

LATE



Committees: Commerce, Consumer Protection, and Health
Hearing Date/Time: Wednesday, February 15, 2017, 8:30 a.m.
Place: Room 229
Re: Testimony of the ACLU of Hawaii in **Support** of S.B. 1129,
Relating to Health

Dear Chair Baker, Vice Chair Nishihara, and Committee Members:

The American Civil Liberties Union of Hawaii (“ACLU of Hawaii”) writes in support of, with a requested amendment to, S.B. 1129, which allows competent, terminally ill adults to obtain prescription medication to end their own life.

The ACLU of Hawaii strongly supports the right to bodily autonomy, which includes, among other things, the right to refuse treatment, the right to access necessary medical care, and the right to make personal decisions about how to spend one’s final days. Six states — Oregon, Montana, California, Vermont, Washington, and Colorado — have legalized physician-assisted death.

While the ACLU of Hawaii is unaware of any documented widespread abuse, it is important that any physician-assisted death legislation include proper safeguards to prevent abuse or coercion. In order for physician-assisted death to truly be a choice, it must not be the only option. Patients must have access to information about pain medication, and palliative care must be readily available. Patients should never be pressured or coerced into requesting life-ending medication, whether by a doctor, spouse, or family member. S.B. 1129 provides adequate safeguards to address these concerns.

The ACLU of Hawaii ultimately supports this measure, but respectfully requests the Committee to amend S.B. 1129 to eliminate any reference to “death with dignity,” which erroneously implies that individuals who rely on caretakers to assist with basic life functions live with less dignity than others. For this reason, the ACLU of Hawaii requests that the term “death with dignity” be replaced with either “physician-assisted death” or “medical aid in dying.”

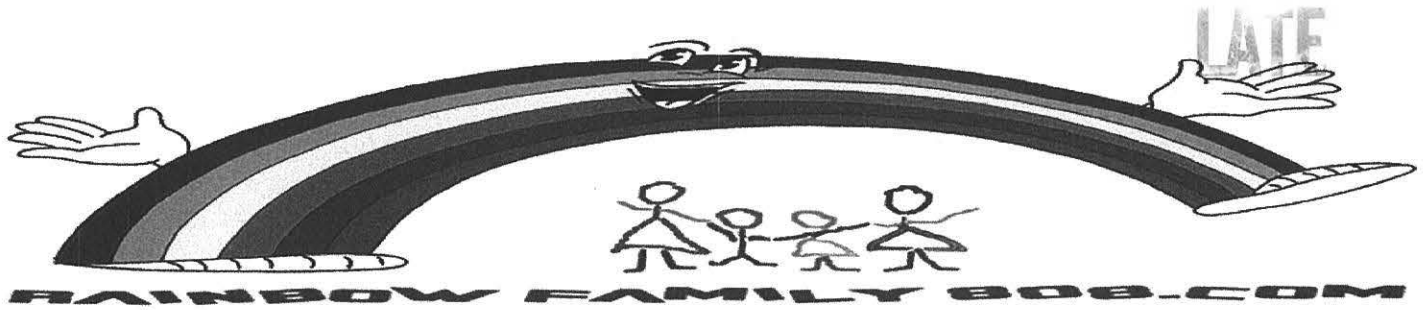
Thank you for this opportunity to testify.

Mandy Finlay
Advocacy Coordinator
ACLU of Hawaii

Chair Baker and Members of the Committee
February 15, 2017
Page 2 of 2

The mission of the ACLU of Hawaii is to protect the fundamental freedoms enshrined in the U.S. and State Constitutions. The ACLU of Hawaii fulfills this through legislative, litigation, and public education programs statewide. The ACLU of Hawaii is a non-partisan and private non-profit organization that provides its services at no cost to the public and does not accept government funds. The ACLU of Hawaii has been serving Hawaii for 50 years.

