobilizing faith communities and others to provide emotional and relational end-of-life support to struggling patients and families.

I implore you to carefully consider this bill, but please STOP it at your committee level. Legalizing Physician-Assisted Suicide is simply wrong and it is too dangerous to unleash on any society. Thank you for your time and careful consideration.

Sincerely,

Daniel S. Bramer,MD

Anesthesiologist
Medical Director
La Cima World Missions

**From:** [redacted]
**Sent:** Friday, February 20, 2015 5:06 PM
**To:** Rep. Paul Seaton
**Subject:** Please Vote NO on HB 99- Doctor-Prescribed Suicide

I was distressed to see the introduction of HB99, a bill that would sanction doctor-prescribed suicide in the state of Alaska. The bill itself deserves a swift death, so I'm writing to ask you to do all that you can to prevent this bill from advancing in this legislature.

The provisions of HB99 open the door to taking advantage of the most vulnerable among us, especially the elderly and the disabled. HB99 endorses the false premise that suicide is medical care.

Human worth does not diminish as we weaken or age. People who are loved and valued maintain dignity, no matter what functions they lose or what help they need. Doctor-prescribed suicide sends vulnerable people the demoralizing message that they're no longer worth our time or trouble. That undermines rather than affirms dignity.

IF HB99 COMES TO A VOTE IN HEALTH AND HUMAN SERVICE'S COMMITTEE, PLEASE VOTE NO!!!

Thank you,

Janet B. McCoy
Anchorage, Alaska

P.S. See http://www.nationalrighttolifenews.org/news/2015/02/assisted-suicides-in-oregon-leap-44-in-2014/#.VOfVcvnF98E for a current look at just one aspect of how it is playing out in Oregon-- the depressing numbers.

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**Sent:** Wednesday, April 08, 2015 10:29 AM
**To:** Rep. Paul Seaton
**Subject:** Hb 99

please oppose HB 99.there are ways to make people comfortable as they die. this sort of legislation turns into a duty to die.

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**From:** reasonforthehope [redacted]
**Sent:** Wednesday, April 08, 2015 10:43 AM
**To:** Rep. Paul Seaton
**Subject:** PLEASE VOTE AGAINST THE ASSISTED SUICIDE BILL!
As we know from experience, these things never stay "voluntary" for very long. People come to this state because they feel safer here than in Oregon or California, so let's keep it that way. Even the AMA opposes this.
Thank you.

Mary L. Barry

Anchorage, AK 99503
907 563-0044

**From:** [redacted]
**Sent:** Thursday, April 09, 2015 4:34 PM
**To:** Rep. Louise Stutes; Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool
**Subject:** Oppose HB 99

Dear Committee Members

I appreciate the hearing you held today on HB 99. I agree with Rep. Stutes' caution to the committee. I have also seen disagreement over how quickly an elderly loved one should die. The elderly person wanted to manage his symptoms and live longer while certain influential family members pressured him and other relatives to change treatment so he would die sooner. Advocates for the dying family member were forced to strongly intervene on the patient's behalf to make sure his care progressed as he wished. I think HB 99 would provide another avenue for this kind of selfish maneuvering.

I oppose HB 99.

Sincerely,
Christine O'Connor
2800 N Park Dr.
Wasilla, AK 99654
(907) 373-5775

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From: Steve and Dorris Stevenson [redacted]
Sent: Thursday, April 09, 2015 12:43 PM
To: Rep. Paul Seaton
Subject: HB99

HB99
As you meet today, Please do not be persuaded to continue to promote or vote for house bill 99 for assisted killing of patients. Anyone who is terminal and wants to die can fine numerous ways to end their life-They do not need doctors to help them. What about the Hippocratic oath that says "I will neither give a deadly drug to anyone if asked for it, nor will I make a suggestion to this effect". It seems this bill would only validate Sarah Palin's death panels.
Please stand up for dignity of life not death with dignity.
Thank you.
Mrs Stevenson
Chugiak

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**From:** Charles & Carole Hart [redacted]
**Sent:** Thursday, April 09, 2015 12:19 PM
**To:** Rep. Paul Seaton
**Subject:** vote no on HB99

Rep. Seaton,
I urge you to vote no on HB 99. This is an example of a bill going too far…and what are we saying to young adults, who are tempted to suicide?
We must protect life, as our constitution does.
Thank you,
Carole Hart

# Emails in opposition to HB 99 – April 8th

*Includes emails from:*

- *Carol Sheridan*
- *George L. Stewart –Anchorage*
- *Ron Bowers – Dillingham*
- *Heather J. Austin – Anchorage*
- *John Tappel*
- *Felicity Young*
- *David Stevens –Tennessee*
- *James Mcintosh*
- *Sherri Gould – Eagle River*
- *Tamera Smith*
- *Peter and Rory Schneeberger – Hoonah*
- *Katie Novcaski*
- *Gail Randall*
- *Jeanette Burdell*
- *Robert Kendall*
- *Joan Watson – Anchorage*
- *Larry Roberts*
- *Heather Parker*
- *Ken Rosentrater – Anchorage*
- *Lynette Phillips – Anchorage*
- *Rosalyn Singleton – Eagle River*
- *Jan Syzdek – Eagle River*
- *Dave and Florie Wilcoxson*
- *Ruth Peters*

**From:** [redacted]
**Sent:** Wednesday, April 08, 2015 1:37 PM
**To:** Rep. Paul Seaton
**Subject:** HB 99

Please vote NO on physician-assisted suicide. Carol Sheridan

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Dear Representative Seaton,

I implore you to vote against House Bill 99 which would legalize physician-assisted suicide. Legalizing a cheap suicide prescription would prove dangerous for the poor, elderly and disabled.

For example, in Oregon, where assisted suicide is legal, the Oregon health services denied medical treatment to Barbara Wagner who had lung cancer, while instead offering to pay for physician-assisted suicide. Insurance companies see dying as a cost-saving measure. Do we want California to send such a tragic message to individuals facing serious or chronic disease and disability?

Physicians cannot always accurately predict when people will only live six months. Another Oregon resident Jeanette Hall, diagnosed with cancer and told that she had six months to live, stated in a 2012 affidavit, *"I wanted to do our law and I wanted my doctor to help me. Instead, he encouraged me to not give up and ultimately I decided to fight. I had both chemotherapy and radiation. I am so happy to be alive! This year, it was 12 years since my diagnosis. If my doctor had believed in assisted suicide, I would be dead."*

This bill is a recipe for elder abuse. Kate Cheney, an 85-year-old woman, saw two physicians. Her daughter thought the first doctor was "dismissive" and requested another opinion. The second physician ordered a psychiatric evaluation, which found that Cheney lacked "the very high level of capacity required to weigh options about assisted suicide." Cheney's request was then denied, and her daughter "became angry." Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive." Cheney soon took the drugs and died, but only after spending a week in a nursing home.

This legislation is not about the right to die. The mortality rate in the United States is still 100 percent. Doctors are not keeping patients alive against their will. Everyone has the right to refuse treatment. The real argument is about giving doctors the RIGHT TO KILL. If that right is given, doctors will be under intense pressure by insurance companies and the government to encourage patients to do the right thing to lower healthcare costs. Those that pay for healthcare know that 50 percent of healthcare costs occur in the last six months of life.

Please reject House Bill 99. Laws such as these pressure people into an early death. Don't let "death with dignity" come to our state of Alaska.

Thank you,

George L Stewart, MD
[redacted]
4431 Edinburgh Dr, Anchorage, AK 99502

**Sent:** Wednesday, April 08, 2015 2:00 PM
**To:** Rep. Paul Seaton
**Subject:** HB 99 Assisted Suicide

Rep. Seaton, Please vote NO on HB 99 promoting assisted suicide, sponsored by Rep. Drummond. I have been a Medic/Firefighter for about 40 years and have watched many folks battle incurable illnesses. I have also seen many loved ones over the years battle courageously before breathing their last breaths and leaving this world into the presence of Jesus.

I wholeheartedly believe that our mission in the medical world is to comfort those who are dying and prepare them for meeting their maker. Assisted suicide can lead to a slippery slope of cheapening life, especially those who are old or sickly.

Please vote NO on HB 99 when this bill comes before your H&SS committee tomorrow.

Thank You,

Ron Bowers EMT-III/Firefighter/Medevac Escort/EMS Instructor---Dillingham 1(907) 842-4186/Cell 528-3711

**From:** Stanley and Heather Austin [redacted]
**Sent:** Wednesday, April 08, 2015 2:07 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; presentative.Dave.Talerico@akleg.gov; Rep. Geran Tarr; Rep. Adam Wool; Rep. Louise Stutes; Rep. Neal Foster
**Subject:** Please vote NO on HB 99, Physician-Assisted Suicide

Dear Representative:

What more can I say but that you can cast a deciding vote to protect lives which are vulnerable, lives that are being coerced into dying, and, often, lives which are depressed with no one to help find a way through the despair. These are among the many who have sought assisted suicide as their solution to life's pain, whether physical or emotional. What does that say about our willingness to reach out to help and to provide viable solutions to those in extreme need?

Even if laypeople are uninformed, medical doctors and their associates are not. There has been palliative medication to alleviate and even stop physical pain for hundreds of generations. There are excellent psycho-tropic drugs to provide for the dark suffering of the many who endure depression.

Mitigation of intractable physical pain was the original idea of the Hospice movement which was regenerated in England, after World War II, by Cecily Saunders, M.D. Dame Cecily was successful with her "Brompton Cocktail" and other medications for relief of pain. It is well documented that, because of her work, people were able to "die with dignity and without pain."

Incidentally, the patients in Dr. Saunders' hospice were not doped; they were walking, talking, and responsive up to the end. There have been innumerable papers, reports, studies, theses, etc., about folks who have been provided palliative medication at the end of life. It's fallacious to state that to mitigate pain the patient must always be rendered unconscious. I'm afraid that's what many want us to believe. With critical observation at the onset of pain, it is possible to plateau the patient. Hospice was made for end of life care. But doctors were not made to kill, and all whom I know who practice medicine remain faithful to the oath which they took to do no harm.

There IS another solution for pain; people need to be told, and it needs to be provided.

Medicate patients up to a level where they are relieved. Further, forget the concern about becoming "habituated." Of course they will be; however this is to *alleviate* end of life pain.

Western society has become comfortable with the simplest course. Holland (the Netherlands) and Switzerland regret that they passed assisted suicide laws. The age to request assisted suicide in Holland is now fourteen! And the request can be for <u>any</u> reason. In February 2014 Belgium passed an assisted suicide law for young CHILDREN.

How any society which kills its vulnerable sick (of any age) can call themselves civilized is beyond me. The act is barbaric. It is a throw back to the days of the Spartans, when parents left their children on rocks to die, or threw their ailing aged out into the street for the same purpose. Respect for the value of all human life appears to have altered drastically throughout the Western world over the past four decades. But when we do not remember history we are doomed to repeat it.

Read: Alfred Hoche and Karl Binder, (one a Medical Doctor, the other a Jurist), "The Release of Life Devoid of Value." (Translation from German .) The authors refer to those who should be killed as "absolutely worthless human beings" and "useless eaters." In their booklet, you will find the 1920s blueprint for everything that Euthanasists believe, along with the most specious arguments and "heartfelt" rationalizations for their acts. That little book was THE text for those in the 1930s who sought to rid Europe of the feeble and sick, including children. It was the beginning of the end for upwards of one quarter million Aryans who were euthanized by Medical Doctors of Germany's National Socialist Party because of incurable disease, physical handicaps, and mental health issues (for which Down Syndrome was one of the categories). It was the blueprint for the methods of destruction of most of the the Jewish population of Europe.

I don't think that we should be deluded. Assisted suicide isn't for the suffering. It has as much to do with the economy as it did in the 1930s.

Please vote NO on HB 99. Alaska, which has four times the suicide rate as the rest of the country, doesn't need to increase the statistic. Please vote NO, and let's work on helping all suffering pain from sickness to mitigate their pain in order to enjoy the time left in their life.

Heather J. Austin

Parish Health Minister, Anchorage, AK

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**From:** John and Kathleen Tappel [mailto:jktappel@gmail.com]
**Sent:** Wednesday, April 08, 2015 2:07 PM
**To:** Rep. Paul Seaton
**Subject:** AK assisted suicide bill

Dear Rep. Seaton,

I strongly oppose the current bill to legalize assisted suicide in AK.

Sincerely,

John Tappel, MD

LaTouche Pediatrics.

From: Felicity Young [redacted]
Sent: Wednesday, April 08, 2015 2:21 PM
To: Rep. Paul Seaton
Subject: HB99

Please oppose HB 99. Society should not encourage suicide and especially shouldn't ask medical professionals to participate in it.
Felicity Young

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Testimony of **David Stevens, MD, MA (Ethics)**
*Statement to the Alaska House Health & Social Services Committee*
In **OPPOSITION** to HB99/Voluntary Termination of Life – Thursday, April 8, 2015

I am writing to OPPOSE HB99. My name is Dr. David Stevens. I am the Executive Director for the American Academy of Medical Ethics. I am concerned about decreasing suffering at the end of life and protecting healthcare. My own father died of cerebral malaria at the age of 65 after he and my mom visited us in Kenya where I practiced for a number of years. My father-in-law lived with us for seven years as he went through the final stages of Alzheimer's disease. I led a medical relief team in Somalia for 10 months during the "Black Hawk Down" days. I also led a relief team in Sudan for 11 months during their country's civil war during which we successfully wiped out an epidemic of relapsing fever during that same time. And I was in charge of a team that worked in Rwanda during the genocide. I've seen more suffering than I ever wanted to. I've stood at patients' beds and prayed that God would go ahead and take them.

But allowing doctors to give lethal prescriptions to their terminally ill patients is dangerous.

It is dangerous for physicians. It wrongly assumes all physicians are idea moral agents. As you know, there are doctors you would send your family members to and those you would not. Physicians are under increasing stress, workloads and costs pressures as well. It takes no great skill and very little time to write a lethal prescription. It takes consummate skill and lots of effort to provide good end-of-life care. Allowing lethal prescriptions also gives the physician too much power as they literally would be judge, jury and assistant executioner in end-of-life cases. We don't allow a single judge that kind of power in trials of mass murderers. The power is not in the patient's hands despite signing a form and giving oral consent. By carefully choosing how I describe their disease and prognosis, I could convince someone that taking a lethal prescription was a good idea without ever saying the words "physician-assisted suicide." Remember, suicide is not illegal in Alaska and can be accomplished painlessly with a running car parked in your garage. This is not about giving patients the so-called "right to die" but about giving physicians the right to kill.

It is dangerous for families. Could you imagine going to visit your parent or other loved one in the nursing home and finding their bed empty? When you ask, you find that their physician had given them a lethal prescription and they have taken their life without saying anything to you. I know I would feel guilt—didn't I visit them often enough? I would feel anger—how could their doctor do this without bringing me into the discussion? And I would feel sadness. Allowing this will also cause enormous dissension in many families, as had been documented in Europe where this has been allowed much longer. It also opens the door to worsened elder abuse. One elderly woman was quoted in a newspaper to say, "...when I started losing my hearing about three years ago, it irritated my daughter...She began to question me about my financial matters and apparently feels I won't leave much of an estate for her... She became very rude...Then suddenly, one evening, my daughter said she thought it was okay for old people to commit suicide...So here I sit, day after day, knowing what I'm expected to do."

It is dangerous for patients. The so-called "right to die" will become the duty to die. My mom is 86 and a few years ago as she began to have some problems living alone I encouraged her to move from Kentucky to Tennessee and live with us. She said to me, "Son, I don't want to be a __...." Yes, you can fill in the word "BURDEN." Many of the elderly will feel a duty to not be a financial burden, time burden or even an inconvenience. Did you know some bioethicists are already teaching there is a duty to die? Dr. John Hartwig teaches students at East Tennessee State University's medical school which is a few miles from our office. Some of the students brought it to my attention and gave me his handout where he tells students that people have a duty to die to not be a burden to the next generation. I went to his lecture where he said the same thing and I asked when that duty kicked in. Without hesitation, he said at age 75. Ezekiel Emmanuel, credited as an architect of the Affordable Care Act wrote an article for *The Atlantic* saying he wasn't promoting physician-assisted suicide legalization, but he does personally believe that people are no longer very productive at age 75 and should end their lives.

The most common reason the elderly take their lives is depression. Studies show that doctors recognize it poorly, especially in the terminally ill even though they respond well to antidepressant drugs. Though 95 percent of the elderly who commit suicide are depressed, the safeguards proposed in legalization laws don't require a consultation by a psychologist or psychiatrist. It happens less than 5 percent of the time in Oregon and Washington. In fact, a survey of mental health specialists in Oregon showed that over half of them said they couldn't diagnose depression reliably in just one visit.

It is dangerous for patients because mental or physical suffering precludes rational decision-making. The definition of being suicidal states that the person has "impaired cognition and distorted judgment." Now proponents are stating there is such a thing as a "rational suicide." That is an oxymoron like saying you can drink a glass of "dry water." We need to deal with the physical and mental suffering and the suicidal ideation will be resolved. We don't have to let the patient kill themselves to kill the suffering.

It is dangerous for patients because the cheapest form of treatment for a terminally ill patient is a handful of lethal pills costing less than $100. The biggest problem in healthcare is it costs too much. People don't have insurance because it costs too much. Half of the lifetime costs of healthcare happen in the last year of life. We could easily solve our cost dilemma by allowing physician-assisted suicide to be legal and promoted. Oregon's Medicaid program will not pay for any treatment that studies show does not give a greater than 5 percent survival rate. When a woman petitioned for a new drug that could prolong her life two or three years, the state program responded that they wouldn't pay for it under the guidelines, but they would be happy to cover the cost of her suicide if she wanted to take that step. Chilling!

Allowing doctors to give lethal prescriptions is dangerous for society. There is no logical place to draw the line if you allow it. If it is "right," how can you deny it to anyone who is suffering? All it takes is a lawsuit after it becomes law to expand it. Doesn't the patient who is terminal but can't swallow have a right to death? After physician-assisted suicide was legalized in The Netherlands in the mid-1970s, they found that patients who took the pills had complications 25 percent of the time. They vomited the pills up or woke up the next day not dead. They decided patients had a right to die well from their suicide, so they allowed doctors to be in attendance and give a lethal injection so it was "done right." They then realized if the justification was "suffering," they couldn't deny it to the chronically ill who would suffer for years, or to the newborns who would suffer from a congenital defect for a lifetime or to the psychiatric patients. How could you say mental suffering was any less that physical suffering?

Now they are working on a protocol in The Netherlands to euthanize patients who desire it on the operating table so they can donate their organs and at least "something good will come out of this."

It is dangerous for society because the so-called "safeguards" won't work. Predicting patients only have six months left to live is impossible. A study in the journal *Cancer* revealed that 40 percent of patients with cancer (that is two out of five) lived longer than the six months predicted by their doctor. A study out of Australia looking at The Netherland's doctors revealed they worked together as "consulting pairs" and the initial doctor almost always referred to a physician who would rubber stamp his assessment about the patient. The laws in Oregon and Washington make the doctor almost immune from malpractice charges. They can miss the diagnosis, botch the suicide or whatever and they only have to meet the legal standard of "good intent." In other words, "I didn't mean for that to happen." We don't allow those kind of standards for anything else in healthcare.

My greatest concern is that the laws being passed are putting a cloak of secrecy around the process. There is no way to study and find out if the process is working well. All the records submitted by physicians assisting with the suicide are destroyed. Only a statistical summary is published. By law, doctors have to lie on the death certificate they sign to say the patient died of their disease. We don't do that in any other areas of healthcare, and that makes it impossible to realize that any of the concerns I've expressed are actually happening. The only thing we know is that the doctors filled out the forms correctly.

I had a friend who went to live in Ethiopia with his wife and young child. They rented a house but found out after they moved in that there were rats in the house. He was unsuccessful in catching them with traps and feared his child would be bitten at night. He complained to his landlord who assured him he would resolve the problem. The next day he showed up with a basket containing two cobras to put in the attic and assured the man again that he would have not rats within a week. What do you think my friend said? He refused. The solution would work, but it was more dangerous than the rats.

That is what legalizing physician-assisted suicide is. It will eliminate suffering in terminally ill patients who choose this option, but it will destroy the literal foundation of the doctor-patient relationship and healthcare as a whole. It will destroy trust and cause much more harm than good. It is not a new idea; doctors before Hippocrates both cured and killed their patients. The trouble was you didn't know which one they would do to you. If someone paid them more, the doctor would kill you and no one would be the wiser. Hippocrates realized medicine could not thrive like that, and so he made it so that doctors had to take an oath before their future colleagues and the community to swear how they would use the powerful knowledge they were being given before their teachers would teach them. Over the next few hundred years, patients voted with their feet and Hippocratic medicine became the standard, the foundation on which Western healthcare grew and prospered.

We need to put our efforts into eliminating the suffering—not eliminating the patient—through research, better end-of-life care, more physicians with palliative training, good drug laws and coming alongside patients to emotionally, spiritually and physically support them in their final days. A handful of lethal pills is not compassion; it is an escape from the duty of compassion.

H.L Mencken summed it up well, "There is always an easy solution to every problem—neat, plausible and wrong." Let's not go down the path of physician-assisted suicide. It is not only wrong, it is too dangerous.

David Stevens, MD, MA (Ethics)

Bristol, Tennessee
United States of America

From: James Mcintosh [[redacted]
Sent: Wednesday, April 08, 2015 4:51 PM
To: Rep. Paul Seaton
Subject: Assisted suicide

Please do not pass a bill to cause doctors to assist in patient suicide. It is morally wrong and the AMA is against it because doctors are supposed to heal, not kill.

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**From:** Gould, Sherri L [redacted]
**Sent:** Wednesday, April 08, 2015 11:17 AM
**To:** Rep. Paul Seaton; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Adam Wool; Rep. Geran Tarr; Rep. Liz Vazquez
**Subject:** Please OPPOSE HB99

Dear members of the House Health & Social Services Committee,

**I respectfully urge you to OPPOSE HB 99 and keep Alaska free of doctor-assisted suicide.**

I agree with the statement made by the American Medical Association in opposition to doctor-assisted suicide:

"...allowing physicians to participate in assisted suicide would cause more harm than good. **Physician-assisted suicide is fundamentally incompatible with the physician's role as healer**, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible." *(AMA Code of Medical Ethics, Opinion 2.211, emphasis added).*

Thank you for your consideration of this important issue.

