HB

54

<TARGET><BILL>HB 54</BILL><SUBJECT>HB
54</SUBJECT><COMM>HHSS30</COMM></TARGET>

Representative Harriet Drummond
Sponsor Statement

Sponsor Substitute House Bill 54 "Voluntary Ending of Life"

House Bill 54 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 in 2013 and Colorado, California, and Washington DC all legalized similar legislation 2016. Similar bills have 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 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
Sponsor Substitute House Bill 54
"Voluntary Ending of Life"
Sectional Analysis

Section 1 & 2:
Page 1: Lines 4-10

New subsections are added to AS 11.41.115 (defenses to murder) and AS 11.41.120 (manslaughter) to allow a defense for acting under 13.55.

Section 3:
Pages 1-11: Lines 11-21

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

Sec. 13.55.010: Describes which individuals may end 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 expressly identified agent of the qualified individual.

Sec. 13.55.030: Requires a qualified individual to make an oral request to their attending physician to receive the necessary medication. Requires the qualified individual to repeat the oral request at least 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 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: 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. 13.55.060: 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. 13.55.070: 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. 13.55.80: Prohibits the attending physician from dispensing or prescribing medication unless the qualified individual has made an informed decision.

Sec. 13.55.90: Prohibits the attending physician from denying the medication request because the individual declines or cannot notify next of kin.

Sec. 13.55.100: Requires certain waiting periods before medication can be dispensed or prescribed.

Sec. 13.55.110: Requires that the medical record of the qualified individual contains the items listed in the section before the individual receives the medication.

Sec. 13.55.120: 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. 13.55.130: 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. 13.55.140: States that a health care provider has no duty to participate.

Sec. 13.55.150: Under certain conditions allows a health care provider to prohibit another health care provider from participating in this chapter.

Sec. 13.55.160: Requires a health care provider to notify a physician in writing if they prohibit the administration of medication on the premises.

Sec. 13.55.170

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: Outlines the qualifications a physician must meet

Sec. 13.55.230: 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. 13.55.240: 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. 13.55.250: 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 11: Lines 22-26

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 11: Lines 27-31

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

Section 6:

Page 12: Line 1

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

Section 7:

Page 12: Line 2

Makes the Act (except Bill Section 5) effective January 1. 2019.

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Monday, April 09, 2018 9:27 AM
To: House Judiciary
Subject: FW: HB 54

From: Rosalyn Singleton <rosalynsingleton2@gmail.com>
Sent: Sunday, April 8, 2018 9:25 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB 54

Dear Representative Claman,

As a pediatrician with 30 years of experience in Alaska, I am deeply concerned to see a HB 54 on Physician Assisted Suicide. I fear for the medical profession when we are forced to turn from "caring" to "killing". I know that there are many arguments about saving suffering and pain, but these are arguments for expert "palliative" care, not killing patients according to my colleagues in palliative medicine. Legalizing physician assisted suicide could take us down an irrevocable journey to euthanasia and killing patients in our trust. I have walked the journey with several friends and patients in their terminal stages. What they requested was compassionate expert care and pain control, not ending their lives prematurely. We all become more human by caring for those who are terminal or disabled.
It is well documented that the Nazi Germany's "final solution" started with euthanasia of terminally ill and disabled before moving to Jews and other ethnicities. Physicians were involved in every aspect of Nazi euthanasia. (Friedlander H. The origins of Nazi genocide: from euthanasia to the final solution. Chapel Hill: University of North Carolina Press, 1995.)

Alaska already has a big problem with suicide. What kind of message are we giving those struggling against making a choice to take their lives if we as a medical profession become complicit in the suicide of patients?

There has been a steady increase in the number of assisted suicides in Oregon since their bill: from 16 in 1998 to 105 in 2014. The vast majority of those choosing to kill themselves are doing so for existential reasons rather than on the basis of real medical symptoms. Many people in give "fear of being a burden on others" as a reason for ending their lives. A substantial number of patients dying under the Oregon Act do not have terminal illnesses.

Physician assisted suicide is dangerous for physicians – it destroys trust, and it is an easy option for busy, stressed physicians. It is dangerous for families - It opens the door to the worst form of elder abuse by the exhausted care providers or greedy relatives. It is dangerous for patients, where the "right to die" will become the duty to die for senior citizens who don't want to be a burden. It's dangerous to society when society finds some lives "not worthy of being lived".

Sincerely
Rosalyn Singleton MD

22423 Columbia Glacier Lp
Eagle River, AK 99577

Lizzie Kubitz

From: schukalt@gci.net
Sent: Tuesday, April 10, 2018 12:32 PM
To: House Judiciary
Subject: input on HB54

I am a physician in Anchorage and am writing to indicate my opposition to HB54.

As physicians, we are trained to be patient advocates. Our goal is to do everything we can for the benefit of the patient. The patient needs to be able to trust his or her physician. Writing prescriptions designed to directly cause the death of the patient is completely opposed to this advocacy.

My most recent practice was in the area of geriatrics. I provided curative as well as palliative care. I worked to ease pain and discomfort at the end of life. I was never involved in a situation where taking an active role in causing a death seemed justified.

I am concerned that if this bill were to pass, vulnerable chronically ill people would feel obliged to end their lives for the convenience of families. How could they be assured that their physician is their advocate when the physician is able to write prescriptions for medications designed to cause death? How would they know families are acting in their best interests when there may be much to gain from a death.

The bill states that the physician needs to be able to certify that the patient has six months or less to live. Any practicing physician will tell you that we can be right as often as we are wrong about predicting length of life.

I think this bill as bad for the practice of medicine. I would never participate in actively causing someone's death. A better effort would be to improve the palliative care options already available, and make them more accessible to people who need them, for example, to people who live outside of the major urban areas of the state.

I would be happy to answer any other questions.

Mary Catherine Schumacher, MD, MSPH
6640 Lawlor Circle
Anchorage AK 99502
907-350-8137

Sent from my iPad

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Wednesday, April 11, 2018 9:08 AM
To: House Judiciary
Subject: FW: HB 54

From: Carol szopa <carolszopa@gmail.com>
Sent: Wednesday, April 11, 2018 9:06 AM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB 54

Dear Representative Claman,
I am writing about HB 54. As a nurse, I have seen people at the end of their lives. There are medications that can relieve pain even when it is severe. Many people in the state of terminal illness and pain use this time to resolve unfinished business in their lives and relationships. To allow termination before natural death robs people of the time they should have to actually come to peaceful terms with people and issues. And for their families to also come to terms with them. We as Alaskans should be helping them preserve this precious time so that they can do that.

I also know that in other countries and states where assisted suicide is legal, it actually allows others to speed the death process for an individual without their knowledge or consent. People who have dementia lose the ability to defend themselves in this situation. Legalizing assisted suicide makes all of us in the State party to another person's death. And eventually, the "safeguards" are disregarded.

This kind of law instills a distrust on the patient's part toward the medical community. By the nature of our profession, we are called to protect a patient's life, not be a party to their death. How can anyone of us trust our medical community when they do not have the safety and protection of our lives as their goal?

Please vote against this ghastly HB 54.

Sincerely,
Carol Szopa RN, BS, MPS
9331 Bothwell Circle
Anchorage, AK 99502

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Thursday, April 12, 2018 11:28 AM
To: House Judiciary
Subject: FW: HB 54

From: sidney Heidersdorf [mailto:sheide70@acsalaska.net]
Sent: Thursday, April 12, 2018 10:56 AM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB 54

We are opposed to House Bill 54 which would legalize physician assisted suicide in Alaska. The law is a teacher. If H.B. 54 becomes law it will teach us that suicide is morally and socially acceptable. This is very poor public policy in view of the fact that suicide is presently a huge problem in our society especially among young people. Also, H.B. 54 teaches us that there is such a thing as a "rational suicide" and that it must be honored. It requires that our doctors be involved in suicide. This legislation strikes another blow at traditional values regarding the sanctity of human life. The harmful ramifications will go far beyond the individuals involved. State sanctioned physician assisted suicide is not an act done in a vacuum. This attitude will permeate our society's institutions and values. It involves the medical profession, health care personnel and medical institutions, As our health care system feels the pinch of funding problems., enormous pressure will be placed on the elderly to commit suicide.

We have been living with abortion-on-demand for over 40 years. We have permitted our physicians to become involved in the destruction of millions of unborn children. With this legislation doctors will get involved in yet another form of killing thereby moving farther away from their proper role as healers. Suicide is a heartbreaking reality. Those who are terminally ill need to have pain controlled with medication. They need to know that someone cares; someone who will provide them with compassionate care and love them. Our laws should ask the question "What can we do to make your life better?" not "Do you want to die?". We should think in terms of "life with dignity" NOT "death with dignity". Please reject H.B. 54 not because of what it may lead to but because of what it is and what it will do to our society. Suicide/Euthanasia is not death with dignity. We can do better than that.

Sidney D. Heidersdorf, President
Alaskans for Life, Inc.

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Thursday, April 12, 2018 1:18 PM
To: House Judiciary
Subject: FW: HB54 Assisted Suicide

From: lagstrom <lagstrom@gci.net>
Sent: Thursday, April 12, 2018 1:17 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB54 Assisted Suicide

I am against HB54. We already have a problem with suicide in our great state as you can see from the paragraph below. I value life and believe people who are NOT in a right frame of mind commit suicide. I believe we need to provide services for people who feel their life is not worth living rather than provide an easy solution. How about the family members are hurt by physician assisted suicide? This is wrong morally, ethically and I would not want this blight against our great state. Alaska has the highest rate of suicide per capita in the country. ⌘ The rate of suicide in the United States was 11.5 suicides per 100,000 people in 2007. In 2007, Alaska's rate was 21.8 suicides per 100,000 people. The rate of suicide among Alaska Native peoples was **35.1 per 100,000 people** in 2007.

Suicide Statistics for Alaska
dhss.alaska.gov/SuicidePrevention/Documents/pdfs_sspc/AKSuicideStatistics.p

Thank you,

Laura Lagstrom
23108 Whispering Birch Dr
Chugiak AK 99567

AMERICANS UNITED FOR LIFE

April 13, 2018

Rep. Matt Claman, Chair
Rep. Jonathan Kreiss-Tomkins, Vice Chair
Members of the House Judiciary Committee
Thirtieth Legislature – Second Session, Alaska State Legislature

Re: Testimony of Bradley N. Kehr, Esq., Government Affairs Counsel, Americans United for Life, on HB 54, the Terminally Ill: Ending Life Option Bill, Regarding Physician-Assisted Suicide

Dear Chair Claman, Vice Chair Kreiss-Tomkins, and Honorable Members:

I am Bradley N. Kehr, Government Affairs Counsel with Americans United for Life. I appreciate the opportunity to provide written testimony on HB 54, regarding the legalization of physician-assisted suicide in Alaska. In my practice, I specialize in life-related legislation and am testifying as an expert in constitutional law generally and the constitutionality of end of life-related laws specifically.

I have thoroughly reviewed HB 54, and it is my opinion that HB 54 goes against the prevailing consensus that states have a duty to protect life, places already vulnerable people groups at greater risk, and fails to protect the integrity and ethics of the medical profession.

The Majority of States Affirmatively Prohibit Physician-Assisted Suicide

Currently, 42 states affirmatively prohibit assisted suicide and impose criminal penalties on anyone who helps another person end his or her life. In *Washington v. Glucksberg*, the United States Supreme Court summed up the consensus, saying: "In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States' assisted suicide bans are not innovations. Rather they are longstanding expressions of the States' commitment to the protection and preservation of all human life."[1]

This longstanding consensus among the vast majority of states is unsurprising when one considers, as the Court did, that "opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal and cultural heritages."[2]

[1] *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997).
[2] *Id.* at 711, 723.

Indeed, more than twenty years ago, the Supreme Court held that there is no fundamental right to assisted suicide in the U.S. Constitution, finding instead that there exists for the states "an unqualified interest in the preservation of human life... in preventing suicide, and in studying, identifying, and treating its causes."[3]

Only by rejecting HB 54 can this committee further Alaska's important state interest in preserving human life, as well as its duty to protect the lives of her citizens, especially the lives of the most vulnerable groups in our society.

Physician-Assisted Suicide Places Already Vulnerable People Groups at Greater Risk

It is also critical to protect vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and coercion. When considering the risk posed to these vulnerable people groups, assisted suicide can be considered neither a "compassionate" nor an appropriate solution for those who may suffer at the end of life. Many in the bioethics, legal, and medical fields have raised significant questions regarding the existence of abuses and failures in jurisdictions that have approved physician-assisted suicide, including a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting patient.[4] America's most vulnerable citizens, including the elderly, the terminally ill, the disabled, and the depressed, are worthy of life and equal protection under the law, and state prohibitions on assisted suicide reflect and reinforce the well-supported policy "that the lives of the terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy."[5]

Physician-Assisted Suicide Erodes the Integrity and Ethics of the Medical Profession

Prohibitions on assisted suicide also protect the integrity and ethics of the medical profession, including its obligation to serve its patients as healers, as well as to the principles articulated in the Hippocratic Oath to "keep the sick from harm and injustice" and to "refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect." Likewise, the American Medical Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of

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[3] *Id.* at 729–30.

[4] J. Pereira, MBChB MSc, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18(2) CURRENT ONCOLOGY (2011) (finding that "laws and safeguards are regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted."); *see Washington State Department of Health 2010 Death with Dignity Act Report*, http://www.doh.wa.gov/portals/1/Documents/5400/DWDA2010.pdf (last visited Feb. 27, 2017) (showing that in 2010, over one-fourth of patients who died after ingesting a lethal dose of medicine in Washington did so because, at least in part, they did not want to be a "burden" on family members, raising the concern that patients were pushed into suicide).

[5] *Glucksberg*, 521 U.S. at 731–32.

life. The AMA states 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."[6]

There is also a close link between physician-assisted suicide and euthanasia where a "right to die" easily becomes a "duty to die." The prohibition of assisted suicide is the only reasonable means to protect against these foreseeable abuses.[7] Importantly, although the original stated intent of most laws in jurisdictions that allow physician-assisted suicide is to provide "a last-resort option for a very small number of terminally ill people, some jurisdictions now extend the practice to newborns, children, and people with dementia. A terminal illness is no longer a prerequisite."[8]

One only has to look to the Netherlands to see how this plays out in reality: a report commissioned by the Dutch government demonstrated that more than half of euthanasia and assisted-suicide-related deaths were involuntary in the year studied.[9] At least half of Dutch physicians actively suggest euthanasia to their patients.[10] Studies in 1997 and 2005 revealed that eight (8) percent of infants who died in the Netherlands were euthanized by doctors.[11]

The slippery slope is also manifest in Belgium. A study published in the *Canadian Medical Association Journal*[12] showed that out of 1,265 nurses questioned, 120 of them (almost 10 percent) reported that their last patient was involuntarily euthanized. Only four percent of nurses involved in involuntary euthanasia reported that the patient had ever expressed his or her wishes about euthanasia. Most of the patients euthanized without consent were over 80 years old, reaffirming the fact that assisted suicide and euthanasia quickly lead to elder abuse. The researchers acknowledged that nurses are likely reluctant to report illegal acts (here, euthanizing a patient without physician involvement). Thus, it is possible that the number of nurses killing their patients without physician involvement is much higher than revealed by the study. The researchers concluded that "[i]t seems the current law... and control system do not prevent nurses from administering life-ending drugs." In other words, the "safeguards" purported by suicide advocates simply do not work.

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[6] American Medical Association, CODE OF MEDICAL ETHICS, *Opinion 5.7 – Physician-Assisted Suicide*, https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf (last visited Feb. 27, 2017).

[7] *Glucksberg*, 521 U.S. at 734–35; *Vacco v. Quill*, 521 U.S. 793, 808–09 (1997).

[8] *See* Pereira, *Legalizing Euthanasia or Assisted Suicide*, 18(2) CURRENT ONCOLOGY.

[9] *See* W.J. Smith, FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER 118–19 (2003) (citing the Dutch government's *Remmelink Report*).

[10] *See id.* at 119 (citing R. Fenigsen, *Report of the Dutch Government Committee on Euthanasia*, 7 ISSUES LAW & MED. 239 (Nov. 1991); *Special Report from the Netherlands*, N.E.J.M. 1699-711 (1996)).

[11] *See id.* at 129-30 (citing A. van der Heide et al., *Medical End of Life Decisions Made for Neonates and Infants in the Netherlands*, 350 LANCET 251 (1997)); A.M. Vrakking et al., *Medical End of Life Decisions Made for Neonates and Infants in the Netherlands*, 1995–2001, 365 LANCET 1329 (2005).

[12] E. Inghelbrecht et al., *The role of nurses in physician-assisted deaths in Belgium*, CAN. MED. ASSN. J. (June 15, 2010).

Alaska should continue to uphold its duty to protect the lives of all its citizens, especially vulnerable people groups such as the ill, elderly, and disabled; and maintain the integrity and ethics of the medical profession by rejecting physician-assisted suicide and rejecting HB 54.

Sincerely,

Bradley N. Kehr
Government Affairs Counsel
Americans United for Life

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Friday, April 13, 2018 12:05 PM
To: House Judiciary
Subject: FW: HB54 Public Testimony

Follow Up Flag: Follow up
Flag Status: Flagged

-----Original Message-----
From: William Deaton <williamgdeaton@gmail.com>
Sent: Friday, April 13, 2018 12:04 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB54 Public Testimony

Dear Rep. Claman,

Please include the following online with the rest of the public Testimony for HB54.

Dear Judiciary Committee Members,

I oppose HB54. This bill preys on the culture of death that we have in our great state. We have among the higher suicide rate per capita in the nation. This bill tells "terminally" ill patients that they can kill themselves with help if the doctor doesn't expect them to live much longer. Please oppose this legislation. "Let it die a natural death" (Taken from a Recent Op-Ed in ADN)

William Deaton, Cordova

Sent from my iPhone

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Friday, April 13, 2018 12:31 PM
To: House Judiciary
Subject: FW: Hb 54

Follow Up Flag: Follow up
Flag Status: Flagged

From: Joe Schlanger <jlschew1968@gmail.com>
Sent: Friday, April 13, 2018 12:27 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: Hb 54

Dear Representative Matt Claman,

I am against HB 54 Suicide Assistance bill. Please do not pass this bill. We are already #1 in the United States for Suicide. We must value life not just throw it away.

Sincerely,
Joe Schlanger

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Friday, April 13, 2018 3:08 PM
To: House Judiciary
Subject: FW: Oppose HB 54

Follow Up Flag: Follow up
Flag Status: Flagged

From: Diane Warta <terndi@gmail.com>
Sent: Wednesday, April 11, 2018 12:48 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: Oppose HB 54

Opposition to HB 54

My name is Diane Warta, RN and I've worked here in the State of Alaska as a RN since my graduation from UAA in 1986. I am greatly opposed to HB 54 because I think it is not only unnecessary but also potentially harmful to a great number of vulnerable people.

For the last 20 years I have worked at the Orthopedics Unit at Providence Alaska Medical Center. I have seen great advances in pain control during that time. Surgeries that used to have very difficult and painful recoveries now provide the surgical benefit with well-managed and well-controlled pain. Those same advances we have working with orthopedic surgery patients in pain control are also available with Palliative care. End of life care with Palliative care team involvement can have pain and distress well-managed and controlled. The patient facing death can do so with dignity, support, and comfort.

We never really know when someone is terminally ill how long their life with last. My father was diagnosed with brain cancer and after surgery to remove the tumor, he was given 1-2 years to live by the surgeon and oncologist. We, as a family, rallied around my father but he died two weeks later from a complication of his surgery.

My father-in-law was also diagnosed with cancer. He was expected to live 3-4 months with his type of lung cancer but ended up living a full year and dying at home in Alaska with family and Hospice support. About three months after his diagnosis, he became very short of breath and was admitted to the hospital for a few days to effectively treat a pneumonia that he developed. He was alert, interactive, and ambulatory until one week before his death.

My step-father, a resident of Oregon, struggled with terrible pain for over a year. He attempted suicide while in Arizona because he could find no relief for his pain and was very nearly successful. Later, in Oregon, he was found to have cancer and was started on Palliative care with adequate pain management. He then wanted to live and interact with his family and neighbors and repeatedly expressed sorrow over attempt to take his own life. When his cancer diagnosis became more defined, he was offered Hospice Care. But to accept Hospice care in Oregon with his Kaiser insurance, he had to agree that he would no longer go to the Emergency Department or have any further doctor visits. In return he was offered pain control, equipment for home use, and nurse support for home visits. Although his pain was well managed with the Palliative Care, he was enticed with the extra support offered through the Kaiser Oregon Hospice to give up his access to medical interventional care. The Oregon Hospice team immediately stopped his blood thinner which he had been on for years as a preventive treatment because of his atrial fibrillation, a heart rhythm that makes a person susceptible to blood clots. He died less than a week after starting Hospice care from lung complications but did not have the option of seeking treatment for his difficulty breathing after starting Hospice because he had given up the option for medical intervention.

I am greatly concerned that if HB 54 is passed, that suffering will not be diminished but will instead be increased as individuals and families lose time together that can be rich and rewarding. I'm concerned that people who are going through a time of struggle will make decisions that they would regret if they were not given the option to end their lives prematurely. I am concerned that the person wishing to die may not truly be terminally ill and that we cheapen human life and destroy dignity as we destroy our vulnerable citizens.

Please oppose HB 54.

Sincerely,
Diane Warta, RN

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Saturday, April 14, 2018 12:23 PM
To: House Judiciary
Subject: FW: House Bill 54

Follow Up Flag: Follow up
Flag Status: Flagged

From: Elowyn Smith [mailto:elowyndo@gmail.com]
Sent: Saturday, April 14, 2018 11:24 AM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: House Bill 54

Dear Chairman Claman:
I would first like to thank you for the time and work you are spending as an Alaska State Represenitive. I have been practicing general pediatrics in Wasilla for 14 years. As pediatrician and breast cancer survivor, I have supported patients and families through the difficult times surrounding the end of life. I became a pediatrician to partner with families to help their children grow to be happy, healthy, successful adults. I also have had support to them during the difficult time when life is coming to an end. I choose to write this letter to you after reading Dr. Jeanne Anderson's opinion piece in the Anchorage Daily News yesterday (4-13). I am not as effective at communicating my ideas and concerns as she but I have to say that I agree with everything she wrote. Upon graduation from medical school, all physicians swear an oath to do no harm. Assisting individuals in ending their lives after they have been given a diagnosis of a terminal illness would be a betrayal of that oath. Terminally ill patients facing the ultimate end are very emotionally vulnerable and, in moments of deep despair, are extremely likely to make death decisions contrary to our society's value of human life. Better practice would be to focus on care and support of an individual during this vulnerable time. Assisting them in ending their life is not considered supportive. I have to agree with Dr. Anderson that HB 54, as put in her words: "aims at hastening death and belittles the value that a person with a terminal illness has to offer." I agree with her that "the Legislatures end-of-life bill is a bad idea." Please vote no on this bill.
Respectfully,
Elowyn Smith, DO
Sent from Mail for Windows 10

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Saturday, April 14, 2018 12:23 PM
To: House Judiciary
Subject: FW: HB54

Follow Up Flag: Follow up
Flag Status: Flagged

-----Original Message-----
From: Magnuson, William J MD [mailto:William.Magnuson@providence.org]
Sent: Saturday, April 14, 2018 11:17 AM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB54

Dear Representative Claman,
I am writing to you today to voice my concerns pertaining to HB54 and why it should not be passed into law.

I read Dr. Jeanne Anderson's opinion piece in the ADN and I could not agree more with her sentiments and rationale. Like her, I also have many stories of being incorrectly estimating how long a patient will live, despite years and years of education, training and experience.

As an Oncologist, I have also seen first hand how innovations and advances in technology can cure patients who were otherwise thought to be incurable and lead long, happy lives.

Finally, we have an excellent system of hospice physicians, palliative care physicians and others who can help patients die a peaceful, natural death, not one that is hastened by artificial measures. Who are we to play God and determine the date of ones death?