American Civil Liberties Union of Hawai'i
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92-954 Makakilo Dr. #71, Kapolei, HI 96707 Email: RainbowFamily808@gmail.com Ph: (808) 779-9078 Fax: (808) 672-6347

DATE: February 15, 2017

RE: SB1129 Relating to Health: Terminally Ill Adults' Choices STRONG SUPPORT

TO: Senate Commerce, Consumer Protection and Health Committee Hearing

Aloha Senators Baker, Nishihara and Committee Members,

Thank you for the opportunity to STRONGLY SUPPORT SB 1129 relating to Terminally Ill Adult Choices at End of Life. Rainbow Family 808 is a support and resource organization that focuses on reaching out to all families in love, support and advocacy.

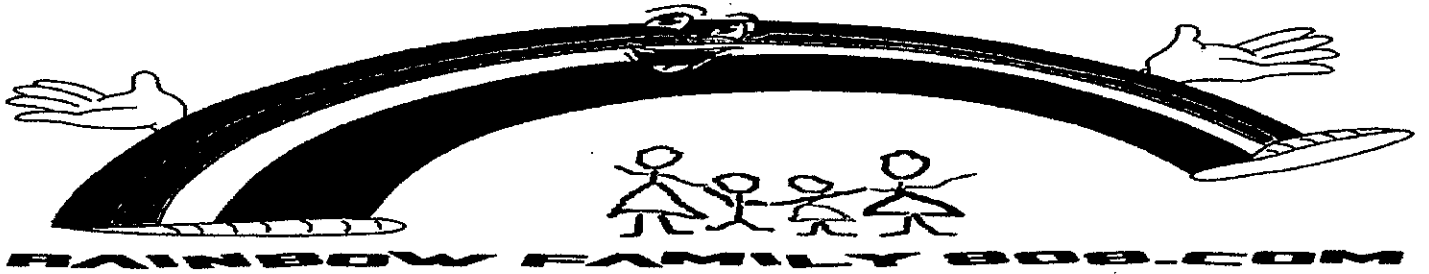
Rainbow Family 808 sees SB 1129 as an important choice for Terminally Ill Adults at the End of their lives because we are all terminal, no one escapes this stage of our lives. We believe that all adult humans at this sensitive time in their lives, need to retain control of their choices. None of us completely control our health issues but science has provided a safe, sane manner to relieve pain that exceeds pain levels due to cancer and other deadly medical conditions. After all possible interventions have been expended, terminal adults need to know they have a choice in End of Live conditions. As conscious, mentally sound adults, we are responsible to care for ourselves and should have a choice, one that gives us a humane avenue to address our End of Life Choices.

SB1129 respects our Terminally Ill Adults to use their logic and fact capabilities to make personal decisions regarding their End of Life choices. No one, no church, no religious organization should pressure anyone or obstruct any adult from practicing their Freedom of Choice at the End of their Life. Hawaii needs to respect our Freedom of Choice and SB 1129 does this. SB 1129 will never force anyone to avail themselves of Compassion and Choices because freedom of choice is our decision.

Please pass SB 1129 so that Terminally Ill Adults have the freedom to choose their own Compassionate Choice. Thank you.

Respectfully,

Carolyn Martinez Golojuch, MSW
President and Co-Founder



92-954 Makakilo Dr. #71, Kapolei, HI 96707 Email: RainbowFamily808@gmail.com Ph: (808) 779-9078 Fax: (808) 672-6347

LATE

From: mailinglist@capitol.hawaii.gov
To: CPH Testimony
Cc: blawaiianlvr@icloud.com
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM
Date: Wednesday, February 15, 2017 6:59:35 AM

SB1129

Submitted on: 2/15/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
De MONT R. D. CONNER	Ho'omana Pono, LLC.	Support	Yes