Sincerely,

Sherri Gould

18700 Upper Skyline Drive

Eagle River, AK 99577

**From:** TAMERA SMITH [redacted]
**Sent:** Wednesday, April 08, 2015 11:14 AM
**To:** TAMERA SMITH
**Subject:** Please vote NO on HB 99

Dear House Health & Social Services Committee Representatives:

As a citizen of the great state of Alaska I am appalled at the legislation you will consider tomorrow, House Bill 99 deceptively titled "Voluntary Termination of Life" that proposes to bring assisted suicide to Alaska.

Alaska has a terrible problem with suicide, and now you want to make it legal and have the medical profession "assist" in its implementation! Truly shameful!

To me, even the entertainment of this bill is in opposition to the Alaska Constitution's Article 1 inherent right that "...all persons have a natural right to life..."

It is my hope that you will honor your pledge to uphold the Alaska Constitution and quickly vote down and permanently discard HB 99 and put your valuable time and effort into legislation that will benefit the people of Alaska, not kill them.

Tammie Smith

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**From:** P-R Schneeberger [redacted]
**Sent:** Wednesday, April 08, 2015 11:54 AM
**To:** Rep. Paul Seaton
**Subject:** Please OPPOSE HB 99
**Importance:** High

**THANK YOU.**
**Peter and Rory Schneeberger**
**Hoonah, 99829-0232**

**From:** Richard Novcaski [redacted]
**Sent:** Wednesday, April 08, 2015 12:59 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool
**Subject:** HB99

Dear Representatives of the people of the State of Alaska,

I would like to write in my own words why I am against assisted suicide, but the following quotes spell it out so succinctly.

**"...allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible."** *(AMA Code of Medical Ethics, Opinion 2.211).*

I will submit to you that two of the main arguments for assisted suicide are rebutted in the quotes below from Marilyn Golden who is a senior policy analyst with the Disability Rights Education and Defense Fund.

"Available data suggests that pain is rarely the reason why people choose assisted suicide. Instead, most people do so because they fear burdening their families or becoming disabled or dependent. *(I have seen the stats from Oregon, and this proves out)*

Anyone dying in discomfort that is not otherwise relievable, may legally today, in all 50 states, receive palliative sedation, wherein the patient is sedated to the point at which the discomfort is relieved while the dying process takes place peacefully. This means that today there is a legal solution to painful and uncomfortable deaths, one that does not raise the very serious problems of legalizing assisted suicide."

In fact, I know of 2 elderly people who were in the hospital for a basic, simple procedure and each had a nurse go in there room, when the patient was by themselves, and encouraged them to consider ending their lives as they were older and it was time to go. I am just one person and so if I know of 2 incidents that happened in 2 different states, it must be happening ALL the time. This was not even in an assisted suicide states, so obviously if our state becomes an assisted suicide state, there will be LOTS of people putting pressure on vulnerable patients to end their lives.

Please vote as an advocate for the patient in pain, not as an advocate for ridding society of people who are in vulnerable life states and need our support.

Thank you,

Katie Novcaski

**From:** Gail Randall [redacted]
**Sent:** Wednesday, April 08, 2015 1:01 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Adam Wool; representativeGeran.Tarr@akleg.gov
**Subject:** HB99

Please oppose HB99 and keep Alaska free of doctor-assisted suicide.

Mrs. Gail Randall

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From: Jeanette Burdell [redacted]
Sent: Wednesday, April 08, 2015 5:54 PM
To: Rep. Paul Seaton
Subject: Oppose HB 99

As the AMA states, physicians are only meant to heal, not abandon, their patients. Please vote against assisted suicide--wrong for Alaska, America, and the world.

Jeanette Burdell

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**From:** Rob Kendall [redacted]
**Sent:** Wednesday, April 08, 2015 10:03 PM
**To:** Rep. Paul Seaton
**Subject:** Please vote against the Doctor Assisted Suicide bill (HB99)

To the Honorable Representative Paul Seaton:

I've learned that the Assisted Suicide bill (HB99) will be heard tomorrow by members of the Alaska House Health and Social Services Committee. Please vote against this legislation.

Sincerely,

Robert Kendall

**From:** Joan Watson [redacted]
**Sent:** Thursday, April 09, 2015 12:37 AM
**To:** Rep. Paul Seaton
**Subject:** House Bill 99

Dear Mr. Chairman

I am writing in regards to House bill 99 –"Voluntary Termination of Life." I ask you to vote against this bill. There are so many reasons to reject this bill, but I would like to suggest a few. It endangers the weak, those who are disabled , or elderly. As Paul Longmore, who was a Professor of History at San Francisco State University and a foremost disability advocate on this subject, has stated, "Poor people, people of color, elderly people, people with chronic or progressive conditions or disabilities, and anyone who is, in fact, terminally ill will find themselves at serious risk" (Longmore, 1999). http://dredf.org/assisted_suicide/assistedsuicide.html

Because of the devaluation of life which an assisted suicide culture will engender, family members may be tempted to see their elderly, or sick parents, disabled children or relatives as burdens, and wish to hasten their death. The elderly and disabled may also be tempted to view themselves as burdens. The compassion and care that should exist in families will be eroded.

Doctors who are healers will become killers. The trust that should exist between doctor and patient will be greatly weakened.

People who are sick, old or disabled are human beings and should be treated as such no matter their condition.

My husband and I are in our sixties. Thankfully we are in good health, but as we age sickness can happen. If our culture accepts assisted suicide and it becomes widespread, what is now presented as a choice to die, will I believe become a duty to die.

A good article to read: http://www.heritage.org/research/reports/2015/03/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak-corrupts-medicine-compromises-the-family-and-violates-human-dignity-and-equality

Thank you.

Joan Watson

Anchorage Ak

From: Larry Roberts [redacted]
Sent: Thursday, April 09, 2015 1:54 AM
To: Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool
Subject: HB 99

Hi,

I encourage you to vote no on this bill. I believe life is precious and shouldn't be discarded. I've heard of many cases where someone is told they have a terminal illness and yet live for many years.

Thank you for your consideration of my view on this bill, Larry Roberts

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**From:** Steve Parker [redacted]
**Sent:** Thursday, April 09, 2015 7:16 AM
**To:** Rep. Paul Seaton
**Subject:** HB99

Dear Legislature,

I urge you to vote no on this proposed bill. Ending one's life causes great pain in many others. Our current healthcare system is to help comfort and heal people. Asking doctors to judge the end of life for others is against their oath of practice. Please vote no.

Heather Parker

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**From:** Ken Rosentrater [redacted]
**Sent:** Thursday, April 09, 2015 7:31 AM
**To:** Rep. Paul Seaton
**Subject:** Assisted Suicide bill (HB99)

Honorable Representative Seaton,

Please vote against the Assisted Suicide and Bill (HB 99). It is not in the best interest of the people of Alaska to exacerbate and add to the culture of death that already exists here.

Thank you.

Sincerely,

Ken Rosentrater

1120 Huffman Road
Suite 24-517
Anchorage AK 99515

**From:** Lynette Phillips [redacted]
**Sent:** Wednesday, April 08, 2015 7:00 PM
**To:** Rep. Paul Seaton
**Subject:** HB 99

Dear Representative Seaton,

I'm writing to ask that you appose HB 99 "Voluntary Termination of Life. " I am a Registered Nurse working with people who experience disabilities. Physician assisted suicide leads to situation where people who want to live, such as those experiencing disabilities, are encouraged to pursue PAS, because some would deem them a burden on society. In other instances, cancer patients who have a good chance with remission, may pursue PAS when they actually need the encouragement of friends, family, and the medical team to continue seeking treatment. Let's provide a culture where our medical team is striving for healing and life, not death. Please appose HB 99.

Lynette Phillips

Anchorage, AK

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**From:** Rosalyn Singleton [redacted]
**Sent:** Wednesday, April 08, 2015 7:02 PM
**To:** Rep. Paul Seaton
**Subject:** HB99

Dear Representative Seaton,

I would like to express my opposition to HB99 Voluntary Termination of Life which would legalize physician assisted suicide in Alaska. This bill would change the foundational trust and healing relationship between a physician and patient. Unfortunately, this is an easy option for a busy stressed physician and undermines the responsibility to provide excellent pain and symptom control at the end of life.

Rosalyn Singleton MD

Eagle River, AK

**From:** Jen Syzdek [redacted]
**Sent:** Wednesday, April 08, 2015 9:42 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Geran Tarr; Rep. Adam Wool
**Subject:** House Bill 99 - please vote "no"

Please vote for House Bill 99. Physician-assisted suicide is fundamentally incompatible with the physician's role as a healer.

Thank you,

Jen Syzdek
16911 Vanover Circle
Eagle River, AK 99577

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**From:** David Wilcoxson [redacted]
**Sent:** Wednesday, April 08, 2015 9:50 PM
**To:** Rep. Paul Seaton; Rep. Liz Vazquez; Rep. Neal Foster; Rep. Louise Stutes; Rep. David Talerico; Rep. Adam Wool
**Subject:** HB 99 Voluntary Termination of Life

Thank you for your time to serve our state in the House of Representatives. As you consider HB 99 Voluntary Termination of Life, please know that this is not what we want for Alaska. Doctors should be healers, not taking the lives of their patients. There are too many potential problems with doctor-assisted suicide. PLEASE keep this out of Alaska.

Thank you.

Dave and Florie Wilcoxson

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From: RUTH PETERS [redacted]
Sent: Wednesday, April 08, 2015 7:22 PM
To: Rep. Paul Seaton
Subject: HB 99

Good Afternoon ,
As an Alaska Citizen, I was alarmed to hear of a bill making it legal for doctors to prescribe lethal medication! This can only be harmful to Alaska! Please, as our representatives, oppose this house Bill 99!
Thank you,
Ruth Peters

# Emails in Opposition to HB 99 – 4.13.2015

*Includes emails from:*

*Chris Selin*
*Octavio Suarez – Spain*
*Heather*

From: Chris Selin [redacted]
Sent: Friday, April 10, 2015 4:48 AM
To: Rep. Paul Seaton
Subject: Voluntary termination bill

Dear Rep. Seaton,
The assisted suicide bill is counter to the role of physician and should not be passed. Please consider this opposition and the advice of many physicians who do not support passage if it.

Thank you for your work.

Sincerely, Christine Selin

**From:** Octavio Suarez [redacted]
**Sent:** Monday, April 13, 2015 8:35 AM
**To:** Rep. Paul Seaton
**Subject:** Octavio Suarez, ID 76947631G, please vote against the House Bill 99

Dear Member of the House Health & Social Services Committee:

In a first place, excuse me for disturbing you. My name is Octavio Suarez, Spanish citizen with ID 76947631G. I write to you because I have read in the news that the Alaska Legislature hold on April 9th the first hearing on the House Bill 99, sponsored by Representative Harriet Drummond, which proposes to bring Oregon-style assisted suicide to Alaska.

I know that I am not American citizen, but, since the USA are the most important country in the world, all that happens in the States is, or can be, an example for other nations. So, I respectfully write this e-mail for asking you to vote against the House Bill 99 in order to keep Alaska free of doctor-assisted suicide. It is said by the Opinion 2.211 of the American Medical Association Code of Medical Ethics that:

"...allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible."

Sincerely yours

Octavio Suarez

---

**From:** Heather [redacted]
**Sent:** Thursday, April 09, 2015 9:44 PM
**To:** Rep. Paul Seaton
**Subject:** Oppose HB 99 & support Hope

**Please OPPOSE HB 99 and keep Alaska free of doctor-assisted suicide.**

I agree that allowing physicians to participate in assisted suicide would cause more harm than good. **Physician-assisted suicide is fundamentally incompatible with the physician's role as healer**, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible." *(AMA Code of Medical Ethics, Opinion 2.211, emphasis added).*

*There is always hope - tell me this is true!!* ~Heather

# OREGON'S DEATH WITH DIGNITY LAW

# AND

# EUTHANASIA IN THE NETHERLANDS:

# FACTUAL DISPUTES

2004

Robin Lunge
Maria Royle
Michael Slater
Legislative Council
115 State Street,

Drawer 33

Montpelier, VT

05633

# TABLE OF CONTENTS

## SECTION 1: INTRODUCTION

Unlike most reports generated by the Legislative Council, there is no statutory mandate to study the Oregon Death with Dignity law or the law on euthanasia in the Netherlands nor is there a study committee comprising members of the legislature. The study of Oregon's law was requested by letter, dated May 13, 2004, from Representative Bill Aswad with 70 additional signatories. The study of the euthanasia law was requested by letter, dated May 19, 2004, from Representatives Haas and Sheltra with 23 additional signatories.

Both letters requested the Council to investigate and report on any factual disputes pertaining to the existing laws and practices, and to attempt to substantiate and reconcile the differing allegations based on empirical evidence. The scope of this report is necessarily limited to the empirical information the Council was able to obtain through its independent research of both primary and secondary sources, attempts to catalogue the areas of dispute, and it indicates where substantiation of the opinions of the proponents and opponents of the laws was not feasible and why. It cannot be overstated that the Council takes no position on the merits or morality of Oregon's Death with Dignity Act or the Netherlands' euthanasia law. Moreover, it is not our intent, nor was it our charge, to express any opinion on whether either practice is consistent with public interest or constitutes legitimate medical care.

The Council solicited information about the areas of study from interested parties[1] in Vermont by sending a brief e-mail questionnaire.[2] We received submissions by e-mail, as well as three voluminous submissions of materials in hard copy.[3] In addition, we did independent research in order to determine the accuracy of the materials and information submitted. Our research included finding reference materials over the internet and in hard copy and interviews with public officials or national experts where feasible and necessary. We did not create or conduct statistically valid surveys of doctors, patients, or other interested parties in Oregon nor in the Netherlands. In addition, the information we were able to obtain regarding the Netherlands was largely by secondary source due to the lack of English translations of the case law and studies.[4]

## SECTION 2: DEFINITIONS AND USE OF TERMINOLOGY

One area of confusion in the debate around the laws in Oregon and in the Netherlands arises because different groups include different medical situations in discussions of "euthanasia" and "assisted suicide." This section of the report reviews the definitions of these terms in two articles. In other areas of the report, we use the definition of the term contained in the specific law we are reviewing. For instance, when we use the term "assisted suicide" in relation to the Death with Dignity law, we are referring to the situations defined by the Oregon law, not what is defined as "assisted suicide" in the Netherlands, and not the general constructs we are discussing in this section.

Ezekiel J. Emanuel, MD, PhD breaks down the concept of medical decisions which result in death into six categories of activity, based on the physician's intent, the patient's ability to consent, and the physician's actions.[5] His definitions are as follows:

| Term | Definition |
|---|---|
| Voluntary active euthanasia | Intentionally administering medications or other interventions to cause the patient's death at the patient's explicit request and with full informed consent |
| Involuntary active euthanasia | Intentionally administering medications or other interventions to cause a patient's death when the patient was competent but without the patient's explicit request and/or full informed consent (e.g. patient was not asked) |
| Nonvoluntary active euthanasia | Intentionally administering medications or other interventions to cause a patient's death when the patient was incompetent and mentally incapable of explicitly requesting it (e.g. patient is in a coma) |
| Terminating life-sustaining treatments (passive euthanasia) | Withholding or withdrawing life-sustaining medical treatments from the patient to let him or her die |
| Indirect euthanasia | Administering narcotics or other medications to relieve pain with incidental consequence of causing sufficient respiratory depression to result in a patient's death |
| Physician-assisted suicide | A physician providing medications or other interventions to a patient with understanding that the patient intends to use them to commit suicide |

The Van Der Maas study breaks down the distinctions somewhat differently in an article reporting the results of a national study requested by the Dutch government.[6] Van Der Maas also uses the physician's actions, his or her intentions, and the patient's involvement in the decision as benchmarks. The three main types of decisions looked at in the study were defined as follows:

> *Non-treatment decisions (NTD)*, the withholding or withdrawal of treatment in situations where the treatment would probably have prolonged life.
>
> *Alleviation of pain and symptoms (APS)*, with opioids in such dosages that the patient's life might have been shortened.
>
> *Euthanasia and related MDEL*,[7] the prescription, supply, or administration of drugs with the explicit intention of shortening life, to include euthanasia at the patient's request, assisted suicide, and life-terminating acts without explicit and persistent request.

Van Der Maas et al., at 670.

As can be seen by this brief comparison, the terms used can be confusing and can include a range of factual situations. When examining the claims of opponents and proponents of the laws in question, it is important to understand what factual situations are included in any statistics or reports on the topic.

## SECTION 3: DEATH WITH DIGNITY - OREGON

### A. INTRODUCTION

This section of the report details several areas of dispute regarding the Death with Dignity law enacted in Oregon in 1997 and describes the legal developments leading to the passage of the Death with Dignity Act. In each area of factual dispute, we identify the issues, describe the allegations and opinions of both the proponents and opponents, and report any empirical evidence on the topic.

### B. DESCRIPTION OF THE DEATH WITH DIGNITY ACT

The Oregon Death with Dignity Act (the Act) is narrowly drawn and encompasses a number of procedural safeguards. This section will outline some of the more significant provisions.[8] A copy of the complete Act, as amended in 1999, is contained in Appendix B.

In order to qualify for physician-assisted suicide, a person must be an Oregon resident, 18 years of age or older, must have decision-making capacity, and must be suffering from a terminal disease that will lead to death within six months. A patient must make one written and two oral requests for medication to end his or her life, the written one "substantially in the form" provided in the Act, signed, dated, witnessed by two persons in the presence of the patient who attest that the patient is "capable, acting voluntarily, and not being coerced to sign the request," and there are stringent qualifications as to who may act as a witness. The patient's decision must be an "informed" one, and the attending physician is thus obligated to provide the patient with information about the diagnosis, prognosis, potential risks, and probable consequences of taking the medication to be prescribed, and alternatives, "including but not limited to, comfort care, hospice care and pain control." Another physician must confirm the diagnosis, the patient's decisionmaking capacity, and voluntariness of the patient's decision. There are requirements for counseling if the patient is thought to be suffering from a mental disorder which may impair his or her judgment, for documentation in the patient's medical record, for a waiting period, for notification of the patient's next of kin, and for reporting to state authorities. The patient has the right to rescind the request for medication to end his or her life at any time.

Having met the above requirements, the patient is entitled to a prescription for medication to end life. The Act does not "authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia." That is, the Act authorizes physician-assisted suicide by lethal prescription but explicitly rejects active euthanasia.

In response to concerns raised that patients will be motivated by depression to seek a physician's assistance in ending their lives, the 1999 amendments to the Act added "depression causing impaired judgment" to the generic "psychiatric or psychological disorder" that the attending physician must determine the patient does not have before prescribing medications.

The amendments also added a reporting mandate, requiring that any health care provider who dispenses medications under the Act file a copy of the dispensing record with the state health division. Finally, the Act requires the state health division to issue an annual report summarizing the experience with the statute.

## C. LEGAL DEVELOPMENTS

There have been a number of state and federal cases in the United States addressing the legal parameters of end-of-life decisionmaking, generally. This section will describe briefly some of those legal decisions to the extent they shed light on the legal issues that have emerged relative to Oregon's physician-assisted suicide law. It will be followed by a separate section analyzing the legal issues relating specifically to Oregon's Death with Dignity Act.

### RIGHT TO WITHDRAWAL OR WITHHOLDING OF LIFE-SAVING TREATMENT

In 1976, in the case of Karen Ann Quinlan, In re Quinlan,[9] the New Jersey Supreme Court held that Quinlan's father could make the decision to turn off the respirator that was keeping his daughter alive. In that case, the patient's constitutional right of privacy, as asserted by her guardian, outweighed the state's interest in preserving the sanctity of human life and defending the best judgment of medical professionals. The court recognized that the state's interest diminished as the potential for life diminished. This was the first of several cases concerning the withdrawal of life support from persons in a persistent vegetative state.

The issue was addressed 14 years later by the United States Supreme Court in the case of Cruzan v. Director, Missouri Department of Health.[10] In that case, Nancy Cruzan sustained brain injuries resulting in a persistent vegetative state, and when it became apparent that she had virtually no chance of regaining her mental faculties, her parents asked the hospital to remove the artificial nutrition and hydration which sustained her. The hospital refused to act absent a court order.

The Cruzan Court specifically found that the right of an individual to refuse life-sustaining medical treatment derived from the common law doctrine of informed consent and has a constitutional basis:

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits and assault." Thus, under common law, a patient can consent to, or, conversely, refuse medical treatment. Since the patient can refuse treatment at any time, the patient can have treatment withdrawn even after it has been initiated.[11]

The Court held that under the Due Process Clause of the Fourteenth Amendment, a *competent* person has a constitutionally protected liberty interest in the right to refuse treatment; however, a state can restrict the ability of others to exercise that right on behalf of an *incompetent* person. Specifically, a state may require that an incompetent person's wish to have life-support withdrawn be proven by clear and convincing evidence. Absent such evidence, a state has a legitimate interest in the protection and preservation of human life. One notable consequence of this decision was a rise in the use of advance directives as a means of meeting the required clear and convincing standard.