Sincerely,
William

William Magnuson, M.D.
Director, Stereotactic Radiosurgery
Alaska CyberKnife Center
Providence Alaska Cancer Center

April 8, 2018

Rosalyn Singleton MD
22423 Columbia Glacier Lp.
Eagle River, AK 99577

HB 54

Dear Representatives

As a pediatrician with 30 years of experience in Alaska, I am deeply concerned to see a bill introduced on Physician Assisted Suicide. I fear for the medical profession when we are forced to turn from "caring" to "killing". I know that there are many arguments about saving suffering and pain, but these are arguments for expert "palliative" care, not killing patients. Legalizing physician assisted suicide could take us down an irrevocable journey to euthanasia. I have walked the journey with several friends and patients in their terminal stages. What they requested was compassionate expert care and pain control, not ending their lives prematurely.

Nazi Germany's "final solution" started with euthanasia of terminally ill and disabled before moving to Jews and other ethnicities. Physicians were involved in every aspect of Nazi euthanasia. (Friedlander H. The origins of Nazi genocide: from euthanasia to the final solution. Chapel Hill: University of North Carolina Press, 1995.)

Alaska already has a big problem with suicide. What kind of message are we giving those struggling against making a choice to take their lives if we as a medical profession become complicit in the suicide of patients?

There has been a steady increase in the number of assisted suicides in Oregon since their bill. The vast majority of those choosing to kill themselves are doing so for existential reasons rather than on the basis of real medical symptoms. Many people in give "fear of being a burden on others" as a reason for ending their lives. A substantial number of patients dying under the Oregon Act do not have terminal illnesses.

Physician assisted suicide is dangerous for physicians – it destroys trust, and it is an easy option for busy, stressed physicians. It is dangerous for families - It opens the door to the worst form of elder abuse by the exhausted care providers or greedy relatives. It is dangerous for patients, where the "right to die" will become the duty to die for senior citizens who don't want to be a burden. It's dangerous to society when society finds some lives "not worthy of being lived".

Sincerely Rosalyn Singleton
Rosalyn Singleton MD

ANCHORAGE LEGISLATIVE INFORMATION OFFICE

Email: Anchorage.LIO@akleg.gov 907-269-0111/ phone, 907-269-0229/fax

WRITTEN TESTIMONY

907 360 2051

NAME: George L Stewart MD

REPRESENTING: Am Academy of Medical Ethics

BILL#/ SUBJECT: HB 54 - Physician Assisted Suicide

COMMITTEE &

HEARING DATE: 04/13/18

I am Testifying in ~~OB~~ OPPOSITION To HB 54 - PLEASE ~~VOTE~~ ~~YES~~ NO

Doctors are Licensed AND TRAINED to Provide Loving Care FOR THEIR PATIENTS - NOT TO KILL THEM !

ALASKA already has one of the highest Rates of SUICIDE in The US - Passing HB54 Will Make it WORSE

PALLIATIVE CARE, PAIN Management and Loving CARE make Patient's outcomes Better

Saying "You've Got 6 MONTHS to Live" is almost always WRONG. In OREGON CANCER Patients have been declined TREATMENT and told to "See a SUICIDE DOCTOR" INSTEAD

PLEASE VOTE NO ON HB 54

ALASKANS DESERVE CARE AND NOT DEATH

Dear House Judiciary Chair Claman and Members of the Alaska Judiciary Committee,

I am writing in support of HB 54 "End of Life Options", a bill which helps ensure Alaskans with 6 months or less to live have a voice about their end-of-life wishes.

As a physical therapist with twenty years of experience, I am an advocate for patient autonomy in health care. When people are provided with information and choices and time to consider their options, they can make the choice which best suits them. With the End of Life Options bill, this would help ensure that Alaskan voices are indeed heard and all options are available to prevent unnecessary suffering.

How we are born and how we die is paramount; these experiences shape who we are, those around us, how we look at the world and tread on the earth. These hours being present, holding the hands of our loved ones as they prepare for death molds our impression of dying, of the death process. There is no greater time to honor ones dignity and wishes than in the final days of life. HB 54 would ensure Alaskans voices are heard and honored.

As a born and raised Alaskan and health care provider, I thank you for introducing this important legislation and look forward to it moving forward so medical aid in dying is an option for terminally ill Alaskans.

Best wishes,

Zoya Herrnsteen

Letter in support of House Bill 54, End Of life Options.

I am 74 years old. I have painfully observed the lingering deaths of my parents, several aunts and uncles, and even more of my friends. In many of those cases the conditions from which they died were beyond the capabilities of the medical profession to do anything more than to prolong life, at any cost, often with no regard to the wishes of the patient or their loved ones and friends. Some of the patients were in a coma and hopefully not in pain, but my Mother and several friends were fully aware of their conditions, were wracked with constant pain, and, although they wished to die as quickly as possible, and voiced that to family, friends, and their doctors, the medical profession was hobbled by their inability to legally assist in that last, most charitable wish.

The Hippocratic Oath states, among other things, "do no harm". I would argue that prolonging ones life beyond their own wish to do so, ensuring they will die a lingering death of days, weeks, or months of excruciating pain, is a form of harm akin to torture! I have been a veterinarian for almost fifty years. I learned a very important lesson very early on that has never been far from my mind. The first few times I was asked to euthanize a terminally ill animal I was conflicted; here I'd been trained to cure animals, to

keep them alive, and now I was being asked to end ones life? Fortunately, euthanasia is not only an established practice in veterinary medicine, it is accepted as (and here is the thing that has stuck with me all these years) the last, best thing we can do for our animal charges.

I have euthanized many hundreds of animals at the end of their lives, ending misery for the critters, and the emotional agony of the owners of those animals who had been watching their beloved pet deteriorate in front of their eyes. Other than a small needle prick for the injection, the process is painless, simply an anesthetic procedure with a lethal overdose of the drug. In most cases I encouraged the owners to be in the room with us, so they, too, could see what I had seen alone at the beginning of my career; these animals simply went to sleep, a serenity replaced what had been a grimace on their faces, and they were at peace. The owners, too, had a sense of relief and knew they had done the right thing for their pet. Sure, there were almost always tears, but every client thanked me for what we were able to do.

It has always been my opinion we veterinarians have a huge advantage over MDs; we can provide that last, best, service, when they cannot. I am confidant that most medical doctors, being the caring people they are, would appreciate having this procedure in their armamentarium. Not that they would have to use it, but knowing they could when the patient desired it.

Back to my opening sentence, I would hope that by the time I may need such a procedure to end my own suffering, I will be able to ask my medical provider for a legal, ethical, and profoundly moral method of ending my life when I want it to end.

Thank you for your consideration.

Karl Monetti, VMD

Box 56302

North Pole, Alaska,99705

907-322-0242

My name is Herb Berkowitz (no relation to Ethan). I am 75 years old and have lived in Anchorage for almost 50 years. When my death comes I want it to be on my terms and in my home in Anchorage. I don't want to spend my final days in the Lower 48 because a vocal minority up here have religious qualms about how I choose to end my life — something that has NOTHING to do with them.

In 2018 religion, and only religion, lies at the heart of all objections to aid in dying. A whole series of "slippery slope" arguments have been debunked by years of experience in other states. It is NOT a plan for getting rid of the elderly, the handicapped, the poor or anyone else. It will be exactly what it is in States where it is legal — a private matter between physician and patient under the protection of safeguards that assure it won't be anything else.

I give HB 54 my unqualified support. No one has anything to fear from this law. It does not require anyone to do anything that violates his or her religious or moral values. It is no more artificial or unnatural than open heart surgery or chemotherapy. I want to be proud of my Legislature for rejecting disingenuous arguments and doing the right thing for Alaska's citizens.

Dear Harriet,

I'm writing to let you know that I stand in support of HB 54 - End of Life Options. I have lost many family members to terminal but lingering diseases. I don't know how they would have chosen, but, having been at their sides while they suffered, I do know that when my time comes I will want a choice.

Thank you,

Chris Bond

Sent from my iPhone

Hello:

I support passing SB 54 this year.

Thank you,

Jill Reese

2980 Lois Drive

Anchorage, AK 99517

My name is Lane Moffitt and I was born and raised in the valley. The last 21 years I have lived in the Wrangell St. Elias Park. My significant other Betty passed from cancer last June. It started 6 years ago with breast cancer and she wet thru double mastectomy,chemo,radiation. . She was still receiving radiation and her mother came down with ovarian cancer and was to old for chemo. We stepped in and took care of her till she passed. Last September Betty was told the cancer had come back and it was in her right foot,lower spine,ribs,sternum and in her neck. She was told they couldn't do anything this time but maybe slow it down. She chose to come home to her nest and our 18 year old son and I took care of her for 8 months till she passed. I will tell you that it was so painful for her that you could not give her enough oxycodone and fentanyl to stop the pain cause she would start having trouble breathing. She

came to the point of having seizures and when they stopped she would have to spit out chunks of broken teeth. I can go on and on about all the other horrible things that happen along the way but I wont. I read hb-99 about 6 months ago and it is very well written. I know that you folks are probably overwhelmed with the budget crisis. No matter what you do with it a lot of people are going to suffer along with the state. This is one aspect of Alaskans life you can eliminate the suffering. There is not a week go by without a friend,neighbor or fellow Alaskan comes down with cancer that I hear about. Please let me know the status on this bill. A heartfelt thanks to all of you.

Lizzie Kubitz

From: Terrie Gottstein <terrie.gottstein@gmail.com>
Sent: Tuesday, April 10, 2018 2:49 PM
To: House Judiciary
Subject: HB 54 - Death with Dignity bill

TO ALL MEMBERS OF THE HOUSE JUDICIARY COMMITTEE:

I am writing to strongly support passage of HB 54 (the Death with Dignity bill), which I understand is currently in your committee, receiving testimony on the bill. Unfortunately, I don't believe
the timing of the hearing on the bill will coincide with my schedule, so I sincerely hope you give equal weight to this email, to be SURE you know how strongly I support this bill.

Hopefully, none of us or our loved ones will ever need to use it, but for anyone who does, HB 54 offers a compassionate, common sense solution for ending unnecessary pain and suffering. Please let Alaska join Hawaii and support the long overdue passage of this mechanism for what should be a basic human right. You've got a chance to make a big difference.

Thank you!

Terrie Gottstein
Anchorage, AK
907- 223-4240

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Thursday, April 12, 2018 10:23 AM
To: House Judiciary
Subject: FW: Letter of Support for HB 54 - End of Life Options

From: Karen Possible [mailto:karenpossible@gmail.com]
Sent: Wednesday, April 11, 2018 8:53 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: Letter of Support for HB 54 - End of Life Options

Dear Committee Members,

Please support this bill. This is very Alaskan legislation and speaks directly to our highest held belief in freedom.

If you have not seen an ugly death, then you cannot comprehend the horror which lives on in the minds of those left behind. We watched our loved ones as they pleaded for death. We don't want to die the same way.

My brother, Mark Greenwell, died of esophageal cancer. He suffered, horribly. He was young and in the care of Hospice. The cancer spread and corrupted the basic functions of his body. Mark's body swelled, filled with everything you can imagine when your guts have turned to mush. While they gave him medication for the pain, nothing could free him from the agony of seeing his own body decay. He was unable to go to the bathroom, unable to eat, unable to drink, parched, given a sponge on a stick to suck. His lips covered in Vaseline because they were so chapped and bloody. This proud, independent father was robbed of his life by cancer and robbed of his freedom, dignity and peace by the state.

Over the last four years I have spoken with many terminally ill people throughout the country, including those in states where they can have a peaceful exit through legal means. They find that just having the knowledge, the power and control to exit when they wish gives them the strength to carry on. This is very much about independence and freedom, something we Alaskans hold dear.

I know someone in Alaska who is terminally ill and is planning on putting a bullet in his brain. He is planning on strangers finding his body. He knows his 'blowing his head off' will be ugly and he doesn't want his family to see. People confide in you when they are desperate. If he is reading this, please know that I have not forgotten and I am fighting for you, too. I remember.

I remember all of you.

You, my fellow Alaskans, have the opportunity to make history. You have the opportunity to give the terminally ill the option of being at home, surrounded by the support and love of their friends and family, listening to music at sunrise and slipping peacefully away, if that is THEIR choice. My brother died in a nursing home, at 2 a.m., in December 2014, just shy of his birthday and Christmas, having slipped into a coma a few hours before after weeks of appalling suffering, pleading for escape, pleading for death.

It is time that we are civilized and that our Alaskan laws catch up with our humanity.

Thank you for your time, attention and your support. I will not forget your support.
Karen Dechman Bond
4620 Golden Spring Circle
Anchorage, Alaska 99507

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Thursday, April 12, 2018 10:26 AM
To: House Judiciary
Subject: FW: Public Testimony from Sitka for House Judiciary Committee on HB54

From: Ken Fate
Sent: Wednesday, April 11, 2018 4:49 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Cc: House Judiciary <House.Judiciary@akleg.gov>
Subject: Public Testimony from Sitka for House Judiciary Committee on HB54

Please accept this Public Testimony from Sitka for House Judiciary Committee on HB54 as submitted to the Sitka LIO. Thank you. Ken Fate

HB 54 Terminally Ill Ending Life Option: Dear Committee members, I'm writing to strongly support House Bill 54 which allows terminally ill patients to ease their suffering and hasten an inevitable and certain death. Death is a natural part of life. This bill preserves dignity and a person's right to live, and die, on their own terms according to they own desires and beliefs and with a much greater focus on a person's life than on the often painful and agonizing process of dying. Oregon, Washington, Colorado, California and Washington DC all have similar legislation. The Supreme Court upheld this in 2006. The bill has safeguards to protect patients from coercion and allows patients and doctors to have honest and open discussion so that patients are able to make their own decisions.

Thank you for taking my comments.

Sincerely,

Libby Stortz,

Sitka, Alaska

Lizzie Kubitz

From: William Kenyon <wtkenyon@hotmail.com>
Sent: Friday, April 13, 2018 8:40 AM
To: House Judiciary
Cc: Rep. Louise Stutes; Sen. Gary Stevens
Subject: HB 54

To: House Judiciary April 13, 2018

Dear Chairman Claman and members of the Judiciary Committee,

My name is William Kenyon, I am 76 years old and a resident of the city of Cordova, Alaska.

A year and a half ago, I was diagnosed with Idiopathic Pulmonary Fibrosis, which is a terminal diagnosis. There is no cure for this condition. I will slowly lose my ability to breathe and near the end, be restricted to bed care.

I had a friend in Oregon who died of terminal cancer and using the Oregon law in that state, went through the process of being approved for medical aid in dying. My friend never used that help. Her explanation to me was that every day and every moment, she was not helpless, but had a valid choice on her future. That fact gave her a great degree of peace and as time went on, through the pain and discomfort, she would put off the decision for the next day and continue to live for another day.

Although I have not yet reached the last weeks or months of my life, I agree with my friend, I would like a choice also. With no hope when I reach that stage, I would like the right to choose, with a clear mind, when it is time for me to leave this world.

Thank you for allowing me to testify, I appreciate it.

Contact info: PO Box 1390, Cordova, AK 99574
wtkenyon@hotmail.com

Lizzie Kubitz

From:	Rep. Matt Claman
Sent:	Friday, April 13, 2018 1:46 PM
To:	House Judiciary
Subject:	FW: Please support the End-of-Life Option Act
Follow Up Flag:	Follow up
Flag Status:	Flagged

-----Original Message-----
From: Compassion & Choices <info@compassionandchoices.org>
Sent: Friday, April 13, 2018 11:44 AM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: Please support the End-of-Life Option Act

Apr 13, 2018

State Representative Matt Claman
State Capitol, Room 118
120 Fourth Street
Juneau, AK 99801-1182

Dear State Representative Claman,

I want you to know that I am among the 70% of Alaskans who support medical aid in dying. As your constituent, I strongly urge you to support House Bill 54, the End-of-Life Option Act.

For me, this issue is personal. I know friends and family members who had a difficult final chapter in their lives and could have benefited from medical aid in dying.

This bill would give terminally ill, mentally capable adults with less than six months to live access to the full range of choices at the end of life, including medical aid in dying. It offers hope and peace of mind to thousands every year who are confronting the possibility of a prolonged, painful death.

There are now eight jurisdictions where the right to choose your own, peaceful ending is affirmed either by legislation, the courts, or popular ballot. This legislation is modeled after legislation in Oregon and other states where it has a proven track record of success.

How we die, like how we live, should be a personal choice. Momentum for medical aid-in-dying legislation is growing across the country. As your constituent, I ask you to help make Alaska the next state to authorize this option.

Sincerely,

Ms. jessie koerner
432 S Ogden St
Anchorage, AK 99529

Laurinda Marcello
1952 Dodge Cir.
Sitka, AK 99835
laurinda.marcello@gmail.com

Alaska House Judiciary Committee

April 13, 2018

Dear House Judiciary Committee Members:

Thank you for allowing me to submit these written comments regarding HB 54 "An Act providing an end-of-life option for terminally ill individuals; and providing for an effective date." I urge you to advance & eventually pass HB 54.

When I was just 18 years old, in the short summer between high school graduation and leaving for my freshman year of college, my family completely changed. My father – then a middle-aged college chemistry professor – was unexpectedly diagnosed with terminal cancer. Scans revealed a stage IV cancer had metastasized all over critical areas in his body. My dad thus opted for palliative or comfort care only. He would die just three weeks after initial diagnosis. Yet during this short time, so much happened to diminish his quality of life. There was a serious infection resulting in a medivac to Seattle and his loss of independence. Although we were able to get him back to Sitka, the cancer was faster than our ability to arrange for in-home hospice care, which my dad very much wished for. During his final several days, he faced the kind of pain that not even the maximum allowable dosage of morphine could erase. He passed away at Sitka Community Hospital.

The speed of his downward progression, would have likely precluded my dad from accessing Death with Dignity. The proposed law contains a very reasonable waiting period to safeguard against misuse. However, I take comfort in knowing that other terminally ill Alaskans could be helped by HB 54. Many terminally ill people have months to contemplate & plan for their deaths. Unfortunately, as I've seen with other loved ones and acquaintances, that extra time to think often comes with a prolonged period of agony. On a personal note, it is also not lost on me that risk for aggressive cancers or other serious diseases can have a genetic component. It remains my greatest hope that Alaska will offer its terminally ill residents the option to die with the assistance of medication. Please support the passage of HB 54.

Sincerely,

Laurinda Marcello
Sitka, AK

Please enter into the record my

WRITTEN TESTIMONY

Name: John Shows

Representing: self

Bill No./Subject HB54

Committee: HJUD

Date of Hearing: 4/13/18 1pm

I am in support of HB54

A close friend of mine recently was diagnosed with terminal cancer and took his own life violently. He should have had a better more humane option that preserved his dignity.

JC Shows
Homer, AK

Testimony of Joel Hanson

Before House Judiciary Committee

HB54 Death with Dignity

Mr. Chairman, Members of the House Judiciary Committee, for the record my name is Joel Hanson, I'm 67 years old, I live in Sitka and I respectfully urge you to support the Death with Dignity legislation before you.

Like a lot of people in their late 60s, I have some personal knowledge and experience with end-of-life issues.

My father died almost 30 years ago from cancer. My mother, my sisters and I all spent time helping him through a prolonged and difficult period of deteriorating health at home, where he eventually died hooked up to a morphine pump which he needed in order to keep his pain in check during his last few months.

Then, 15 years ago, my mother died, also of cancer, also in pain, and also at home with her children at her bedside.

When I heard about this legislation recently, I went online and listened to a recording of the hearing it received before the House Health and Social Services Committee on the 30th of January.

To those who supported the bill at that hearing, and to those who support it here today, I say thank you for your efforts. End of life issues are not easy to deal with. But deal with them we must...both personally and as a society.

To those who opposed this legislation in January, and to those who have determined to oppose it today, I say this: It is the epitome of cruelty for a person to force months of physical agony on another person simply because of a religious

or ethical belief in the "sanctity of life." If this is your position, as it was for the only two objectors at the January hearing, understand that what you advocate is, in effect, condemning someone else to suffer perhaps many months of pain in order to avoid being subject yourself to nothing more than a measure of doctrinal or ethical distress. Call it whatever you want, but don't call your position a commitment of your devotion to a compassionate god or higher moral sense? No! Call it what it is: a commitment to prolonging human anguish.

I have my own confession: If this legislation fails, it won't matter much to me personally because in a few years if I find myself near my own life's end in the same kind of shape my parents were before their deaths (and there's a reasonable chance I will), I have a backup plan. It won't be the most dignified solution, but absent a legally sanctioned pharmaceutical alternative, it will be better than suffering...and possibly causing those around me to suffer. I know what that's like.

I hope that those of you who are still undecided on Death with Dignity will give some thought to the fact that more than a few elderly and seriously unwell Alaskans choose to take their own lives every year with a bullet to the head. You could help reduce the frequency of such incidents by supporting HB54.

Thank you.

House Judiciary Committee Testimony – Friday, April 13, 2018 – Gruenberg 120

Hello, my name is Amy Lujan and I am a resident of Juneau. Thank you for hearing this bill. I'm here today to testify in favor of HB54, representing only myself today

I've been a part of the death process for four grandparents and my father. I don't believe that in any of those five cases, a medically assisted end-of-life option would have been chosen, if available. However, these situations made me think deeply about the choice or lack of choice we have, or should have, at the end of life.

Having lived in rural Alaska for fifteen years prior to moving to Juneau, I've seen suicide and the aftermath close at hand. Clearly we must do everything possible to prevent the suicide of a mentally unstable person and to promote healing and future happiness for these individuals. This is VERY different from the end-of-life situation contemplated in this bill.

As I mentioned, I don't believe my grandparents or my father would have chosen a medically assisted end-of-life option. However, through the dying process I could see how our medical system pushes patients and families to always take the next treatment, even when quality of life plummets and hope is extremely remote.

One of the strongest Alaskan values is independence. Therefore, I believe Alaskans should be allowed to make their own choices in their final days, in consultation with their loved ones and their medical providers. It is a choice that I would very much like have available to me.

I respect the opinion of medical providers such as Dr. Jeanne Anderson, who has written movingly on this subject, including in today's Anchorage Daily News. Generally speaking, doctors are trained to push for a solution that could possibly lead to a recovery of health. We rely on their expertise. I myself would not be sitting here today were it not for life-saving surgery when I was 25 years old. Other medical procedures since then have greatly improved my quality of life.

I am glad that this bill allows Dr. Anderson and others to "opt out" of participating in the end of life option. However, we as individual humans

must have the ability to override the opinions of others, in cases where we alone can make the judgment for ourselves of what we're willing to endure. We must be allowed to choose death with dignity.

In two cases, I have observed friends deal with the horrific ALS, or Lou Gehrig's disease that afflicted their family members. Dr. Stephen Hawking benefitted from a miracle and lived a productive life with this disease. These individuals were not so lucky. It was heart wrenching to watch their families go through this terrible dying process. I believe they might have chosen a medically assisted end-of-life option, if available. Or, at least the choice might have been a comfort to these patients and their families.

It is horrific to think about the unnecessary pain that family members may have had, if in fact they did bring about the death of their loved one by some other means. This could of course be labeled illegal and lead to serious consequences on many levels.

Please support this bill to spare both patients and families unnecessary pain. The medically assisted end-of-life process has worked in many other states and other countries, and we can learn from their experience to allow Alaskans the independence to make choices they deserve to have.

Thank you.

To: House Judiciary Committee

From: Susan Schrader

Date: April 13, 2018

RE: Support for: HB 54 "An Act providing an end-of-life option for terminally ill individuals; and providing for an effective date"

Good afternoon, Committee Members. My name is Susan Schrader; I have lived in Juneau for nearly 30 years. I am here to offer my full support for this legislation and to encourage you to do so also.