Comments: I FULLY SUPPORT this bill. I have Chronic Mylogenous Leukemia(a.k.a. "CML"). I was first diagnosed with CML in February of 2015. I have undergone a variety of Chemo treatments (pills), none of which has worked. As I share this with you right now, my white blood cell(WBC), is in excess of 120 thousand, that's 12x the normal WBC count. The meds I take now does nothing for my cancer, it is only designed to bring down my WBC to a normal level so that I can fly to a cancer treatment facility in Seattle, Washington where I must first undergo an assessment to see if I qualify for a bone marrow transplant. If that is successful, then I will have to make arrangements to move to Washington State for 3-4 months while I undergo intensive Chemo therapy & a bone marrow transplant, if a suitable donor is found. If not, I will be forced to accept the inevitable. I have already discussed with my wife, plans on how to handle my death & I currently have an Advanced Health Care directive. I will choose how I will hala ("pass over into the next life"), regardless of what the government says or does. I am not here for me, I am here for those who cannot be here to speak to their acceptance of how they choose to go. Having this bill passed & enacted into law, will empower the powerless to make their inalienable choice of the most hardest decision of their lives: The one that dictates how they will die! The government needs to stay out of the business of denying its citizens the right to make personal choices that deal with their mortality. Please pass this bill. Mahalo.

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February 14, 2017

LATE

Aloha Senator Rhoads, Inouye, Kidani and Ruderman,

I am submitting my testimony in opposition to SB 1129 (Death with Dignity Act). I am Registered Nurse in the state Hawaii and I love serving the community. I would like to give you an idea what is my role for these patients or individuals who are terminally ill. Also, to briefly provide a background on the definitions of terminally ill and dignity.

The SB 1129 states that if it becomes a law it will allow a “mentally competent adult residents who have a terminal illness with a confirmed prognosis of six or fewer months to live to voluntarily request and receive a prescription medication so that they can die in a peaceful, humane manner.” According to the study conducted by Hui et. Al (2014) published in *The Journal of Pain and Symptom Management*, the following terms “actively dying,” “end of life,” “terminally ill,” “terminal care,” and “transition of care” are commonly used but rarely and inconsistently defined. The researchers also added that, “part of the challenge with these prognostic terms is that both our science and language of prognostication are imprecise. Because death is often mediated by catastrophic events such as myocardial infarction and pneumonia, it is difficult to know exactly how long a patient is going to live” (Hui et al., 2014). For the purpose of Medicare coverage for a patient to qualify for Hospice, he or she must have a life expectancy of six month or less. I have taken care of many terminally ill patients who outlived their diagnoses or have lived beyond their “expiration date.” I am going to also emphasize that a mentally competent individual who has a chronic condition/s who is stable on maintenance medicines or treatment can become terminally ill if they decide to stop treatment. For example, a patient with Type 2 Diabetes who is on stable with diet, regular glucose monitoring and insulin regimen can be considered “terminally ill” or will probably die within six months if he or she decides to stop taking insulin and liberalized diet. A person dependent and stable on hemodialysis can die within six months or less if he or she decides to stop hemodialysis treatment. A physician based on the context of “life expectancy of six months or less” can categorize the above scenarios as patients with

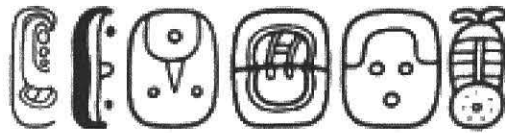
terminal illness. A physician, regardless of experience and expertise can only “guesstimate” a patient’s last days. Who is to say that a mentally competent adult is going to use this “aid in dying” as another legalized form of suicide? Who and what will rule out mental competence? Also one can argue that a patient with mental illness has the same suffering and debilitating characteristics as a person with physical illness seeking to end his or her life through “aid in dying.” Why does a person with mental illness excluded if their suffering is the same? This bill does not provide safeguards but paves the way for more confusion and delay of care. I have the utmost compassion to these individuals who are terminally ill. I have held them in my arms and provided the patient centered care they needed while they are in the hospital. I completely agree in alleviating their suffering but I am not going to assist them in killing themselves because there is no cure for their disease. As a nurse, I know that the dignity or self-worth of individuals are not dictated by their disease, how much days their doctor told them they are going to live or how much pain or discomfort they are going to endure until their last breath. I will take care of them with their dignity intact until their last heart beat. The bill claims that the drug will provide a peaceful and humane death. Swallowing a cocktail of 100 de-capsulated Secobarbital and expecting to die within 3 hours if all goes right is nothing humane and peaceful. This bill makes a notion that terminally patients are going to be in great deal of suffering or end up in ICU with bright lights surrounded by strangers. This is not all true. Most of our patients are discharged in the comfort of their home surrounded by their love ones or a facility that will provide hospice care here in the islands. This bill is a mockery of the Palliative and Hospice care we offer to these types of patients. Terminally ill patients are provided and cared for holistically in their own home surrounded by their love ones through hospice care. There are challenges as the public has huge knowledge deficit about these said services. I firmly believe that this SB 1129 is not the answer for our terminally ill patients seeking “peaceful death.” I ask that the legislature find means to support the current standard evidence-based practice and care to expand it to other islands instead of providing unnecessary “other option.”