## PHYSICIAN-ASSISTED SUICIDE

No American jurisdiction currently treats suicide or attempted suicide as a crime.[12] There is very little case law, however, on whether *assisting* suicide is a crime under the common law. There is no right to assisted suicide under the United States Constitution.[13] The right may exist under a specific state constitutional provision, though to date no courts have so held, and two state supreme courts have refused to strike down state laws banning assisted suicide on grounds that they violated privacy clauses in their respective state constitutions.[14]

The two most significant cases that addressed the issue of whether there was a federal constitutional right to assisted suicide arose from challenges to state laws banning physician-assisted suicide brought by terminally ill patients and their physicians: Washington v. Glucksberg[15] and Vacco v. Quill.[16]

In Glucksberg, the Court held that the asserted right to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment. The majority distinguished the facts and rationale of Cruzan:

"The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct."[17] Upon determining that a fundamental liberty interest was not at stake, the Court went on to conclude that the Washington statute being challenged was rationally related to five legitimate governmental interests: protection of life, prevention of suicide, protection of ethical integrity of the medical profession, protection of vulnerable groups, and protection against the "slippery slope" toward euthanasia.[18] The Court then noted that perhaps the individual states were more suited to resolving or at least addressing the myriad concerns raised by both proponents and opponents of physician-assisted suicide: "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[19]

In Vacco, the Court ruled that New York's ban on assisting suicide does not violate the Equal Protection Clause of the U.S. Constitution. As in Glucksberg, the Court recognized a distinction between refusing lifesaving medical treatment and taking lethal medication. The Court disagreed "with the Second Circuit's submission that ending or refusing lifesaving medical treatment 'is nothing more nor less than assisted suicide.'"[20] Rather, it determined that "[t]he distinction between letting a patient die and making that patient die is important, logical, rational, and well established . . . [and] comports with fundamental legal principles of causation . . . [T]he line between the two acts may not always be clear, but certainty is not required, even were it possible."[21] Thus, New York may ban the latter without violating the Equal Protection Clause. The Court then concluded that the New York law, like Washington's, is rationally related to legitimate state interests: namely, prohibiting intentional killing and preserving life, preventing suicide, maintaining physicians' role as their patients' healers, protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives, and avoiding a possible slide toward euthanasia.

Most states have addressed the issue of assisted suicide legislatively. Forty states have enacted laws which explicitly make it a crime to provide another with the means of taking his or her life.[22] Oregon is the only state presently permitting assisted suicide by statute. Vermont has no statute specific to assisted suicide. It is unclear how a Vermont court would apply the common law in an assisted suicide case.

## LEGAL CHALLENGES TO THE DEATH WITH DIGNITY ACT

As mentioned, Oregon is the only state to date with a statute affirming and regulating the right to physician-assisted suicide. Oregon voters approved the Death with Dignity Act by referendum (Ballot Measure 16) in 1994. The Act immediately was challenged in federal District Court, and implementation was delayed for three years as the case made its way through the federal court system until 1997 when the United States Supreme Court declined to review the case on appeal.[23] (While the litigation was in progress, the Oregon legislature approved legislation to permit the electorate to vote to repeal the Death with Dignity Act. Repeal was defeated by a 60 – 40% margin.)[24] Shortly after the law's implementation in 1997, the compliance with the Act was again challenged, this time by the federal Department of Justice, which issued a directive calling for the prosecution of health care professionals who participated in the assisted-suicide program. The federal challenge, likewise, has proved unsuccessful to date. A more detailed description of these legal developments follows.

### Lee v. Oregon

The initial challengers of the Act consisted of terminally ill patients, physicians, and residential care facilities. They argued that the Act violated their equal protection and due process rights under the Fourteenth Amendment, their free exercise of religion and freedom of association rights under the First Amendment, and their statutory rights under the Americans with Disabilities Act (ADA) of 1990, the Rehabilitation Act of 1973, and the Religious Freedom Restoration Act (RFRA) of 1993. The Oregon District Court granted summary judgment for plaintiffs on their equal protection claim and issued a permanent injunction against the Act's enforcement on August 3, 1995. The court found that the Act violated the Equal Protection Clause because it provided insufficient safeguards to prevent against an incompetent (i.e., depressed) terminally-ill adult from committing suicide, thereby irrationally depriving terminally-ill adults of safeguards against suicide provided to adults who are not terminally ill.[25]

The court did not decide plaintiffs' other claims for relief. However, a description of those claims will be reviewed here in the interest of providing a brief overview of the legal challenges to the Act. The due process claim was based on the allegation that the Act deprives persons who are disabled due to a terminal disease of protections for their right to live and, moreover, violates plaintiffs' liberty interests because it does not guarantee sufficiently that the choice to end life will be both informed and voluntary.[26] Plaintiffs' ADA claim was based on the argument that the Act unlawfully deprives persons who are disabled due to a terminal disease of protection afforded other persons under Oregon law in violation of the ADA and, to the extent the statute applies to federally funded programs, Section 504 of the Rehabilitation Act of 1973.[27] Defendants countered that the Act does not require any individual with disabilities to use assisted suicide but rather provides the option of assisted suicide as a benefit under the law; and, accordingly, no person with disabilities is deprived of legal protections against suicide.[28] Plaintiffs also argued that the Act was unconstitutionally vague particularly in regard to the definition of "terminal illness." Finally, plaintiffs argued that the Act required health care professionals to act in a manner inconsistent with their religious and moral convictions and in violation of the free exercise clause and freedom of association protections of the First Amendment and the RFRA. Again, the court did not determine the merits of these claims.

The case was appealed to the Ninth Circuit. The Ninth Circuit vacated and remanded with instructions to dismiss the case for lack of jurisdiction. The court determined that it lacked Article III jurisdiction because all of the plaintiffs lacked standing,[29] and the claim of the doctors and health care facilities, in particular, was not ripe.[30] Specifically, the patients had not displayed an "injury-in-fact" because the asserted injury—the possibility that the plaintiff would commit suicide as a result of inadequate detection of her depression—was too speculative and not actual or imminent. The doctors and health care facilities, on the other hand, failed to show both that their alleged forced participation was a "concrete and particularized" injury and that their claim was "ripe" because the Act does not penalize a health care worker or facility for not participating.[31] And, in any event, the alleged forced association with those who do follow the Act also failed to show an "injury in fact."

## Federal Challenges to Death with Dignity

Soon after the Oregon Death with Dignity Act went into effect, members of the United States Congress suggested that physicians who participated under the law's guidelines would be in violation of the federal Controlled Substances Act (CSA).[32] Attorney General Janet Reno agreed to review the matter and, in June 1998, announced that the Department of Justice would not prosecute physicians who complied with the Oregon law. Attorney General Reno concluded that the CSA did not support the ban on the use of legitimate drugs for an approved medical purpose.[33]

Later that year, a congressional bill known as the Lethal Drug Abuse Prevention Act of 1998 was introduced, proposing to block the use of controlled substances in physician-assisted suicide, euthanasia, or mercy killing.[34] It failed to pass the 105th Congress. It was revised and resubmitted to the 106th Congress as the Pain Relief and Promotion Act, but it too failed to pass.[35]

In November 2001, Attorney General John Ashcroft issued an interpretive rule reversing the position of his predecessor.[36] He directed the Justice Department to pursue action under the CSA against physicians and pharmacists who prescribed, filled, or dispensed drugs under the Death with Dignity guidelines; the so-called Ashcroft Directive. The state of Oregon immediately filed suit seeking to enjoin the federal government from enforcing the Ashcroft Directive.[37] The federal district court ruled in favor of Oregon, and the Justice Department appealed to the Ninth Circuit.

On May 26, 2004, the Ninth Circuit issued an opinion affirming the lower court's ruling.[38] Specifically, the court held that Attorney General Ashcroft exceeded his authority under the CSA when he adopted the directive declaring physician-assisted suicide in violation of the CSA. Congress had intended to limit the CSA to problems associated with drug abuse and addiction, and physician-assisted suicide was not a form of drug abuse that Congress intended to cover. Rather, physician-assisted suicide is a general medical practice to be regulated by state lawmakers in the first instance. The CSA did not give Attorney General Ashcroft unmistakably clear authority to exercise control over an area of law traditionally reserved for state authority; and, furthermore, the court held the directive violates the plain language of the CSA by not reflecting the standards and requirements of the federal statute.[39] On November 9, 2004, the Justice Department appealed that decision to the United States Supreme Court.

## D. UTILIZATION AND PATIENT CHARACTERISTICS

The Oregon Department of Human Services is required by the Act to issue an annual report including statistics on the usage of the Act. This section of our report includes a summary of this information and the results of studies in Oregon regarding patient views, characteristics, and utilization of the Act. The factual disputes identified in this area are the reasons a patient would choose physician-assisted suicide, whether the rates of utilization are underreported, and concerns over utilization by people with disabilities or depression.

### REQUESTS AND UTILIZATION

One survey of Oregon physicians in 1999 reports that 5% of practicing physicians received at least one request by a patient for a lethal prescription under the Death with Dignity law.[40] The total number of requests received was 221, several of which appeared to be duplicate requests by patients.[41] Of the 165 patients for which physicians included outcomes in the questionnaire, 29 received prescriptions. Of the 29 patients with prescriptions, 17 (59%) took the prescription, 11 (38%) died from other causes, and one was still alive at the time of the survey.[42] Of the 136 patients who did not receive prescriptions, 27 (20%) died prior to the time the provisions of the law were met, 21 (15%) did not meet the legal criteria, and 21 (15%) changed their minds.[43] In 30 (22%) of the cases, the physician was not willing to provide the prescription, and the physician was not willing to provide a prescription in any circumstance in 40 (29%) of the cases.[44]

The Oregon Department of Human Services is required under the law to collect information on the utilization of and compliance with the Death with Dignity law. Although the law allows the Department to review a sample, due to the low utilization rates, the Department reviewed all the mandated physician and pharmacy reports.[45] Below is a table showing the utilization rates in Oregon since the law went into effect:[46]

| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|---|---|
| Number of Prescriptions written | 24 | 33 | 29 | 44 | 58 | 67 |
| Number of those with prescriptions who used medication | 16 | 27 | 27 | 21 | 38 | 42 |
| Number of deaths pursuant to DWD law/per 10,000 total deaths in Oregon | 5.5 | 9.2 | 9.1 | 7 | 12.2 | 14 |

One concern raised by opponents of the law is whether the statistics accurately reflect any violations or utilization of the law because the information is self-reported by physicians.[47] One argument presented is that physicians do not have first-hand knowledge of what occurred during the patient's death because the medication is self-administered, and there may be unreported clinical problems or violations of the law.[48] The Oregon Department of Human Services reported that in the year 2000, physicians were present at 14 of 27 deaths.[49] There is no empirical evidence specifically on underreporting, although studies done on the Oregon law have surveyed hospice nurses and hospice social workers, in addition to physicians, and have found similar utilization statistics among these provider groups who are often at the death of a patient.[50] Although there is no study specifically on underreporting, one recent study of family members of deceased Oregonians did not identify any unreported cases of assisted suicide.[51]

There is also a criticism of the statistics gathered by the Department of Human Services because the data is based only on reported cases. The criticism is that there may be underreporting by physicians and that, because of patient confidentiality, there is insufficient information about physician-assisted suicide. There is no way for this office to determine if physicians in Oregon are or are not underreporting patient deaths under the Death with Dignity Act. The law does require that the death be reported, and failure to do so is a legal violation. Although the law does not state a specific penalty for failure to report, the general penalties apply.[52] The physician could be prosecuted under Oregon law or be reported to the professional conduct board if a case is not reported, as he or she would not have met the statutory requirements for legally assisting in a suicide.[53] It is also important to note that academic studies interviewing physicians, hospice nurses, and hospice social workers come to similar conclusions as the state studies.[54] Of course, it can be argued that a physician who was unwilling to report the death to the Department of Human Services may also not report the death in an academic study. Underreporting has been documented by studies in the Netherlands; it is difficult to determine if the incidence of underreporting in another country is comparable to the situation in Oregon due to cultural differences and the difference in how the law in the Netherlands arose. See generally Section 4 of this report on the Netherlands.

A concern raised by the proponents of the law is that the opponents often use the percentage increase in deaths, in lieu of the actual number of deaths, in Oregon.[55] The percentage change of deaths by lethal medication between 1998 and 2003 is dramatic, approximately 275%; this percentage represents a shift from 16 to 42 deaths.[56] The number of deaths in 2003 (42) is approximately 1/7 of 1% of all deaths in Oregon, still a small number of total deaths in that state.[57]

### PATIENTS' REASONS AND VIEWS

The characteristics and views of patients and their families who use Oregon's Death With Dignity law have been studied by questionnaires and interviews with physicians, nurses, social workers, psychiatrists, and psychologists working with this population.

Overall, the patients choosing assisted suicide are described as independent, determined, and inflexible.[58] Fifty-seven percent of patients requesting a lethal prescription cited a loss of independence as an important reason in the patient's decision, 55% cited poor quality of life (current or future concern of), 54% cited a readiness to die, and 53% cited a desire to control the circumstances of death.[59] In a study of hospice nurses, it was reported that among patients who had received prescriptions for lethal medications from a physician, the most important reasons cited for wanting assistance with suicide were a "desire to control the circumstances of death, a desire to die at home, the belief that continuing to live was pointless and being ready to die." Ganzini et al., "Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide," N Engl J Med 347, No. 8, (2002): 584. The Department of Human Services in Oregon found similar results with losing autonomy, less able to engage in activities making life enjoyable, and loss of dignity cited as the primary end of life concerns.[60] In addition, a study of those patients who died in 1999 in which family members were interviewed found similar reasons, including concern about loss of control of bodily functions (68%), loss of autonomy (65%), physical suffering (53%), an inability to participate in activities that make life enjoyable (47%), and concern about being a burden on others (47%).[61]

One area of concern is that patients may be requesting a lethal prescription because of financial or family pressures. One study found that 11% of patients requesting a lethal prescription cited a perception of a financial burden as a reason for the request and 6% of these patients said they lacked social support.[62] Nearly one-third (38%) of patients cited a concern about burdening others as a reason, but only three of these patients actually received a prescription.[63] This study looked at patient *requests*, not only at those patients who actually received or used the medication, which is a smaller number of patients. Also, a study of hospice nurses and social workers found that lack of social support and concern about finances were relatively unimportant to the patients who actually had *received* a lethal prescription.[64]

The study also reported information on the health insurance status of those requesting the prescription for lethal medication. The results are as follows:

| **Health Insurance by Type** | **No. (%)**<br>**Total responses received: 143** |
|---|---|
| Medicare | 63 (44) |
| Health maintenance organization | 23 (16) |
| Other managed care | 20 (14) |
| Fee for service | 17 (12) |
| Oregon Health Plan (Medicaid) | 11 (8) |
| Military coverage | 4 (3) |
| None | 3 (2) |
| Unknown | 18 (13) |

Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 561.

The study determined that the demographic characteristics of the patients who requested the lethal prescription were "nearly identical to those of members of the general population of Oregon who died." Id. at 562. In addition, the type of health insurance was not correlated with whether the patient received a lethal prescription nor with whether another type of intervention, such as a referral to hospice, was made by the physician.[65]

A recent study of family members of deceased patients with a terminal illness found that "dying Oregonians were approximately 100 times more likely to consider [assisted suicide] than to follow through with obtaining a lethal prescription."[66] The study also determined that those with a high school education were as likely to personally consider assisted suicide as those with post-baccalaureate education, but those with post-baccalaureate education were significantly more likely to get a lethal prescription.[67]

## CHARACTERISTICS OF PATIENTS REQUESTING A LETHAL PRESCRIPTION

The mean age of the patients who requested lethal prescriptions from physicians was 68 years; 52% were men and 97% were white.[68] Forty-six percent of those who requested lethal medications were married or living as married.[69] Ninety-three percent of these patients were competent, and 20% had symptoms of depression.[70] Thirty-two percent of the patients were currently enrolled in a hospice program at the time of the request.[71] Seventy-six percent had an estimated life expectancy of less than six months and in 41% of the cases, the request followed an acute deterioration in the person's medical condition.[72] It is important to note that not all the patients who requested the lethal medications received the prescription from the physician. In addition, not all patients who received the prescription filled it or used it.[73]

## DEPRESSION

Depression in patients is a concern often cited in regard to the law, because physicians who are not psychiatrists under-diagnose depression, and because the number of patients who *received* a lethal prescription in Oregon in 2003 and were referred for psychiatric evaluation was about 5%.[74] Under Oregon law, a psychological evaluation is required when the attending or consulting physician believes that the patient may suffer from a "psychiatric or psychological disorder or depression causing impaired judgment."[75] The legal purpose of this safeguard is to ensure that the patient is competent to make an informed choice.

In 70% of all suicides over the age of 60, medical illness is an important factor.[76] One study determined that the incidence of depression in those patients *requesting* assistance with suicide[77] in Oregon is 20% and reported the incidence of depression among dying cancer patients to be between 59-100% based on other studies.[78] In addition, 11% of the patients who requested a lethal prescription in Oregon who had symptoms of depression changed their mind about their request after receiving a trial of medication for depression or anxiety or after evaluation by a mental health expert.[79] Patients who received comprehensive palliative-care services through a hospice program, whether depressed or not, were more likely to change their minds about assisted suicide than those who did not receive these services.[80] A study of patients with amyotrophic lateral sclerosis (ALS) found that depression was not linked to a desire to participate in assisted suicide, but that a feeling of hopelessness was.[81] Patients with depression often have feelings of hopelessness, but patients may be hopeless without being depressed.[82]

There is not much clinical research on depression in dying patients nor on the effectiveness of treatment of depression in dying patients.[83] One study of patients in four inpatient palliative care units in England given common medications to treat depression found that 75% of patients died within two weeks, prior to the time the medication was effective.[84] Another study of 24 hospice inpatients found that if patients were given a specific, quick acting drug, 46% improved.[85] Only 7% of the patients improved, however, if they were within the last six weeks of death.[86]

Depression in patients facing death as the result of a terminal illness is a complicated issue. Competence can be a shifting state,[87] and determinations of decision-making capacity are based on a professional judgment that a patient's decision is rational or reasoned, not on an objective standard.[88] Also, even serious mental disorders may not effect decision-making capacity.[89]

## PEOPLE WITH DISABILITIES

Another often cited concern is that people with disabilities will be pressured to use the law or will use the law more often than people without disabilities. We were able to gather the type of illnesses patients using a lethal prescription had and some evidence on the predictors of interest in assisted suicide among patients with amyotrophic lateral sclerosis (ALS). Otherwise, we were unable to find empirical evidence on the underlying causes of the decisions of people with disabilities in regard to physician-assisted suicide.

The Department of Human Services has reported on the underlying illness of those who died by using a lethal medication prescribed pursuant to the law.[90] In 2003, 83% (35 of 42) of patients had a malignant neoplasm (cancer), 7% (3/42) had amyotrophic lateral sclerosis (ALS), 5% (2/42) had HIV/AIDS, 2% (1/42) had chronic lower respiratory disease. Between 1998-2002, 78% (100/129) of patients had malignant neoplasms, 8% (10/129) had ALS, 1% (1/129) had HIV/AIDS, 6% (8/129) had chronic lower respiratory disease, and 8% (10/129) had one of the following: aortic stenosis, congestive heart failure, diabetes mellitus with renal complications, gastrointestinal stromal tumor, myelodysplastic syndrome, pulmonary disease with fibrosis, scleroerma, and Shy-Drager syndrome.[91]

In Oregon in 1999, 5% of patients with ALS chose assisted suicide, as opposed to 0.4% of cancer patients who died that year.[92] In patients with ALS who discussed wanting physician-assisted suicide in the month before their death, family members reported "more frequent and severe insomnia, more frequent pain, more severe discomfort other than pain and greater distress at being a burden in comparison to ALS patients who did not discuss wanting assisted suicide." Ganzini et al., "Predictors and Correlates of Interest in Assisted Suicide in the Final Month of Life Among ALS Patients in Oregon and Washington," J Pain Symptom Manage 24 (2002): 314. Predictors of interest in assisted suicide included the patient's indication that she or he would consider assisted suicide and high feelings of hopelessness.[93] Depression was not an indicator.[94] Another study of attitudes of patients with ALS found that patients with strong religious beliefs and frequent religious practices were "much less likely to consider assisted suicide an option than those who were less religious." Ganzini et al., "Attitudes of Patients with Amyotrophic Lateral Sclerosis and Their Care Givers Towards Assisted Suicide," N Engl J Med 339 (1998): 971. A majority of the patients with ALS surveyed indicated they would consider assisted suicide.[95] In this study, no correlation was found between the caregiver's perception of the patient's suffering, level of social support, emotional distress and economic burden, and the patient's attitude toward assisted suicide.[96]

### TIME BETWEEN PRESCRIPTION AND DEATH

Another concern raised is that there are patients who received the medication, but were not in the last six months of life.[97] It is accurate that there have been patients who received the medication and who lived longer than six months.[98] The explanation presented by physicians is that a physician cannot predict death with exactitude, and this is necessarily a profession opinion, which is not always accurate. There are also many patients that die prior to completing the requirements of the law and that do not receive lethal prescriptions.[99]

## E. IMPACT ON END-OF-LIFE CARE

### GENERAL BACKGROUND

In November 1992, the Robert Wood Johnson foundation issued a report entitled Means to a Better End: A Report on Dying in America Today. As stated in that report

"Experts - and the public - generally agree that the best end-of-life care treats the whole person - body, mind and spirit. This is called palliative care. Palliative care works aggressively to relieve pain and other physical symptoms; it also offers emotional and spiritual support to the patient and family, while respective their culture and traditions. Care for people near the end of life is largely financed and delivered through Medicare and Medicaid - programs that were not designed to provide comprehensive palliative care."

Palliative care is provided in hospitals, nursing homes, other long-term care facilities, hospices, and in the home of the patient. The availability and quality of service varies from state to state. The Robert Wood Johnson Foundation established Last Acts which is a national coalition of health care providers and others, to promote end-of-life care throughout the country. In the Means to a Better End report, Last Acts rates each of the 50 states and the District of Columbia on the basis of eight criteria measuring end-of-life care. An unfortunate finding of this report is that "Despite many recent improvements in end-of-life care and greater public awareness about it, this report shows that Americans at best have no better than a fair chance of finding good care for their loved ones or for themselves when facing a life-threatening illness. In most states, too few patients are accessing hospice and palliative care services, there are too few professionals trained in pain management and palliative care, and there are too many patients dying in hospitals and nursing homes-in pain-rather than at home with their families." Although the state-by-state analysis of service is discouraging, the report describes "how state coalitions composed of diverse professional and consumer groups have recognized the serious problems with care of the dying in their states and are working actively to try to fix them. Already some of their efforts have resulted in substantial progress. . . ."

## PALLIATIVE CARE SERVICES IN OREGON

The issue raised around palliative care is whether this type of care was improved by the enactment of the Death with Dignity law. In order to determine the factual basis, this office interviewed Ann Jackson, Executive Director, Oregon Hospice Association (OHA), and a member of the Task Force to Improve the Care of Terminally Ill Oregonians. Ms.

Jackson was asked to evaluate the impact the Oregon Death with Dignity Act (the Act) has had on palliative care services in that state.