I'm not sure what to say that would help change the minds of those of you who oppose giving Alaskans additional end-of-life options. I can only suspect that you have not yet been in the very difficult position of watching a beloved family member or friend suffer from a terminal illness. But I have. Three of my husband's and my parents died from cancer, and I can tell you from personal experience that hospice and palliative care did NOT gain them the peace and freedom from suffering they wanted in their long final days.

Alaskans treasure our independence, our freedom, and our privacy. I feel incredibly fortunate to have been born in a country where I could make my own choices about how I live my life....and I think it is our right to be able to make choices about how to end our lives.

In my opinion, Rep. Drummond's Sponsor Statement provides an excellent rationale for, and analysis of, this bill. I certainly hope you have read her statement and the bill carefully and thoughtfully, and will recommend a "Do Pass" from this committee.

Thank you for your consideration of my testimony.

Dear Rep. Drummond,

I hope it is not too late for me to state my support for HB 84. I believe it was 2016 when I and a friend spoke telephonically from the Fairbanks LIO office in favor of passing legislation that would give dying individuals a choice tp shorten hours, days even weeks of extended suffering. Many states in the United States as well as our close neighbor Canada have such laws.
The bill under discussion at that time, as other existing laws, was very careful to make sure that the choices/options offered would not be abused.

As we know, medical science has progressed in many ways including the ability to maintain an individual life far beyond what could have been expected. While this can be a godsend to the patient and family in some cases it simply prolongs the suffering.

I am a hospice volunteer and as such was able to attend a presentation on Washington's law by a Physician from a children's hospital in Seattle. He explained how the process works in Washington state. First, you were required to be a citizen of the state before you were eligible to make a decision under their law, which seems a reasonable requirement. He discussed the statistics about who opted to end their life when death was inevitable. It was a surprisingly low number including many who originally were in favor of that option but later changed their mind.

We humans always like to believe we have control over our lives plus we have choices about the important decisions in our lives. Therefore, how much more important the choice of the end of your life is.

I am confident that our Alaska Legislature can pass a law that will give Alaskan citizens choice and dignity at the end of our lives.

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

mjresourceak@ gmail.com

Good afternoon, members of the committee, my name is Barbara McDaniel and I am here to testify on my own behalf in support of House Bill 54.

In my fortunately healthy life, I've always accepted that my death is inevitable. When I was young I would say, "I hope I die in my sleep." But later I discovered I don't need to simply hope I die comfortably. I realized I can at least make legal, mitigating plans that increase the odds that I won't die a drawn-out, sick, painful, and very expensive death, one that would traumatize my children.

In consultation with my children, all adults, I modeled taking responsibility for one's life (and that includes death) and created my Advanced Directives when I was 52. When I was 57, on my request, my doctor helped me obtain my Certificate of Comfort One Status, the do-not-resuscitate order for emergency or medical personnel. My local hospital has copies of the documents on file. I wear a bracelet. Basic information is in my wallet and glove box. And the best part is my children know what is coming, they know the plan, and they know what to do. We are prepared.

Now I am covered legally in instances of sudden, life-threatening accidents, violence, or physical failures. But I still do not possess the last piece of control I need to ensure my access to careful, professional assistance in ending my life in the event of terminal illness. HB 54 is the missing piece I need to complete my personal plan to increase my likelihood of experiencing a comfortable, orderly, dignified, death. Please pass HB54.

I whole-heartedly thank Rep. Drummond for bringing forward this compassionate bill for personal rights and responsibility. And I thank you all very much for hearing my testimony today.

Barbara McDaniel
1040 N Craig Stadler Loop
Wasilla, AK 99623
907-355-3204

My name is Barbara E. Hunt who is in support of HB 54 and was responsible in getting the Girdwood Board of Supervisors to pass a resolution in favor of the bill. I moved to Girdwood in February 2017 after losing my husband of 37 years to Renal Cancer. He fought a courageous losing battle with various treatments until death was imminent. I was his sole caregiver until he was placed under Hospice care in November 2016, At that time, our son joined me at his father's bedside. On the first night of the Hospice nurses' 24 hour care, he asked for medication to peacefully end his life. However, it was made known to him that the support was not possible. He didn't want us to live with the imagery of his final deterioration and unbearable discomfort. He chose starvation as a means to hasten the process. He always sought quality of life, but that was not to be at his end. My hope is to prevent another person from having to spend their last days with their loved ones worrying unnecessarily about what kind of death they will have and how to mentally, emotionally and physically support them.
I encourage the Judiciary Committee to continue to allow HB 54 to move through the Legislative process. Girdwood has shown their support to the State on this bill by passing a local resolution and hopefully this will pave the way to make Alaska the 8th state in the country to have options at the end of life.

Barbara E. Hunt
Compassion and Choice Team Leader Girdwood

Dear Rep Drummond

I very much support HB 54. I have facilitated a class dealing w end of life issues and those taking this class were sympathetic for legislation such as HB 54. A similar law became legal in Canada 2 yrs ago and several US states have laws in place for those near the end of life. Folks have not abused these options already in place.

I would hate to force my loved ones to suffer needlessly. Aid in dying is not a choice of death over life. It is an option that allows those who are dying the option of a controlled and peaceful ending. Thanks for introducing this bill.

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

2113 Jack St
Fairbanks, AK 99709

Hi, As a man about to turn 73 years old, this issue is becoming more personal.

I strongly believe that citizens should has as much control and choice as possible over their own lives. I have prepared instructions to the local medical staff that I do not want heroic measures to prolong my "life" when recovery is no longer possible. I refuse food, hydration, IV medications, permitting only pain-killers.

I do not want any state laws to override my intentions for my own care.

Best wishes,

Sam Bunge
Petersburg, Alaska

Dear Representative Drummond,

For a person as old as I am, (71), having cancer is a bummer but not a disaster. Though I was not born in Haines, it is here where I want to die - here where I have lived for more than 40 years. This is where I am happy and healthy in many ways. If you have a condition that is a conscious prelude to death, while

conscious many people want to plan that experience. HB54 allows patients to work with doctors to make a plan so that death is not a surprise nor is it full of physical pain. HB54 also helps patients stay in Alaska instead of moving, as many have, in order to have access to decision making strategies in Washington and Oregon. Please help us by voting in favor of HB 54.

Sincerely,

Stephanie K. Scott
Box 431
Haines, Alaska 99827
907-766-2718

I am deeply in favor of Alaska becoming one more state that allows people to die the way they want to die. When we talk about dying with dignity we're not talking about our valuable, young, vibrant teenagers in villages or other places in Alaska, we're not talking about depression or mental illness. We're talking about people who are actively dying and have no hope of recovery. We're talking about giving people more options than just starving to death in a hospital or a hospice, or hording medication to kill themselves.
The world is not black and white, you can still love life and fight for life while understanding that people have a right to choose to not be in horrible agonizing pain, or to not be sitting slowly wasting away for while they wait for death. Why do we hate those who do not fear death at the end? do we not praise soldiers for this same trait? I grew up hearing people talk of those who had died "at peace" in reverent tones. We're not affording peace or dignity in prolonging the lives of those who wish to die.
No one is forcing people to make this choice either. There are no death panels killing off our grandparents, no one is strapping down patients and killing them because of these dignity laws.

Please support HB 54.

Angie Fraker
1650 Eastridge Drive 104
Anchorage, AK 99501

Dear Representative Drummond,

I am in support of HB 54 because it gives patients and families time to plan and prepare for end of life. And it provides physicians and nurses and other care givers an opportunity to support the patient and their loved ones as they transition to end of life as a care team.
When my mother was diagnosed with ALS in 1999, there were no options that were at the time socially or legally acceptable. She was 70 years young, had lived independently and worked until her body no longer allowed her the freedom to work. My husband and children made the best of a most terrible circumstance. We cared for her until her death 15 months after she was diagnosed. There is no cure for ALS. Along with her care team, our family did our best to give our mother and grandmother all we could to make her last chapter comfortable and peaceful. Mom and I talked about assisted suicide at great length. For my mom, the end was inevitable. She was frustrated a death with dignity option was not available. The fight to stay alive with medications and tube feedings would have extended her life by weeks or months. This was not in her game plan. She wanted to die at home, not in a hospital. She had

worked in the medical field and knew about heroic measures to save a life that was destined to be short. She had a Comfort One bracelet. She was ready. If HB 54 had been enacted, she would most definitely have opted in. I wish she had the opportunity to plan her death with the dignity she had in life.

Like you, I will never know what it is like to die until it is my turn. The best I can hope for is that I will be kept comfortable and pain free in peaceful surroundings. Giving people an option with HB 54 will not impact the majority of the people in Alaska. Giving one person the option will make a difference not only to him or her, but also to the loved ones struggling with the transition. Once the decision to plan for a good death has been made, a subtle shift from struggling to live longer to acceptance of living well begins. Sharing of stories, and having memorable conversations can begin.

My hope for people with a terminal illness is for each of them to have the option of a good death. At the right time. One that is peaceful, one that allows a transition that is at best difficult, but fully accepted by the patient. And hopefully accepted by the family and loved ones that take the longer journey after a death, the journey that brings grief, conversations, stories and ultimately acceptance of a life well lived and an appreciation of a death with dignity. A good death is the ultimate gift to a life well lived. Please approve HB 54.

Elizabeth Bacom
PO Box 683
Petersburg, AK 99833

ANCHORAGE LEGISLATIVE INFORMATION OFFICE

Email: Anchorage.LIO@akleg.gov 907-269-0111/ phone, 907-269-0229/fax

WRITTEN TESTIMONY

NAME: Joni Bruner

REPRESENTING: Self

BILL#/ SUBJECT: HB54

COMMITTEE &

HEARING DATE: 4/13/18

I Agree with Voluntary Termination of Life. Concern is DEATH CERTIFICATE - REASON - will there be problem with Life insurance ~~using~~ refusing payment as a result? NOT written in the Bill clearly as to what the certificate will say.

Joni Bruner

Please Keep / PASS THIS BILL!

AND THANK YOU!

ANCHORAGE DAILY NEWS

Opinions

I'm a doctor who treats Alaskans with cancer. Here's why I think the end-of-life bill in the Legislature is a bad idea.

Author: Dr. Jeanne E. Anderson | Opinion Updated: 6 hours ago Published 19 hours ago

Life, from its beginning, is a terminal condition, yet it is a gift that brings both joy and suffering. House Bill 54 (short title "Terminally ill: ending life option") aims to hasten death and belittles the value that a person with a terminal disease has to offer. Toward the end of life, patients may fear death, pain, suffering and aloneness. We as a community, both medical professionals and caring friends and family, need to support and accompany such patients on their unpredictable end of life journey.

I am a medical oncologist, a physician caring for patients with cancer. I have been in this specialty for 27 years, including the last 17 years in Anchorage. Alaska state legislators need to let HB 54 die a natural death and not pass it into law.

Here are some problems with the bill:

1. HB 54 states that a patient must have an "...irreversible disease that has been medically confirmed and that will, within reasonable medical judgment, produce death within six months." Doctors are notoriously poor at assessing survival duration. Unless a patient is imminently dying, within hours to days, we cannot predict a survival of less than six months.

When a patient is imminently dying there are many appropriate treatment options: oxygen, morphine, benzodiazepines, and loving support of family, friends and medical personnel. When a physician tries to predict a "less than 6 month" survival, they are relying on published data collected years ago which are not relevant to today's practices and current treatment options.

2. HB 54 implies patients with life-threatening or life-ending diseases do not have alternative options. Advances in management of cancer and other diseases have increased dramatically in recent years. Many patients in Alaska are alive much longer than previously predicted due to new targeted therapies. Chronic leukemia and multiple myeloma are examples with survival rates of 10 years, compared to previous 2-3 years. A patient who lives 1 more year with a new drug, has the potential to receive another new therapy in the future.

HB 54 capitalizes on Alaskans' fear of suffering and abandonment, particularly in our elders. When given treatments to control pain, shortness of breath, anxiety, and depression that do not hasten death, patients then have improved quality of life leading to life-giving experiences. Experts in supportive care are available in Alaska, including palliative care specialists, pain specialists, counselors and support groups, and the No One Dies Alone (NODA) program.

Two patient examples offer hope:

David Wight had stage IV bladder cancer and exhausted all known standard treatments in 2014. I predicted a survival of less than six months. He chose to enroll on a clinical trial with a novel drug (now standard of care) and is alive on treatment with no evidence of cancer, more than three years later. This example speaks to success and unpredictability of new treatments.

Donald Dunkleberger had stage IV lymphoma, which did not respond to standard chemotherapy. Specialists in Seattle declined to offer a life-saving bone marrow transplant due to the unresponsiveness of his cancer. In 2016, I expected a survival of less than six months. Without any further treatment, he is alive two years later without active lymphoma. This example speaks to the inability of expert physicians to predict prognosis.

Unintended consequences of the bill:

1. Alaskans are well aware of our "culture of death." Alaska has among the highest rate of suicide per capita in the country. HB 54 fosters this low regard of life. We need to support and accompany patients with terminal diseases and not offer them the option to commit suicide.

[How strangers touching strangers transformed the moment of death]

2. Alaskans are all well aware of the financial toxicity of medical care. Several columns by Charles Wohlforth in the ADN have discussed this problem. There is increasing risk of financial bankruptcy for patients treated for cancer. HB 54 will put implicit pressure on patients with terminal diseases to hasten death in order to decrease financial burden on their surviving family members.

We need to turn the culture in Alaska to value and care for our ill and elderly. As caring Alaskans, we can help people without harming them. If this bill is of concern to you, contact your state legislators.

Dr. Jeanne E. Anderson is an oncologist who practices in Anchorage.

Comments

Representative Harriet Drummond
House Bill 54 Sectional Analysis
"Voluntary Termination of Life"

Section 1:

Amends AS 11.41.115 (defenses to murder) to allow an affirmative defense for acting under 13.56.

Section 2:

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 13.56.

Section 3:

Adds a new chapter AS 13.56, which provides the process in which terminally ill individuals may request medication to terminate their life.

Sec. 13.56.010: 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. 13.56.020: 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. 13.56.030: Requires a qualified individual to make an oral and 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. 13.56.040: 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. 13.56.050: 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. 13.56.060: Lays out a form for the written request to be signed by the qualified individual.

Sec. 13.56.070: 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. 13.56.080: 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. 13.56.090: 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. 13.56.100: Prohibits the attending physician from dispensing or prescribing medication unless the qualified individual has made an informed decision.

Sec. 13.56.110: Prohibits the attending physician from denying the medication request because the individual declines or cannot notify next of kin.

Sec. 13.56.120: Requires certain waiting periods before medication can be dispensed or prescribed.

Sec. 13.56.130: Requires that the medical record of the qualified individual contains the items listed in the section before the individual receives the medication.

Sec. 13.56.140: 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. 13.56.150: 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. 13.56.160: States that a health care provider has no duty to participate.

Sec. 13.56.170: Under certain conditions allows a health care provider to prohibit another health care provider from participating in this chapter.

Sec. 13.56.180: Establishes prohibition notice to another patient to administer medication on the premises of another health care provider.

Sec. 13.56.190: States that the chapter does not limit liability for civil damages and sanctions resulting from a person's negligent conduct or intentional misconduct.

Sec. 13.56.200: Creates criminal penalties for an administered termination of life unintended by the individual classifying death without intention as a class A felony and punishable by AS 12.55

Sec. 13.56.210: This chapter does not limit liability for civil damages resulting from a person's neglect conduct or intentional misconduct.

Sec. 13.56.220: A government entity that incurs expenses that result from a qualified individual ending the qualified individuals life in a public place mat file a claim against the estate and recover cost and attorney fees.

Sec. 13.56.230: 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. 13.56.240: States the criteria of attending physician qualifications needed to administer medication. The physician must have primary responsibility of the patient's health care, Primary treatment for patients terminal illness, routinely provide medical care, notwithstanding an individuals practice solely made up of individuals requesting medication under this chapter.

Sec. 13.56.250: 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. 13.56.260: Exempting insurance from providing coverage of medication to be used for termination purposes.

Sec. 13.56.270: 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. 13.55.290: Defines the terms used in the new chapter.

Section 4:

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:

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

Section 6:

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

Section 7:

Makes the Act (except Bill Section 5) effective January 1. 2019.

Fiscal Note

State of Alaska
2018 Legislative Session

Bill Version:	CSSSHB 54(HSS)
Fiscal Note Number:	2
(H) Publish Date:	2/2/2018

Identifier: HB054SS-DHSS-BVS-1-25-18
Title: TERMINALLY ILL: ENDING LIFE OPTION
Sponsor: DRUMMOND
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Public Health
Allocation: Bureau of Vital Statistics
OMB Component Number: 961

Expenditures/Revenues

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

	FY2019 Appropriation Requested	Included in Governor's FY2019 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2019**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Personal Services							
Travel	1.8		1.8				
Services	5.0		40.4	36.4	37.5	37.5	37.5
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**6.8**	**0.0**	**42.2**	**36.4**	**37.5**	**37.5**	**37.5**
Fund Source (Operating Only)							
1004 Gen Fund (UGF)	6.8		42.2	36.4	37.5	37.5	37.5
Total	**6.8**	**0.0**	**42.2**	**36.4**	**37.5**	**37.5**	**37.5**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY2018) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2019) cost: 140.0 *(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? 01/01/20

Why this fiscal note differs from previous version/comments:

Not applicable; initial version.

Prepared By: Jay C. Butler, MD, Chief Medical Officer — Phone: (907)269-6680
Division: Public Health — Date: 01/25/2018
Approved By: Shawnda O'Brien, Asst. Commissioner — Date: 01/25/18
Agency: Health and Social Services

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2018 LEGISLATIVE SESSION

Analysis

HB54 version "O" adds a new statutory chapter, Sec. 13.55, *Voluntary termination of life* (effective January 1, 2019) that allows terminally ill Alaska residents age 18 or older to request and use prescribed medications to voluntarily terminate their own life. Under current Alaska law, it is illegal to intentionally aid another person in committing suicide. 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.

Given passage of this bill, Alaska would join six states and the District of Columbia in allowing voluntary termination of life for residents: Oregon, Washington, Vermont, Montana, California, and Colorado. As is true in these other states, this bill requires the Department 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.

If Alaska experienced about the same rate of participation as Oregon per year, it would be expected that less than 40 voluntary termination of life applications would be submitted and less than 20 deaths would result. According to the 2015 Oregon Death with Dignity Act report, there were 218 Death with Dignity Act prescriptions written to requesting individuals in Oregon; of those, 125 individuals, or just over half, ingested the prescribed medication and died as expected. No individual that ingested the medication regained consciousness nor died first of the terminal condition. For Oregon, this corresponds to 38.6 Death with Dignity Act deaths per 10,000 total deaths.

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, 2018. Bureau staff does not have the capacity or expertise required to develop complex regulations and do extensive outreach. Therefore, a $5.0 contract for professional services would be needed for the latter half of FY2019 and again in the first part of FY2020. 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 January 1, 2020. A small amount of travel would be associated with stakeholder meeting facilitation in several areas of the state.

The Bureau would require a one-time capital appropriation to add a custom module to its existing Electronic Vital Records System. Additional funds would be required in the out years to maintain and license the system module as an addition to a current, ongoing contract with an automatic 3% increase annually through FY2021. After 2021, the contract must be re-negotiated; therefore, FY2022-2024 do not include the 3% increase. The module would 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.

Given passage of this bill, the Department would provide training, register forms received by health care providers, and prepare the annual report. This training would be provided to funeral homes and health care providers regarding the proper completion of death certificates for voluntary termination of life patients to ensure confidentiality is maintained. Based off Oregon's ongoing FTE estimates, less than 1/10th of one FTE is required to register the forms; the personal services costs can be absorbed within the current appropriation.

Fiscal Note

State of Alaska
2018 Legislative Session

Bill Version:	CSSSHB 54(HSS)
Fiscal Note Number:	1
(H) Publish Date:	2/2/2018

Identifier: SSHB054-LAW-CIV-01-26-2018
Title: TERMINALLY ILL: ENDING LIFE OPTION
Sponsor: DRUMMOND
Requester: House Health & 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)

	FY2019 Appropriation Requested	Included in Governor's FY2019 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2019**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
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							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY2018) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2019) 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/comments:

Updated to SLA2018 fiscal note template.

Prepared By: Valerie Rose, Budget Analyst — Phone: (907)465-3674
Division: Administrative Services Division — Date: 01/26/2018
Approved By: Jahna Lindemuth, Attorney General — Date: 01/26/18
Agency: Department of Law

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2018 LEGISLATIVE SESSION

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 oral request. A person may rescind their request at any time.

The legislation creates a defense to murder in the first degree, murder in the second degree, 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, completes, 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.

Fiscal Note

State of Alaska
2018 Legislative Session

Bill Version: HB 54
Fiscal Note Number:
() Publish Date:

Identifier: SSHB054-LAW-CIV-01-26-2018
Title: TERMINALLY ILL: ENDING LIFE OPTION
Sponsor: DRUMMOND
Requester: House Health & 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)

	FY2019 Appropriation Requested	Included in Governor's FY2019 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2019**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
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							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY2018) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2019) 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/comments:

Updated to SLA2018 fiscal note template.

Prepared By: Valerie Rose, Budget Analyst — Phone: (907)465-3674
Division: Administrative Services Division — Date: 01/26/2018
Approved By: Jahna Lindemuth, Attorney General — Date: 01/26/18
Agency: Department of Law

FISCAL NOTE ANALYSIS

STATE OF ALASKA **BILL NO.** SSHB 54
2018 LEGISLATIVE SESSION

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 oral request. A person may rescind their request at any time.

The legislation creates a defense to murder in the first degree, murder in the second degree, 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, completes, 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.

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.

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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 deserving of care. These pressures would result, it is assumed, 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 with Dignity Act; PAS, physician-assisted suicide

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, four nationwide studies (the first of which is known as the 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 suicide" is used here to distinguish the form of 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 physician-assisted dying (PAS in Oregon; PAS or voluntary 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 other, less vulnerable people? The results presented (table 1)

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, information in the 1990 study about professional status, 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 is thus no evidence that physician-assisted dying poses

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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The Washington Post

Opinions

Archbishop Desmond Tutu: When my time comes, I want the option of an assisted death

By Desmond Tutu October 6, 2016

Desmond Tutu is archbishop emeritus of Cape Town and a Nobel Peace laureate.

Throughout my life, I have been fortunate to have spent my time working for dignity for the living. I have campaigned passionately for people in my country and the world over to have their God-given rights.

Now, as I turn 85 Friday, with my life closer to its end than its beginning, I wish to help give people dignity in dying. Just as I have argued firmly for compassion and fairness in life, I believe that terminally ill people should be treated with the same compassion and fairness when it comes to their deaths. Dying people should have the right to choose how and when they leave Mother Earth. I believe that, alongside the wonderful palliative care that exists, their choices should include a dignified assisted death.

There have been promising developments as of late in California and Canada , where the law now allows assisted dying for terminally ill people, but there are still many thousands of dying people across the world who are denied their right to die with dignity. Two years ago, I announced the reversal of my lifelong opposition to assisted dying in an op-ed in the Guardian. But I was more ambiguous about whether I personally wanted the option, writing: "I would say I wouldn't mind." Today, I myself am even closer to the departures hall than arrivals, so to speak, and my thoughts turn to how I would like to be treated when the time comes. Now more than ever, I feel compelled to lend my voice to this cause.

I believe in the sanctity of life. I know that we will all die and that death is a part of life. Terminally ill people have control over their lives, so why should they be refused control over their deaths? Why are so many instead forced to endure terrible pain and suffering against their wishes?

I have prepared for my death and have made it clear that I do not wish to be kept alive at all costs. I hope I am treated with compassion and allowed to pass on to the next phase of life's journey in the manner of my choice.

Regardless of what you might choose for yourself, why should you deny others the right to make this choice? For those suffering unbearably and coming to the end of their lives, merely knowing that an assisted death is open to them can provide immeasurable comfort.

I welcome anyone who has the courage to say, as a Christian, that we should give dying people the right to leave this world with dignity. My friend Lord Carey, the former archbishop of Canterbury, has passionately argued for an assisted-dying law in Britain. His initiative has my blessing and support — as do similar initiatives in my home country, South Africa, throughout the United States and across the globe.