Sincerely,

Carm Akim, RN BSN

References

- Hui, D., Nooruddin, Z., Didwaniya, N., Dev, R., De La Cruz, M., Kim, S. H., ... Bruera, E. (2014). Concepts and Definitions for “Actively Dying,” “End of Life,” “Terminally Ill,” “Terminal Care,” and “Transition of Care”: A Systematic Review. *Journal of Pain and Symptom Management*, 47(1), 77–89.
<http://doi.org/10.1016/j.jpainsymman.2013.02.021>



LATE

Juliet A. F. Begley
67-5111 Yutaka Pen Place,
Kamuela, Hawai'i 96743

February 14, 2017

Senator Rosalyn Baker, Chair
Senator Clarence Nishihara, Vice Chair
Committee on Commerce, Consumer Protection and Health

SUPPORT SB 1129 - Relating to Health, establishing a Death with Dignity Act

Dear Senate Members of the CCPH:

In 2002 I gave testimony for Death with Dignity legislation due to my friend who died with great suffering in 1998. This event had caused me to ask Governor Cayetano if we could put forth a bill to address the hastening of death in the Governor's legislative package that year. He agreed, and Death with Dignity legislation almost passed on the floor of the Senate on the last day of the 2002 Session. Since that time I have been involved with this issue. I do end of life care. So I want to impress upon you that my opinion is not purely intellectual, I have hands on experience with the daily care of dying people.

I fully support legislation to allow for a legal venue for terminally ill people of sound mind to be able to choose when they die. I have cared for over a dozen people in the final stages of life - and all of my patients have asked me why we do not have a safe and reasonable manner of addressing death, that would allow them a peaceful exit, one where they were able to exercise a level of self-control. A death with dignity law in Hawaii, that adheres to the safeguards that Oregon has, is a reasonable response to this need.

It has been fifteen years since people in Hawaii started to push for a law to mirror the Death With Dignity law in Oregon for Hawaii. Since that time the entire West Coast of the United States has put in place legal options for people who are terminally ill and of sound mind to be able to end their lives. Please allow the residents of Hawaii to be able to have this same choice. It is the ultimate act of personal autonomy.

Sincerely,

Juliet Begley

CPH Testimony

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, February 14, 2017 3:28 PM
To: CPH Testimony
Cc: kimcoco@kimcoco.com
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM

LATE

Categories: Late

SB1129

Submitted on: 2/14/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Kim Coco Iwamoto	Individual	Support	No

Comments: My family lives in the Nuuanu Ahapuaa and like a majority of this state's residents, we are in strong support SB1129. Patients who are suffering should be offered a full range of medical options related to their care. The narrow religious beliefs of a few strangers should not limit decision made by a patient after consultation with their physician. I would ask that your committee consider removing the following requirement: "If the patient is an inpatient at a long-term care facility, one of the witnesses shall be an individual designated by the facility." If that particular facility has religious objections to this particular treatment, they should not be allowed to stand in the way of this treatment option. It seems cruel to force the patient, their family, friends, to move the patient out of the facility before that person could get the medical treatment they are requesting. Ultimately I believe that all individuals should have the right to pass with dignity; I support SB1129.