Ms. Jackson found that after the law was passed, hospice nurses reported that physicians in Oregon were doing better at managing pain. More physicians attended continuing education classes in palliative care after passage of the Act than before. These classes were offered by Oregon Health and Science University (OHSU) which trains medical students, interns, and residents in end-of-life care. Ms. Jackson also determined that prior to 1994, hospice organizations which sponsored pain programs for physicians in 2001 in eastern Oregon were not well attended by area doctors.

Oregon has a strong history of palliative care. OHSU's inpatient palliative care team was developed around 1994. In Oregon, the law allows hospice organizations to provide palliative care as well as hospice care. The Oregon law allowing advanced directives was passed in 1977. Oregon was the first state to combine advance directives and health care powers of attorney and remains among the least restrictive. Utilization of advance directives in Oregon is believed to be the highest in the nation. A 1997 study revealed that two-thirds of Oregonians had an advance directive at death, and 85% of families believed the deceased's wishes were respected. Oregon developed physician orders for life sustaining treatment beginning in 1992. When the Physician Orders for Life Sustaining Treatment (POLST) is in use, respect for wishes increases to virtually 100%. Recent studies indicate that advance directives elsewhere in the country are not a factor in the kind of care a patient receives.

Ms. Jackson also indicated that the rate of assisted suicide has been roughly 1/10th of 1%. It is Ms. Jackson's opinion that assisted suicide "is not disproportionately used by minorities, people in rural areas, the poor, the uneducated, or the uninsured. There are no places in Oregon where care is not accessible. The educated appear to have better access to information. There is no evidence to suggest that anyone has been coerced into using it. People who are depressed do not use it, probably because depression makes it difficult to carry out many actions. High hospice utilization also means that mental health is constantly monitored by hospice social workers. There have been no botched cases. There have been no calls to 911 related to the use of medication. There has not been a migration to Oregon. Opponents often state that it would be essential to have the kind of infrastructure that Oregon had when such a law is considered. I think the law has been a catalyst in many respects in Oregon, even though we already had good palliative care here."

## HOSPICE CARE IN OREGON

Hospice provides pain and symptom management and a range of psychosocial services and spiritual support to patients and their families through the duration of life-limiting illness. Hospice provides information on care options and carries out those decisions with respect for wishes of the people involved and the laws of the state.

In an interview with this office, Linda Ganzini, M.D., Associate Professor of Psychiatry at Oregon Health and Science University (OHSU), states that an extensive network of hospice care services was essential before the Death with Dignity law was in place. She further states that hospice services are provided extensively and at a high level of competence in Oregon.

We also interviewed Joan Teno, M.D. who is a practicing physician in Rhode Island. Her practice involves end-of-life care for patients. Dr. Teno is also a researcher at Brown University and the current Chair of the American Geriatric Society Ethics Committee. She believes that 50 – 60% of end-of-life patients in each state should have hospice care available. She stated that the Oregon law has been well implemented in Oregon, and that hospice is an important component of the end-of-life care.

Ann Jackson, Executive Director of OHA, was also asked to evaluate the availability and quality of hospice care in Oregon during the period the Act has been in effect. She found that:

"Hospice and/or palliative/comfort care was available to all Oregonians when [the Act] was passed. Both were required as part of the basic health package for the Oregon Health Plan.[100] One county did not have hospice care in 1994. . . ." The last county had a hospice program certified by Medicare in October 2002. Ms. Jackson indicates that "hospice services are available even in the most remote and rural areas of Oregon at this time. One county with a population of 7,000 and 10,000 square miles was Medicare-certified in 1992. Analysis of Medicare data (over 65) throughout the U.S. confirms that Oregon's physical access to hospice care is greater than any other state." Oregon has ranked highly in terms of the use of hospice since at least 1992 according to Ms. Jackson.

Ms. Jackson has found that "awareness of end-of-life care options is probably greater in Oregon, especially among health care professionals. Every Oregonian who has used [the Act] has been offered hospice care. . . . Nearly 89% [of patients] over the six years were in hospice care at the time they ingested medication, 93% in 2003. Most significantly, I think, is the long length of stay in hospice these individuals have. Oregon's median length of stay is approximately 16 days. . . . Not having been referred or admitted earlier is always the number-1 complaint regarding hospice care. In 1999, the median length of stay for individuals using [the Act] was 49 days. Individuals are eligible for hospice when they have a life expectancy of 6 months or less, similar to [the Act]."

## DYING IN THE HOME—HAS THE OREGON DEATH WITH DIGNITY ACT HAD AN IMPACT?

Research indicates that 70% of Americans would prefer to die in their homes as opposed to in a hospital, nursing home, or other facility. Ann Jackson was asked about the percentage of people dying in their homes and what, if any, impact the Act has had on these numbers. Her response follows:

"Oregon has had a very high rate of home deaths and a very low rate of hospital deaths. In 1961, Oregon's hospital utilization in length of stay (LOS) was shortest in the nation. A high rate of hospital deaths is directly correlated with the number of beds available. Oregon has deliberately kept the number of beds low and has developed alternative care settings such as foster homes and assisted living facilities. Oregon has also not had many inpatient hospices. Fewer than 2% of hospice deaths occur in an inpatient setting. This does not include individuals whose residence is a facility, but it does include individuals who are in an inpatient setting for general acute inpatient care or respite care. The death rate at home has continued to increase over the years, slowing somewhat recently."

## PAIN MANAGEMENT—HAS IT BEEN AFFECTED BY THE OREGON DEATH WITH DIGNITY ACT?

Pain management is a critical factor in end-of-life experiences throughout the country. Various researchers, including Linda Ganzini and Joan Teno report that the range of pain management solutions varies from state to state. Ann Jackson, again, provided assistance:

"The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) studies of the late 80s and early 90s revealed that the lowest rate of pain in five major medical centers in the country was above 50%. A 1997 study in Oregon revealed a rate of moderate to severe pain at approximately 35-38% across all settings, which is, of course, horrific. There was an increase of pain in the hospital setting in November-December 1997, nearly doubling." As Ms. Jackson explained, this increase may have been the result of efforts to repeal the Act, ongoing at that time, as well as threats of prosecution under federal law.

Ms. Jackson also indicates that proponents of assisted suicide often mislead their audiences by arguing that the only alternative to pain is death. However, Ms. Jackson indicates "pain has not been a significant reason for individuals to use [the Act]. Fear of pain appears to be a greater factor than actual pain." Palliative care provides adequate pain relief as an option.

William Lamers, M.D. is a medical consultant to the Hospice Foundation of America and a practicing physician in Malibu, California. He has had over 30 years of experience with end-of-life care. It is his position that Oregon is at the forefront of end-of-life care and that the Oregon law has not diminished that care but rather, has enhanced it. His remarks were not intended as an endorsement of assisted suicide but a factual representation of its consequences. He additionally stated that he considers Ann Jackson and the work of her office to be of the highest quality and credibility.

In conclusion, it is quiet apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options. There is agreement among the professionals we interviewed that the Oregon experience does not necessarily translate into an equivalent experience in other states adopting a similar death with dignity law.

## F. SELECTION OF HEALTH CARE PROVIDER & PROVIDER VIEWS

One criticism made by opponents of the Death with Dignity Act is that patients who are refused a lethal prescription from one physician are able to go to another physician to request the prescription. A study of patients reported to the Oregon Department of Human Services found that in 1999, 31% (8 of 26) of patients *received* a prescription by the first physician approached.[101] In another study, the researchers found that 35% (57 of 161) of patients who requested a lethal prescription had requested a prescription from another physician.[102] A study of patients reported to the Oregon Department of Human Services found that in 1998, the first year the law was in effect, 40% of patients were "unable to initiate the prescription process with the first physician they approached and had to request a prescription from a second or third physician." Chin et al., "Legalized Physician-Assisted Suicide in Oregon – the First Year's Experience," N Engl J Med 340 (1999): 582. This study attributed the patient's inability to get a prescription to physician opposition to Death with Dignity and hospital systems choosing not to participate in physician-assisted suicide based on official hospital policies in place at that time and a 1995 survey of physician attitudes.[103]

Not surprisingly, health care professionals express a broad range of views on the Death with Dignity Act. In 1994, the Oregon Medical Society chose to remain neutral with respect to Ballot Measure 16 and neither supported nor opposed the concept of physician-assisted suicide.[104] In 1997, when the Legislature referred to the voters the issue of whether to repeal the Act, the Oregon Medical Society came out in favor of repeal on grounds that the law was flawed with regard to several unclear issues related to physicians' statutory duties and prerogatives. Since then, the Legislature addressed those flaws by amending certain provisions of the Act, and the Medical Society's original 1994 position of neutrality remains in place.[105]

According to a 1995 survey of physicians thought to be eligible to prescribe a lethal dose of medication under the Act if the law was upheld, 60% of the respondents thought physician-assisted suicide should be legal in some cases, and nearly half (46%) said they might be willing to prescribe a lethal does of medication if it were legal to do so; 31% responded that they would be unwilling to do so on moral grounds.[106] According to a 1999 survey of 4,053 physicians eligible to prescribe under the Act, 65% participated in the survey (2,649) and indicated that physicians grant about one in six requests for a prescription for lethal medication and one in 10 requests actually results in suicide.[107] The 1999 study contained some problems reported by physicians who assisted suicide under the Act, including unwanted publicity (3 physicians), difficulty obtaining the lethal medication or a second opinion (3), difficulty understanding the requirements of the law (3), difficulties with hospice providers (1), not knowing the patient (1), or the absence of someone to discuss the situation with (1).[108] With respect to the law's requirement that physicians confidentially report lethal medication to the Oregon Department of Human Services, some physicians were concerned about reporting because they feared that the patient's privacy (in 16 cases), their own privacy (in 18), or the privacy of the patient's family (in 15) would be violated or that retroactive sanctions would be imposed by the Drug Enforcement Agency (in 7).[109] Four physicians expressed ambivalence about having provided assistance with suicide, though two of the four noted that they had become less ambivalent over time; one deciding not to provide such assistance again.[110]

In 2000, 35 physicians were interviewed about the impact requests for assisted suicide had on them, focusing on emotional reactions, factors influencing their decisions, and sources of support.[111] The interviews revealed that requests for assisted suicide had a powerful impact on physicians and their practices. Physicians often felt unprepared and experienced apprehension and discomfort before and after receiving requests. Sources of discomfort included concerns about adequately managing symptoms and suffering, not wanting to abandon patients, and incomplete understanding of patients' preferences, especially when physicians did not know patients well. Participation in assisted suicide required a large investment of time and was emotionally intense. Regardless of whether they prescribed or not, physicians did not express major regrets about their decision. Requests often facilitated discussion of important issues, and many physicians felt that the process increased their confidence and assertiveness in discussing end-of-life issues with other patients. Physicians rarely sought support from colleagues; instead they tended to discuss emotional aspects of their experiences with their spouses.

In 1997, a national survey was taken of forensic psychiatrists asked to evaluate the process, thresholds, and standards they believe mental health professionals should use in assessing a terminally ill patient's capacity to consent to assisted suicide.[112] Of the 456 who were sent a questionnaire, 290 (64%) responded. Two of the conclusions reached were: First, that the ethical views of psychiatrists may influence their clinical opinions regarding patient competence to consent to assisted suicide; and second, that the extensive evaluation recommended by forensic psychiatrists likely would minimize this bias and assure that only competent patients have access to assisted suicide, but the process itself might burden terminally ill patients.[113]

In a 1996 random sample of 625 Oregon psychologists, of which 423 were included in the final sample, a majority of the respondents felt that, for a competent individual, both suicide and assisted suicide were acceptable under some circumstances, or the decision should be left to the individual involved.[114] Seventy-eight percent of the respondents favored the enactment of the Death with Dignity Act. Twenty percent felt that psychologists' participation in the assisted suicide process would constitute a threat to the profession, for reasons such as tarnishing psychology's public image (36%), politicization of professional issues (23%), and role conflicts (20%).[115] One-third of the respondents indicated that performing an evaluation under the Act would be outside their practice area.[116]

When asked about the level of confidence in performing an assessment to determine whether a psychiatric disorder was impairing a patient's judgment, responses varied with the nature of the evaluation. For example, in the context of a single evaluation, one-half the respondents replied that they were "not at all confident," with only seven reporting they were "very confident." In the context of a long-term relationship with the patient, only three felt "not at all confident," whereas 64 reported they would feel "very confident." When asked if they felt a request for assisted suicide from a terminally ill patient was prima facie evidence of a mental disorder, 13 of the respondents (3%) agreed or strongly agreed with this assertion, whereas 21% disagreed and 76% strongly disagreed.[117]

All of the studies show that a significant number of patients go to more than one physician before receiving a prescription for a lethal medication. All the surveys also indicate that physician-assisted suicide has been and continues to be a very controversial issue within the medical profession.

## G. MONITORING OREGON'S DEATH WITH DIGNITY ACT

The Oregon Death with Dignity Act requires that a comprehensive medical file be established for each person requesting a physician-assisted suicide.[118] This requirement reads as follows:

> The following shall be documented or filed in the patient's medical record:
>
> (1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
>
> (2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
>
> (3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
>
> (4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
>
> (5) A report of the outcome and determinations made during counseling, if performed;
>
> (6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and
>
> (7) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

In addition to the above, the Act requires a psychiatric/psychological consultant's compliance form and a pharmacy dispensing record.[119] And finally, a chronology and death certificate extract form is placed in the patient's file. See Appendix C for the forms required.[120]

The Oregon Death with Dignity Act requires the Oregon Department of Human Services (DHS) to monitor compliance with the law. Each year since inception of the act, the department has analyzed the required information for each patient requesting physician-assisted suicide. This information is compiled in an annual report.[121]

The sole responsibility for monitoring the Oregon law is vested in the DHS, and a review of the process indicates that a thoroughly comprehensive examination takes place in the case of each patient. Darcy Neimeyer, Executive Assistant at the Oregon Department of Human Services for the Office of Disease Prevention and Epidemiology, reports that since inception of the act, referrals have been made by the DHS to the Oregon Board of Medical Examiners approximately four to six times. The referrals involved irregularities found in the patient request forms required by ORS 127.855 s. 3.09(2). There is a requirement that two witnesses sign the form in the presence of the requesting patient. In the few cases mentioned, the date of the signatures revealed that the witnesses did not sign in the presence of the patient. In each case, the Medical Practice Board determined that the Death with Dignity Act was not violated.

In addition to the monitoring requirement outlined above, there are penalties for noncompliance.[122]

## SECTION 4: EUTHANASIA - THE NETHERLANDS

### A. INTRODUCTION

This section of the report describes the law on euthanasia and physician-assisted suicide in the Netherlands and reviews the primary areas of dispute around the law. Generally speaking, the concept of euthanasia has broad public and social acceptance in the Netherlands.[123] Unlike in Oregon, the law on euthanasia was developed through the courts, not through the legislative process. It was not until the 2000-2001 legislative session that the common law which had developed in the courts became codified, and somewhat expanded, in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.[124] Because the criteria initially were created by the courts on a case-by-case basis, some of the disputes pertain to differing interpretations of the court cases[125] or to situations which have not been resolved through the court process. In addition, there are two national studies of the end of life medical practices, which include some practices which are arguably illegal under current Dutch law. In the debates, sometimes no distinction is made between a practice that is legally defensible and a practice that is not. We have done our best to summarize the issues presented by the opponents and proponents of the law and to provide empirical data where possible.

## B. LEGAL DEVELOPMENTS AND CRITERIA

The practice of euthanasia and physician-assisted suicide is still illegal - a criminal offense - in the Netherlands.[126] The common law and now the legislation, however, have created an exemption from criminal liability for doctors who meet certain criteria. It is worth noting at the outset that the Dutch court system is very different from that of the United States. The Dutch system is not based on an adversarial process where each party presents its side of the story and the judge resolves factual disputes. Moreover, the concepts of individual rights based on a Constitutional document and of consumer/patient protections are foreign in the Dutch legal system, and malpractice suits are rare.[127] Instead, the Dutch system relies on a balancing of issues, looking for the societal good, and there is a recognition of a professional's ethical responsibilities as a valid defense to statutorily defined criminal activity.[128]

Prior to the 2001 legislation, there were two sections of the Dutch Criminal Code which were implicated by the practices of euthanasia and assisted suicide. Section 293 of the Dutch Criminal Code prohibits the killing of someone at his or her request, and section 294 prohibits assisting someone in committing suicide, including furnishing the means for the suicide.[129] Also in the Dutch criminal code[130] is a provision allowing an individual accused of a crime to raise a defense of necessity where the person is confronted with conflicting duties.[131] The necessity defense was first accepted by the Dutch Supreme Court in a euthanasia case in 1984, when a doctor argued that the patient's wish to die created a conflict of duties - the duty to preserve life and the duty to relieve the patient's suffering.[132] Prior to that time, there were at least two cases where doctors raised the necessity defense in euthanasia situations.[133] The courts in these cases, however, rejected the necessity defense and found the doctors guilty.[134] The courts did not impose harsh sentences on the doctors, which then sparked a public debate about euthanasia.[135]

In the 1984 case, the court set forth several criteria[136] which doctors must meet in order to raise a successful necessity defense in a euthanasia situation. These criteria are (1) the patient must request euthanasia repeatedly and knowingly, (2) the patient must be experiencing suffering that cannot be relieved by any means except death, and (3) the doctor must consult with a second doctor.[137] These criteria were adopted by the Royal Dutch Medical Association (RDMA) in 1984. This is legally significant because the local prosecutors and courts look to the professional ethical standards when reviewing the necessity defense.[138] Many of the factual disputes about euthanasia in the Netherlands are due to differing interpretations of each of these criteria.

In 1991, the RDMA established guidelines for reporting euthanasia and physician-assisted suicide.[139] In 1994, the RDMA proposal was codified by the legislature.[140] The notification procedure requires a doctor performing euthanasia to inform the local medical examiner through the use of an extensive questionnaire, the medical examiner reports the information to the public prosecutor, and the prosecutor investigates to determine if prosecution is warranted. The 1994 laws did not change the Dutch Criminal Code or legalized euthanasia.[141]

The criteria developed by the Dutch courts became codified in 2001 with the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.[142] This act amends sections 293 and 294 of the Dutch criminal code to allow euthanasia or assisted suicide where a doctor meets the due care criteria and informs the local medical examiner of his or her actions.[143] The due care criteria are:

> The doctor must have been convinced that the patient's request was sincere and voluntary;
>
> The doctor must have been convinced that the patient's suffering was both hopeless and unbearable;
>
> The doctor must have consulted with the patient about his or her situation and his or her prospects;
>
> The doctor and the patient together must have come to the conclusion that no alternative is realistically available;
>
> The patient must have been seen by at least one impartial doctor, who must have given his or her opinion, in writing, about the first four criteria; and
>
> The doctor must have carried out the euthanasia or assisted suicide with due care. de Vries et al., at 377.

In addition, the statute sets up ethics committees to assess the doctor's conduct based on the information provided to the local coroner.[144]

## C. UTILIZATION

Utilization rates of euthanasia and reporting by physicians are two related areas where there is much dispute. There have been two studies requested by the Dutch government on the use of euthanasia and other medical decisions at the end of life. This section reviews the findings of these studies, including statistics on utilization rates, statistics on reporting rates by physicians, and any related findings explaining the incidence. At the core of the dispute is the issue of what acts by physicians should be included in the statistics on "euthanasia." We have broken down the statistics into the most specific details. Another dispute arises in this area around underreporting by physicians. There is one study on reporting by physicians, which we include in this section. Another disputed issue is whether there has been a "slippery slope" effect in the Netherlands. We include a brief discussion of this issue; however, it is at its core an interpretation of facts, which goes beyond the scope of this report.

The first national Dutch study on euthanasia and other medical decisions concerning the end of life was done in 1990 and published in 1991. The study included three methods of collecting information - interviews with physicians (Study I), analysis of death certificates with a follow up questionnaire to the physician (Study II), and a different questionnaire sent to physicians regarding current patients (Study III) – and, thus, three distinct samples.[145] Because of this, the statistics can be analyzed at least four different ways. Each of the three sample sets resulted in an estimate of incidence of euthanasia, plus a best estimate was developed by the researchers by comparing the three samples. The table below includes the complete set of statistics on the incidence of euthanasia as a percentage of all deaths in the Netherlands.[146]

| *Euthanasia and related MDEL* [147] | Study 1 | Study II | Study III | Best Estimate |
|---|---|---|---|---|
| Euthanasia | 1.9% (1.6-2.2) | 1.7% (1.4-2.1) | 2.6% (2.0-3.5) | 1.8% |
| Assisted Suicide | 0.3% (0.2-0.4) | 0.2% (0.1-0.3) | 0.4% (0.2-0.9) | 0.3% |
| Life-terminating acts without explicit and persistent request | Unavailable | 0.8% (0.6-1.1) | 1.6% (1.1-2.2) | 0.8% |
| Totals | | 2.7% (2.3-3.1) | 4.7% (3.5-5.8) | 2.9% |

Van Der Maas et al. at 670.

In 1995, a follow up study was commissioned to look at the incidence of euthanasia and related end-of-life decisions, describe the patients, physicians and circumstances involved, and evaluate changes in these practices between 1990 and 1995. The methodology was nearly identical to that of the first study, but did not include a questionnaire about current patients, and was completed by some of the same researchers. [148]

It is important to note that one of the legal changes that occurred in this time was new law on the reporting of euthanasia and related practices by the medical profession.

The 1995 study found the estimated incidence of medical decisions related to the end of life as a percentage of total number of deaths in the Netherlands:[149]

| Type of decision | Interview study | Death-certificate study |
|---|---|---|
| Euthanasia | 2.3% (1.9-2.7) | 2.4% (2.1-2.6) |
| Physician-assisted suicide | 0.4% (0.2-0.5) | 0.2% (0.1-0.3) |
| Life-terminating acts without patient's explicit request | 0.7% (0.5-0.8) | 0.7% (0.5-0.9) |

Van Der Maas, (1995) at 1701. The study determined that there had been a total increase in physician-assisted death, which includes the use of pain medication at the end of life and withdrawal of treatment, of 5% between 1990 and 1995.[150] The incidence of euthanasia compared to the total population increased by between 0.4 to 0.7%.[151] The increase in euthanasia deaths is approximately 1,000 patients.[152] The study also finds that 36-38% of the explicit patient requests for euthanasia or assisted-suicide were agreed to and acted on by physicians in 1995, as compared to 27-32% of requests in 1990.[153]

One issue in the debate around euthanasia is whether there is a "slippery slope," meaning that as euthanasia is accepted in the country, the incidence will rise and the types of allowable physician involvement will also rise. There is no way for this office to determine conclusively if there has or has not been a "significant" increase in the rates, because what amount of increase is significant is subjective. For instance, one commentator feels that an increase of deaths from euthanasia from 671 patients to 1,064 in a five-year period is significant and a sign that the practice is becoming increasingly accepted.[154] The 1995 study, however, concluded that the data did not support or refute the slippery slope argument.[155] The statistics can be interpreted to support or deny the slippery slope argument, depending on how they are broken down and presented.