In refusing dying people the right to die with dignity, we fail to demonstrate the compassion that lies at the heart of Christian values. I pray that politicians, lawmakers and religious leaders have the courage to support the choices terminally ill citizens make in departing Mother Earth. The time to act is now.

Read more on this topic:

The Post's View: Make the District a place to die with dignity

Kathleen Parker: Freedom to kill, permission to die

Ellen Goodman: Don't let polarizing politics derail how we talk about death

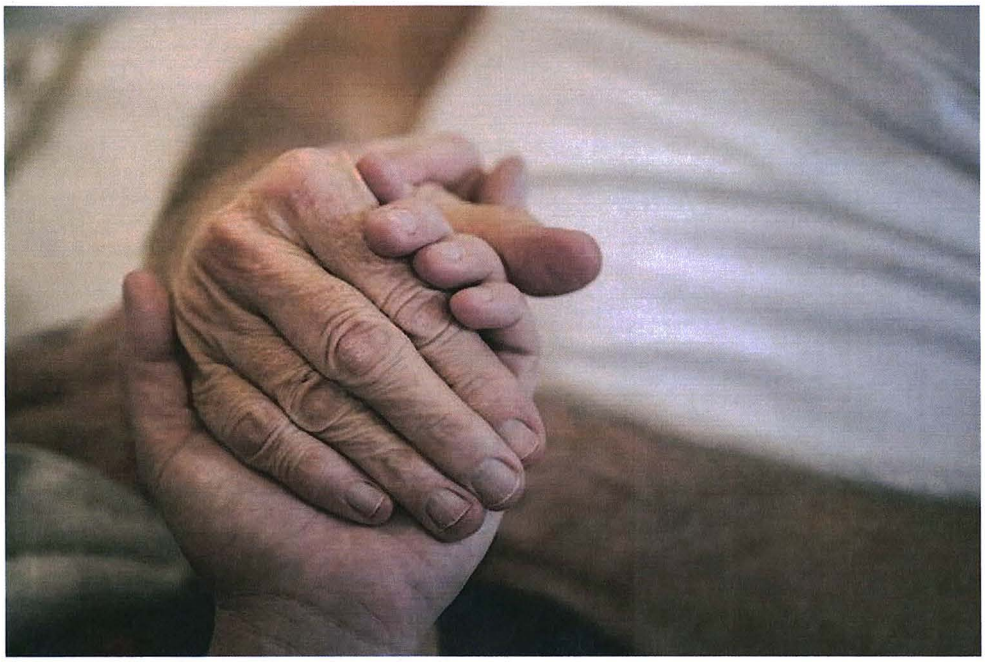
Charles Lane: Where the prescription for autism can be death

CaliforniaHealthline
The Daily Digest of News, Policy & Opinion

Docs In Northwest Tweak Aid-In-Dying Drugs To Prevent Prolonged Deaths

By JoNel Aleccia (http://californiahealthline.org/news/author/jonel-aleccia/)

February 21, 2017



(iStock/Getty Images Plus)

Two years after an abrupt price hike for a lethal drug used by terminally ill patients to end their lives, doctors in the Northwest are once again rethinking aid-in-dying medications — this time because they're taking too long to work.

The concerned physicians say they've come up with yet another alternative to Seconal (http://khn.org/news/in-colorado-a-low-price-drug-cocktail-will-tamp-down-cost-of-death-with-dignity/), the powerful sedative that was the drug of choice under Death with Dignity laws until prices charged by a Canadian company doubled to more than $3,000 per dose.

It's the third drug mixture recommended by the doctors whose medication protocols help guide decisions for prescribers in the six U.S. states where aid-in-dying is allowed.

The first Seconal alternative turned out to be too harsh, burning patients' mouths and throats, causing some to scream in pain. The second drug mix, used 67 times, has led to deaths that stretched out hours in some patients — and up to 31 hours in one case.

"[Twenty percent] of the cases were 3 hours or more before death, which we think is too long," said Robert Wood, a retired HIV/AIDS researcher who volunteers with the advocacy group End of Life Washington (http://endoflifewa.org/), in an email. "The longest was 31 hours, the next longest 29 hours, the third longest 16 hours and some 8 hours in length."

Patients and families are told to expect sleep within 10 minutes and death within four hours. When it takes far longer, family members get worried, even distressed, said Dr. Carol Parrot, a retired anesthesiologist who has prescribed drugs for dozens of aid-in-dying patients in Washington.

The doctors say this can be addressed with larger doses of the three drugs they have been using — diazepam, often used to treat anxiety; digoxin, used to treat heart issues; and morphine, a narcotic pain reliever — plus another heart medication, propranolol, in a four-drug cocktail aimed at quickly inducing death, Wood said.

Parrot and Wood are part of a seven-member group of doctors in the Northwest who came up with the three-drug protocol after Valeant Pharmaceuticals Inc., (http://www.valeantnow.com/valeant-statement-on-seconal/) acquired the rights to secobarbital, known as Seconal, in 2015 and raised the price sharply.

"We wanted the new drug regime to be safe, reliable and effective — and cost $500 or less," said Parrot.

Since 1997, when Oregon's Death with Dignity (http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx) law became the first in the nation, doctors had relied on fast-acting, relatively inexpensive barbiturates — either secobarbital or pentobarbital — for patients with terminal diagnoses who sought aid in dying in Oregon, Washington, California, Colorado, Montana and Vermont. The practice also has been approved in Washington, D.C., but is being reviewed by Congress.

Pentobarbital became unavailable after drugmakers blocked its use in U.S. death penalty executions.

Concerns about the overly long deaths surfaced last summer, Parrot said. Nearly all of the problems occurred in patients already taking high doses of opiates.

"We run into patients who are so tolerant or dependent on narcotics that even the astronomically high doses of oral narcotics in our prescription do not stop them from breathing," she said.

If patients have diseases that slow or alter normal organ function, it can affect the speed and amount of drugs absorbed in the small intestine, metabolized in the liver and sent to the rest of the body. Very large patients, too, may require larger doses.

Deaths aren't required to be supervised, and no doctor was present with the unidentified patient who took 31 hours to die, so doctors would only be speculating about the reason, Parrot said.

Not all patients — or doctors — experienced overly long deaths with the previous drug mixture. Dr. Lonny Shavelson (http://khn.org/news/aid-in-dying-laws-dont-guarantee-that-patients-can-choose-to-die/) , a Berkeley, Calif., physician who has supervised two dozen aid-in-dying deaths under California's new law, said it worked fine.

"My personal experience is I haven't had long deaths with it," Shavelson said.

And not all doctors think long deaths are a problem. In Oregon, even with fast-acting barbiturates, time to death has ranged from one minute to 104 hours during the 20 years the law has been in effect, state records show.

"I've heard stories where it took quite a number of hours to die, and it was fine," said Dr. David Grube, an Oregon-based medical director for the advocacy group Compassion & Choices (https://www.compassionandchoices.org/research/speakers/speaker-david-grube/).

Scott and Amy Kreiter, of Wenatchee, Wash., didn't know what to expect when Scott's mother, Patricia Hansen, 69, decided to take the lethal drugs on Dec. 26, 2016. Hansen, a lively woman who once ran a gourmet ice cream business, had endured frequent hospitalizations for end-stage kidney failure, congestive heart failure and other ailments.

"She said, 'I want to listen to Willie Nelson, I want to play a game of Scrabble, I want to drink a Rob Roy or two, and then I want to be done,'" Scott Kreiter, 47, said.

Hansen proceeded to "kick our butts" at Scrabble, her son said — including fulfilling a goal of getting a triple-word score with a dirty word. Then she mixed the drugs with scotch and drank the solution.

"She didn't complain. She just took it," her son recalled. "She said, 'You thought I'd chicken out, didn't you?'"

Within two minutes of downing the mixture, Hansen was asleep. Within 20 minutes, her breathing had stopped.

"We thought it would take one to two hours," Amy Kreiter said. "It if had gone on for hours, we would have thought we did it wrong."

Critics of aid-in-dying say growing reports of overly long deaths underscore their objections. Dr. David Stevens, CEO of Christian Medical & Dental Associations (https://www.cmda.org/), which has tried to halt or reverse laws, said coming up with new drug protocols could eventually be a step toward Holland's practice of allowing euthanasia by lethal injection "so the patient could be killed 'humanely.'"

"We are heading down that same path," Stevens said in an email.

But Parrot and other frequent prescribers of aid-in-dying drugs say they are looking for the best way to honor the wishes of patients in states where the practice is allowed. Doctors recently began using the newest drug mixture and will gather data about its effectiveness.

"We're not experimenting," Parrot said. "We are working with available drugs to provide dying patients a comfortable, peaceful death that is reliable and safe for them and comforting for their families as well."

Pat Hansen, 69, of Wenatchee, Wash., chose to end her life with lethal medications under Washington's aid-in-dying law. Hansen, who had end-stage kidney failure, congestive heart failure and other ailments, went to sleep within minutes after taking the drugs and stopped breathing within 20 minutes, her family said. (Courtesy of Scott Kreiter)

This story was produced by Kaiser Health News (http://khn.org/), an editorially independent program of the Kaiser Family Foundation (http://kff.org/).

CATEGORIES: Uncategorized

TAGS: Aid In Dying (http://californiahealthline.org/news/tag/aid-in-dying/), End Of Life (http://californiahealthline.org/news/tag/end-of-life/), Prescription Drugs (http://californiahealthline.org/news/tag/prescription-drugs/), Washington (http://californiahealthline.org/news/tag/washington/)

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Local advocates for medical aid in dying law

Kodiak Daily Mirror
Nov. 16, 2017
By JOANN SNODERLY
joann@kodiakdailymirror.com

Ella Saltonstall has spent a lot of time contemplating death.

At age 16, the Kodiak resident faced the death of her father. In 2016, she lost her mom.

Now, she is one of two Compassion and Choices action team leaders operating in the state of Alaska. Compassion and Choices is a nonprofit advocacy organization supporting expanded options for end of life care, including medical aid in dying.

Saltonstall is leading a local effort to raise support in Kodiak and statewide for a medical aid in dying bill introduced by Rep. Harriet Drummond, D-Anchorage, to the Alaska House in each of the last two legislative sessions.

If passed, the bill would allow an adult patient deemed to be mentally competent but terminally ill with less than six months to live to request and receive a prescription for medication that would end that patient's life.

In her efforts, Saltonstall has collected 70 signatures in Kodiak since September expressing support for medical aid in dying. Anticipating reintroduction of Drummond's bill in the next session, she plans to send them to legislators early next year.

She has also asked the borough assembly to consider a resolution in support of the bill and will help man the Compassion and Choices booth at the Alaska Municipal League Conference this week.

Saltonstall's activism began in 2014 after hearing the story of Brittany Maynard, a 29-year-old California woman who moved to Oregon after being diagnosed with terminal brain cancer in order to take advantage of the state's medical aid in dying laws.

Saltonstall had experience with death much earlier than 2014, however.

At age 16, Saltonstall lost her father, former Kodiak Island Borough Mayor and Assembly Member Dave Herrnsteen, to cancer.

"My family and I surrounded our father ... as he passed away from terminal cancer in our home on Monashka Bay Road. That experience forever shaped how I view death and one's choices surrounding it," she said. "Even though he left this earth too soon, I was grateful to have had that as an experience compared to what it could have been. His death was not prolonged or overly painful."

It was a different experience in 2016 when her mother was diagnosed with terminal cancer. She died two months later after choosing not to undergo treatment.

During those two months, Saltonstall and her sister served as their mother's caregivers. The family had discussions about what the process of dying looks and feels like, and the options afforded to those with a terminal diagnosis.

"Our mother had to spend time in her last days worrying about what kind of death we would have to witness. She didn't want months of unbearable discomfort and progressive decline for my sister and I to watch," Saltonstall said.

"My hope is to prevent one other person from having to spend time in their last days

with their loved ones worrying unnecessarily about what kind of death they will have and how it may impact their caregivers."

Saltonstall acknowledges it is an issue fraught with moral questions for many. Over 20 people spoke during the House Health and Social Services Committee's two hearings on the bill, with emotional and often tearful testimony on both sides of the issue.

Physicians spoke both for and against the bill, as did people facing terminal and debilitating diseases.

On one side were people like Carol Egner, whose husband, Harry Egner, died last year.

"Sometimes when Harry's friends came to visit, he would beg them to bring a gun next time. Some of them then found it hard to keep visiting since they would not do this for him, and they felt terrible. Although Harry was blessed with caring children and grandchildren bringing joy and love to him during his darkest times, he was still trapped in a continuous nightmare for 16 months until he died on Thanksgiving morning, Nov. 24, 2016, at the age of 72," she said.

"It is a difficult journey when one is unable to move and recovery is not happening. That last day, he was suddenly going downhill fast. His heart and organs were shutting down and he did not die comfortably, but struggled with the problem of drowning in his own fluids."

On the other side was James Hanson, a New York resident suffering from brain cancer who was told by doctors he had four months to live three years ago. Hanson was unable to read due to his condition, so his wife, Kristin Hanson, read his statement for him.

Although living three years with terminal brain cancer has been difficult, he is glad to be alive, according to the couple's testimony.

"If I had suicide pills with me in those dark moments, I might not be here today and you can't undo that. You can't unmake that decision. There's no going back; you're dead," Kristin Hanson read.

"Many patients in my exact circumstances are offered lethal drugs and denied or delayed coverage for the care they need. I felt at times, as most terminal patients do, that I was a burden to my family and experienced depression at points during my illness. Tragically, those feelings are enough for people in my shoes to choose death over care. This is a very real danger when suicide becomes a social norm for people who are terminally ill."

Those opposed to the bill questioned the protections against misuse, and some cited religious beliefs. Some said a plea to end one's life should be taken as a sign the person is in need of psychiatric treatment.

Those in favor see it as a compassionate choice, offering peace of mind and relief from prolonged suffering.

"We hook terminally ill patients up to machines that prolong death for weeks. We have machines that can breathe, eat and urinate for people. We administer CPR on sick patients and break their ribs, burrow large IV lines into burned out veins and plunged tubes into swollen, bleeding airways. God is looking down on us and asking, 'What are you thinking?'" Drummond said when introducing the bill in committee.

"Science is not God. Medicine is here to help sick people, and when people are too

sick to keep living, medicine should still be able to help people. We have stopped seeing the person and are only looking at the patient."

Some have expressed concern about the impact the legislation may have on suicide rates in the state. Alaska has the second-highest suicide rate in the United States, according to the Centers for Disease Control and Prevention.

"I'm really disturbed that this is something we're talking about right now is trying to increase the numbers of people dying from suicide," said Christopher Kurka of Alaska Right to Life, a Christian political action committee that advocates against medical aid in dying.

For Saltonstall, suicide and medical aid in dying "represent opposite ends of the spectrum with regard to one's end of life and closure," as medical aid in dying allows a patient to tie up loose ends and die at peace.

"Suicide is when you're choosing to end your life. When you're given a terminal diagnosis, that is something that is out of your hands," she said.

Saltonstall said her goal is to open up the conversation in Kodiak and the state.

"It's a heavy cause. It's about death. People aren't in general always able to talk about that," she said. "What this is doing is opening up a conversation in our community about death."

She welcomes anyone with questions about the movement to reach out to her at (907) 942-2166 or ella2076@gmail.com.

Snoderly can be reached at (907)512-2624. Follow her on Twitter, @KDMjoann

JuneauEmpire.com

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Posted February 9, 2018 07:43 am

By B. Ella Saltonstall (/b-ella-saltonstall)

For the Juneau Empire

Enabling terminally ill Alaskans to die peacefully

B. Ella Saltonstall

What do you want your final days and hours to look like?

An important end-of-life option, known as medical aid in dying, allows mentally capable, terminally ill patients with less than six-months to live, to request from their physician a prescription for medication they can decide to take to die peacefully in their sleep if their suffering becomes unbearable.

The End of Life Option Act (House Bill 54), which is being considered in the Alaska Legislature, provides Alaskans this option at the end of one's life by authorizing medical aid in dying.

Talking about death is something I've become used to over the past couple of years. My advocacy for passing medical aid-in-dying legislation began after witnessing both of my parents' deaths. I was present as they both died from terminal cancer, 25 years apart from each other, here in Alaska. For my father's death, I was a teenager in Kodiak when hospice didn't even yet formally exist; however, our father died in our home, free from any machines as we said goodbye to him following a short but very intense unsuccessful cancer treatment.

SEE ALSO

2017 Legislative bill summaries (http://juneauempire.com/news/state/2018-01-15/2017-legislative-bill-summaries)

Goodbye bail: Alaska switches to new system of criminal justice (http://juneauempire.com/state/news/2017-12-20/goodbye-bail-alaska-switches-new-system-criminal-justice)

My mother declined all treatment after she was given her terminal illness diagnosis and died at home a couple of months later, surrounded by my sister and me. However, even with her confidence in her decision of no treatment, she spent time in her final days carrying the emotional burden of not wanting to cause my sister or me undue discomfort in caregiving for her for a potentially prolonged or painful death at home.

In these conversations, I learned that refusing treatment ultimately widens the conversations about other end-of-life care options, such as hospice and palliative care, that enable the dying person to live the remaining days with maximum quality of life instead of continuing efforts at "living" longer with possible negative side effects of medication. The fact that medical aid in dying was not a possible option for my mom in Alaska came up often in our remaining time with her.

Support for medical aid in dying is increasing across the country, with national and state polls showing a majority of people across the ethic, political and religious spectrum want this option. Increasingly, state medical societies nationwide are rescinding either their opposition to medical aid in dying and taking a neutral stance. Since Oregon passed medical aid-in-dying legislation in 1994, Washington, Vermont, California, Colorado and the District of Columbia have passed comparable legislation and Montana authorized this end-of-life care option via a state Supreme Court ruling. Safeguards in place for medical aid in dying have succeeded — not a single incidence of misuse has been reported in the cumulative 40 years of experience with this option in these six states and the District of Columbia.

Alaskans support this important option.

Alaskans are increasingly taking notice of this topic. Last month, the Board of Supervisors in Girdwood unanimously passed a resolution in support of medical aid-in-dying.

In my discussions with hundreds of Alaskans from all corners of the state over the past six months, I've seen an overwhelming support for this option at the end of life. People who have held the hand of someone with a terminal illness diagnosis often express an understanding for the need for this option. No individual wants to see their loved one in unnecessary prolonged pain at the end of their life.

It is time for Alaska to grant terminally-ill individuals the freedom to live their final days focusing on the love, joy and beauty around them with the option of peacefully dying when they are ready. If you support having this option for yourself or those around you, please contact your state senators and representatives and let them know you support HB 54.

B. Ella Saltonstall, a volunteer team leader for Compassion and Choices in Kodiak and mother of two boys, is a lifelong Alaskan, as well as arts and music advocate in Kodiak, who is completing her graduate studies in Speech and Language Pathology.

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3 Comments Sort by **Oldest**

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Bill Burk
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Resolution 2017-18
Of the Girdwood Board of Supervisors
RESOLUTION OF SUPPORT FOR END OF LIFE OPTIONS LEGISLATION

WHEREAS, advances in science and technology have created medical interventions that often prolong the dying process and prolong suffering; and

WHEREAS, "aid in dying" describes a medical practice defined by established standards of care, which enables a mentally competent, terminally ill adult to obtain a prescription for medication, which the patient may choose to self-administer, in the face of unbearable suffering, to advance the time of an approaching death; and

WHEREAS, many find comfort and peace of mind in having access to options at the end of life, including aid in dying, even if they do not choose to exercise those options; and

WHEREAS, six states and the District of Columbia affirmatively authorize the medical practice of aid in dying, enabling terminally ill, mentally competent adult residents to receive a prescription for life-ending medication from their doctor.

THEREFORE, the Girdwood Board of Supervisors resolves by a vote of 5 to 0, its support for End of Life Options legislation to be moved from the Health and Human Service Committee and to continue in the process of consideration and approval by the Alaska State Legislature.

PASSED AND APPROVED this 18th day of December, 2017.

Jerry Fox, GBOS — Date: 12/18/17

Attest

ALASKA SURVEY RESEARCH

MEASURING MINDSHARE

THE ALASKA SURVEY
3RD QUARTER 2017

Hello, my name is _____ and I'm calling for Alaska Survey Research, an Alaska public opinion research firm. We are conducting a public opinion survey today called the Alaska Survey. The survey concerns a variety of different topics that you'll probably find interesting.

IF CELLPHONE RESPONDENT… We'd like to get your input to the survey as a cellphone respondent. We've deliberately called you on the weekend so that hopefully we're not using up your minutes, and we'd like to ask if you can safely respond to the survey where you are right now.

IF LANDLINE RESPONDENT… Is this a residential telephone? IF "YES", CONTINUE... If they are available, I'd like to speak with the youngest male aged 18 or older in your household. (IF AVAILABLE, SWITCH AND REPEAT INTRO. IF NOT AVAILABLE…) How about the youngest female aged 18 or older? (IF AVAILABLE, SWITCH AND REPEAT INTRO. IF NOT AVAILABLE, CONTINUE WITH RESPONDENT.)

All phone numbers used for this survey were randomly generated. We don't know your name, but your opinions are important to us, and we'd appreciate your participation if that's OK with you. Of course, your responses will be completely confidential.

S1. What is the zipcode where you live?

	AREAS OF ALASKA:	
	Count	%
Southeast	79	10.5%
Rural	72	9.6%
Southcentral	192	25.5%
Anchorage	307	40.9%
Fairbanks	101	13.5%

1A. Are you registered to vote in the State of Alaska?

	REGISTERED TO VOTE?	
	Count	%
Yes	649	86.4%
No	102	13.6%

1B. (IF YES TO 1A…) Do you think that a person in Alaska who has been diagnosed with a terminal illness and has been given a prognosis by two physicians of less than six months to live, should have the legal right to end their life on their own terms, through the use of a doctor's prescription, yes or no?

	LEGAL RIGHT TO END LIFE?	
	Count	%
Yes	449	70.2%
No	159	24.9%
Not sure	31	4.9%

The following questions are for statistical purposes only.

2A. (IF LANDLINE, THEN ASK…) Do you use a cellphone?

2B. (IF CELLPHONE, THEN ASK…) Do you have a landline telephone in your home?

2C. (IF YES TO EITHER 2A OR 2B, THEN ASK…) On which line do you conduct most of your day-to-day telephone communication, your landline or your cellphone?

	LANDLINE/CELL STATUS:	
	Count	%
Land only	28	3.8%
Both - land dominant	68	9.1%
Both - cell dominant	182	24.3%
Cell only	472	62.9%

Representative Harriet Drummond
Sponsor Statement

House Bill 54 "Voluntary Termination of Life"

House Bill 54 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 in 2013 and Colorado, California, and Washington DC all legalized similar legislation 2016. Similar bills have 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.

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3RD QUARTER 2017

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Municipality of Anchorage

P.O Box 390
Girdwood, Alaska 99587
http://www.muni.org/gbos

Ethan Berkowitz, Mayor

GIRDWOOD VALLEY SERVICE AREA BOARD OF SUPERVISORS
Jerry Fox & Robert Snitzer, Co-Chairs
Eryn Boone, Mike Edgington, Sam Daniel

Resolution 2017-18
Of the Girdwood Board of Supervisors
RESOLUTION OF SUPPORT FOR END OF LIFE OPTIONS LEGISLATION

WHEREAS, advances in science and technology have created medical interventions that often prolong the dying process and prolong suffering; and

WHEREAS, "aid in dying" describes a medical practice defined by established standards of care, which enables a mentally competent, terminally ill adult to obtain a prescription for medication, which the patient may choose to self-administer, in the face of unbearable suffering, to advance the time of an approaching death; and

WHEREAS, many find comfort and peace of mind in having access to options at the end of life, including aid in dying, even if they do not choose to exercise those options; and

WHEREAS, six states and the District of Columbia affirmatively authorize the medical practice of aid in dying, enabling terminally ill, mentally competent adult residents to receive a prescription for life-ending medication from their doctor.