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From: [Lynne Beckstrom](#)
To: [CPH Testimony](#)
Subject: In support of Senate Bill 1129, Death with Dignity
Date: Wednesday, February 15, 2017 12:19:55 AM

I am writing in support of Senate Bill 1129. As a senior in my mid-seventies, I have seen death come to family and friends. Some were fortunate enough to slip away in peace, with dignity. Others were frantic with unremitting pain that could never quite be medicated away, something that horrifies me as I move ever closer to my own demise.

As lawmakers, you have the opportunity to enact a law that allows patients and physicians to voluntarily participate in assisted end of life. The groups in Hawaii who oppose passage of this bill continue to express unfounded fears including rampant euthanasia. Certainly, Oregon's experience has long put those fears to rest. Several local physicians have said that the law would require them to break their oath to "do no harm." For me, withholding assistance would be doing great harm. A letter to the editorial page of the newspaper claimed that assisted dying was not the "Hawaiian way." And although ohana is a strong value here, not everybody has the support of family.

Please pass this bill through to a vote. It creates options for everyone without forcing anyone to participate against their beliefs.

Lynne Beckstrom
91-1182 Bryan St.
Ewa Beach, Hi 96706
888-6412

TESTIMONY IN STRONG OPPOSITION TO SB 1129
Committee on Commerce, Consumer Protection, and Health
Hearing Wednesday, February 15, 2017 in Conf Room 229 at 8:30 a.m.

LATE

From Name and Address:

Estelle Fujii
930 Kahaka St #2901
Honolulu, HI 96814

Dear Senators Rosalyn Baker, Chair
Clarence Nishihara, Vice Chair

I submit this testimony in strong **OPPOSITION** to physician assisted suicide under any description for the following reasons:

- Proper medical care includes only treating diseases NOT killing the patient
- Legalizing physician assisted suicide sends the wrong message to our troubled teens that suicide is an acceptable way to solve problems
- In Hawaii, we take care and love our Kupuna, we don't abandon them to suicide

Other: _____

I urge you to vote no and kill SB1129 at the hearing on Wednesday, February 15, 2017.

Estelle Fujii
Sign name

Estelle Fujii
Print name

930 Kahaka St #2901 96814
Print street address with zip code

SENT VIA:

- Email to CPHtestimony@capitol.hawaii.gov
 Fax to 808-586-6071
 In person to Committee Clerk, Rm 230, State Capitol

LATE

From: mailinglist@capitol.hawaii.gov
To: [CPH Testimony](#)
Cc: tfras89012@gmail.com
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM
Date: Wednesday, February 15, 2017 6:51:28 AM

SB1129

Submitted on: 2/15/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
tony frascarelli	Individual	Support	No

Comments: I am a 67 year old Vietnam Vet. If I am ever diagnosed with an incurable illness, I want the option to end my life rather than becoming a vegetable in a hospital bed. Than you.

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From: mailinglist@capitol.hawaii.gov
To: [CPH Testimony](#)
Cc: terrynuiyoshinaga@hotmail.com
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM
Date: Wednesday, February 15, 2017 1:20:03 AM

SB1129

Submitted on: 2/15/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Terry Yoshinaga	Individual	Oppose	No

Comments: Our state should support life and not give individuals the right to end their lives when they are terminally ill. It opens the way for abuse of these vulnerable individuals at a time when they should be encouraged to live. No one knows how long they may live if they do not give up hope.

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From: mailinglist@capitol.hawaii.gov
To: [CPH Testimony](#)
Cc: rkailianu57@gmail.com
Subject: *Submitted testimony for SB1129 on Feb 15, 2017 08:30AM*
Date: Wednesday, February 15, 2017 6:33:19 AM

SB1129

Submitted on: 2/15/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Rachel L. Kailianu	Individual	Support	Yes

Comments:

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CPH Testimony

From: Ann Kern <akern@hawaii.edu>
Sent: Wednesday, February 15, 2017 7:46 AM
To: CPH Testimony
Subject: SUPPORT FOR MEDICAL AID-IN-DYING BILL

LATE

Please support the proposed medical aid-in-dying bill. It will prevent further needless pain and suffering, not only on the part of patients but also on the part of their caregivers, family, and friends. Please remember that in the United States the rule of law is separation of church and state, so it is important not to be influenced by the arguments of religious organizations against this issue.