## D. REPORTING REQUIREMENTS

In 1991, the RDMA established a reporting guideline asking physicians to report deaths as a result of euthanasia and physician-assisted suicide to the county coroner. This guideline did not have the force of law. The procedure involves the coroner who notifies the public prosecutor who initiates an investigation. In 1994, this notification procedure was codified in statute and became a civil law as part of the Burial and Cremation Act 1994. It was not until 2001, however, that the reporting requirement became part of the legal test for the necessity defense. In 2001, the reporting procedure was also changed to require the reports to go to regional ethics committees, who then decided if referral to the prosecutor was appropriate. In other words, a physician's failure to report prior to 2001 did not support criminal prosecution, although it was a civil violation. It is also important to note that the necessity defense only applies to euthanasia and physician-assisted suicide. For instance, a life-terminating act without patient request remains illegal in the Netherlands.

In 1995, the Dutch minister of health and justice requested an evaluation of the notification procedure then in place.[156] The study determined that 41% of all cases of euthanasia and physician-assisted suicide were reported in 1995,[157] an increase from 18% in 1990.[158] Included in the study was a review of the reasons cited for reporting by physicians. The reasons physicians reported were:

physician reports all cases (75%)

reporting is required (17%)

reporting is the official policy of the physician's institution (13%)

reporting gives an account to society (13%).[159]

Thirty-seven percent (37%) of the physicians thought the reporting requirements were time-consuming, 30% found it burdensome, 11% felt incriminated by the process, 5% found it to be a breach of privacy, 30% were neutral on the process, 19% felt supported, 13% had general positive views, and 7% felt relieved by the process.[160]

Of the 49 physicians who said they had not reported cases of euthanasia or assisted suicide, the reasons given for failing to report were a wish to avoid the fuss of a judicial inquiry (25 doctors), a wish to protect the patient's relatives from a judicial inquiry (12), a request from the patient's relatives to be protected from a judicial inquiry (10), failure to fulfill the legal requirements (8), and the belief that this is a confidential matter between doctors and patients (6).

One fact which is often cited in relation to the issue of underreporting is that in 11% of the cases where a doctor did not report the death, he or she consulted with another physician as required by the Dutch medical society guidelines for prudent practice.[161] The study also shows that in 58% of these same cases, the physicians discussed the case with colleagues.[162] It is unclear from the literature what the difference between a consultation and a discussion with colleagues is.

## E. VOLUNTARINESS REQUIREMENT

One disputed issue is whether the requirement in the necessity defense of a repeated and persistent patient request is met when a physician suggests euthanasia as an option to the patient prior to the time the patient asks about euthanasia. One side of the debate argues that a physician should, as with all medical procedures, provide the patient with the options, and that it is not fatal to the legal requirement for the physician to include euthanasia as an option. The other side argues that the voluntariness of the process is compromised by a physician offering the suggestion to the patient. In the 1991 study, the researchers determined that physicians initiated the discussion of euthanasia or physician-assisted suicide 12% of the time.[163] The 1995 study found a 15% incidence.[164] The legality of the issue is currently undecided by the courts and is not addressed in the 2001 statute. At the heart of this issue is whether one believes that the physician-patient relationship is coercive or advisory in nature. This is not an issue that lends itself to empiric data and we are therefore unable to resolve this dispute.

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[1] The list of interested parties was generated from the witness lists of the public and committee hearings held in the last legislative session, from personal knowledge by members of the Council as to which groups had expressed interest in the study, and by a request in the e-mail that the questionnaire be forwarded broadly to anyone else who might be interested.

[2]

[3] See Appendix A.

[4] These materials are available for public inspection by contacting the Council.

The Council, in fact, contacted the Dutch Embassy in an effort to obtain primary source materials in English, but was unable to do so. The case law is only available in Dutch. We did not have a budget to provide translation of the materials, and so were unable to read the original materials and had to rely on reports or secondary materials in English.

[5]

[6] Emanuel, Ezekiel, "Euthanasia: Historical, Ethical, and Empiric Perspectives," Arch Intern Med (9/12/94): 154.

Van Der Maas, van Delden, Pijnenborg, Looman, "Euthanasia and other medical decisions concerning the end of life," The Lancet 338 (9/14/91): 669.

[7]

MDEL means medical decisions concerning end of life. Id. at 669.

[8]

In large part this section reflects the analysis of the law contained in the following treatise: Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking, § 12.06[A], (3rd ed. 2004).

[9]

355 A.2d 647 (N.J. 1976), cert. denied, 429 U.S. 922 (1976).

[10]

497 U.S. 261 (1990).

[11]

Id. At 269 (quoting Shloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914)).

[12]

Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking, § 12.02[A], (3rd ed. 2004).

[13]

Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997).

[14]

Krischer v. McIver, 697 So. 2d 97 (Fla. 1997); Sampson v. State, 31 P.3d 88 (Alaska 2001).

[15] 521 U.S. 702 (1997).

[16] 521 U.S. 793 (1997).

[17] Glucksberg at 724.

[18] Id. at 730-733.

[19] Id. at 735.

[20] Vacco at 798 (quoting 80 F.3d 716, 729).

[21] Id. at 793-794, 808.

[22] Meisel, § 12.09, Table 12-1.

[23] Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995) (implementation enjoined), vacated and remanded, 107 F.3d 1382 (9th Cir.) (lack of federal jurisdiction), cert. denied, 522 U.S. 927 (1997).

[24] Meisel, § 12.06[A] (citing Gail Kinsey Hill, Suicide Law Stands, Oregonian, Nov. 5, 1997, at 1).

[25] 891 F. Supp. at 1438.

[26] 869 F. Supp. at 1498-1499.

[27] Id. at 1499.

[28] Id. As mentioned, the court did not decide whether the Act provides an option or a benefit under the law. A related and more recent ADA claim was considered by Oregon Deputy Attorney General David Schuman in a letter to Oregon Senator Neil Bryant dated March 15, 1999. Deputy A.G. Schuman indicated that, because the Death with Dignity Act does not allow individuals who because of a disability are unable to self-medicate to avail themselves of the "benefit" of a "death with dignity," it may unlawfully discriminate against such persons and, moreover, raises the issue of whether the state should provide "reasonable accommodation" for such disabled individuals. As Deputy A.G. Schuman acknowledged, however, this claim presents a novel legal issue, and it is by no means clear the challenge would succeed in a court of law. (To date, no such claim has been made in court.)

[29] The standing requirement has three elements: (1) the plaintiff must have suffered an "injury in fact," an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical; (2) there must be a causal connection between the injury and the conduct complained of—the injury must be traceable to the challenged action of the defendant and not the result of the independent action of some third party not before the court; and (3) it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision. 107 F.3d at 1387.

[30] Ripeness concerns timing, and its basic rationale is to prevent the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements. Whether a claim is ripe depends on the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration. 107 F.3d at 1387-1388.

[31] In fact, the Oregon Act explicitly provides that no health care provider is required to participate in the Act even if such participation may seem to be mandated by contract or statute. Or Rev State § 127.885(4) (2001).

[32] 21 U.S.C.A. §§ 801-971.

[33] Meisel, § 12.06[B].

[34] H.R. 4006, 105th Cong. (1998).

[35] H.R. 2260, 106th Cong., 1st Sess. (1999); S. 1272, 106th Cong., 1st Sess. (1999).

[36] 66 Fed. Reg. 56,607.

[37] Oregon v. Ashcroft, 102 F. Supp. 2d 1077 (D. Or. 2002).

[38] Oregon v. Ashcroft, 368 F.3d 1118, C.A. 9 (Or. 2004).

[39] Id. at 1125.

[40] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8, (2000): 558.

[41] Id. at 558.

[42] Id. at 561.

[43] Id. at 561.

[44] Id. at 561.

[45] See generally, Annual Reports on www.dhs.state.or.us/publichealth/chs/pas/pas.cfm

[46] Sixth Annual Report on Oregon's Death with Dignity Act, Department of Human Services, Oregon. Available at www.dhs.state.or.us/publichealth/chs/pas/pas.cfm

[47] Foley & Hendin, "The Oregon Report Don't Ask, Don't Tell," Hastings Center Report, 37 (May-June 1999); Letter by National Legal Center for the Medically Dependent & Disabled, Inc. (4/13/99), Appendix X.

[48] Submissions by Dr. Orr and the Roman Catholic Diocese of Burlington.

[49] Sullivan et al., Correspondence, N Engl J Med 344, (2001): 605.

[50] See studies by Ganzini et al., Chin et al., & Sullivan et al.

[51] Tolle, et al., "Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide," J Clinical Ethics 15, No. 2 (2004): 115.

[52] Oregon Revised Statutes 127.890 s.4.02(4).

[53] Id.

[54] Compare studies by Ganzini et al. with Chin et al. and Sullivan, et al.

[55] Submission by Death with Dignity Vermont & End-of-Life Choices Vermont.

[56] Sixth Annual Report, Dept. of HS.

[57] Id.

[58] Ganzini et al., "Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families", Journal of Palliative Medicine 6, No. 3 (2003): 381.

[59] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559. See also Chin et al., "Legalized Physician-Assisted Suicide in Oregon – the First Year's Experience," N Engl J Med 340 (1999): 582; Sullivan et al., "Legalized Physician-Assisted Suicide in Oregon – The Second Year," N Engl J Med 342 (2000): 599.

[60] Sixth Annual Report, Table 4, Department of Human Services, Oregon. Available at www.dhs.state.or.us/publichealth/chs/pas/pas.cfm

[61] Sullivan et al., "Legalized Physician-Assisted Suicide in Oregon – The Second Year," N Engl J Med 342 (2000): 601. Four of the ten patients who expressed concern about suffering were not perceived to be suffering by their family members at the time of the request. Id.

[62] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8, (2000): 559. See also Chin et al., "Legalized Physician-Assisted Suicide in Oregon – the First Year's Experience," N Engl J Med 340 (1999): 582, which had similar findings.

[63] Id. at 562.

[64] Ganzini et al., "Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance

with Suicide," N Engl J Med 347 (2002): 584.

[65] Id. at 562.

[66] Tolle, et al., "Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide," J Clinical Ethics 15, No. 2 (2004): 115.

[67] Id. at 116.

[68] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559.

[69] Id. at 559.

[70] Id. at 559.

[71] Id. at 559.

[72] Id. at 558.

[73] See generally, Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559.

[74] Correspondence, N Engl J Med 343, No. 2 (2000): 150-152; Submission by the Roman Catholic Diocese of Burlington: Foley & Hendin, "The Oregon Report Don't Ask, Don't Tell," Hastings Center Report (May-June 1999): 39.

[75] Oregon Rev. Stat. Sections 127.800-897 (1994).

[76] Foley & Hendin, "The Oregon Report Don't Ask, Don't Tell," Hastings Center Report (May-June 1999): 37.

[77] Not all of the patients who requested a lethal prescription received one.

[78] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 562.

[79] Id.

[80] Correspondence, N Engl J Med 343, No. 2 (2000): 150-152.

[81] Ganzini et al., "Attitudes of Patients with Amyotrophic Lateral Sclerosis and Their Care Givers toward Assisted Suicide," N Engl J Med 339 (1998): 971-972. This study was performed prior to the time the Death with Dignity Act was implemented.

[82] Id. at 972.

[83] Id.

[84] Id.

[85] Id.

[86] Id.

[87] Sullivan et al., "Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide?", Hastings Center Report (July-August 1998): 26.

[88] Ganzini, "Commentary: Assessment of Clinical Depression in Patients Who Request Physician-Assisted Death", Ethics Rounds 19 (2000): 476.

[89] Sullivan at 27.

[90] Sixth Annual Report on Oregon's Death with Dignity Act, Department of Human Services. Available at www.dhs.state.or.us/publichealth/chs/pas/pas.cfm

[91] Id.

[92] Ganzini, "Physician-Assisted Death – A Last Resort", N Engl J Med 346 (2002): 1663; Ganzini et al., "Predictors and Correlates of Interest in Assisted Suicide in the Final Month of Life Among ALS Patients in Oregon and Washington," J Pain Symptom Manage 24 (2002): 313.

[93] Ganzini et al., "Predictors and Correlates of Interest in Assisted Suicide in the Final Month of Life Among ALS Patients in Oregon and Washington," J Pain Symptom Manage 24 (2002): 314.

[94] Id.

[95] Id.

[96] Ganzini et al., "Attitudes of Patients with Amyotrophic Lateral Sclerosis and Their Care Givers Toward Assisted Suicide," N Engl J Med 339 (1998): 972.

[97] Submission by the Roman Catholic Diocese of Burlington.

[98] Sixth Annual Report, Dep. of HS.

[99] Ganzini et al., "Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families", Journal of Palliative Medicine 6, No. 3 (2003): 381; Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559; Sixth Annual Report, Dept. of Human Services.

[100] The Oregon Health Plan legislation was passed in 1987, per Ms. Jackson.

[101] Sullivan et al., at 601.

[102] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559.

[103] Chin et al., "Legalized Physician-Assisted Suicide in Oregon – the First Year's Experience," N Engl J Med 340 (1999): 582.

[104] Statement from Jim Kronenberg, CAE, Associate Executive Director, Oregon Medical Association, dated September 30, 2003.

[105] Id.

[106] Lee, Melinda A. et al., "Legalizing Assisted Suicide – Views of Physicians in Oregon," N Engl J Med 334 (1996): 310-315.

[107] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 557-563.

[108] Id. at 562.

[109] Id.

[110] Id.

[111] Dobscha et al., "Oregon Physicians' Responses to Requests for Assisted Suicide: A Qualitative Study," Journal of Palliative Medicine 7, No. 3 (2004): 451-471.

[112] Ganzini et al., "Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists," Am Jrnl Psychiatry 157 (April 2000): 4.

[113] Id.

[114] Fenn et al., "Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death with Dignity Act," Am Psychological Assoc Jrnl 30, No. 3 (1999): 235-244.

[115] Id.

[116] Id.

[117] Id.

[118] ORS 127.855, s. 3.09.

[119] ORS 127.800 – ORS 127.897.

[120] The information required by subsection (7) of ORS 127.885 s. 3.09 may also be obtained through an interview if requested by the physician.

[121] Appendix D is a description of the reporting system and data analysis as published in the Sixth Annual Report of DHS.)

[122] ORS 127.890 s. 4.02.

[123] Emanuel, EJ "Euthanasia: Historical, Ethical & Empiric Perspectives." Archives of Internal Medicine 154 (1994): 1895. See also deVries, Ubaldus, A Dutch Perspective, The Limits of Lawful Euthanasia, 13 Annals Health L (2004): 392 fr. 1. Hendin, Herbert, The Dutch Experience at 98. Foley (eds.), Chapter 5 in The Case Against Assisted Suicide and for the Right to End of Life Care, Johns Hopkins Univ. Press (2002). See also Meisel and Cerminara, The Right to Die: The Law of End-of-Life Decisionmaking 3rd, Section 12.07 (2004).

[124] The Act is available in English on the Dutch government website: www.mimbuza.ul. See also Appendix E.

[125] Unfortunately, the court cases are only reported in Dutch, so the Council is unable to access the original case law to give an independent interpretation and must rely on secondary sources.

[126] WVS §§ 293, 294 [Dutch Criminal Code].

[127] de Vries et al., at 366-367; Schwatz, Robert "Euthanasia and Assisted Suicide in the Netherlands, Cambridge Quarterly of Health Care Ethics 4 (1995): 111-112, translation of Legemaate Johan, Legal Aspects of Euthanasia and Assisted Suicide in the Netherlands, 73-94.

[128] Id.; de Vries et al., at 366-368.

[129] WVS §§ 293, 294 (Dutch Criminal Code).

[130] WVS § 40 (Dutch Criminal Code).

[131] See de Vries et al., at 370-376.

[132] de Vries et al., at 371.

[133] de Vries et al., at 370-371.

[134] Id.

[135] de Vries et al., at 370-371.

[136] The criteria are broken down in different ways, so are sometimes described as 2, 3, or 5 different criteria. This is a semantic difference, not a legally significant difference.

[137] Welie, Jos. The Medical Exception: Physicians, Euthanasia & the Dutch Criminal Law, Journal of Medicine & Philosophy 17 (1992): 436.

[138] Schwartz, at 114.

[139] Schwartz, at 116-117.

[140] Schwartz, at 115-116.

[141] Schwartz, at 115.

[142] de Vries et al., at 376.

[143] Id. at 376-377.

[144] Id. at 377.

[145] Van Der Maas at 670. Van Der Maas, van Delden, Pijnenborg, Looman, "Euthanasia and other medical decisions concerning the end of life." The Lancet 338 (9/14/91): 660.

[146] Total deaths in the Netherlands was 128,786 in 1990. Van Der Maas et al. at 670.

[147] The definition of "euthanasia and related MDEL" is the prescription, supply, or administration of drugs with the explicit intention of shortening life to include euthanasia at the patient's request, assisted suicide, and life-terminating acts without explicit and persistent request. Id. at 670.

[148] Van Der Maas et al., "Euthanasia, Physician-Assisted Suicide, and other Medical Practices Involving the End of Life In the Netherlands, 1990-1995" N Engl J Med 335 No. 22 (1995): 1699-1711.

[149] The total number of deaths in the Netherlands in 1995 was 135,546.

[150] Van Der Maas (1995) at 1704.

[151] Because there were two studies, the exact percentage varies depending on which study you examine.

[152] Glick, Shimon. Letter, N Engl J Med 336, No. 19 (5/8/97): 1385.

[153] Van Der Maas (1995) response to letters at 1386.

[154] Hendin, Rutenfrans & Zylicz, "Physician-Assisted Suicide and Euthanasia in the Netherlands", JAMA, vol. 277, No. 21 (6/4/97): 1721.

[155] Van Der Maas (1995) at 1705.

[156] Van Der Wal et al., "Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands," N Engl J Med 335, No. 22 (11/28/96): 1706-1711.

[157] Id. at 1706.

[158] Id. at 1707.

[159] Id. at 1707.

[160] Id. at 1707.

[161] Id. at 1709.

[162] Id. at 1709

[163] Van Der Maas (1995) response to letters at 1386

[164] Id.

LAW, ETHICS AND MEDICINE

# Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups

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**Background:** Debates over legalisation of physician-assisted suicide (PAS) or euthanasia often warn of a "slippery slope", predicting abuse of people in vulnerable groups. To assess this concern, the authors examined data from Oregon and the Netherlands, the two principal jurisdictions in which physician-assisted dying is legal and data have been collected over a substantial period.
**Methods:** The data from Oregon (where PAS, now called death under the Oregon Death with Dignity Act, is legal) comprised all annual and cumulative Department of Human Services reports 1998–2006 and three independent studies; the data from the Netherlands (where both PAS and euthanasia are now legal) comprised all four government-commissioned nationwide studies of end-of-life decision making (1990, 1995, 2001 and 2005) and specialised studies. Evidence of any disproportionate impact on 10 groups of potentially vulnerable patients was sought.
**Results:** Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS. While extralegal cases were not the focus of this study, none have been uncovered in Oregon; among extralegal cases in the Netherlands, there was no evidence of higher rates in vulnerable groups.
**Conclusions:** Where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.

If physician-assisted suicide (PAS) and/or voluntary active euthanasia were legalised, would this disproportionately affect people in "vulnerable" groups? Although principles of patient autonomy and the right to avoid suffering and pain may offer support for these practices, concerns about their impact on vulnerable populations speak against them. Warnings about potential abuse have been voiced by many task forces, courts and medical organisations in several countries where the issue is under debate. Box 1 presents some of these concerns.

We must take these concerns seriously, not only because they are repeated so often but because they are of such gravity. Would accepting or legalising physician-assisted dying at a patient's explicit request weigh more heavily on patients in vulnerable groups—the elderly, women, the uninsured, the poor, racial or ethnic minorities, people with disabilities, people with sometimes stigmatised illnesses like AIDS, and others? Would vulnerable patients be especially heavily targeted? Would these patients be pressured, manipulated, or forced to request or accept physician-assisted dying by overburdened family members, callous physicians, or institutions or insurers concerned about their own profits? This slippery-slope argument assumes that abusive pressures would operate on all seriously or terminally ill patients but would selectively disfavour patients whose capacities for decision making are impaired, who are subject to social prejudice or who may have been socially conditioned to think of themselves as less

in heightened risk for physician-assisted dying among vulnerable persons compared with background populations.

These are concerns both for those who oppose physician-assisted dying on moral grounds and for those who support it but are uneasy about the possible social consequences of legalisation. They are also concerns for proponents of legalisation who assume that the risks for vulnerable patients are heightened if these practices remain underground, as well as for those who favour legalisation but fear that vulnerable patients will be denied a privilege reserved for better-situated patients and that healthcare inequities already affecting vulnerable persons will be exacerbated. In short, slippery-slope concerns about vulnerable patients confront both those who do and those who do not find physician-assisted dying objectionable on moral grounds.

Of course, to observe that patients are members of potentially vulnerable groups is to assert neither that each such person or the group as a whole is actually vulnerable nor that people who are seriously or terminally ill but not considering physician-assisted dying are not vulnerable. But it is to recognize a special and appropriate concern about persons and groups seen as vulnerable because of impairment, disadvantage or stigmatisation.

Warnings of potential abuse rest on predictive claims, claims typically assuming that higher rates of death in this way suggest abuse. We do not attempt to evaluate putative criteria

**Abbreviations:** ALS, amyotrophic lateral sclerosis; ODDA, Oregon Death

### Box 1 " Slippery-slope" concerns about vulnerable patients in health policy statements on physician-assisted dying

"... no matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care."