THEREFORE, the Girdwood Board of Supervisors resolves by a vote of 5 to 0, its support for End of Life Options legislation to be moved from the Health and Human Service Committee and to continue in the process of consideration and approval by the Alaska State Legislature.

PASSED AND APPROVED this 18th day of December, 2017.

Jerry Fox, GBOS — Date: 12/18/17

Attest

Local advocates for medical aid in dying law

Kodiak Daily Mirror
Nov. 16, 2017
By JOANN SNODERLY
joann@kodiakdailymirror.com

Ella Saltonstall has spent a lot of time contemplating death.

At age 16, the Kodiak resident faced the death of her father. In 2016, she lost her mom.

Now, she is one of two Compassion and Choices action team leaders operating in the state of Alaska. Compassion and Choices is a nonprofit advocacy organization supporting expanded options for end of life care, including medical aid in dying.

Saltonstall is leading a local effort to raise support in Kodiak and statewide for a medical aid in dying bill introduced by Rep. Harriet Drummond, D-Anchorage, to the Alaska House in each of the last two legislative sessions.

If passed, the bill would allow an adult patient deemed to be mentally competent but terminally ill with less than six months to live to request and receive a prescription for medication that would end that patient's life.

In her efforts, Saltonstall has collected 70 signatures in Kodiak since September expressing support for medical aid in dying. Anticipating reintroduction of Drummond's bill in the next session, she plans to send them to legislators early next year.

She has also asked the borough assembly to consider a resolution in support of the bill and will help man the Compassion and Choices booth at the Alaska Municipal League Conference this week.

Saltonstall's activism began in 2014 after hearing the story of Brittany Maynard, a 29-year-old California woman who moved to Oregon after being diagnosed with terminal brain cancer in order to take advantage of the state's medical aid in dying laws.

Saltonstall had experience with death much earlier than 2014, however.

At age 16, Saltonstall lost her father, former Kodiak Island Borough Mayor and Assembly Member Dave Herrnsteen, to cancer.

"My family and I surrounded our father ... as he passed away from terminal cancer in our home on Monashka Bay Road. That experience forever shaped how I view death and one's choices surrounding it," she said. "Even though he left this earth too soon, I was grateful to have had that as an experience compared to what it could have been. His death was not prolonged or overly painful."

It was a different experience in 2016 when her mother was diagnosed with terminal cancer. She died two months later after choosing not to undergo treatment.

During those two months, Saltonstall and her sister served as their mother's caregivers. The family had discussions about what the process of dying looks and feels like, and the options afforded to those with a terminal diagnosis.

"Our mother had to spend time in her last days worrying about what kind of death we would have to witness. She didn't want months of unbearable discomfort and progressive decline for my sister and I to watch," Saltonstall said.

"My hope is to prevent one other person from having to spend time in their last days

with their loved ones worrying unnecessarily about what kind of death they will have and how it may impact their caregivers."

Saltonstall acknowledges it is an issue fraught with moral questions for many. Over 20 people spoke during the House Health and Social Services Committee's two hearings on the bill, with emotional and often tearful testimony on both sides of the issue.

Physicians spoke both for and against the bill, as did people facing terminal and debilitating diseases.

On one side were people like Carol Egner, whose husband, Harry Egner, died last year.

"Sometimes when Harry's friends came to visit, he would beg them to bring a gun next time. Some of them then found it hard to keep visiting since they would not do this for him, and they felt terrible. Although Harry was blessed with caring children and grandchildren bringing joy and love to him during his darkest times, he was still trapped in a continuous nightmare for 16 months until he died on Thanksgiving morning, Nov. 24, 2016, at the age of 72," she said.

"It is a difficult journey when one is unable to move and recovery is not happening. That last day, he was suddenly going downhill fast. His heart and organs were shutting down and he did not die comfortably, but struggled with the problem of drowning in his own fluids."

On the other side was James Hanson, a New York resident suffering from brain cancer who was told by doctors he had four months to live three years ago. Hanson was unable to read due to his condition, so his wife, Kristin Hanson, read his statement for him.

Although living three years with terminal brain cancer has been difficult, he is glad to be alive, according to the couple's testimony.

"If I had suicide pills with me in those dark moments, I might not be here today and you can't undo that. You can't unmake that decision. There's no going back; you're dead," Kristin Hanson read.

"Many patients in my exact circumstances are offered lethal drugs and denied or delayed coverage for the care they need. I felt at times, as most terminal patients do, that I was a burden to my family and experienced depression at points during my illness. Tragically, those feelings are enough for people in my shoes to choose death over care. This is a very real danger when suicide becomes a social norm for people who are terminally ill."

Those opposed to the bill questioned the protections against misuse, and some cited religious beliefs. Some said a plea to end one's life should be taken as a sign the person is in need of psychiatric treatment.

Those in favor see it as a compassionate choice, offering peace of mind and relief from prolonged suffering.

"We hook terminally ill patients up to machines that prolong death for weeks. We have machines that can breathe, eat and urinate for people. We administer CPR on sick patients and break their ribs, burrow large IV lines into burned out veins and plunged tubes into swollen, bleeding airways. God is looking down on us and asking, 'What are you thinking?'" Drummond said when introducing the bill in committee.

"Science is not God. Medicine is here to help sick people, and when people are too

sick to keep living, medicine should still be able to help people. We have stopped seeing the person and are only looking at the patient."

Some have expressed concern about the impact the legislation may have on suicide rates in the state. Alaska has the second-highest suicide rate in the United States, according to the Centers for Disease Control and Prevention.

"I'm really disturbed that this is something we're talking about right now is trying to increase the numbers of people dying from suicide," said Christopher Kurka of Alaska Right to Life, a Christian political action committee that advocates against medical aid in dying.

For Saltonstall, suicide and medical aid in dying "represent opposite ends of the spectrum with regard to one's end of life and closure," as medical aid in dying allows a patient to tie up loose ends and die at peace.

"Suicide is when you're choosing to end your life. When you're given a terminal diagnosis, that is something that is out of your hands," she said.

Saltonstall said her goal is to open up the conversation in Kodiak and the state.

"It's a heavy cause. It's about death. People aren't in general always able to talk about that," she said. "What this is doing is opening up a conversation in our community about death."

She welcomes anyone with questions about the movement to reach out to her at (907) 942-2166 or ella2076@gmail.com.

Snoderly can be reached at (907)512-2624. Follow her on Twitter, @KDMjoann

LAW, ETHICS AND MEDICINE

Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups

Margaret P Battin, Agnes van der Heide, Linda Ganzini, Gerrit van der Wal, Bregje D Onwuteaka-Philipsen

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Accepted 10 July 2007

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 deserving of care. These pressures would result, it is assumed, 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 with Dignity Act; PAS, physician-assisted suicide

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, four nationwide studies (the first of which is known as the 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 suicide" is used here to distinguish the form of 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 physician-assisted dying (PAS in Oregon; PAS or voluntary 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 other, less vulnerable people? The results presented (table 1)

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, information in the 1990 study about professional status, 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 is thus no evidence that physician-assisted dying poses

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

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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.

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How Doctors Die

By: **Ken Murray, M.D.**

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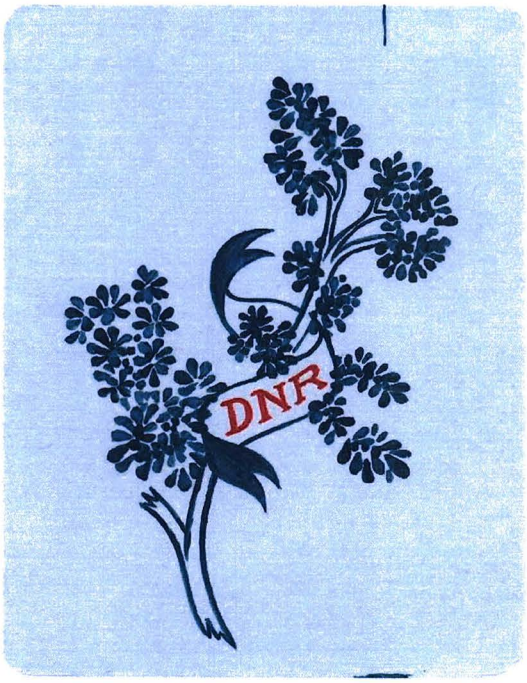

Should I have been more forceful at times? I know that some of those transfers still haunt me. One of the patients of whom I was most fond was an attorney from a famous political family. She had severe diabetes and terrible circulation, and, at one point, she developed a painful sore on her foot. Knowing the hazards of hospitals, I did everything I could to keep her from resorting to surgery. Still, she sought out outside experts with whom I had no relationship. Not knowing as much about her as I did, they decided to perform bypass surgery on her chronically clogged blood vessels in both legs. This didn't restore her circulation, and the surgical wounds wouldn't heal. Her feet became gangrenous, and she endured bilateral leg amputations. Two weeks later, in the famous medical center in which all this had occurred, she died.

It's easy to find fault with both doctors and patients in such stories, but in many ways all the parties are simply victims of a larger system that encourages excessive treatment. In some unfortunate cases, doctors use the fee-for-service model to do everything they can, no matter how pointless, to make money. More commonly, though, doctors are fearful of litigation and do whatever they're asked, with little feedback, to avoid getting in trouble.

Even when the right preparations have been made, the system can still swallow people up. One of my patients was a man named Jack, a 78-year-old who had been ill for years and undergone about 15 major surgical procedures. He explained to me that he never, under any circumstances, wanted to be placed on life support machines again. One Saturday, however, Jack suffered a massive stroke and got admitted to the emergency room unconscious, without his wife. Doctors did everything possible to resuscitate him and put him on life support in the ICU. This was Jack's worst nightmare. When I arrived at the hospital and took over Jack's care, I spoke to his wife and to hospital staff, bringing in my office notes with his care preferences. Then I turned off the life support machines and sat with him. He died two hours later.

Even with all his wishes documented, Jack hadn't died as he'd hoped. The system had intervened. One of the nurses, I later found out, even reported my unplugging of Jack to the authorities as a possible homicide. Nothing came of it, of course; Jack's wishes had been

spelled out explicitly, and he'd left the paperwork to prove it. But the prospect of a police investigation is terrifying for any physician. I could far more easily have left Jack on life support against his stated wishes, prolonging his life, and his suffering, a few more weeks. I would even have made a little more money, and Medicare would have ended up with an additional $500,000 bill. It's no wonder many doctors err on the side of over-treatment.

But doctors still don't over-treat themselves. Almost anyone can find a way to die in peace at home, and pain can be managed better than ever. Hospice care, which focuses on providing terminally ill patients with comfort and dignity rather than on futile cures, provides most people with much better final days. Amazingly, studies have found that people placed in hospice care often live longer than people with the same disease who are seeking active cures. I was struck to hear on the radio recently that the famous reporter Tom Wicker had "died peacefully at home, surrounded by his family." Such stories are, thankfully, increasingly common.

Several years ago, my older cousin Torch (born at home by the light of a flashlight—or torch) had a seizure that turned out to be the result of lung cancer that had gone to his brain. I arranged for him to see various specialists, and we learned that with aggressive treatment of his condition, including three to five hospital visits a week for chemotherapy, he would live perhaps four months. Ultimately, Torch decided against any treatment and simply took pills for brain swelling. He moved in with me.

We spent the next eight months doing a bunch of things that he enjoyed, having fun together like we hadn't had in decades. We went to Disneyland, his first time. We hung out at home. Torch was a sports nut, and he was very happy to watch sports and eat my cooking. He even gained a bit of weight, eating his favorite foods rather than hospital foods. He had no serious pain, and he remained high-spirited. One day, he didn't wake up. He spent the next three days in a coma-like sleep and then died. The cost of his medical care for those eight months, for the one drug he was taking, was about $20.

Torch was no doctor, but he knew he wanted a life of quality, not just quantity. Don't most of us? If there is a state of the art of end-of-life care, it is this: death with dignity. As for me, my physician has my choices. They were easy to make, as they are for most physicians. There will be no heroics, and I will go gentle into that good night. Like my mentor Charlie. Like my cousin Torch. Like my fellow doctors.

Illustrations by Brian Cronin.

Bonus: For more on end of life care, don't miss Hospice Girl Friday, our weekly blog from hospice volunteer Devra Lee Fishman.

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About the Author

Ken Murray, M.D.

Ken Murray, M.D., is a retired clinical assistant professor of family medicine at University of Southern California.

I strongly believe Alaska should join the list of states that have humane end of life statutes in place and urge you to pass this bill. I wanted to testify in person, but unfortunately have had laryngitis for over a week.

Five states have Death with Dignity statutes:
California (End of Life Option Act; 2016) Colorado (End of Life Options Act; 2016) Oregon (Oregon Death with Dignity Act; 1994/1997)
Vermont (Patient Choice and Control at the End of Life Act; 2013) Washington (Washington Death with Dignity Act; 2008)

Until my parents went through terrible suffering, I had not given much thought to the choices that were or were not available to us humans. I'd been raised in ranching country where any beloved animal that was terminally sick or had untreatable injuries, was put down.

My Mother was moved to a nursing home in Colorado after I moved to Alaska. At age 89 she became bed-ridden because her bones were not strong enough to support her weight. Once while being moved she fell, one leg broke and bone went through the skin. Gangrene set in. Her constitution was such that she could not live through an operation. Her leg, which had a large open sore, would not heal. She wanted to die and refused to drink anything, but they kept her alive with intravenous liquids.

My sister asked the doctor to give her something to end her suffering, but he said it was not god's will. Mother stayed in that condition several weeks before she died. Colorado did not yet have its End of Life Options Act.

My sister and I will never get over our own agony in remembering the last days of our once proud and dignified Mother.

At 91 my Father realized that due to his balance problems and failing health, he couldn't stay out on his ranch alone any longer. We sold it and moved him to an assisted living facility. Within a few months he got bored with their routines and restrictions. He moved to a motel. He called me in AK and said he'd had a wonderful, useful and active life, but there was nothing more to live for. He feared he was going to be made to move to a nursing home and just exist 'til the end,' as Mother had. He wanted to end it. I said I understood but didn't know what he could do other than talk to a doctor to see if one could help him. No one would, so he ended his misery by shooting himself in the head. He was 92.

Susan Arthur
[redacted]

My name is Dale Judge. I've lived in Alaska since 1972. I am a colon cancer survivor. I know what it's like to be near death's door. In 2014 I was diagnosed with Stage III-B next to terminal. I had major chemo, radiation and surgery. I know what it's like to be deathly sick. I have some glimpse of what terminally ill people experience. I was so sick and felt so terrible that life was not good. I could have committed suicide, but I didn't. The bill permits assisted suicide and I am against it. We have too many people in Alaska killing themselves already.

This bill is one more example of not valuing human life. There are many choices besides suicide. You know them all: pain control, hospice, etc. Saying it's legal to help someone who's 18 take their own life is disgusting. Not telling relatives that they're going take their own life is.....(I can't find the right words.) People's emotions are at extreme levels when sick. The next day after death they could have decided to stay alive. New treatments are being developed all over the world. This legislation opens all types of possibilities for abuse: undue influence from family, "friends", and doctors. It is not possible to put enough restrictions in this legislation to prevent lives lost that could have been saved. This is a very bad bill. Please vote it down. Thank you.

Dale Judge
[redacted]
99517

Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: HB 54
Fiscal Note Number:
() Publish Date:

Identifier: HB054SS-LAW-CRIM-03-31-17
Title: TERMINALLY ILL: ENDING LIFE OPTION
Sponsor: DRUMMOND
Requester: House Health & 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)

	FY2018 Appropriation Requested	Included in Governor's FY2018 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
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

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY2017) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2018) 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:

This fiscal note reflects the changes made in the sponsor substitute.

Prepared By: Valerie Rose, Budget Analyst — Phone: (907)465-3674
Division: Administrative Services — Date: 03/29/2017 09:55 AM
Approved By: Jahna Lindemuth, Attorney General — Date: 03/29/2017
Agency: Department of Law

FISCAL NOTE ANALYSIS

STATE OF ALASKA **BILL NO.** HB 54
2017 LEGISLATIVE SESSION

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 oral request. A person may rescind their request at any time.

The legislation creates a defense to murder in the first degree, murder in the second degree, 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, completes, 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.

TO: The Alaska House Health & Social Services Committee

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

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

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

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

MEMO DATE: March 28, 2017

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* Margaret Dore, Law Office of Margaret K. Dore, PS, Choice is an Illusion, a nonprofit corporation, www.margaretdore.com, www.choiceillusion.org 1001 4th Avenue, Suite 4400, Seattle, WA 98154, 206 697 1217

I. INTRODUCTION

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

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

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

II. DEFINITIONS

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

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

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

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

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

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

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

B. Withholding or Withdrawing Treatment

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

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

III. ELDER ABUSE

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

Elder abuse is a widespread problem in Alaska and throughout

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[4] Id.

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

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

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

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

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

B. Victims Rarely Report

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

- Fear they will not be believed

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

[8] Met Life Mature Market Institute, supra.

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

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

[11] Id.

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

IV. ASSISTED SUICIDE AND EUTHANASIA

A. Thomas Middleton

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

B. Few States Allow Assisted Suicide

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

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

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

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

15 Id.

allow euthanasia.[16]

C. Other States Push Back

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

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

V. THE BILL

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

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

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

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

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

VI. DECADES TO LIVE

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

A. The Six Months to Live Is Determined Without Treatment

The bill states:

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

Oregon's law has a nearly identical definition:

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

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

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

[21] The bill states:

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

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

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

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

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

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

B. Predictions of Life Expectancy Can Be Wrong

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

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

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

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

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

five years.[27] Instead, the disease progression stopped on its own.[28] In a 2012 affidavit, at age 74, he states:

> If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.[29]

C. Treatment Can Lead to Recovery

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

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

VII. "CHOICE" IS A BIG FAT FIB

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

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

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27 Id., ¶ 1.

28 Id., ¶ 4, attached hereto at A-38.

29 Id., ¶ 5.

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

31 Id.

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

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

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

> "Capable" means that an individual [patient] has the ability to make and communicate health care decisions to health care providers; in this paragraph, "communicate" includes communication through a person familiar with the individual's manner of communicating if the person is available. (Emphasis added).[34]

Being familiar with an individual's "manner of communicating" is a very minimal standard. Consider, for example, a doctor's assistant who is familiar with a patient's "manner of communicating" in Spanish, but she, herself, does not understand Spanish. That, however, would be good enough for her to speak for the patient during the lethal dose request process. With this situation, patient choice and control is far from guaranteed.

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

1. Present law

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

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

[35] AS 09.55.556(a) states:

> A health care provider is liable for failure to obtain

2. The bill

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

> "Informed decision" means a decision that is based on an appreciation of the relevant facts and that is made after the attending physician fully informs a qualified individual of the . . .
>
> (E) feasible alternatives, including comfort care, hospice care, and pain control; (Emphasis added).[36]

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

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

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

Attached hereto at A-82.

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

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

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

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

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

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

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

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

Attached hereto at A-103 to A-104.

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

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

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

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

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

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

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

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

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

[42] Id.

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

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

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

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

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

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

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

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

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

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

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

F. The Bill Does Not Prohibit Euthanasia

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

> This chapter may not be construed to authorize a physician or another person to end an individual's life by lethal injection, mercy killing, or active euthanasia.[48]

This prohibition is defined away in the next sentence:

> An action allowed by this chapter is an affirmative defense to a criminal charge of homicide, murder, manslaughter, criminally negligent homicide, suicide, assisted suicide, mercy killing, or euthanasia under the law of this state. (Emphasis added).[49]

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

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

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

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

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

49 Id., lines 17 to 19.

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

patient struggled, who would know?

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

> With assisted suicide laws in Washington and Oregon [and with the proposed act], perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. . . . [I]f a patient struggled, "who would know?" (Emphasis added).[51]

VII. OREGON IS NOT A VALID CASE STUDY

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

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

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

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

[53] Id.

[54] Id.

data cannot be verified.

VIII. OTHER CONSIDERATIONS

A. Compassion & Choices' Mission is to Promote Suicide

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

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

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

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

[56] Id.

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

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

[59] Id.

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

B. In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide; the Financial Cost Is "Enormous"

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

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

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60 Compassion & Choices Newsletter, at A-73.

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

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

63 *Id.*

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

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

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

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

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

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

D. My Clients Suffered Trauma in Oregon and Washington State

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

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[65] See report at A-78.

[66] "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," B. Wagner, J. Muller, A. Maercker; *European Psychiatry* 27 (2012) 542-546, available at http://choiceisanillusion.files.wordpress.com/2012/10/family-members-traumatized-eur-psych-2012.pdf (Cover page attached hereto at A-80)

[67] Id., at A-80.

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

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

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

IX. CONCLUSION

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

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

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Appendix

Margaret Dore Memo

Reject HB 54

(Sponsor Substitute Version)

as of

March 28, 2017

CURRICULUM VITAE

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ATTORNEY EXPERIENCE:

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

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

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

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

JUDICIAL CLERKSHIPS:

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

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

ADMITTED TO PRACTICE:

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

PROFESSIONAL MEMBERSHIPS:

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

PUBLICATIONS:

Assisted Suicide and Euthanasia

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

Margaret Dore, "Preventing Abuse and Exploitation: A Personal Shift in Focus" (An article about elder abuse, guardianship abuse and assisted suicide), *The Voice of Experience*, ABA Senior Lawyers Division Newsletter, Winter 2014;

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

State Senator Jim Shockley & Margaret Dore, "No, Physician-Assisted Suicide is not Legal in Montana: It's a recipe for elder abuse and more." *The Montana Lawyer*, November 2011;

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;

Margaret Dore, "'Death with Dignity': A Recipe for Elder Abuse and Homicide (Albeit not by Name)," *Marquette Elder's Advisor*, Vol. 11, No. 2, Spring 2010;

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

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

Guardianship, Elder Abuse and Family Law

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

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

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

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

Margaret K. Dore, The Stamm Case and Guardians ad Litem, King County Bar Association, *Bar Bulletin*, June 2005, Washington State Bar Association, *Elder Law Section Newsletter*, Winter 2004-2005, p. 3;

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

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

Margaret K. Dore and J. Mark Weiss, "Lawrence and Nunn Reject the 'Friendly Parent' Concept", *Domestic Violence Report*, Vol. 6, No. 6, August/September 2001;

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

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

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

AWARDS/RECOGNITIONS:

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

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

PUBLISHED DECISIONS:

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

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

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

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

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

EDUCATION:

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

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

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

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

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

AMA Principles of Medical Ethics: I,VII

5.7 Physician-Assisted Suicide

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

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

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

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

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

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

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

AMA Principles of Medical Ethics: I,IV

5.8 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.

However, permitting physicians to engage in euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.

Terminal Uncertainty

Washington's new "Death With Dignity" law allows doctors to help people commit suicide—once they've determined that the patient has only six months to live. But what if they're wrong?

By Nina Shapiro
published: January 14, 2009

Nina Shapiro

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

Details:

— Study: Why Now? Timing and Circumstances of Hastened Deaths

— Dilemmas by caretakers and other Oregon studies

— Stats on people who have used Oregon's Death with Dignity law.

— Harvard professor Nicholas Christakis looking at the accuracy of prognosis.

— JAMA study examining the accuracy of prognosis.