New York State Task Force on Life and the Law, 1994[1]

"... the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes. The Court of Appeals [Ninth Circuit] dismissed the State's concern that disadvantaged persons might be pressured into physician assisted suicide as ludicrous on its face.... We have recognized, however, the real risk of subtle coercion and undue influence in end of life situations ..."

US Supreme Court, joint opinion in *Washington v Glucksberg* (1997) and *Vacco v Quill* (1997)[2]

"Euthanasia and assisted suicide are opposed by almost every national medical association and prohibited by the law codes of almost all countries. ... If euthanasia or assisted suicide or both are permitted for competent, suffering, terminally ill patients, there may be legal challenges ... to extend these practices to others who are not competent, suffering or terminally ill. Such extension is the "slippery slope" that many fear."

Canadian Medical Association, 1998[3]

"Both society in general and the medical profession in particular have important duties to safeguard the value of human life. This duty applies especially to the most vulnerable members of society—the sick, the elderly, the poor, ethnic minorities, and other vulnerable persons. In the long run, such persons might come to be further discounted by society, or even to view themselves as unproductive and burdensome, and on that basis, "appropriate" candidates for assistance with suicide."

"... the ramifications [of legalization] are too disturbing for the ... value our society places on life, especially on the lives of disabled, incompetent, and vulnerable persons."

American College of Physicians–American Society of Internal Medicine (ACP–ASIM), 2001[4]

"... the College concluded that making physician-assisted suicide legal raised serious ethical, clinical, and social concerns and that the practice might undermine patient trust and distract from reform in end of life care. The College was also concerned with the risks that legalization posed to vulnerable populations, including poor persons, patients with dementia, disabled persons, those from minority groups that have experienced discrimination, those confronting costly chronic illnesses, or very young children."

American College of Physicians, 2005[5]

"... allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks ..."

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

American Medical Association, 1996, 2005[6 7]

"In the BMA's view, legalizing euthanasia or physician-assisted suicide would have a profound and detrimental effect on the doctor–patient relationship. It would be unacceptable to put vulnerable people in the position of feeling they had to consider precipitating the end of their lives...The BMA acknowledges that there are some patients for whom palliative care will not meet their needs and wishes, but considers that the risks of significant harm to a large number of people are too great to accommodate the needs of very few."

British Medical Association, 2003[8]

for whether assisted dying might seem "appropriate" for some vulnerable groups. Rather, we ask the prior question of whether there is evidence that where assisted dying is already legal, the lives of people in groups identified as vulnerable are more frequently ended with assistance from a physician than those of the background population. We can now begin to evaluate this factual issue by examining directly what is happening in the two principal jurisdictions—Oregon and the Netherlands—where physician-assisted dying is legal and data have been collected over a substantial period.

## DATA AVAILABLE IN OREGON AND THE NETHERLANDS

In Oregon, nine annual reports issued by the Department of Human Services cover the period since the Oregon Death with Dignity Act (ODDA) took effect in 1997.[9] Three surveys of Oregon physicians and hospice professionals add information beyond that drawn from official reports.[10–12] In the Netherlands,

Remmelink report) commissioned by the Dutch government used cross-sectional analyses of data from interviews, death certificates and questionnaires to cover all end-of-life decision making in the years 1990,[13 14] 1995,[15] 2001[16] and 2005.[17] Several smaller, focused Dutch studies provide additional data, as noted below. The Oregon data are from the 2006 report and cumulative study[9] and the Dutch data are from the 2005 nationwide study[17] unless otherwise mentioned. The Oregon Department of Human Services data include all legal cases reported under the ODDA; additional surveys have not uncovered extralegal or unreported cases.[10 12] The nationwide Dutch data cover cases reported to the authorities as required under Dutch guidelines as well as extralegal, unreported cases.

Box 2 provides the legal background, incidence and regulation of assisted dying in the two jurisdictions. The term "physician-assisted suicide" was used by Oregon in reporting its data for the first several years of legalisation, but it does not appear in the statute; Oregon now refers to "death under the Oregon Death with Dignity Act". The term "physician-assisted

## Box 2 Legal background, incidence and regulation of assisted dying in Oregon and the Netherlands

**Oregon**

- The Oregon Death with Dignity Act was passed as a ballot initiative in 1994; implementation was delayed by a legal injunction and the measure was returned to the ballot by the legislature and passed again in 1997; the Act became law on October 27 of that year. A federal challenge to the ODDA was rejected by the US Supreme Court in 2006. Oregon is the only US state to legalize PAS (now referred to as utilisation of the ODDA). Euthanasia remains illegal.
- A total of 292 people have died under the ODDA in the 9 years since its enactment; this is approximately 0.15% of people who have died during this period.
- The Act allows terminally ill Oregon residents to obtain from their physicians a prescription for lethal medication for the purpose of ending their lives if the following conditions are met:
  - The patient must be adult (18 years of age or older) and a resident of Oregon.
  - The patient must be capable (defined as able to make and communicate healthcare decisions).
  - The prescribing physician and a consulting physician must confirm the diagnosis and prognosis.
  - The patient must be diagnosed by two physicians as having a terminal illness (defined as 6 months or less to live).
  - The patient must make two oral requests to his or her physician, separated by at least 15 days, and one witnessed written request.
  - If either physician believes the patient's decision may be influenced by a mental disorder, the patient must be referred for a mental health evaluation.
  - The patient must be informed by the prescribing physician of feasible alternatives, including comfort care, hospice care and pain control.
  - The prescribing physician must request, but may not require, the patient to notify his or her next of kin of the request.
  - The physician must report the prescription for lethal medication to the Oregon Department of Human Services (formerly the Oregon Health Division); and the Department must make available an annual statistical report of information collected under the Act.[18]
  - Pharmacies are required to report filling such prescriptions.
- Oregon's statute requires terminal illness but makes no reference to the patient's pain, symptoms or suffering. It does not indicate whether the prescribing physician must, may or may not be present at the patient's death. It stipulates that ending one's life under the Death with Dignity Act does not constitute suicide.

**The Netherlands**

- Voluntary active euthanasia and PAS have been openly practised and, in effect, legal since the 1980s under guidelines developed in the courts and by the Royal Dutch Medical Association. According to an exception in the criminal code enacted in 2002, physicians who perform euthanasia or provide assistance in suicide commit no offense if they follow the guidelines for "due care".
- Of the total annual mortality of 136 000 (2005), approximately 1.7% of deaths are by voluntary active euthanasia and 0.1% by physician-assisted suicide; another 0.4% involve life-ending acts without explicit current request (known as LAWER).
- The guidelines require that:
  - The patient must make a voluntary, informed and well-considered request.
  - The patient must be facing unbearable and hopeless suffering, either currently or in the immediate future and with no outlook for improvement.
  - The physician must agree with the patient that no reasonable alternative treatment that might reduce the suffering is available.
  - The physician must consult with another, independent physician.
  - The action must be performed with due care.
  - The action must be reported to the appropriate authorities.
- Since 1998, five regional committees appointed by the Ministry of Justice review all reported cases. If they decide that the physician's behavior met the requirements of due care, their decision is final.
- Dutch law does not require that the patient be terminally ill but does require that the patient be facing "unbearable and hopeless suffering". Advance directives requesting euthanasia in the event that the patient becomes comatose or demented are also legal. Both before and after statutory legalization in the 2002 law, a physician has been protected from prosecution if the guidelines are met.

dying legally permitted in Oregon from the wider range of physician-assisted dying in the Netherlands, namely, both physician-assisted suicide and voluntary active euthanasia.

This paper examines available data concerning the use of

active euthanasia in the Netherlands) to determine whether there is evidence of disproportionate impact on vulnerable populations. Are the lives of people in vulnerable groups more frequently ended with a physician's assistance than those of move from the most robust data to that which is partial, inferential or in other ways less secure. Detailed accounts of the statistical and other methods used in each source study are available in those studies, variously including information on response rates, survey questions asked, sample sizes, actual numbers, statistical power and confidence intervals, methods of calculation of rate ratios, detectable differences, changes over time, and methodology, design and analysis techniques. We recognize that substantial differences in the methodologies of the source studies make it impossible to determine with certainty the actual incidence of assisted dying in several of the vulnerable groups studied. Our question is whether the available data show evidence of heightened risk to persons in vulnerable groups.

## IS THERE EVIDENCE OF HEIGHTENED RISK TO PEOPLE IN VULNERABLE GROUPS?

### Findings based on robust data

#### The elderly: *no evidence of heightened risk*

In Oregon, 10% of patients who died by PAS were 85 or older, whereas 21% of all Oregon deaths were among persons in this age category. Persons aged 18–64 years were over three times more likely than those over age 85 years to receive assisted dying. In the Netherlands, rates of assisted dying were lowest in the people over 80 (0.8% in 2005), next lowest in the age range 65–74 years (2.1%) and higher below age 65 (3.5%). People over 80 formed 30% of the group of patients whose requests were refused and 13% of those whose requests were granted and carried out.[19]

#### Women: *no evidence of heightened risk*

In Oregon, 46% of individuals receiving assisted dying were women and women were not more likely than men to use assisted suicide. In the Netherlands, despite some fluctuation in different years of the nationwide studies, the rates tend to be slightly higher in men.

#### Uninsured people: *no evidence of heightened risk*

Three Oregon patients (1%) did not have documented health insurance, and in four cases, insurance status was unknown. In contrast, 16.9% of non-elderly adults in Oregon were uninsured[20] (persons 65 and older are insured by Medicare). In the Netherlands, virtually all patients are covered by mandated nationwide health insurance.

#### People with AIDS: *heightened risk found*

In 9 years in Oregon, a total of six persons with AIDS died under the ODDA; although the numbers are small (2% of the total of 292 ODDA deaths), persons with AIDS were 30 times more likely to use assisted dying than those who died of chronic respiratory disorders in the interview portions of the nationwide studies in the Netherlands, very few patients with AIDS had received a physician's assistance in dying. However, in an Amsterdam cohort of 131 homosexual men with AIDS diagnosed between 1985 and 1992 who had died before 1 January 1995, 22% died by euthanasia or PAS.[21]

### Findings based on partly direct, partly inferential data

#### People with low educational status: *no evidence of heightened risk*

In Oregon, the likelihood of dying by PAS was correlated with higher educational attainment. Terminally ill college graduates in Oregon were 7.6 times more likely to die with physician assistance than those without a high school diploma. While no direct quantified data are available in the Netherlands about the educational status of patients receiving assisted dying, associated with educational status, showed no special relationships to patterns of euthanasia or PAS.

#### The poor: *no evidence of heightened risk*

The Oregon data do not include direct measures of income, employment or assets, but death under the ODDA was associated with having health insurance and with high educational status, both indirect indicators of affluence. In the Netherlands, data inferred from the postal codes of the location in which the person was living before death showed that the overall rates of assisted dying were somewhat higher for people of higher socioeconomic status.[22]

#### Racial and ethnic minorities: *no evidence of heightened risk*

In Oregon, 97% of the 292 patients who had a physician's assistance in suicide were white; six of the non-white patients were persons of Asian descent, one was Hispanic and one was Native American. Although 2.6% of Oregonians are African-American, no African-American has received physician-assisted dying under the Act. Dutch mortality statistics do not include information about race or ethnicity; however, even the most vocal opponents of assisted dying in the Netherlands do not claim that it is imposed more frequently on stigmatised racial or ethnic minorities.

#### People with non-terminal physical disabilities or chronic non-terminal illnesses: *no evidence of heightened risk*

In one sense, virtually all patients who are seriously or terminally ill are to some extent physically disabled and chronically ill. Patients who are dying lose functional capacities and may be bedridden toward the end; in this sense, most patients who received assistance in dying in either Oregon or the Netherlands were chronically ill and (recently) disabled. Cancer, the diagnosis in about 80% of all cases of assisted dying in both Oregon and the Netherlands, is often identified as a chronic illness; so is amyotrophic lateral sclerosis (ALS), also a frequent diagnosis. Concerns about persons in vulnerable categories have focused, however, on pre-existing physical disabilities and chronic non-terminal illnesses.

Although the data from Oregon do not indicate whether a person had a disability before becoming terminally ill (defined as having 6 months or less to live), no one received physician-assistance in dying who was not determined by two physicians to be terminally ill—that is, no one received such assistance for disability alone. That some patients received lethal prescriptions that they did not ingest and lived longer than 6 months may represent limitations in prognostication, although clinicians caring for terminally ill cancer patients are likely to overestimate rather than underestimate survival.[23] [24] In the Netherlands, assisted dying for disability alone would not be illegal in principle; a terminal diagnosis is not required by the Dutch guidelines, and a person who faces unbearable suffering, in his or her own view, and who has been offered all forms of treatment but has no hope of improvement may request assistance in dying. Estimates made by physicians of the amount of life forgone can be used to make an approximation of disability or chronic illness status: about 0.2% of patients receiving euthanasia or assistance in suicide were estimated to have forgone more than 6 months of life, or less than 10 of the approximately 2400 cases in 2005. Dutch general practitioners infrequently grant and frequently refuse assistance in dying to patients whose diagnosis is "old age/general deterioration" or "other" (this includes the category of patients with no terminal illness and no ALS or multiple sclerosis).[19] There heightened risk to people with disabilities who are not also seriously ill.

## Minors and mature minors: *no evidence of heightened risk*

The Oregon ODDA requires that a patient be an adult (18 years of age or older) before assisted dying is granted; no cases of physician-assisted death were reported among minors. In the Netherlands, mature and relatively mature minors are understood to have some decision-making capacity and are not excluded under the Dutch guidelines, but because they are below the age of majority must be regarded as "vulnerable". Since death rates among minors in the Netherlands (0.4% of all deaths) were the lowest in any age group, it is difficult to reach statistically firm conclusions. In 2001, less than 1% of all deaths of persons aged 1–17 years were the result of euthanasia: no cases of PAS were found in this age group.

The Netherlands has recently developed a protocol for euthanasia in newborns with very serious deficits who have a hopeless prognosis and experience what parents and medical experts deem to be unbearable suffering; the decision is to be made in collaboration with the parents and requires their full approval. This is known as the Groningen protocol.[25] Such cases are infrequent—22 cases have been reported to district attorneys in the Netherlands during the past 7 years, and there are an estimated 10 to 20 cases annually among the somewhat

**Table 1** Physician-assisted dying in potentially vulnerable groups in Oregon and the Netherlands: overview of data from Oregon reports and studies, and Dutch nationwide and focused studies

| | Oregon—PAS patients 1998–2006 | | | Netherlands*— PAS/euthanasia patients 2005 (n = 2400) | | |
|---|---|---|---|---|---|---|
| **Potentially vulnerable group** | **Characteristic** | **No. (%)** | **Rate ratio** | **Characteristic** | **No. (%)** | **Rate ratio** |
| **Findings based on direct data** | | | | | | |
| The elderly (age in years) | 18–44 | 11 (4) | 3.4 | 0–64 | 900 (38) | 1.7 |
| | 45–64 | 83 (28) | 3.2 | 65–79 | 950 (39) | 1.7 |
| | 65–84 | 170 (58) | 2.3 | 80+ | 550 (23) | 1.0 |
| | 85 + | 28 (10) | 1.0 | | | |
| | Median 70 (range 25–96) | | | | | |
| Women | Male | 157 (54) | 1.1 | Male | 1350 (56) | 1.3 |
| | Female | 135 (46) | 1.0 | Female | 1050 (44) | 1.0 |
| Uninsured people | Private insurance | 180 (62) | | Not applicable (all are insured) | | |
| | Medicare or Medicaid | 105 (36) | | | | |
| | No insurance | 3 (1) | | | | |
| | Status unknown | 4 (1) | | | | |
| People with AIDS | HIV/AIDS† | 6 (2) | 30.3 | HIV/AIDS‡ | 29 (22) | 7.9 |
| **Findings based on partly direct and partly inferential data** | | | | | | |
| People with low educational status | <High school | 25 (9) | 1.0 | Indirect data (via SES); no direct relationship | | |
| | HS graduate | 82 (28) | 1.8 | | | |
| | Some college | 64 (22) | 3.2 | | | |
| | Baccalaureate or higher | 121 (41) | 7.6 | | | |
| The poor (people with low SES) | Rate low¶ | | | Low SES§ | 1400 (38) | 1.0 |
| | | | | Moderate SES | 1200 (33) | 1.0 |
| | | | | High SES | 800 (22) | 1.2 |
| | | | | Institutions§ | 300 (8) | 0.3 |
| Racial and ethnic minorities | White | 284 (97) | 1.0 | No data (Dutch mortality statistics are not kept by race) | | |
| | African-American | 0 (0%) | | | | |
| | Hispanic | 1 (<1%) | 0.4 | | | |
| | Native American | 1 (<1%) | 0.5 | | | |
| | Asian | 6 (2) | 1.8 | | | |
| | Other | 0 | 0 | | | |
| People with chronic physical or mental disabilities or chronic non-terminal illnesses | Not legal; no cases reported or identified | | | No data to calculate denominator; probably 10 cases or fewer per year | | |
| Minors | Not legal; no cases reported or identified | | | 1.6% of all deaths of minors aged 1–16 years | | |
| **Findings based on inferential or partly contested data** | | | | | | |
| People with psychiatric illness, including depression and Alzheimer disease | Not legal; no clear cases; three disputed cases among those given prescription (n = 456) | | | No data to calculate denominator; increased requests among cancer patients with depression; probably rare for psychiatric illness as main diagnosis; legal in Alzheimer disease with advance euthanasia directive but compliance rare | | |

*All estimates are based upon data about a sample of 9000 deaths from August to November 2005, unless indicated otherwise; 2005 data are used for simplicity. Data are roughly comparable for entire period studied. Also see van der Heide *et al*, 2007.[17]

†Referent is chronic lower respiratory disorder.

‡Estimate based upon prevalence study from early 1990s.

¶Indirect data (via educational level and insuredness).

§Estimates based upon 2001 nationwide study; also see Onwuteaka-Philipsen *et al*, 2003.[16]

LAWER, life-ending acts without explicit current request; PAS, physician-assisted suicide; SES, socioeconomic status.

over 1000 children born in the Netherlands who die during the first year of life, about 1% of newborn deaths.

## Findings based on inferential or partly contested data

### Patients with psychiatric illness, including depression and Alzheimer disease: *no evidence of heightened risk*

Approximately 20% of requests for physician assistance in dying came from depressed patients, but none progressed to PAS.[10] None of the 292 patients who died under the ODDA were determined to have a mental illness influencing their decision, though there have been three disputed cases among the 9-year total of 456 who received prescriptions.[26 27] Because not all patients who requested assistance were specifically evaluated by mental health professionals and because many cases of depression are missed in primary care, it is possible that some depressed patients received lethal prescriptions; it is also possible that a patient without a mental disorder at the time of receiving the prescription became depressed by the time they ingested it. There is, however, no direct evidence that depressed patients are at higher risk for receiving assistance in dying under the ODDA.

In the Netherlands, about two-thirds of explicit requests for assistance in dying are not granted. In 31% of all requests not granted in the 1995 study, the physician gave the presence of psychiatric illness as at least one reason for not complying. Physicians in the interview portion of the 1995 Dutch nationwide study mentioned depression as the predominant symptom in patients who died by PAS or euthanasia in 3% of all cases, compared with "loss of dignity" in 60%, pain as an associated complaint in 45% and debility in 43%. In one study, cancer patients with depressed mood were four times more likely to request euthanasia, but how often the request was granted is unknown.[28]

In 1994, the Dutch supreme court ruled in the *Chabot* case, in which a psychiatrist assisted with suicide for a woman with intractable depression but without concomitant physical illness, that "intolerable suffering" might consist in mental suffering alone without somatic origins and not involving the terminal phase of a disease, though the court commented that such cases would be rare and that they require heightened scrutiny.[29] The 2001 Dutch interview study estimated that about 3% of all requests for euthanasia or PAS that physicians had received the previous year were from patients with predominantly psychiatric or psychological illnesses, but none were granted. In the Dutch 1995 nationwide substudy on end-of-life decision making in psychiatric practice, there appeared to be about two to five physician-assisted deaths on request per year, mostly but not always in patients with a concurrent serious physical illness, often in the terminal phase. Explicit requests for a physician's assistance in dying are not uncommon in psychiatric practice in the Netherlands, and a majority of Dutch psychiatrists consider assisted suicide for psychiatric patients acceptable in certain circumstances. However, this rather liberal attitude appears to be associated with quite reluctant practice: despite the fact that Dutch law would permit it, it occurs only very rarely.

Since 2002, the Netherlands has also recognised as legal advance euthanasia directives of patients with dementia, including Alzheimer disease. Although approximately 2200 demented patients with advance directives requesting euthanasia after the onset of dementia die annually having been treated by a physician who knows about this directive—indeed, in 76% of such cases, compliance with the directive was discussed—euthanasia is seldom performed.[30]

Table 2 summarises the comprehensive data provided in table 1.

## THE COMPREHENSIVE PICTURE IN OREGON AND THE NETHERLANDS

The data from Oregon and the Netherlands are the most informative sources concerning legal physician-assisted dying, though they are not comparable in a number of respects: they cover different time periods, were obtained by different methods, and are of different strengths. Neither the Oregon nor the Dutch studies were corrected throughout for considerations of whether diagnoses that may make physician-assisted dying attractive are equally distributed in vulnerable and non-vulnerable groups. Clearly, more work needs to be done.