UPDATE: "It Felt Like the Big One"

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

That was almost four years ago.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Washington Post

Morning Mix

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

By Yanan Wang March 21, 2016

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

KTVZ.COM
CENTRAL OREGON'S NEWS LEADER

Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

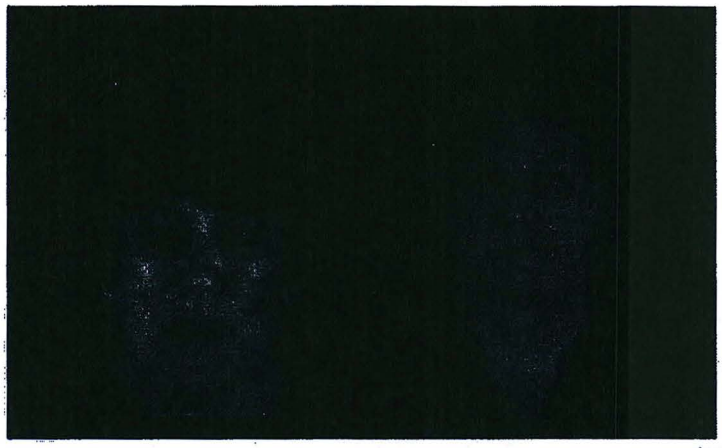
Sunday, July 10, 2016 | 10:49 pm

State dropping Tami Sawyer fraud case

DOJ says prosecution likely would not add time behind bars

Barney Lerten

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



Lane County Jail

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

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

MORE FROM KTVZ.COM

- Sawyers' tenants still will pay the couple in prison
- Sawyers go to prison; victims see justice - but money?
- Tami Sawyer Back in Bend Court; Plea Delayed
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Sawyer and her husband, Kevin, a former Bend police captain, were sentenced last spring to years in prison – two for him – for fraud, money-laundering and other crimes. They also were ordered by the federal judge to pay nearly $6 million to their victims.

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

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

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

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

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May 2009 Bar Bulletin

'Death with Dignity':

What Do We Advise Our Clients?

By Margaret Dore

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

Patient "Control" is an Illusion

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

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

How the Act Works

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

Interested witness

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

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

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

"Self-administer"

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

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

No witnesses at the death

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

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

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

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

What to Tell Clients

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

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

2. Reality check

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

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

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

Conclusion

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

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

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

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

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

4 id.

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

6 RCW 11.88.160(2).

7 RCW 70.245.010(12).

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

9 RCW 70.245.010(11) & (13).

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

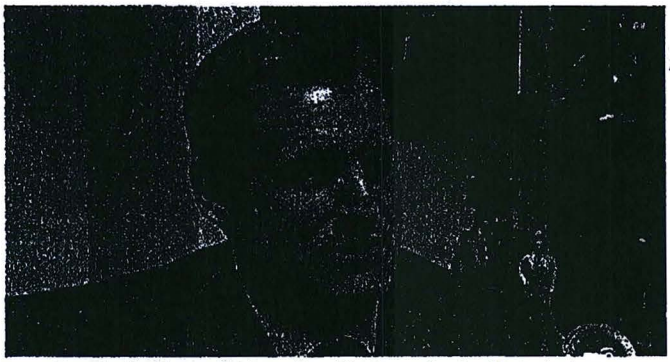
11 id.

Go Back

ARIZONA CAPITOL TIMES
Your Inside Source for Arizona Politics, Government and Business

Brewer signs bill targeting assisted suicide

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



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

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

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

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

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

Brewer signed the bill on Wednesday.

ONE COMMENT

Pingback: Week Two 1/21-1/28 Healthcare Policy and the Role of Ethics | dignitydiscussion

Related Links

- Assisted-suicide suspect found dead
- 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.

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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(3) Ramsey, Matt 72nd
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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

Votes

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

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"

ISSUES BY STATE & CANADA

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- US Overview
- Canada Overview
- Idaho Strengthens its Law Against Assisted Suicide
- New Hampshire Defeats Assisted Suicide Again
- Hawaii AG Rejects Claim That Assisted Suicide is "Already Legal"
- A Legal Analysis: The Oregon & Washington Physician-Assisted Suicide Laws
- What People Mean When They Say They Want to Die
- Who is at Risk?
- Definitions

BAR ARTICLES

- Idaho: The Advocate

MONDAY, JULY 4, 2011

Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

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

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

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

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

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

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

* * *

[1] Bill Status S1070, entry for April 5, 2011.
[2] *See* here for bill text.
[3] Then existing civil law included *Cramer v. Slater*, 146 Idaho 868, 878, 204 P.3d 508 (2009), which states that doctors "can be held liable for [a] patient's suicide." Existing law also included a common law crime in which an "aider and abettor" of suicide is guilty of murder. Assisted suicide can also be statutorily charged as murder. *See* Margaret K. Dore, "Aid in Dying: Not Legal in Idaho; Not About Choice," *The Advocate*, official publication of the Idaho State Bar, Vol. 52, No. 9, pages 18-20, September 2010 (describing existing law prior to the new bill's enactment); and The Hon. Robert E. Bakes, Retired Chief Justice of the Idaho Supreme Court, Letter to the Editor, "Legislature rejected euthanasia," *The Advocate*, September 2010 ("in both the Idaho criminal statutes as well as I.C.6-1012, the Idaho legislature has rejected physician-assisted suicide"). Entire issue, available here: http://www.isb.idaho.gov/pdf/advocate/issues/adv10sep.pdf
[4] Revised Statement of Purpose, RS20288.
[5] Ian Dowbiggin, A CONCISE HISTORY OF EUTHANASIA: LIFE, DEATH, GOD AND MEDICINE, Rowman & Littlefield Publishers,

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LINKS

- Montana's Campaign Against Assisted Suicide (Following Idaho's Lead)

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LABELS

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- assisted suicide (1)
- common law (1)
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- Hemlock Society (1)
- Kathryn Tucker (1)
- Margaret Dore (1)
- Robert E. Bakes (1)
- S1070 (1)

IDAHO ARCHIVE

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

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

VIII. CONCLUSION

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

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

WE CONCUR:

CHARLES W. DANIELS, Chief Justice

PETRA JIMENEZ MAES, Justice

BARBARA J. VIGIL, Justice

JAMES M. HUDSON, District Judge, Sitting by designation

All Citations

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

End of Document

Morris v. Brandenburg
376 P.3d 836

Oregon Revised Statute

Chapter 127

Contact Us
dwda.info@state.or.us

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

Please browse this page or download the statute for printing - (*or read the statute at* https://www.oregonlegislature.gov)

127.800 s.1.01. Definitions.

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

(1) "Adult" means an individual who is 18 years of age or older.

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

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

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

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

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

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

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

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

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

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

(Section 2)

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

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

IN THE STATE OF COLORADO

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

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

1. I am a professor of Family Medicine and a practicing physician in Oregon for over 30 years. I write to provide some insight on the issue of physician-assisted suicide, which is legal in Oregon, and which I understand has been proposed for legalization in Colorado.

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

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

Exhibit A, attached hereto.

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

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

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

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

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

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

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

Oregon Revised Statute

Chapter 127

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dwda.info@state.or.us

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

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(a) His or her medical diagnosis;

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(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.

TOFFLER EXHIBIT A
A-28

OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY

Oregon Public Health Division
February 4, 2016

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

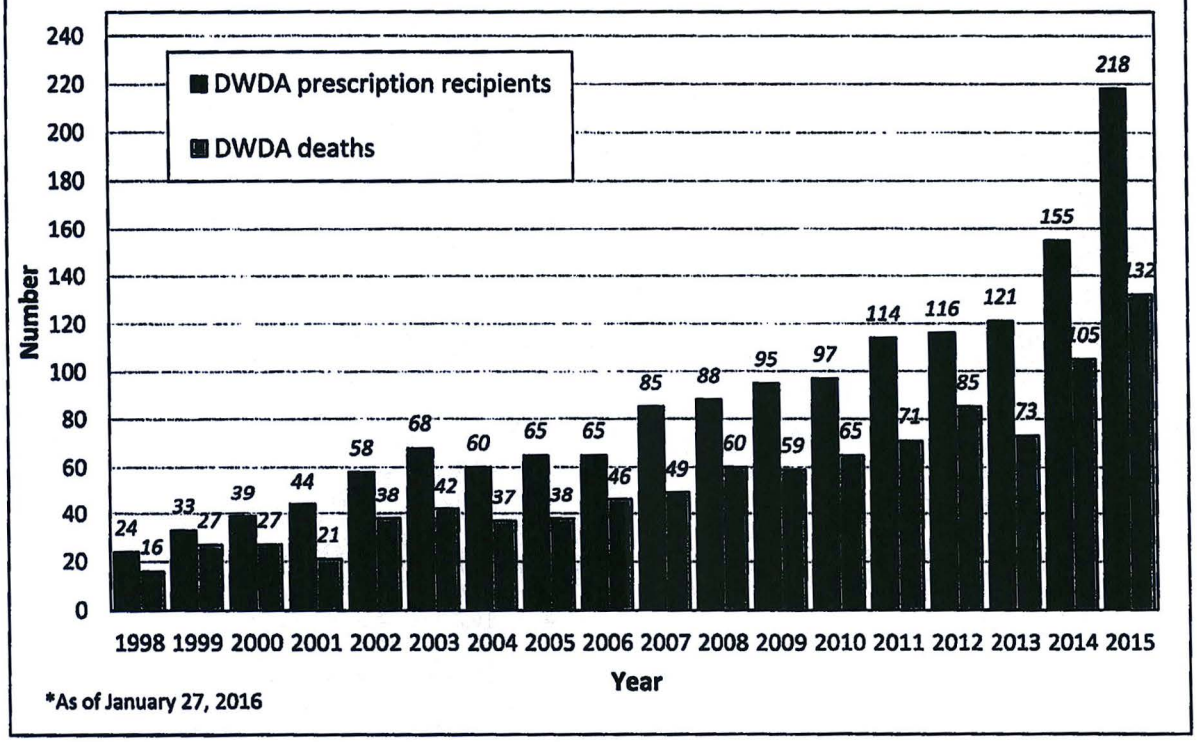
TOFFLER EXHIBIT B

A-29

Introduction

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

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



*As of January 27, 2016

Participation Summary and Trends

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

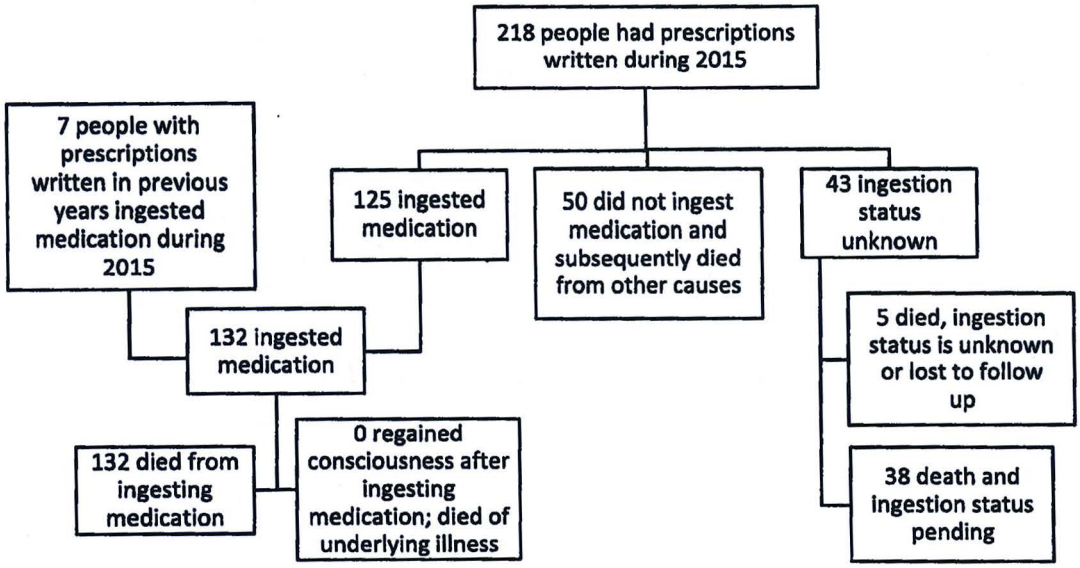
Since the law was passed in 1997, a total of 1,545 people have had prescriptions written under the DWDA, and 991 patients have died from ingesting the medications. From 1998 through 2013, the number of prescriptions written annually increased at an average of 12.1%; however, during 2014 and

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

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

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

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



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

TOFFLER EXHIBIT B

Patient Characteristics

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

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

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

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

DWDA Process

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

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

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

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

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

TOFFLER EXHIBIT B

A-34

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

1 Unknowns are excluded when calculating percentages.

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

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

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

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

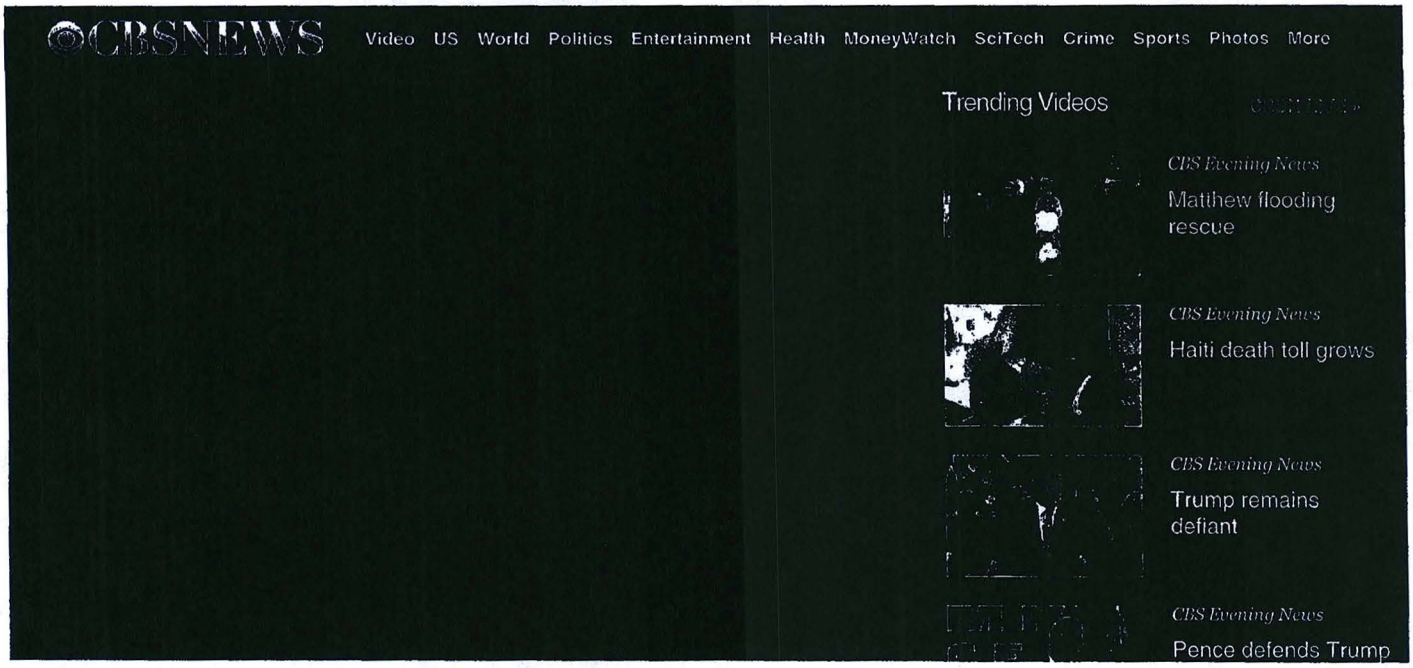
6 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted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

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

diabetes

TOFFLER EXHIBIT B

A-35



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

12 million Americans misdiagnosed each year

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

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

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

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

→ More from Morning Rounds with Dr. LaPook

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

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

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CANADA **C O U R S U P É R I E U R E**

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO ASSISTED SUICIDE AND EUTHANASIA

THE UNDERSIGNED, being first duly sworn on oath, STATES:

1. I live in Florence Massachusetts USA. When I was eighteen years old and in my first year of college, I was diagnosed with Amyotrophic Lateral Sclerosis (ALS) by the University of Iowa Medical School. ALS is commonly referred to as Lou Gehrig's disease. I was told that I would get progressively worse (be paralyzed) and die in three to five years.

2. I was a very physical person. The diagnosis was devastating to me. I had played football in high school and was extremely active riding bicycles. I also performed heavy labor including road construction and farm work. I prided myself for my physical strength, especially in my hands.

3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the

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

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

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

SWORN BEFORE ME at
MASSACHUSETTS, USA
on, August 1st, 2012

NAME: Heidi Pruzynski
A notary in and for the
State of ~~Washington~~ Massachusetts

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

PLACE SEAL HERE:

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

JOHN NORTON

CANADA **C O U R S U P É R I E U R E**

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse
c.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur
et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

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

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

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

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

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

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

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

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

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

Attached hereto at page SI-1.

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

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

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

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

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

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

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

NAME: Jessica Borgo

A notary in and for the
State of Oregon

ADDRESS: 16100 SW Tualatin-Sherwood Rd

EXPIRY OF COMMISSION: Aug, 30, 2015

PLACE SEAL HERE: Jessica Borgo

Ken Stevens MD
Ken Stevens, MD

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

STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

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

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

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

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

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

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

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

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

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

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

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

Ventricular assist devices are not covered for destination therapy.

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

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

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

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

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

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

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

DECLARATION OF JEANETTE HALL

I, JEANETTE HALL, declare as follows:

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

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

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

4. This July, it will be 16 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this June 30 day of 2016

Jeanette Hall

Jeanette Hall

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

WESTLAW

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

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

HRS § 671-3

§ 671-3. Informed consent

Currentness

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

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

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

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

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

(1) The condition to be treated;

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

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

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

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

(A) The proposed treatment or procedure;

(B) The recognized alternative treatments or procedures; and

(C) Not undergoing any treatment or procedure; and

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

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

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

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

Credits

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

NOTES OF DECISIONS (97)

BEFORE THE LEGISLATURE OF THE STATE OF NEW YORK

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Kenneth Stevens Jr. MD

Kenneth Stevens, Jr., MD
Sherwood, Oregon

lethal injection

noun

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

Examples from the Web for lethal injection

Contemporary Examples

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

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

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

June 12, 2012

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

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

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

July 22, 2014

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

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

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

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Mercy killing - definition of mercy killing by The Free Dictionary

http://www.thefreedictionary.com/mercy+killing

mercy killing

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

mercy killing

n.

Euthanasia.

mercy killing

n

(Medicine) another term for **euthanasia**

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

n.

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

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

Thesaurus

Legend: ≡ Synonyms ↔ Related Words ≠ Antonyms

Switch to **new thesaurus**

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

≡ **euthanasia**

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

A-53

State of Alaska

Department of Administration

Division of Office of Public Advocacy

Department of Administration
Office of Public Advocacy

Elder Fraud Assistance Education

The office was created by statute in September of 2006.

Mission

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

Vision

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

Contact Us

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

or simply contact us at:

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

A-54

State of Alaska

Department of Administration

Division of Office of Public Advocacy

Financial Exploitation Explained

What is Financial Exploitation?

Financial Exploitation takes many forms

Definitions:

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

How much of this goes on?

A Widespread Problem:

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

Why aren't more cases reported?

A-55

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

Who are the perpetrators?

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

General

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

- Site Map
- Accessibility

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

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- Business in Alaska
- Resident
- Employee

DECLARATION OF TESTIMONY

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

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

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

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

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

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

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

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

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

///

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

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

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

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

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

Dated Sept. 18 2012

Isaac Jackson, OSB 055494
Jackson Law Office, LLC

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

JOHN R. KROGER
Attorney General

MARY H. WILLIAMS
Deputy Attorney General

DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

November 3, 2010

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

Re: Death with Dignity Act Records Request

Dear Mr. Jackson:

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

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

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

Please contact me if you have additional questions.

Sincerely,

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

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

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

11/29/10

Oregon
Theodore R. Kulongoski, Governor

RECEIVED
12-6-10

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

November 29, 2010

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

Dear Mr. Jackson:

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

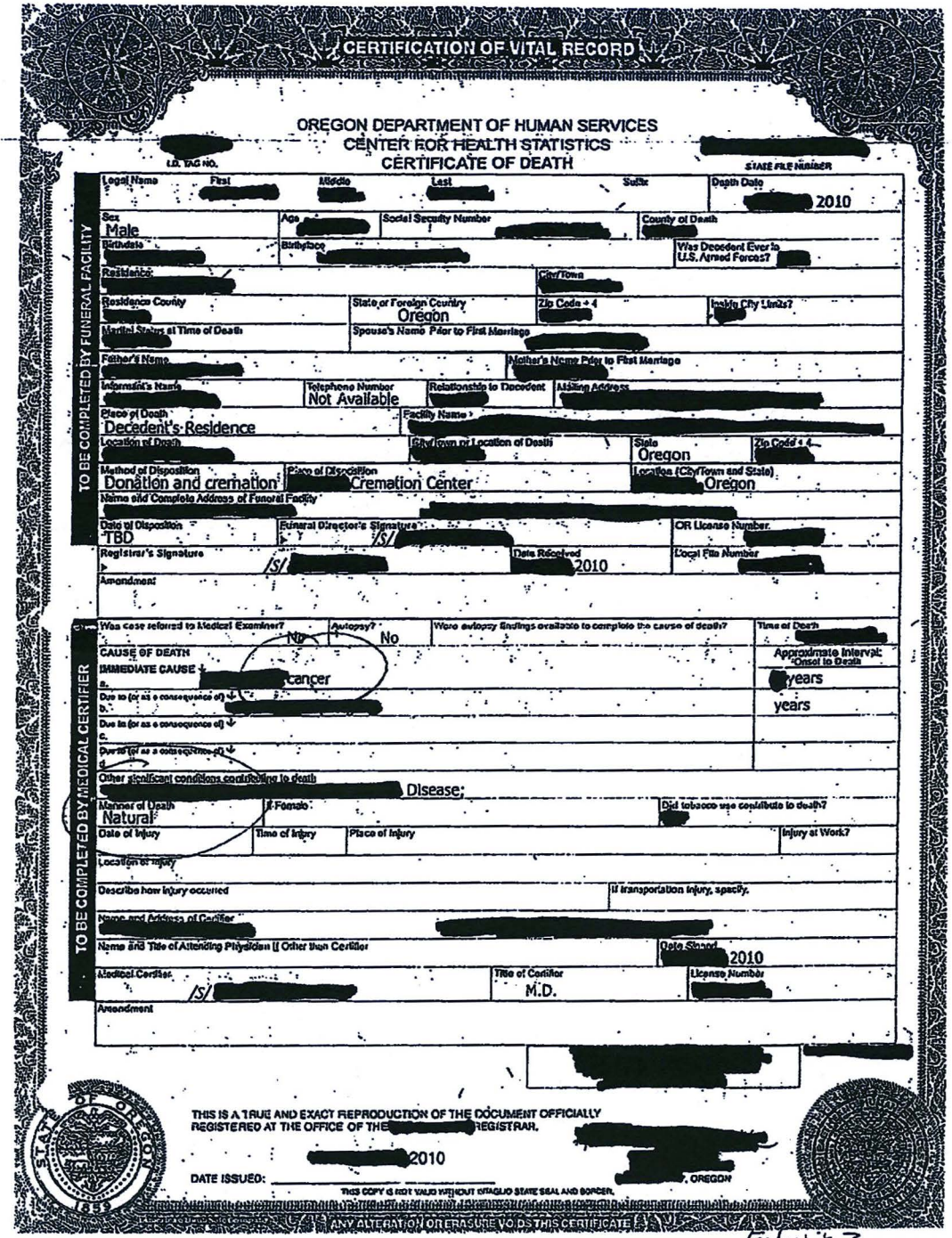
While sympathetic to concerns about the circumstances of his father's death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Human Services collects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

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

Sincerely,

Randy H. Day
Complaint Resource Officer
Investigations/Compliance Unit

Exhibit 2



CERTIFICATION OF VITAL RECORD

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

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

TO BE COMPLETED BY FUNERAL FACILITY

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

TO BE COMPLETED BY MEDICAL CERTIFIER

Was case referred to Medical Examiner? No | Autopsy? No | Were autopsy findings available to complete the cause of death? | Time of Death: [redacted]

CAUSE OF DEATH
IMMEDIATE CAUSE
a. [redacted] cancer — Approximate Interval: Onset to Death: [redacted] years
Due to (or as a consequence of)
b. [redacted] — years
Due to (or as a consequence of)
c.
Due to (or as a consequence of)
d.
Other significant conditions contributing to death: [redacted] Disease;

Manner of Death: Natural | If Female: | Did tobacco use contribute to death? [redacted]
Date of Injury | Time of Injury | Place of Injury | Injury at Work?
Location of Injury
Describe how injury occurred | If transportation injury, specify.
Name and Address of Certifier: [redacted]
Name and Title of Attending Physician if Other than Certifier | Date Signed: [redacted] 2010
Medical Certifier: /S/ [redacted] | Title of Certifier: M.D. | License Number: [redacted]
Amendment

[redacted]

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE [redacted] REGISTRAR.

DATE ISSUED: [redacted] 2010 [redacted], OREGON

THIS COPY IS NOT VALID WITHOUT EMBOSSED STATE SEAL AND BORDER.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

Exhibit 3

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

Oregon Health

Data Release Policy

Release of Information Regarding the Death with Dignity Act

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

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

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

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

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

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

Frequently Asked Questions Related to Additional Data Requests

Exhibit 4

Margaret K. Dore

Margaret Dore <margaretdore@margaretdore.com>

RE: Death with Dignity Act

1 message

Parkman Alicia A <alicia.a.parkman@state.or.us> Wed, Jan 4, 2012 at 7:57 AM
To: Margaret Dore <margaretdore@margaretdore.com>
Cc: BURKOVSKAIA Tamara V <tamara.v.burkovskaia@state.or.us>

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

Please let me know if you have further questions.

Thank you,

Alicia

Alicia Parkman

Mortality Research Analyst

Center for Health Statistics

Oregon Health Authority

Ph: 971-673-1150

Fax: 971-673-1201

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

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

I have these follow up questions:

A-63

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

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

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

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

Margaret K. Dore

Margaret Dore <margaretdore@margaretdo

Re: Record Retention Policy

1 message

DWDA INFO <dwda.info@state.or.us> Mon, Jun 27, 2011 at 4:18 PM
To: Margaret Dore <margaretdore@margaretdore.com>

Hello Ms. Dore,

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

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

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

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

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

Please let me know if you have further questions.

Thank you,

Alicia

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

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

Hi. I am an attorney in Washington State.

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

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

Thanks.

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

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

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

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

Q: Who can participate in the Act?

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

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

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

Q: How does a patient demonstrate residency?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Confidentiality of Death Certificates

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION

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

December 12, 1997

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

SUBJECT: CONFIDENTIALITY—DEATH WITH DIGNITY

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

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

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

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

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

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

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

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

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

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

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

The Oregon Death with Dignity Act:

A Guidebook for Health Care Professionals

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

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

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

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

First Edition (print): March 1998

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

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

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

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

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

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

Dear Editor:

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

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

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

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

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

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

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

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

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

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

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

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

COMPASSION & CHOICES
OF WASHINGTON
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In This Issue

Derek Humphry to be Keynote Speaker at 2011 Annual Meeting

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

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

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

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

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

Police kick in door in confusion over suicide kit.

Byline: Jack Moran The Register-Guard

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

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

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

They soon learned the man was not home.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

quote →

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

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

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

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

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

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

Article Details

Title Annotation: Local News; The FBI message to police about the purchase of the gear failed to mention it was bought seven months ago
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Next Article: Local man pleads guilty to federal gun charge.
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Publications by Date before 1988 1988-1999 2000-2004 2005-2009 2010-
Authors A B C D E F G H I J K L M N O P Q R S T U V W X Y Z
Literature A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

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.

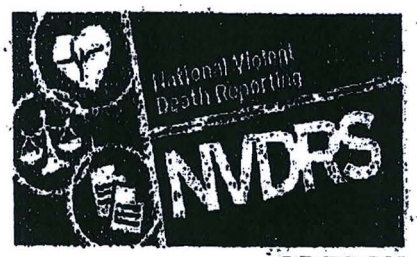
There are likely many reasons for the state's rising suicide rate, according to Millet. The single most identifiable risk factor associated with suicide is depression. Many people can manage their depression; however, stress and crisis can overwhelm their ability to cope successfully.

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.
-



OREGON

Public Health Division

Suicides in Oregon: Trends and Risk Factors

-2012 Report-

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

Oregon Health Authority

Excerpt printed 2/9/14

Executive Summary

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

Key Findings

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

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

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

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

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

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

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

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

Introduction

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

The cost $

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

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[3] Oregon Vital Statistics Annual Report, Vol. 2, 2010. Oregon Heath Authority.

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Original article

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

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ABSTRACT

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

1. Introduction

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

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient's home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient's home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.

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http://www.legis.state.ak.us/basis/statutes.asp#09.55.556

Sec. 09.55.556. Informed consent.

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

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

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

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

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

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

SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 54

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTIETH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE DRUMMOND

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

A BILL

FOR AN ACT ENTITLED

"An Act providing an end-of-life option for 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 a 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 a 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 Ending of Life.

Sec. 13.55.010. Individuals allowed to end life. (a) As provided in this chapter, a qualified individual may use medicine obtained from the qualified individual's attending physician to end the qualified individual's life.

(b) To be a qualified individual under (a) of this section, an individual must

(1) be a resident of this state;

(2) be 18 years of age or older;

(3) have been determined to be capable;

(4) have been determined to be suffering from a terminal disease; and

(5) have voluntarily expressed the wish to die.

(c) An individual does not qualify under (b) 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 in person, by mail, or by electronic transmission 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 to the qualified individual's attending physician. The qualified individual shall repeat the oral request to the qualified individual's attending physician not sooner 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.

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. A qualified

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

Sec. 13.55.050. Attending physician duties and authority. (a) The attending physician shall

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

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

(3) inform the individual of the

(A) individual's medical diagnosis;

(B) individual's prognosis;

(C) potential risks associated with taking the medication;

(D) probable result of taking the medication; and

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

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

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

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

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

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

(9) immediately before dispensing or prescribing medication under this

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

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

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

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

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

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

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

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

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

causing impaired judgment.

Sec. 13.55.080. 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. 13.55.090. 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. 13.55.100. Waiting periods. An attending physician may not dispense medication or write a prescription for medication for a qualified individual unless at least 15 days have elapsed between the qualified individual's initial oral request and the writing of the prescription.

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

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

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

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

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

(5) a record of 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;

(6) 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. 13.55.120. 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. 13.55.130. Immunity; effect of action on status of individuals. (a) A person is not subject to civil or criminal liability or professional disciplinary action, including disciplinary action by a licensing authority, for participating or otherwise acting 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. 13.55.140. 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. 13.55.150. Prohibitions. Notwithstanding another provision of law to the contrary, a health care provider may not prohibit another health care provider, including an employee, contractor, or lessee of the prohibiting health care provider, from participating in this chapter. However, a health care provider may prohibit

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

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

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

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

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

(b) A prohibiting health care provider who imposes sanctions under (a) 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.

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

Sec. 13.55.180. Criminal penalties. (a) A person commits the crime of abuse of life-ending 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; in this paragraph, "undue influence" means the control of an individual by a person who stands in a position of trust or confidence to exploit wrongfully the trust, dependency, or fear of the individual to gain control over the decision making of the individual.

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

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

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

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

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

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

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

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

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

Services.

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

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

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

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

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

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

Sec. 13.55.250. Coordination with other law. A 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 a physician who qualifies under

AS 13.55.220 as an attending physician;

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

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

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

(5) "health care provider" means a person or health care facility licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession; in this paragraph, "health care facility" means a private, municipal, or state hospital; independent diagnostic testing facility; primary care outpatient facility; skilled nursing facility; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility; ambulatory surgical facility; Alaska Pioneers' Home or Alaska Veterans' Home administered by the department under AS 47.55; state correctional facility as defined in AS 33.30.901; private, municipal, or state facility employing one or more public health nurses; and long-term care facility;

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

(A) individual's medical diagnosis;

(B) individual's prognosis;

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

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

and

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

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

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

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

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

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

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

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

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

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

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

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

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

* **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, 2019.

TESTIMONY AGAINST HB54, April 5, 2017

My name is Jeanne E Anderson, MD. I am medical oncologist in private practice in Anchorage at Katmai Oncology Group, LLC.

Specialists in Medical Oncology diagnosis patients with cancer; counsel them regarding prognosis and treatment options; prescribe medical (i.e., drug) treatment; and provide supportive, palliative and end-of-life care.

I received my medical degree from Stanford University in 1988. I completed internal medicine specialty training in 1991, and medical oncology fellowship training in 1994, both at the University of Washington. I have been taking are of patients with advanced cancer since 1987 when I was a medical student.

Over the 30 years that I have been caring for patients with cancer, I have seen dramatic improvements in the science of cancer biology and in prognosis, treatment and palliation of patients.

I am strongly against HB54 for many reasons, including 1) the uncertainty in determining an individual patient's prognosis, 2) improvements in palliative care, and 3) hastening death is not the role of the physician or the medical system.

<u>Uncertainty in Prognosis</u>

A critical feature of SSHB54 is that the patient has a "terminal" disease. There is no definitive way to determine that a patient has less than 6 months to live. Estimates of survival are based on published data and a physician's clinical judgment. Survival data come from studies performed years earlier, often using treatment that is not the most up-to-date, and is based on narrowly defined patient populations. Physicians then use their clinical judgment to determine if they think the patient in question fits the published data. Even well informed and well-meaning oncologists make drastic mistakes in their estimates of prognosis.

I would like to describe several of my current patients:

1. David has stage IV bladder cancer and his disease had progressed through several lines of aggressive treatment by 2014. At that time I would have confidently said that he had less than 6 months to live. Now, in 2017, he is in remission living a full, active life after receiving a new form of treatment, known as immunotherapy.

2. Donald has stage IV lymphoma and his disease was refractory to several lines of chemotherapy. He was denied a bone marrow transplant in Seattle, due to the lack of benefit. He declined participation in experimental therapies. I recommended hospice treatment in June of 2016 due to expected survival of less than 6 months. Currently, he is in remission, and just returned from a cruise with his family in January 2017. He knows that when his lymphoma recurs in the bone, we can offer radiation, pain medications and other palliative care therapy to control symptoms of progression.

3. Karen has stage IV breast cancer, in a particularly lethal form, known as "triple negative". Her cancer had spread to her brain in 2015. Chemotherapy made her very sick and I decline to administer her any more treatment. Based on her functional status, spread of her cancer, and the known biology of triple negative breast cancer, I also predicted less than 6 months survival in 2015. She has had an unusually slow course of disease progression and remains alive today without any further chemotherapy.

Patients often live longer than expected due to unexpected diminishment in the aggressiveness of their cancer; due to unexpected response to treatment; due to response to new treatments; due to inaccuracy in assessment of stage or status of their disease; due to the normal statistical variation when individual people are characterized by data; and due to factors outside of our assessment or control, such as a patient's inherent will to live or their strong immune system or vital organ function.

With my experience and credentials, I would be an appropriate attending physician and/or consulting physician for the type of patient that SSHB is designed to serve. However, these cases described above show my inability to determine prognosis as precisely as is required by this bill. In addition, note that a medical oncologist just completing training in his or her early 30s would be considered qualified to make such decisions.

Improvements in Palliative Care

Many patients or their loved ones are fearful of symptoms related to advanced cancer, such as pain and shortness of breath. These are very valid concerns. A core function of a medical oncologist is alleviation of suffering. There are a vast number of approaches that can be taken to alleviate suffering without resorting to active ending of life. These options include numerous medications, localized radiation to painful sites of active cancer, nerve blocks, pain pumps, and oxygen to mention just a few. In addition, there is the growing specialty of Palliative Care. Palliative Care specialists address supportive care for patients in all stages of illnesses, including cancer. They address the many aspects of the "terminally" ill patient including the social, psychological, physical, and medical aspects of these patients.

I recently heard about someone in favor of this bill because of his wife's experience. When she was dying of cancer, her lungs were filling up with fluid. She was not given timely care for her symptoms, resulting in a difficult death. I would like to speak to such a scenario. When a patient is dying of cancer, family and medical providers generally have a sense that the end is imminent in hours, days, or perhaps weeks. At this point, aggressive management of symptoms is the primary focus even if a side effect of management is a sooner death. There are resources for such care, without resorting to a lengthy, complex, and legally defined system that is provided for in SSHB54. Such care in the setting of cancer patients is provided for by medical oncologists, palliative care specialists, nurses, and hospice programs. Fear of poor palliative care and abandonment is not a reason to hasten death.

A physician's job is to alleviate suffering, provide compassionate care, and prevent foreseeable adverse outcomes. Our job is not to hasten death. I request that our resources be placed in improving care for our patients with advanced diseases, including communication with all health care providers and expanding palliative care services. Please vote against SSHB54.

TO: The Alaska House Health & Social Services Committee

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

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

- Bad Things Happen in the Dark
- Don't Let Alaska Become Corrupt Like Oregon

HEARING: **Thursday, April 6, 2017 at 3 p.m.**
120 East 4th Street, Room 106
Juneau, Alaska

MEMO DATE: March 31, 2017

INDEX

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* Margaret Dore, Law Office of Margaret K. Dore, PS, Choice is an Illusion, a nonprofit corporation, www.margaretdore.com, www.choiceillusion.org and www.hawaiiagainstassistedsuicide.org 1001 4th Avenue, Suite 4400, Seattle, WA 98154, 206 697 1217

C:\Users\Margaret\Documents\ASE 2016 +\Alaska\HB 54 Transparency Memo Index.wpd

I. INTRODUCTION

HB 54 legalizes physician-assisted suicide and euthanasia as those terms are traditionally defined. The bill is based on a similar law in Oregon, which has a near complete lack of transparency.

If Alaska enacts HB 54 and follows Oregon practice, there will be a similar lack of transparency. The safely and welfare of individual patients will be unverifiable from Alaska State sources.

II. DISCUSSION

A. If Alaska Follows Oregon's Interpretation of "Not a Public Record," the Department of Health & Social Services Will Be Insulated from Review, Even by Law Enforcement

HB 54 charges the Department of Health and Social Services with issuing an annual statistical report based on data collected pursuant to the bill.[1] The bill also states:

> The information collected is not a public record under AS 40.25.110, and the department may not make the information available for inspection by the public. (Emphasis added).[2]

Oregon's law has a similar provision, as follows:

> Except as otherwise required by law, the information collected shall not be a public record and may not be made available for

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[1] HB 54, Sponsor Substitute Version, Section 3, § 13.55.210. (Attached hereto at A-1 & A-2).

[2] Id., § 13.55.210 (c).

inspection by the public. (Emphasis added).[3]

In Oregon, this similar provision is interpreted to bar release of information about individual cases, to everyone, including law enforcement. Oregon's website states:

> [T]he Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority [which oversees Oregon's Department of Health] from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.... [4]

Consider also this e-mail from Alicia Parkman, Mortality Research Analyst for the Oregon Health Authority, which states:

> We have been contacted by law enforcement . . . in the past, but have not provided identifying information of any type. (Emphasis added).[5]

If Alaska enacts HB 54 and follows Oregon's interpretation of "not a public record," there will be a similar lack of transparency in which even law enforcement will have no access to information about individual cases. The bill will create a government entity above the law.

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[3] ORS 127.865 s.3.11(2) (Attached hereto at A-3)

[4] Oregon Data Release Policy, copy attached hereto at A-62.

[5] E-mail from Alicia Parkman to me, 01/04/12, attached hereto at A-63.

B. If Alaska Follows Oregon's Data Collection Protocol, Patient Identities Will Not Be Recorded in Any Manner, Source Documentation Will Be Destroyed

Oregon's website describes the data collection protocol for its annual reports, as follows:

> The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed. (Emphasis added).[6]

Alicia Parkman, Mortality Research Analyst for the Oregon Health Authority, makes a similar representation as follows:

> To ensure confidentiality, our office does not maintain source information on participants. (Emphasis added).[7]

The significance is that Oregon's annual reports are unverifiable. If Alaska, based on its similar statutory language, follows Oregon, Alaska's annual reports will also be unverifiable.

C. If Alaska Follows Oregon, Compassion & Choices, a Non-Governmental Entity, Will Displace the Department of Health and Social Services to Become the Defacto "Agency" Overseeing HB 54

Passage of HB 54 is being spearheaded by the suicide

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[6] Oregon Health Authority, Frequently Asked Questions, attached at A-67.

[7] E-mail from Alicia Parkman to Margaret Dore, 01/04/12, attached hereto at A-63.

promotion group, Compassion & Choices.[8] In Oregon, this organization has used the Oregon law to disable and largely displace the Department of Health as the entity overseeing Oregon's law. See below.

1. In Oregon, the police officer assigned to the case was not able to get information from the State; the decedent's death certificate was falsified; the officer obtained information from Compassion & Choices

In 2010, I had client who wanted to know if his father had died under Oregon's law. I referred him to an Oregon attorney, Isaac Jackson, who asked the police to investigate. Jackson's subsequent declaration states:

> 2. I write to inform the court regarding a lack of transparency under Oregon's assisted suicide act. Even law enforcement is denied access to information collected by the State of Oregon. Moreover, according to the current Oregon State website, this lack of access is official Oregon State Policy.
>
> 3. In 2010, I was retained by a client whose father had apparently died under Oregon's law. The client wanted to know whether that was true. I therefore made inquiry on his behalf. However and unlike other deaths I have investigated, it was difficult to get information. . . .
>
> 6. I . . . received a copy of the decedent's death certificate, which is the official death record in Oregon. A true and correct,

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[8] Compassion & Choices is a successor organization to the Hemlock Society, originally founded by suicide promoter, Derek Humphry. See newsletter attached hereto at A-73

> but redacted copy, is attached hereto . . . . The "immediate cause of death" is listed as "cancer." The "manner of death" is listed as "Natural."
>
> 7. Per my request, a police officer was assigned to the case. Per the officer's confidential report, he did not interview my client, but he did interview people who had witnessed the decedent's death.
>
> 8. The officer's report describes how he determined that the [father's] death was under Oregon's assisted suicide law due to records other than from the State of Oregon. The officer's report also describes that he was unable to get this information from the Oregon Health Authority, which was not willing to confirm or deny whether the deceased had used the act . . . . (Emphasis added).[9]

I also read the officer's report. According to the report, Compassion & Choices provided the records necessary for the officer to determine that the decedent had, in fact, died under Oregon's law. In Oregon, Compassion & Choices, a non-governmental entity, has displaced the Department of Health as the agency overseeing Oregon's law.

2. In Oregon, Compassion & Choices is like "the fox in the proverbial chicken coop" reporting to the farmer what's happening in the coop

In 2008, the Editorial Board for *The Oregonian*, which is Oregon's largest newspaper, urged Washington State voters to

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[9] Isaac Jackson, Declaration of Testimony, 09/18/12, at A-57 to A-58.

reject its then pending assisted suicide measure.[10] The Editorial Board stated:

> Oregon's physician-assisted suicide program has not been sufficiently transparent. Essentially, a coterie of insiders run the program, with a handful of doctors and others deciding what the public may know. (Emphasis added).[11]

Four days later, Oregon doctors, Kenneth Stevens and William Toffler, published a follow up article, stating:

> The group promoting assisted suicide, so-called "Compassion and Choices (C&C)", are like the fox in the proverbial chicken coop; in this case the fox is reporting its version to the farmer regarding what is happening in the coop. . . .
>
> In 2006, C&C's attorneys intimidated the Oregon Department of Human Services (DHS) to change to euphemisms in referring to Oregon's assisted suicide law. The limited DHS reports of assisted suicides is another indication of this organization's influence. Information that is damaging to the "good public image" of Oregon's assisted suicide law is hidden or glossed-over in the DHS reports. . . .[12]

III. CONCLUSION

The proposed Oregon-style "oversight" is a sham and will create the opportunity for a non-governmental entity to displace

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[10] The Oregonian Editorial Board, "Washington state's assisted-suicide measure: Don't go there," *The Oregonian*, September 20, 2012, available at http://www.oregonlive.com/opinion/index.ssf/2008/09/washington_states_assisted suic.html

[11] Id.

[12] Kenneth Stevens MD and William Toffler MD, "Assisted suicide: Conspiracy and control," *The Oregonian*, September 24, 2008.

a government agency. The safely and welfare of individuals will be unverifiable from state sources. I urge you to vote "No" on HB 54.

Respectfully submitted this 31ST day of March 2017

Margaret Dore, Esq., MBA
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206 697 1217

Appendix

Margaret Dore Memo

Reject HB 54

as of

March 31, 2017

individual's request; or

(2) exerts undue influence on an individual to request medication for the purpose of ending the individual's life or to destroy a rescission of the individual's request; in this paragraph, "undue influence" means the control of an individual by a person who stands in a position of trust or confidence to exploit wrongfully the trust, dependency, or fear of the individual to gain control over the decision making of the individual.

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

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

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

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

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

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

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

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

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

Services.

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

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

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

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

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

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

Sec. 13.55.250. Coordination with other law. A 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 a physician who qualifies under

(4) Filing of an Oregon tax return for the most recent tax year. [1995 c.3 s.3.10; 1999 c.423 s.8]

127.865 s.3.11. Reporting requirements.

(1)(a) The Health Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The division shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the division.

(2) The Health Services shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The division shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 s.3.11; 1999 c.423 s.9]

127.870 s.3.12. Effect on construction of wills, contracts and statutes.

(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 s.3.12]

127.875 s.3.13. Insurance or annuity policies.

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 s.3.13]

127.880 s.3.14. Construction of Act.

Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 s.3.14]

(Immunities and Liabilities)

(Section 4)

127.885 s.4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.

Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

DECLARATION OF TESTIMONY

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

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

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

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

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

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

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

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

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

///

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

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

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

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

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

Dated Sept. 18 2012

Isaac Jackson, OSB 055494
Jackson Law Office, LLC

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

JOHN R. KROGER
Attorney General

MARY H. WILLIAMS
Deputy Attorney General

DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

November 3, 2010

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

Re: Death with Dignity Act Records Request

Dear Mr. Jackson:

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

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

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

Please contact me if you have additional questions.