Where they do overlap, however, the studies are largely consistent. Where the data are robust, the picture in Oregon and the Netherlands is similar: in both jurisdictions, a smaller percentage of older people received assistance in dying than of younger patients; gender ratios were slightly higher for males over time; and assistance was not more common among the uninsured. Socioeconomic data of intermediate strength, usually inferred from other, more robust data, also suggest similar pictures in the two jurisdictions: recipients of assistance in dying were likely to be of equal or higher educational status and were less likely than the background population to be poor. Data that are robust in one jurisdiction but partly inferential and hence less secure in the other did not reveal cases in either

**Table 2** Summary of evidence of heightened risk in physician-assisted dying in Oregon and the Netherlands

| Potentially vulnerable group | Evidence of heightened risk | No evidence of heightened risk |
|---|---|---|
| **Direct data** | | |
| The elderly | | × |
| Women | | × |
| Uninsured people | | × |
| People with AIDS | × | |
| **Partly direct, partly inferential data** | | |
| People with low educational status | | × |
| The poor: people with low socioeconomic status | | × |
| Racial and ethnic minorities | | × |
| People with chronic physical or mental disabilities or chronic non-terminal illnesses | | × |
| Minors | | × |
| **Inferential or partly contested data** | | |
| People with psychiatric illness, including depression and Alzheimer disease | | × |

data set of assisted dying associated with physical disability alone without concomitant serious or terminal illness. The rates of physician-assisted dying among mature minors, which is legal in the Netherlands, were too low to be statistically valid. Although the rates of request for physician-assisted dying may have been higher among patients with depression, it appears that most such requests did not culminate in euthanasia, even though such cases may be legal in the Netherlands if given heightened scrutiny; studies of patients in the process of making requests are needed to clarify the risk conferred by depression. Even where the data involve very few cases or are absent in one or the other jurisdiction, the picture appears to match: neither in Oregon nor in the Netherlands was there any report of assisted dying disproportionately practised among racial minorities. Thus, there is no evidence of heightened risk of physician-assisted dying to vulnerable patients in either legal or extralegal practice groups, with the sole exception of people with AIDS.

Thus, we found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalised physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups. The evidence available cannot provide conclusive proof about the impact on vulnerable patients, and full examination of practice in Oregon would require studies of the complexity, duration and comprehensiveness of the four Dutch nationwide studies. Nevertheless, the joint picture yielded by the available data in the two jurisdictions shows that people who died with a physician's assistance were more likely to be members of groups enjoying comparative social, economic, educational, professional and other privileges. This conclusion does not directly speak to the moral issues in physician-assisted dying; it does not argue whether physician-assisted dying would be more or less appropriate for people in some groups; and it does not show that people in vulnerable groups could not be disproportionately affected in the future or in other jurisdictions. It also does not show whether low rates of physician-assisted dying among vulnerable persons reflect a protective effect of safeguards or, rather, are evidence of unequal access to assistance. But it does show that there is no current factual support for so-called slippery-slope concerns about the risks of legalisation of assisted dying—concerns that death in this way would be practised more frequently on persons in vulnerable groups.

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Competing interests: None declared.

## REFERENCES

1 **New York State Task Force on Life and the Law.** *When death is sought. Assisted suicide and euthanasia in the medical context.* New York: New York State Task Force on Life and the Law, May 1994 (executive summary, p, xiii).
2 *Washington v Glucksberg,* 521 US 702 (1997) and *Vacco v Quill,* 521 US 793 (1997).
3 **Canadian Medical Association.** *Euthanasia and assisted suicide (update 1998).* Ottawa: CMA, 1998.
4 **Snyder L**, Sulmasy DP, for the Ethics and Human Rights Committee, American College of Physicians–American Society of Internal Medicine. Physician-assisted suicide. *Ann Intern Med* 2001;**135**:209–16.
5 **Snyder L**, Leffler C, for the Ethics and Human Rights Committee, American College of Physicians. Ethics manual: fifth edition [position paper]. *Ann Intern Med* 2005;**142**:560–82.
6 **American Medical Association.** Ethical statement, E-2.211 Physician-assisted suicide (adopted 1993) revised 1996, reaffirmed August 22, 2005. http://www.ama-assn.org/ama/pub/category/8459.html (accessed 8 Aug 2007).
7 **American Medical Association.** Ethical statement, E-2.21 Euthanasia (adopted 1991), revised 1996, reaffirmed August 22, 2005.
8 **British Medical Association.** End of life issues – Patient (Assisted Dying) Bill, June 2003.
9 **Oregon Department of Human Services, Office of Disease Prevention and Epidemiology.** 2006 Annual Report on the Death with Dignity Act, March 2007 http://egov.oregon.gov/DHS/ph/pas/ (accessed 9 Sep 2007) (Includes references to all previous annual and cumulative reports).
10 **Ganzini L**, Nelson HD, Schmidt TA, *et al.* Physicians' experiences with the Oregon Death with Dignity Act. *New Engl J Med* 2000;**342**:557–63.
11 **Ganzini L**, Harvath TA, Jackson A, *et al.* Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide. *New Engl J Med* 2002;**347**:582–8.
12 **Tolle SW**, Tilden VP, Drach LL, Fromme EK, Perrin NA, Hedberg K. Characteristics and proportion of dying Oregonians who personally consider physician-assisted suicide. *J Clin Ethics* 2004;**15**:111–18.
13 **van der Maas PJ**, van Delden JJ, Pijnenborg L. Euthanasia and other medical decisions concerning the end of life: an investigation performed upon request of the Commission of Inquiry into the Medical Practice Concerning Euthanasia. *Health Policy* 1992;**21**:1–262.
14 **van der Maas PJ**, van Delden JJ, Pijnenborg L, *et al.* Euthanasia and other medical decisions concerning the end of life. *Lancet* 1991;**338**:669–74.
15 **van der Maas PJ**, van der Wal G, Haverkate I, *et al.* Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990–1995. *New Engl J Med* 1996;**335**:1699–705.
16 **Onwuteaka-Philipsen BD**, van der Heide A, Koper D, *et al.* Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001. *Lancet* 2003;**262**:395–9.
17 **van der Heide A**, Onwuteaka-Philipsen BD, Rurup M, *et al.* End-of-life practices in the Netherlands under the euthanasia act. *N Engl J Med* 2007;**356**:1957–65.
18 Oregon Death With Dignity Act, Oregon Revised Statutes, 1996 (127.800-127.897, sections 3.09, 3.11).
19 **Jansen-van der Weide MC**, Onwuteaka-Philipsen BD, van der Wal G. Granted, undecided, withdrawn, and refused requests for euthanasia and physician-assisted suicide. *Arch Intern Med* 2005;**165**:1698–704.
20 **Kaiser Family Foundation, State Health Facts online.**
21 **Bindels PJE**, *et al.* Euthanasia and physician-assisted suicide in homosexual men with AIDS. *Lancet* 1996;**347**:499–504.
22 **van der Wal G**, van der Heide A, Onwuteaka-Philipsen BD, *et al.* Medische besluitvorming aan het einde van het leven. De praktijk en de toetsingsprocedure euthanasie. Utrecht: De Tijdstroom, 2003:69–70.
23 **Glare P**, Virik K, Jones M, *et al.* A systematic review of physicians' survival predictions in terminally ill cancer patients. *BMJ* 2003;**327**:195–8:
24 **Christakis N.** *Death foretold.* Chicago: University of Chicago Press, 1999.
25 **Verhagen E**, Sauer PJJ. The Groningen protocol—euthanasia in severely ill newborns. *N Engl J Med*, 2005;**352**:959–62. (Despite its appearance in the title of this article, the practice is more frequently called ''termination of life'' rather than ''euthanasia'' when referring to newborns. ).
26 **Hamilton NG**, Hamilton CA. Competing paradigms of response to assisted suicide requests in Oregon. *Am J Psychiatry* 2005;**162**:1060–5.
27 **Ganzini L**. Physician-assisted suicide [letter to the editor]. *Am J Psychiatry* 2006;**163**:1109–10.
28 **van der Lee ML**, van der Bom JG, Swarte NB, *et al.* Euthanasia and depression: a prospective cohort study among terminally ill cancer patients. *J Clin Oncol* 2005;**23**:6607–12.
29 **Griffiths J**, Bood A, Weyers H. *Euthanasia and law in the Netherlands.* Amsterdam: Amsterdam University Press, 1998:329–40.
30 **Rurup ML**, Onwuteaka-Philipsen BD, van der Heide A, *et al.* Physicians' experiences with demented patients with advance euthanasia directives in the Netherlands. *J Am Geriatr Soc* 2005;**53**:1138–44.

## MEMORANDUM

**TO:** Alaska House Health & Social Services Committee

**FROM:** Margaret Dore, Esq., MBA

**RE:** Vote "No" on HB 99. (No Assisted Suicide/Euthanasia)

**HEARING:** April 9, 2015, 3:00 p.m.

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## INDEX

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**APPENDIX**

## I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.[1] Our law is modeled on Oregon's law. Both laws are similar to the proposed bill, HB 99.[2]

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

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

## II. FACTUAL AND LEGAL BACKGROUND

### A. Financial Exploitation is a Large and Uncontrolled Problem.

The Alaska Office of Public Advocacy defines financial

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

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

[3] Sponsor Statement, House Bill 99.

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

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

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

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

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

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

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

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[4] http://doa.alaska.gov/opa/oefa/fin.html

[5] Id.

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

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

[8]

[9]

death by providing the necessary means and/or information to enable the patient to perform the life-ending act."[10] "Assisted suicide" is a general term in which the aiding person is not necessarily a physician. "Euthanasia," by contrast, is the direct administration of a lethal agent with the intent to cause another person's death.[11]

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

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

### C. **Withholding or Withdrawing Treatment.**

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

> [I]nstead of dying as expected, [he] slowly began to get better.[13]

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

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

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

[13] Nina Shapiro, *Terminal Uncertainty – Washington's new 'Death with Dignity' law allows doctors to help people commit suicide – once they've determined that the patient has only six months to live. But what if they're*

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

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

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

## III. THE BILL

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

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

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

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

[15] See article at A-25.

[16] See materials at A-26 to A-29.

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

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

HB 99 states:

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

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

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

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

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

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[18] *Id.*

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

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

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

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

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

### 2. Predictions of life expectancy can be wrong.

Patients may also have years to live because predicting life expectancy is not an exact science.[23] Consider John Norton who was diagnosed with ALS. He was told that he would get progressively worse (be paralyzed) and die in three to five years. Instead, the disease progression stopped on its own. In a 2012 affidavit, at age 74, he states:

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

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

### 3. Treatment can lead to recovery.

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

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[22] *Id.*

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

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

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

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

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

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

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

### C. How the Bill Works.

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

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[25] *Id.*

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

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

[28] Id.

[29] Oregon House Bill 3337.

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

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

### D. A Comparison to Probate Law.

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

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

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

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

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

[33] Id.

[34] *Id.*

[35] RCW 11.88.160(2).

## E. Patient Control is not Assured.

### 1. No witnesses at the death.

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

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

### 2. Adding witnesses will not fix the problem.

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

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

Patients signing the lethal dose request form are required

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

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

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

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

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

### 4. Individual "opt outs" are not allowed.

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

> A provision in a will or contract, whether

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

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

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

So much for the patient's choice and control.

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

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

### 6. HB 99 legalizes euthanasia.

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

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

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

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[40] HB 99, § 13.55.040, states:

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

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

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

[43] § 13.55.220(b), at A-12.

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

The bottom line, HB 99 legalizes euthanasia.

## IV. PUBLIC POLICY, SAFETY AND WELFARE

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

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

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

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

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[44] Id.

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

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

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

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

> [All] the protections end after the prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is [taken on a voluntary basis].
>
> So frankly, any of the studies that come out of the state of Oregon's experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.[47]

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

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

The report implies that these deaths were voluntary, stating

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

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

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

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

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

#### 1. The Swiss study.

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

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

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

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

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

[52] *Id.*

suicide.[53]

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

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

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

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

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

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[53] *Id.*

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

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

## V. PAIN IS NOT THE ISSUE.

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

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

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

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

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

[56] *Id.*

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

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

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

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

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

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

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

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[59] *See* Ian Dowbiggin, A Concise History of Euthanasia 146 (2007)("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices").

[60] *Id.*

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

[62] Id.

[63] *See* Compassion & Choices newsletter at A-57.

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

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

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

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

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

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[64] NBC News, Associated Press, "Children around the world kill themselves after watching televised images," January 14, 2007, attached at A-94. See also http://www.nbcnews.com/id/16624940/ns/world_news-mideast_n_africa/t/copycat-hangings-follow-saddam-execution/#.VDr5AfldWSo

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

[66] Will Johnston, MD, Vancouver Canada.

campaign is real. The persons at risk include children.

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

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

> Oregon's assisted suicide act went into effect "in late 1997."[67]
>
> By 2000, Oregon's conventional suicide rate was "increasing significantly."[68]
>
> By 2007, Oregon's conventional suicide rate was 35% above the national average.[69]
>
> By 2010, Oregon's conventional suicide rate was 41% above the national average.[70]

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

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

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

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

[69] *Id.*

[70] Attached at A-77.

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

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

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

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

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

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[71] Attached at A-78.

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

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

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

> The burning public policy question is whether we inadvertently encourage patients to act against their own self-interest, chase an unattainable dream of cure, and foreclose the path of acceptance that curative care has been exhausted.[75]

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

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

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

Attached at A-87 to A-88.

## VII. CONCLUSION

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

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

Respectfully submitted April 9, 2015

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[75] *Id.*

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

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## HOUSE BILL NO. 99

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - FIRST SESSION

**BY REPRESENTATIVES DRUMMOND, Josephson, Gruenberg**

**Introduced: 2/9/15**
**Referred: Health and Social Services, Judiciary**

## A BILL

## FOR AN ACT ENTITLED

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

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

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

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

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

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

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

### Chapter 55. Voluntary Termination of Life.

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

qualified, an individual shall

(1) be a resident of this state;

(2) be an adult;

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

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

(5) have voluntarily expressed the wish to die.

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

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

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

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

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

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

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

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

**Sec. 13.55.040. Right to rescind request.** When a qualified individual makes the second oral request under AS 13.55.030, the attending physician shall offer the qualified individual an opportunity to rescind the initial oral request and the written 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. Written request requirements.** (a) A written request for medication under this chapter must be in substantially the form described in AS 13.55.060, signed and dated by the qualified individual, and witnessed by at least two other individuals. The attending physician may not witness the request. The witnesses shall, in the presence of the qualified individual, attest that, to the best of their knowledge and belief, the qualified individual is capable, acting voluntarily, and not under undue influence to sign the request.

(b) Only one witness may be

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

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

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

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

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

REQUEST FOR MEDICATION TO END MY LIFE

I, ________________, am an adult of sound mind.

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

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

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

INITIAL ONE OF THE FOLLOWING:

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

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

_____ I have no family to inform of my decision.

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

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

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

Signed: ____________________

Dated: ____________________

DECLARATION OF WITNESSES

We declare that the person signing this request

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

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

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

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

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

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

_______________________ Witness 1 Date: _____

_______________________ Witness 2 Date: _____

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

1 of 2 witnesses on the lethal dose request is allowed to be an heir who will financially benefit from the patient's death.

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

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

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

(3) inform the individual of the

(A) individual's medical diagnosis;

(B) individual's prognosis;

(C) potential risks associated with taking the medication;

(D) probable result of taking the medication; and

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

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

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

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

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

(8) inform the qualified individual that the qualified individual has an opportunity to rescind the request at any time and in any manner and offer the qualified 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 qualified individual is making an informed decision;

(10) fulfill the requirements of AS 13.55.130 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 written consent,

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

(B) deliver the written prescription personally or by mail 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. 13.55.080. 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. 13.55.090. 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 causing impaired judgment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) In this section,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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 40.25.100, 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.

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

(b) 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. 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.

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

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

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

(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 individual and treatment of the individual's terminal disease;

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

Someone else, even a stranger can speak for the individual

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

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

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

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

during the lethal dose request proc.

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

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

(A) qualified individual's medical diagnosis;

(B) qualified individual's prognosis;

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

prescribed;

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

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

(10) "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;

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

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

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

(14) "qualified individual" means an individual who is qualified under AS 13.55.010 to end the individual's life under this chapter;

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

(16) "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;

(17) "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.

* **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, 2016.

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

* **Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect January 1, 2016.

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Alaska Statutes.

Title 11. Criminal Law

Chapter 41. Offenses Against the Person

Section 100. Murder in the First Degree.

previous: Chapter 41. Offenses Against the Person
next: Section 110. Murder in the Second Degree.

## AS 11.41.100. Murder in the First Degree.

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

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

**(A)** causes the death of any person; or

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

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

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

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

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

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

**Note to HTML Version:**

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

This page has been updated: 08/26/2011 17:35:09

AMA
AMERICAN MEDICAL ASSOCIATION

Resources » Medical Ethics » AMA Code of Medical Ethics » Opinion 2.211

# Opinion 2.211 - Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient t perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come t decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandone once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral suppor family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

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

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AMERICAN MEDICAL ASSOCIATION

Resources » Medical Ethics » AMA Code of Medical Ethics » Opinion 2.21

# Opinion 2.21 - Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come t decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once i is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respec for patient autonomy, and good communication. (I, IV)

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

A-18

# 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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# Colorado rejects right-to-die legislation

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

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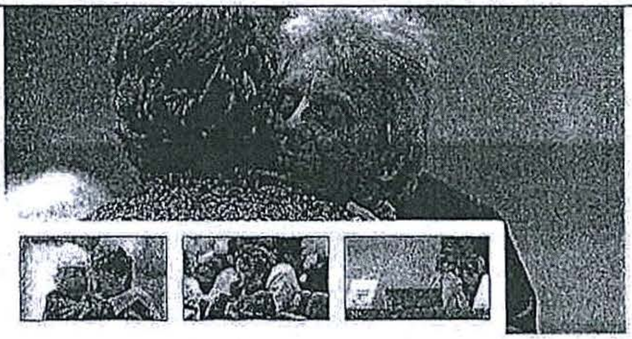

DENVER (AP) — Colorado lawmakers rejected a proposal to give dying patients the option to seek doctors' help ending their lives, concluding a long day of emotional testimony from more than 100 people.

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

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

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

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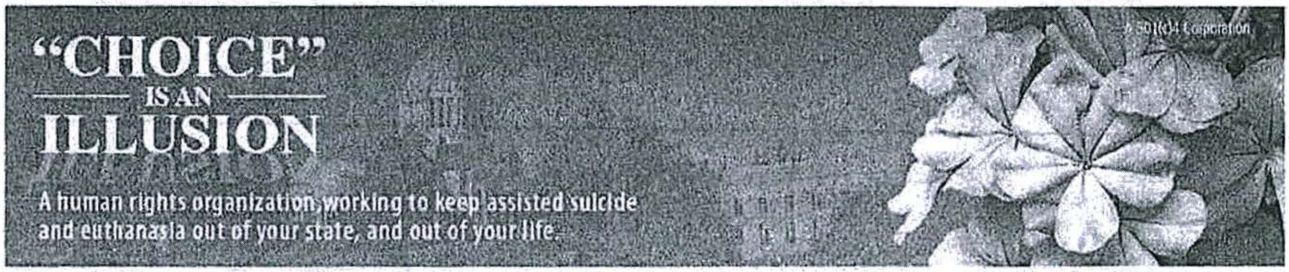

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**ASSISTED SUICIDE BATTLE IN COURT**

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

**MY BLOG LIST**

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

**VOICES AGAINST ASSISTED SUICIDE AND EUTHANASIA**

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

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DC DE FL **GA HI** IA **ID**
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**MAJOR TOPICS**

**MONDAY, MAY 5, 2014**

## Arizona Strengthens its Law Against Assisted Suicide

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

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

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

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

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

Brewer signed the bill on Wednesday.

Labels: assisted suicide

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**HELP US HELP YOU**

Choice is an Illusion gives you a voice against assisted suicide, euthanasia and palliative care abuse. Please donate now.

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**MARGARET DORE BLOG**

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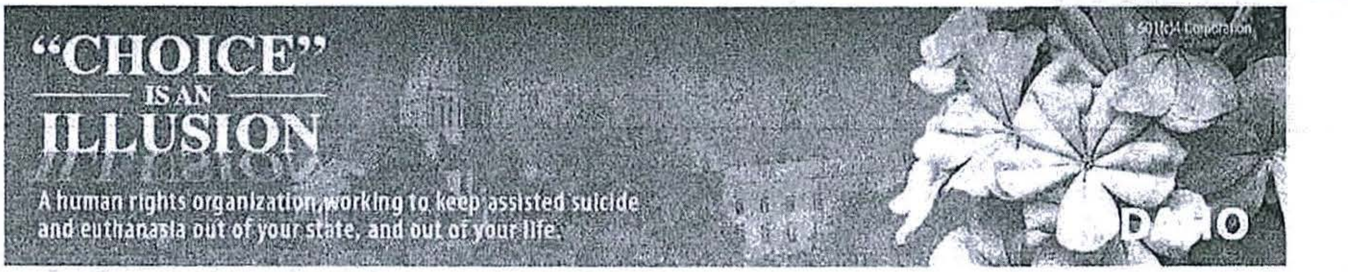
**WELCOME**

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

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

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

A-26



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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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- 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,

**LINKS**

- Montana's Campaign Against Assisted Suicide (Following Idaho's Lead!)