Sincerely,

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

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

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

11/29/10

Oregon
Theodore R. Kulongoski, Governor

RECEIVED 12-6-10

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

November 29, 2010

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

Dear Mr. Jackson:

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

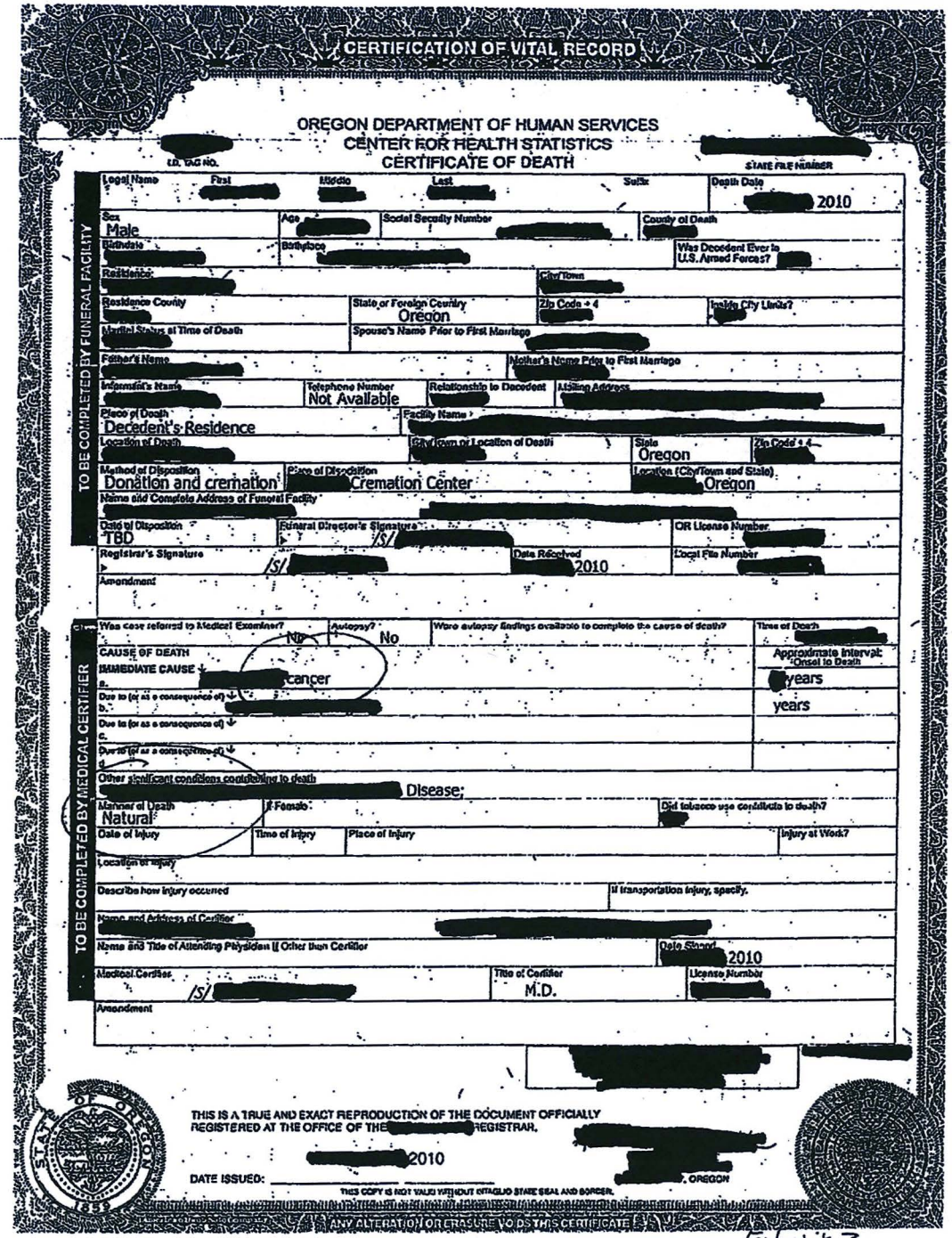
While sympathetic to concerns about the circumstances of his father's death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Human Services collects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

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

Sincerely,

Randy H. Day
Complaint Resource Officer
Investigations/Compliance Unit

Exhibit 2



CERTIFICATION OF VITAL RECORD

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

LOCAL FILE NO. [redacted] STATE FILE NUMBER [redacted]

TO BE COMPLETED BY FUNERAL FACILITY

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

TO BE COMPLETED BY MEDICAL CERTIFIER

Was case referred to Medical Examiner? No
Autopsy? No
Were autopsy findings available to complete the cause of death?
Time of Death: [redacted]

CAUSE OF DEATH
IMMEDIATE CAUSE
a. [redacted] cancer — Approximate Interval: Onset to Death: [redacted] years
Due to (or as a consequence of)
b. [redacted] — years
Due to (or as a consequence of)
c.
Due to (or as a consequence of)
d.
Other significant conditions contributing to death: [redacted] Disease;

Manner of Death: Natural
If Female:
Did tobacco use contribute to death?
Date of Injury
Time of Injury
Place of Injury
Injury at Work?
Location of Injury
Describe how injury occurred
If transportation injury, specify:
Name and Address of Certifier: [redacted]
Name and Title of Attending Physician if Other than Certifier
Date Signed: [redacted] 2010
Medical Certifier: /S/ [redacted]
Title of Certifier: M.D.
License Number: [redacted]
Amendment

[redacted]

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE [redacted] REGISTRAR.

DATE ISSUED: [redacted] 2010

[redacted], OREGON

THIS COPY IS NOT VALID WITHOUT EMBOSSED STATE SEAL AND BORDER.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

STATE OF OREGON 1859

Exhibit 3

Oregon Health

Data Release Policy

Release of Information Regarding the Death with Dignity Act

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

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

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

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

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

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

Frequently Asked Questions Related to Additional Data Requests

Exhibit 4

Margaret K. Dore

Margaret Dore <margaretdore@margaretdore.com>

RE: Death with Dignity Act

1 message

Parkman Alicia A <alicia.a.parkman@state.or.us> Wed, Jan 4, 2012 at 7:57 AM
To: Margaret Dore <margaretdore@margaretdore.com>
Cc: BURKOVSKAIA Tamara V <tamara.v.burkovskaia@state.or.us>

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

Please let me know if you have further questions.

Thank you,

Alicia

Alicia Parkman

Mortality Research Analyst

Center for Health Statistics

Oregon Health Authority

Ph: 971-673-1150

Fax: 971-673-1201

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

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

I have these follow up questions:

A-63

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

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

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

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

Margaret K. Dore

Margaret Dore <margaretdore@margaretdo

Re: Record Retention Policy

1 message

DWDA INFO <dwda.info@state.or.us> Mon, Jun 27, 2011 at 4:18 PM
To: Margaret Dore <margaretdore@margaretdore.com>

Hello Ms. Dore,

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

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

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

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

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

Please let me know if you have further questions.

Thank you,

Alicia

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

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

Hi. I am an attorney in Washington State.

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

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

Thanks.

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

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

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

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

Q: Who can participate in the Act?

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

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

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

Q: How does a patient demonstrate residency?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Confidentiality of Death Certificates

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION

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

December 12, 1997

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

SUBJECT: CONFIDENTIALITY—DEATH WITH DIGNITY

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

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

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

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

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

If the funeral home chooses to forward the death record to your office, you may forward it to this office for registration. You should not maintain a white copy of the death record for six months nor should you issue certified copies.

If you do register the death locally then you may not maintain a six-month copy of the death record. Before issuing any certified copies of the death record you will need to contact this office for special permission to do so. There are three people in this office that can grant that permission:

Edward Johnson, II—State Registrar (503) 731-4109
Carol Sanders, Manager, Certification Unit 731-4416
Sharon Rice, Manager, Registration Unit 731-4412

Since we do not anticipate a large number of these cases, the different rules for the handling, these deaths should not adversely affect your work. You may never have this type of death occur within your county.

If you haven't by now determined the seriousness of this, let me add one additional statement so you will know how seriously this matter is being taken by the State Health Division. Any staff within the Center for Health Statistics that reveals any information they are not authorized to release, will immediately be terminated. Any county vital records staff, releasing information will have their registrar-deputy registrar commissions immediately revoked, thus eliminating you from having any contact with vital records within your county.

Remember if you are asked if any physician assisted deaths have occurred in your county you may neither confirm nor deny their occurrence. This may put you in a difficult position if you are being asked from Personnel within your own health department. Again, you will need to explain that you have been told you are not to discuss this topic with anyone, and refer the caller as mentioned earlier in this memo.

The Oregon Death with Dignity Act:

A Guidebook for Health Care Professionals

Developed by
The Task Force to Improve the Care of Terminally-Ill Oregonians

Convened by
The Center for Ethics in Health Care, Oregon Health & Science University

Patrick Dunn, M.D., Task Force Chair and Co-Editor
Bonnie Reagan, M.D., R.N., Co-Editor
Susan W. Tolle, M.D., Reviewer and Major Contributor
Sarah Foreman, Manuscript Preparation

Initial writing of the Guidebook was supported in part by
The Greenwall Foundation

First Edition (print): March 1998

Current Edition (2008): Published on this website
Updated as information becomes available

Registrar, Center for Health Statistics, 800 NE Oregon St., Suite 205, Portland, OR 97232; or by facsimile to (971) 673-1201. Information to be reported to the Department shall include: (a) Patient's name and date of birth; (b) Prescribing physician's name and phone number; (c) Dispensing health care provider's name, address and phone number; (d) Medication dispensed and quantity; (e) Date the prescription was written; and (f) Date the medication was dispensed.

Attending physicians are encouraged to inform patients of the requirement that the Department of Human Services have access to data regarding implementation of the Oregon Act. They may wish to have the patient's written request for enacting the provisions of the statute include a statement of consent for release of medical records to the Department of Human Services. The patient and attending physician should discuss post-death arrangements as part of the overall plans. As discussed in the chapter, *Attending Physician and Consulting Physician*, the attending physician may want to be present at the time of death or make arrangements to be notified by the family immediately following the death. The attending physician could then notify the funeral home that this is an expected death and that he/she will be signing the death certificate. The death certificate will then be filed and processed according to routine procedures and the death will not go into the medical examiner's system. The Medical Examiner is required to investigate any death that is suspicious (i.e., not natural or expected).[6] In addition, if Emergency Medical Services (EMS) are present at the time of death the Medical Examiner will be called. Because medical examiner investigations allow for limited public disclosure,[7] the confidentiality of the patient cannot be assured in these instances. Additionally, family members may be questioned regarding the circumstances surrounding these deaths.

The death certificate originates in the mortician's office, and is sent to the physician to complete the cause of death information. The death certificate is then sent back to the mortician's office, which files it with the local health department. Finally, the death certificate is forwarded to the Department of Human Services, State Registrar for Vital Records. While the confidentiality of the death certificate can be assured once it has reached the local health department and the Department of Human Services, physicians must ensure confidentiality in the clinical setting. Because death certificates have multiple purposes, including settling the estate as well as for public health information, the Department of Human Services suggests physicians record the underlying terminal conditions as the cause of death and mark the manner of death "natural", rather than recording that the patient ingested a lethal dose of medication prescribed under the Oregon Death with Dignity Act. Death certificates should not be left on desktops or at nurses' stations. Health care professionals and institutions might consider implementing a policy of keeping all death certificates in envelopes marked "confidential" until they are formally filed.

Confidentiality is of paramount importance in ensuring compliance with this Oregon Act. The Oregon Act ensures that "information collected shall not be a public record and may not be made available for inspection by the public" (see *Liability and Negligence*). Thus, information regarding the identity of patients, health care professionals, and health care facilities obtained by the Department of Human Services with respect to compliance with the Oregon Act shall be confidential. Summary information released in Department of Human Services' annual reports will be aggregated to prevent identification of individuals, physicians, or health care professionals complying with the Oregon Act. Death certificates are also confidential: OAR 333-11-096 (1) states that the Department of Human Services "... shall not permit inspection of, or

Don't follow Oregon's lead: Say no to assisted suicide

Dear Editor:

I am an internal medicine doctor, practicing in Oregon where assisted suicide is legal. I write in support of Margaret Dore's article, Aid in Dying: Not Legal in Idaho; Not About Choice. I would also like to share a story about one of my patients.

I was caring for a 76 year-old man who came in with a sore on his arm. The sore was ultimately diagnosed as a malignant melanoma, and I referred him to two cancer specialists for evaluation and therapy. I had known this patient and his wife for over a decade. He was an avid hiker, a popular hobby here in Oregon. As he went through his therapy, he became less able to do this activity, becoming depressed, which was documented in his chart.

During this time, my patient expressed a wish for doctor-assisted suicide to one of the cancer specialists. Rather than taking the time and effort to address the question of depression, or ask me to talk with him as his primary care physician and as someone who knew him, the specialist called me and asked me to be the "second opinion" for his suicide. She told me that barbiturate overdoses "work very well" for patients like this, and that she had done this many times before.

I told her that assisted-suicide was not appropriate for this patient and that I did NOT concur. I was very concerned about my patient's mental state, and I told her that addressing his underlying issues would be better than simply giving him a lethal prescription. Unfortunately, my concerns were ignored, and approximately two weeks later my patient was dead from an overdose prescribed by this doctor. His death certificate, filled out by this doctor, listed the cause of death as melanoma.

The public record is not accurate. My patient did not die from his cancer, but at the hands of a once-trusted colleague. This experience has affected me, my practice, and my understanding of what it means to be a physician.

What happened to this patient, who was weak and vulnerable, raises several important questions that I have had to answer, and that the citizens of Idaho should also consider:

- If assisted suicide is made legal in Idaho, will you be able to trust your doctors, insurers and HMOs to give you and your family members the best care? I referred my patient to specialty care, to a doctor I trusted, and the outcome turned out to be fatal.
- How will financial issues affect your choices? In Oregon, patients under the Oregon Health Plan have been denied coverage for treatment and offered coverage for suicide instead. See e.g. KATU TV story and video at http://www.katu.com/home/video/26119539.html (about Barbara Wagner). Do you want this to be your choice?
- If your doctor and/or HMO favors assisted suicide, will they let you know about all possible options or will they simply encourage you to kill yourself? The latter option will often involve often less actual work for the doctor and save the HMO money.

In most states, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient received was a lethal prescription, intended to kill him.

Is this where you want to go? Please learn the real lesson from Oregon.

Despite all of the so-called safeguards in our assisted suicide law, numerous instances of coercion, inappropriate selection, botched attempts, and active euthanasia have been documented in the public record.

Protect yourselves and your families. Don't let legalized assisted suicide come to Idaho.

Charles J. Bentz MD
Oregon Health & Sciences University
Portland, OR

COMPASSION & CHOICES
OF WASHINGTON
PO BOX 61369 SEATTLE WA 98141

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In This Issue

Derek Humphry to be Keynote Speaker at 2011 Annual Meeting

This year our keynote speaker will be Derek Humphry, the author of *Final Exit* and the founder of the Hemlock Society USA in 1980. Derek is generally considered to be the father of the modern movement for choice at the end of life in America.

Save the Date!
Sat., October 22, 2011, 1-3 p.m.
University Unitarian Church
6556 35th Ave NE
Seattle, WA 98115-7393

Derek is a British journalist and author who has lived in the United States since 1978, the same year he published the book *Jean's Way* describing his first wife's final years of suffering from cancer and his part in helping her to die peacefully. The public response to the book caused him to start the Hemlock Society USA in 1980 from his garage in Santa Monica. Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion In Dying to become Compassion & Choices.

In 1991 he published *Final Exit*. Much to his surprise, it became the national #1 bestseller within six months. Since then it has been translated into 12 languages and is now in its fourth edition.

Although not affiliated with – and sometimes even at odds with – Compassion & Choices, Derek is still actively involved in the movement. Always interesting and sometimes controversial, Derek will provide our supporters and their guests with his perspective about the evolution of the movement for choice at the end of life in A

March 28, 2017

Chair, & Members, House HSS Committee

Ref: HB-54 / TERMINALLY ILL: ENDING LIFE OPTION

I support HB-54 as a needed option for informed Alaskan patients who find themselves terminally ill and in need of respectful relief.

I definitely want to see this, or equivalent, language added to Alaska Statutes so that I would not have to travel "outside" (likely Oregon) to be able to receive the departure of my choice. I am also a supporter of strong supporter of *Hospice* as well as *Compassion & Choices* for end-of-life care.

I trust the details to my legislators in consultation with medical and palliative experts.

Respectfully,

Wayne Aderhold
353 Grubstake Ave.
Homer, AK 99603

Dear Representative Drummond:

I am submitting my strong support of House Bill 54, An Act relating to the voluntary termination of life by terminally ill individuals.

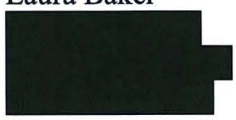
This topic is of great personal interest to me. We lost my Mom to breast cancer about six years ago and it was an excruciatingly painful and long ending for her. My mother was an active, loving and moral individual and was the main stay of our family. When originally diagnosed with breast cancer she tackled the chemo and radiation treatment head on and always continued to show strength to those around her. She went into remission for eight years and continued to enjoy life, but then the cancer came back and attacked her bones. A short bout of chemo ultimately could not control, let alone diminish the cancer – treatment stopped. She endured months of pain, many silently from us, while getting things in order often quietly not asking help of her family – just another demonstration of her strength and determination. Her last few months of life were with family at home, care of her doctor and hospice. However, each hour she battled the hourly pain and debilitation of the terminal disease and the last few weeks were more than she should have had to endure. While pain killer medication dosages were outlined and administered on a schedule; you could tell from her actions they were not sufficing and she still suffered. Over her last few weeks of life it was so difficult to see how much she hurt, how she was uncomfortably and wasting away, usually such a strong and vibrant person – these are weeks she may have chosen to avoid if Alaska had a death with dignity law on the books.

Before her second round of cancer we talked periodically about choices and that Washington and Oregon had death with dignity laws to allow terminally ill to make their own decisions about their life ending, but Juneau is where home is. For me, being at risk of breast cancer, I would want the ability to make my personal choice in terms of time and method of death if terminally ill from this very invasive and painful disease. I have lived in Alaska for over 45 years, this is the first piece of legislation I have felt so personally strong about.

I realize that there are some major issues to be addressed by the legislature this session, however I hope that this bill will advance for committee hearings. I commend you for proposing this legislation and offer my support in any way I can. I am copying my local legislative delegation as well to share my support for this legislation.

Sincerely,

Laura Baker



March 2, 2017

Dear Members of the Health and Social Services Committee,

HB54, "An Act relating to the voluntary termination of life by terminally ill individual" allows freedom of choice - compassionate choice. I want to choose for myself when, toward the end of my life, my quality of life is unbearable. Please allow me that dignity by voting in favor of the bill.

Respectfully yours,

Joyanne Bloom
[redacted]

Dear Chair Spohnholz,

I am writing to support House Bill 54 - "An Act relating to the voluntary termination of life by terminally ill individuals; and providing for an effective date."

A majority of US voters support the choice offered by bills like this. In states where it is an authorized medical practice, it is not subject to abuse. It also provides great peace of mind to terminally ill adults as they approach life's end.

Aid in dying is not a choice of death over life. It is an option for those who are dying that spares them unbearable suffering and offers a controlled and peaceful ending. All dying people deserve that option, and the tremendous peace of mind that comes with it.

Please give this bill a fair hearing.

Thanks
--

Ron Johnson
Professor Emeritus
Mechanical and Environmental Engineering
Univ of Alaska Fairbanks

[redacted]

Jan 17, 2017

Dear Representative Drummond,

I am writing to thank you for introducing House Bill 54 – "An Act relating to the voluntary termination of life by terminally ill individuals and providing for an effective date."

Like 70 percent of people in this country, I believe that our rights and freedoms are ours to exercise until we take our last breath, and having a terminal illness doesn't change that. I am calling on you as my elected representative to guarantee those rights for me.

I support this bill and the freedom it provides. The record shows that in states where it is an authorized medical practice, aid in dying works as intended, and is not subject to abuse. It also provides great peace of mind to terminally ill adults as they approach life's end.

Sincerely,
Marydith, age 80, a cancer survivor

Marydith Beeman
[redacted]

Serious consideration of the "Right to Die" bill would be appreciated. Too many people spend the last weeks or more of life in pain/impoverishment/despair when no relief/reversal is possible. At this point, suicide is the answer for many, when Dr. assisted effort would be appreciated and humane.

Contact Info:
Valerie Luczak
[redacted]

Dear Representative Drummond:

I am submitting my strong support of House Bill 54, An Act relating to the voluntary termination of life by terminally ill individuals.

This topic is of great personal interest to me. We lost my Mom last year, 2016 and it was an excruciatingly painful ending for her. After a mishap of medications while she was being treated for a heart condition that left her wheelchair bound, my mother was in a home for nearly 7 years. My mother was a fun-loving individual who enjoyed being out and about at all times.

Towards the end of my mother's life, she had lost most of her sight and some of her cognizance. She had severe arthritis as well as other bone deformities which caused her severe pain. She was continually asked to define her pain on a medical scale of 1-10 (10 being the worst) and always said it was between an 8-9. Although she needed medical operations, due to her age and underlying conditions, no physician in Juneau or Anchorage would operate on her for fear that she would die on the table. She wanted to die, and in her last month, my mother asked not only her good friends to end her life but also her family. That being said, it was extremely hard to explain to a loved one that is was not possible in this State to give her what she wanted most of all, peace, comfort and most importantly no more pain.

She endured years of pain, each day she battled the hourly pain and debilitation of her body and the last few weeks were more than she should have had to endure. When her physician believed she only had no more than a couple of weeks to live, she was placed on a what is called a "comfort care plan". By the good graces of that physician, strong pain medication was administered on an as needed basis for pain; but you could tell from my mother's actions that the medication was not sufficing and she still suffered greatly. It was extremely difficult to watch and see how much she hurt. She was uncomfortable and wasting away. How every day she begged me to "put her out of her misery" before she couldn't take the pain anymore. This was the time that she and I prayed that Alaska would have had a death with dignity law on our books like other states have.

I have lived in Alaska since 1963. I have talked to many of our elderly who were or are currently in the homes where they are cared for and the "one thing that they ask for is to be able to die with their dignity in place". This one piece of legislation is so significant I had to write to you to express how personally important it is.

I realize that during this legislature session there are many other important issues to address. However, this bill is so significant to many, my hope and the hope of others who have been through this, is that this bill will advance for committee hearings. I personally commend you for proposing this legislation and offer my support in any way I can.

Sincerely,

Susan Mitten

March 22, 2017

I am writing in support of HB 54 – "An Act relating to the voluntary termination of life by terminally ill individuals."

I hope you never have to watch a loved one suffer through a debilitating, terminal illness. It is a helpless feeling. HB 54 will allow terminally ill patients to ease their suffering and hasten an inevitable death. It preserves dignity and a person's right to live, and die, on their own terms according to their own beliefs.

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.

Please hear HB 54 and vote to move it out of committee.

Thank you,

Russ McDougal

Dear Represntative Drummond,

I support HB 54. I grew up in Oregon and moved to Alaska 40 years ago. My father was in general practice medicine in Oregon when I was growing up. He retired to Southern California but after he had a stroke my family brought him back to Oregon because of their death with dignity law. I totally support people's right to choose death with dignity.

Best Regards,

Pam Woolcott
Juneau, AK 99801

March 19, 2017

Dear Representative Drummond,

Thank you for introducing House Bill 54 – "An Act relating to the voluntary termination of life by terminally ill individuals and providing for an effective date."

As a health woman, I can only imagine what it might be like to contemplate and then act to hasten my own death. Nevertheless, I fervently want that right: the power over one's body. Not unlike a woman's right to choose her reproduction, a person's right to assistance in dying, under the care of a medical professional, is critical to our American freedoms.

Citizens of Alaska, the Last Frontier, shouldn't have to resort to other ghastly resources to hasten an inevitable death. Having the aid of a doctor, who won't lose her privileges to practice, is humane. In states where it is an authorized medical practice, aid in dying works as intended, and is not subject to abuse.

Let's be leaders in the nation, along with Oregon, Washington, Hawaii, California, Vermont, the District of Columbia, and Colorado, to allow terminally ill citizens to make their own choices over how to spend their last months without the agony of having to die a "natural" death with pain and suffering.

Thank you for bringing HB54 to the Alaska State Legislature. I admire your courage and hope your colleagues will vote for this bill and bring peace of mind to all Alaskans.
Sincerely,
Amy Volz
Sitka, AK 99835

I am writing in support of HB54.

My spouse of 30 years, a medical provider herself, was diagnosed with Stage 4 Melanoma in May 2015. We were advised on the first day of this diagnosis that hers was a terminal illness. Following 8 weeks of hospitalization, Leslie was released to hospice care in our home. I witnessed nearly every moment of tremendous and unnecessary psychological pain and suffering as she simply waited to die over the next 8 weeks. Leslie died at home on September 15, 2015.

Leslie strongly supported voluntary termination of life by the terminally ill - both as a health care provider, and as a terminally ill patient. HB54 is a well-reasoned bill that addresses both a patient's right of self-determination, and a physician's right not to participate in this practice. The bill's statutory safeguards address every rational objection to voluntary termination of life, with no compulsory action for patient or physician. The foreseeable religious objections have no place in a system of laws which fundamentally prohibit discrimination based upon religion.

Respectfully,
Michael Haukedalen

Please OPPOSE HB 54

Life is more valuable than anyone can fully appreciate.

I am a super-voter and a registered Republican

Thank you for your service to Alaska and for your consideration,

JR Dailey

Sterling Alaska

Rep. Drummond:

Your proposal, HB 54, to legalize assisted suicide in Alaska is evil.
What right do you have to say that assisted suicide is ok when it is contrary to the U.S. Constitution, the Declaration of Independence, the Alaska Constitution, to the Natural Law and to God's Law? I sincerely hope HB 54 is a failure.

Vince Fennimore
[redacted]