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**LABELS**

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**IDAHO ARCHIVE**

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

# Georgia General Assembly

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

### Sponsored By

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(6) Rice, Tom 51st

### Sponsored In Senate By

Ligon, Jr., William 3rd

### Committees

HC: Judiciary Non-Civil
SC: Judiciary

### First Reader Summary

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

### Status History

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

### Footnotes

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

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- Police say fugitive attempts suicide

# La. assisted-suicide ban strengthened

The Associated Press

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

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

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

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

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

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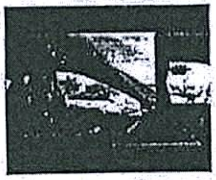
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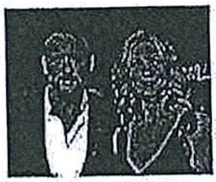
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Public Health > Provider and Partner Resources > Evaluation and Research > Death with Dignity Act > Oregon Revised Statute

# Oregon Revised Statute

## Chapter 127

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

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

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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

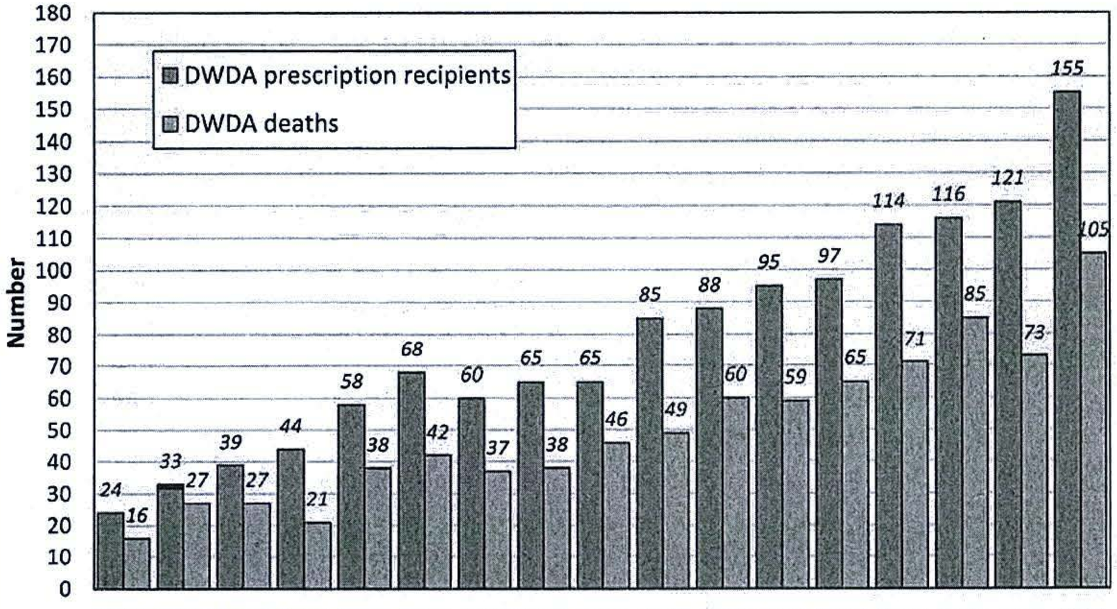
A-30

Oregon Public Health Division

## Oregon's Death with Dignity Act--2014

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

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



*As of February 2, 2015

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

---

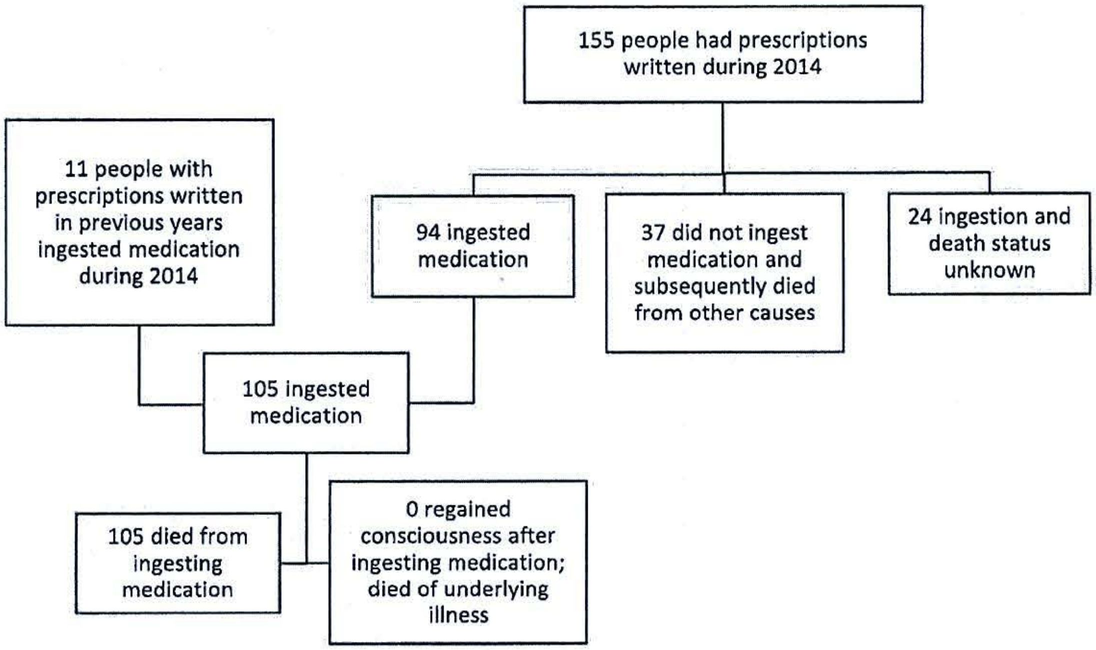
[1] Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2013 (33,931), the most recent year for which final death data are available.

http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf

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

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

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



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

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

| Characteristics | 2014 (N=105) | 1998-2013 (N=754) | Total (N=859) |
|---|---|---|---|
| **Underlying illness** | | | |
| **Malignant neoplasms (%)** | **72 (68.6)** | **596 (79.4)** | **668 (78.0)** |
| Lung and bronchus (%) | 16 (15.2) | 139 (18.5) | 155 (18.1) |
| Breast (%) | 7 (6.7) | 57 (7.6) | 64 (7.5) |
| Colon (%) | 5 (4.8) | 49 (6.5) | 54 (6.3) |
| Pancreas (%) | 9 (8.6) | 47 (6.3) | 56 (6.5) |
| Prostate (%) | 2 (1.9) | 33 (4.4) | 35 (4.1) |
| Ovary (%) | 5 (4.8) | 28 (3.7) | 33 (3.9) |
| Other (%) | 28 (26.7) | 243 (32.4) | 271 (31.7) |
| **Amyotrophic lateral sclerosis (%)** | **17 (16.2)** | **54 (7.2)** | **71 (8.3)** |
| **Chronic lower respiratory disease (%)** | **4 (3.8)** | **34 (4.5)** | **38 (4.4)** |
| **Heart Disease (%)** | **3 (2.9)** | **14 (1.9)** | **17 (2.0)** |
| **HIV/AIDS (%)** | **0 (0.0)** | **9 (1.2)** | **9 (1.1)** |
| **Other illnesses (%)**[6] | **9 (8.6)** | **44 (5.9)** | **53 (6.2)** |
| ***Unknown*** | ***0*** | ***3*** | ***3*** |
| **DWDA process** | | | |
| Referred for psychiatric evaluation (%) | 3 (2.9) | 44 (5.9) | 47 (5.5) |
| Patient informed family of decision (%)[7] | 95 (90.5) | 634 (93.6) | 729 (93.2) |
| Patient died at | | | |
| Home (patient, family or friend) (%) | 94 (89.5) | 716 (95.3) | 810 (94.6) |
| Long term care, assisted living or foster care facility (%) | 8 (7.6) | 29 (3.9) | 37 (4.3) |
| Hospital (%) | 0 (0.0) | 1 (0.1) | 1 (0.1) |
| Other (%) | 3 (2.9) | 5 (0.7) | 8 (0.9) |
| *Unknown* | *0* | *3* | *3* |
| Lethal medication | | | |
| • Secobarbital (%) | 63 (60.0) | 403 (53.4) | 466 (54.2) |
| • Pentobarbital (%) | 41 (39.0) | 344 (45.6) | 385 (44.8) |
| Other (%)[8] | 1 (1.0) | 7 (0.9) | 8 (0.9) |
| **End of life concerns**[9] | **(N=105)** | **(N=754)** | **(N=859)** |
| Losing autonomy (%) | 96 (91.4) | 686 (91.5) | 782 (91.5) |
| Less able to engage in activities making life enjoyable (%) | 91 (86.7) | 667 (88.9) | 758 (88.7) |
| Loss of dignity (%)[10] | 75 (71.4) | 504 (80.6) | 579 (79.3) |
| Losing control of bodily functions (%) | 52 (49.5) | 376 (50.1) | 428 (50.1) |
| Burden on family, friends/caregivers (%) | 42 (40.0) | 300 (40.0) | 342 (40.0) |
| Inadequate pain control or concern about it (%) | 33 (31.4) | 178 (23.7) | 211 (24.7) |
| Financial implications of treatment (%) | 5 (4.8) | 22 (2.9) | 27 (3.2) |
| **Health-care provider present**[11] | **(N=105)** | **(N=684)** | **(N=789)** |
| When medication was ingested[12] | | | |
| Prescribing physician | 14 | 119 | 133 |
| Other provider, prescribing physician not present | 6 | 238 | 244 |
| No provider | 4 | 76 | 80 |
| *Unknown* | *81* | *251* | *332* |
| At time of death | | | |
| Prescribing physician (%) | 14 (13.9) | 107 (15.9) | 121 (15.7) |
| Other provider, prescribing physician not present (%) | 6 (5.9) | 263 (39.2) | 269 (34.8) |
| No provider (%) | 81 (80.2) | 301 (44.9) | 382 (49.5) |
| *Unknown* | *4* | *13* | *17* |
| **Complications**[12] | **(N=105)** | **(N=754)** | **(N=859)** |
| Regurgitated | 0 | 22 | 22 |
| Seizures | 0 | 0 | 0 |
| Other | 0 | 1 | 1 |
| None | 20 | 487 | 507 |
| *Unknown* | *85* | *244* | *329* |
| **Other outcomes** | | | |
| Regained consciousness after ingesting DWDA medications[13] | 0 | 6 | 6 |

Chronic

Lethal meds are water & alcohol soluable

Concerns

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

[1] Unknowns are excluded when calculating percentages.

[2] Includes Oregon Registered Domestic Partnerships.

[3] Clackamas, Multnomah, and Washington counties.

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

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

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

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

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

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

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

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

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

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

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

Margaret K. Dore

**Margaret Dore <margaretdore@margaretdore.com>**

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## Letter to editor, New Haven Register

1 message

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

Dear Editor,

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

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

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

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

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

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

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

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

I confirmed the content with Dr. Toffler.

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

**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 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 18th, 2012

NAME: HEIDI PRUZYNSKI
Heidi

A notary in and for the
State of ~~Washington~~ MASSACHUSETTS

ADDRESS: 85 MAIN ST
Florence MA 01062

EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

HEIDI PRUZYNSKI
JUNE 22, 2018

JOHN NORTON

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*Attorneys for Petitioner*

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

| | |
|---|---|
| MONTANANS AGAINST ASSISTED SUICIDE & FOR LIVING WITH DIGNITY, a Montana Nonprofit Public Benefit Corporation,<br>PETITIONER,<br>vs.<br>BOARD OF MEDICAL EXAMINERS, MONTANA DEPARTMENT OF LABOR & INDUSTRY,<br>RESPONDENT. | **Cause No. ADV-2012-1057**<br>**AFFIDAVIT OF KENNETH R. STEVENS, JR., MD** |

STATE OF OREGON )
) ss.
COUNTY OF CLACKAMAS )

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

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

patients with cancer.

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

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

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

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

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

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

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

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

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

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

Attached hereto as Exhibit B, page SI-1.

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

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

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

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

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

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

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

FURTHER AFFIANT SAYETH NOT.

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

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

Sheri A Acker

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

OFFICIAL SEAL
SHERI A ACKER
NOTARY PUBLIC - OREGON
COMMISSION NO. 451896
MY COMMISSION EXPIRES SEPTEMBER 03, 2014

12/5/11

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

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

Dear Montana Medical Examiner Board member:

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

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

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

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

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

Kenneth R.Stevens, Jr., MD
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Professor Emeritus and former Chair, Radiation Oncology Department, Oregon Health & Science University, Portland, Oregon
503 625 5044 503 481 8410

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

### STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

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

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

Some examples of covered palliative care treatments include:

A) Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.

B) Surgical decompression for malignant bowel obstruction.

C) Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.

D) Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.

E) Acupuncture with intent to relieve nausea.

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

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

### STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

### STATEMENT OF INTENT 3: INTEGRATED CARE

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

## GUIDELINE 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

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Filed 2013 Dec 6 P 4:

*Attorneys for Petitioner*

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

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

PETITIONER,

vs.

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

RESPONDENT.

**Cause No. ADV-2012-1057**

# AFFIDAVIT OF JEANETTE HALL

STATE OF OREGON )
) ss.
COUNTY OF Washington )

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

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

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

370752

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

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

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

FURTHER AFFIANT SAYETH NOT.

Jeanette Hall
JEANETTE HALL

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

N. Andrade

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

OFFICIAL SEAL
NORMA ANDRADE
NOTARY PUBLIC-OREGON
COMMISSION NO. 471012
MY COMMISSION EXPIRES AUGUST 19, 2016

The Seattle Times
Winner of Nine Pulitzer Prizes

## Columnists

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

# Planning for old age at a premium

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

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

Jerry Large

Seattle Times staff columnist

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

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

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

– So if you work hard all your life, pay taxes and your pension plan goes broke – this is how society pays you back?

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

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

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

The only certainty is that nothing is universally true.

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

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

X At least a couple mentioned euthanasia as a solution.

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

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

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

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

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

– Margaret Dore

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

### B. *Defendant's "Unusual Case" Argument*

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

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

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

### C. *Defendant's "Provocation and Duress" Argument*

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

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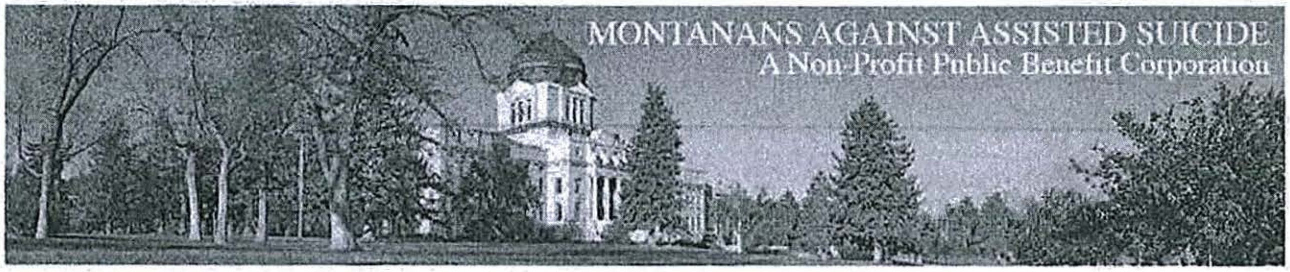

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Bradley Williams Takes on Compassion & Choices Increased Reports of Involuntary Deaths Rapist charged with "aiding or soliciting suicide"

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

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

**Voices From Oregon and Washington Where Assisted Suicide is Legal**

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

**Law Enforcement Viewpoint Against Assisted Suicide**

**Friday, March 29, 2013**

## Physician-Assisted Suicide Part of Elder Abuse Fraud

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

> "State and court documents show Middleton, who suffered from Lou Gehrig's disease, moved into Sawyer's home in July 2008, months after naming her trustee of his estate, *The Bulletin* reported Saturday. Middleton deeded his home to the trust and directed her to make it a rental until the real estate market improved.
>
> Instead, Sawyer signed documents that month to list the property for sale, *two days after Middleton died by physician-assisted suicide*. The property sold in October of that year for more than $200,000, the documents show, and it was deposited into an account for one of Sawyer's businesses, Starboard LLC, and $90,000 of that was transferred to two other Sawyer companies, Genesis Futures and Tami Sawyer PC." (Emphasis added).

To read the entire article, go here:
http://www.ktvz.com/news/Sawyer-Arraigned-on-State-Fraud-Charges/-/413192/619440/-/view/print/-/1w9ly3z/-/index.html

Posted by Admin at 7:32 PM

8+1 Recommend this on Google

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

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Please click on the flag to learn how you can donate to support our work. Thank you.

**WHY WE CARE**

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

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

**Choice is an Illusion**

Click on the banner to see website

**Print our handouts!**

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

# SUICIDE KITS SELL DEATH BY MAIL.

*Title Annotation:* *Health; Legislation is being prepared to outlaw sale of helium hoods*
*Geographic Code:* *1U9OR*
*Date:* *Mar 20, 2011*
*Words:* *3515*
*Publication:* *The Register-Guard (Eugene, OR)*
*ISSN:* *0739-8557*

Byline: Randi Bjornstad The Register-Guard

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

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

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

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

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

He had just turned 29.

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

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

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

A.55

Selling a "suicide kit" - coupled with detailed instructions from another right-to-suicide organization on where to buy it and how to use it - raises complex legal, ethical and emotiona questions about what constitutes helping another person to take his or her own life. Assis another person's suicide vio the law in most states, includi egon. But definitions of aiding, promoting, encouraging or assisting are not legally precise.

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

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

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

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

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

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

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

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

A.56

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

COMPASSION & CHOICES
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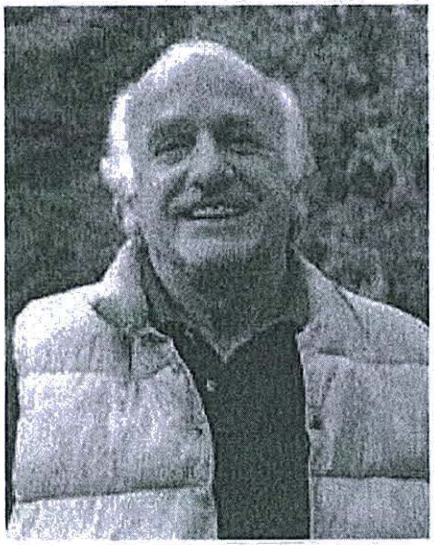
PO BOX 61369 SEATTLE WA 98141

## IN THIS ISSUE

# Derek Humphry to be Keynote Speaker at 2011 Annual Meeting



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

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

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

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

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

A.57

abc NEWS

# Death Drugs Cause Uproar in Oregon

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

**By SUSAN DONALDSON JAMES**

**Aug. 6, 2008 —**

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

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

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

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

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

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

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

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

### Letter's Impact 'Devastating'

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

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

A-66

"I'm not too good today," said Wagner, a Springfield great-grandmother. "But I'm opposed to the [assisted suicide] law. I haven't considered it, even at my lowest point

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

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

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

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

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

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

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

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

## Playing With 'My Life'

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

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

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

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

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

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

**KATU.com**

# Letter noting assisted suicide raises questions

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

PLAY VIDEO (HTTP://WWW.KATU.COM/NEWS/SPECIALREPORTS/26119539.HTML?TAB=VIDEO&C=Y)

Barbara Wagner

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

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

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

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

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

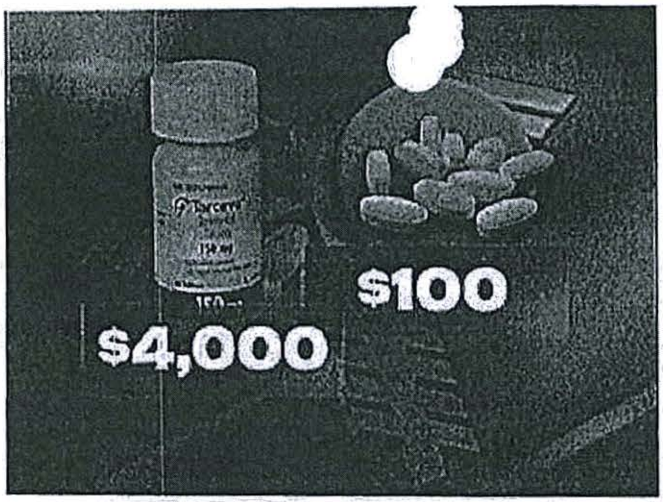
**An unfortunate interpretation?**

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

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

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

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



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

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

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

**Health plan hasn't evolved?**

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

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

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

"We are looking at today's ... 2008 treatment, but we're using 1993 standards," Fryefield said. "When the Oregon Health Plan was created, it was 15 years ago, and there were not all the chemotherapy drugs that there are today."

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

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

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.
-

9/2010

O N DEPARTMENT OF HUMAN SERVIC

Public Health
Division (PHD)

# Suicides in Oregon
## Trends and Risk Factors

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

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DHS | Independent. Healthy. Safe.

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

## Executive Summary

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

*Key Findings*

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

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

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

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

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

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

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

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

## Introduction

Suicide is an important public health problem in Oregon. Each year there are more than 550 Oregonians who died by suicide and more than 1800 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon with more deaths due to suicide among Oregonians than car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all ages in Oregon[1]. The cost of suicide is enormous. In 2006 alone, self-inflicted hospitalization charges exceeded 24 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 570 million dollars [1,2]. The loss to families and communities broadens the impact of each death.

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

## Methods, data sources and limitations

Suicide is a death resulting from the intentional use of force against oneself. In this report, suicide deaths are identified according to International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of deaths on death certificates. Suicide was considered with code of X60-84 and Y87.0.[4] Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore are excluded from this report.

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

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

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

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

National Violent Death Reporting
NVDRS
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**Public Health Division**

# Suicides in Oregon: Trends and Risk Factors

## -2012 Report-

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

Oregon Health Authority

Excerpt printed 2/9/14

## Executive Summary

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

### *Key Findings*

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

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

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

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

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

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

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

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

## Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year[1,2]. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts[3,4]. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in 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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[1] Oregon Healthy Teens 2009 -11th Grade Results. http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2009/11/Documents/mental11.pdf

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

[3] Oregon Vital Statistics Annual Report, Vol. 2, 2010. Oregon Heath Authority.

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

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

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

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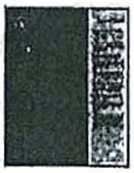

Original article

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

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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 $\geq 35$), 6.5% met the criteria for subthreshold PTSD (cut-off $\geq 25$), 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.

## 1. Introduction

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

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient's home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient's home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.

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## Sensationalizing a sad case cheats the public of sound debate

**Posted by rattig November 29, 2008 19:30PM**

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

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

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

Barbara Coombs Lee

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

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

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

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

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

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

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

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

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

While the OHP decision was closely scrutinized, there was no scrutiny of realistic options considered or not considered and the decision-making process. The burning health policy question is whether we inadvertently encourage patients to act against their own self interest, chase an unattainable dream of cure, and foreclose the path of acceptance that curative care has been exhausted and the time for comfort care is at hand. Such encouragement serves neither patients, families, nor the public.

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

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

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

*Coombs Lee is president of the group Compassion & Choices.*

Categories:

## Comments

**LetDocDecide says...**

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

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

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

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

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

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

Respectfully
Bob

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

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

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## Blog Entries by Barbara Coombs Lee

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

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2 Comments | Posted September 3, 2010 | 04:33 PM (EST)

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

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Word came Sunday night from Compassion & Choices New York that Governor Paterson had signed our bill, the Palliative Care Information Act, (PCIA) and it would take effect in 180 days. Hooray!! We hope and trust this event marks the beginning of the end for endemic medical habits that...

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

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Recently Capitol Hill staffers pulled Compassion & Choices into federal politics, suggesting the new Administrator of the Centers for Medicare and Medicaid Services, Donald Berwick, should be called before Congress to answer accusations that he is a member, or affiliated somehow with C&C. "Are you now,...