Mahalo nui loa for your consideration,
Ann Kern
Keauhou, Hawai'i Island

February 15, 2017

LATE

TO: Senate Commerce, Consumer Protection , and Health Committee
Senator Rosalyn Baker, Chair and Senator Clarence Nishihara, Vice Chair, and
Members Senator Stanley Chang, Senator Will Espero, Senator Les Ihara, Jr.,
Senator Michelle Kidani, Senator Russell Ruderman
RE: Testimony on SB1129

This year, HB 559 titled "Suicide Prevention Task Force Relating to Health," was introduced. This proposed legislation states in part:

"SECTION 1. The legislature finds that suicide is a major health concern that claims approximately one million lives worldwide each year. In Hawaii suicide was the most common cause of fatal injuries among Hawaii residents between 2010-2014, accounting for one-quarter of all fatal injuries. One person dies by suicide in Hawaii every two days. The legislature is concerned with the health, safety, and welfare of all the people of Hawaii, including military personnel, veterans, and visitors.

The purpose of this Act is to establish a suicide prevention task force to reduce suicides in Hawaii by twenty five percent by year 2025.

SECTION 2. (a)...The suicide prevention task force shall examine, evaluate, and determine methods to improve education, awareness, support services, and outreach to best prevent suicides in Hawaii."

This measure indicates that the legislature is concerned about the high number of suicides in Hawaii and that its goal is to prevent them by offering various forms of supportive care for those wanting to end their lives, for whatever the reasons may be.

On the other hand, the "Death with Dignity" bill is written to encourage people to choose suicide. But death is final and once the evil deed has been done, one cannot go back and say, "Oops, that was a mistake, I want to undo this suicide." And prohibiting certain acts that cause a patient's death with the penalty of a class A felony charge helps neither the deceased nor his/her family.

If you really want to help terminally ill patients cope with their difficult health challenges, leading them to an untimely death is not the answer. There are medical professionals, palliative care programs, hospice services, and other ways to receive compassionate and effective health care.

Please vote NO on SB 1129. Hawaii should work toward preventing suicides, not promoting them.

Thank you.

Sharon Nagasako
(808)285-2370

CPH Testimony

From: Melissa Crisostomo <alohamc@yahoo.com>
Sent: Tuesday, February 14, 2017 11:36 PM
To: CPH Testimony
Subject: Testimony opposing SB1129

LATE

I oppose SB1129. As a registered nurse for 31 years, 11 years as an oncology nurse working with cancer patients and 6 years as a hospice nurse working with terminally ill patients and their families, I can tell you that predicting the time of death within 6 months is inexact and with modern pain and symptom management practices, patients can have a dignified death with minimal suffering and without assisted suicide. Often times, the suffering I witnessed was the suffering the patient's family were going through, which seemed to them unbearable. On the other hand, the patient was accepting of his death and suffered little. Many of my terminally ill patients lived longer than 6 months. Also, as a caregiver of my elderly parents, I can tell you that the challenge and frustration of caring for them as a nurse and daughter could even push me to end the suffering. Not the suffering for my parents, but for myself. What more challenging would it be for non-clinically trained family to care for their disabled or terminally ill family members. Legalizing assisted suicide opens the door to caregivers abusing their ill or disabled family members. As a hospice nurse, I have witnessed large doses of pain medications being left in unsecured locations in the home where children or those who would like to steal them for personal use or gain. If a lethal dose of drugs for assisted suicide is prescribed, these too, could end up in the wrong hands causing serious injury and unintended deaths. I can also see how this law would cause healthcare insurance companies to deny approval of healthcare treatments for cancer patients who are at a more advanced stage of their disease, and as a result, leaving these patients with little or no alternatives for treatment which would cause depression and pressure them to choose assisted suicide. Finally, assisted suicide would irreversibly damage the trust relationship between healthcare professionals and their patients and families. In Hawaii, family or Ohana means caring and loving for family from the being to the end of life, selflessly and with great love, trust and respect. Please vote against SB1129.

Respectfully submitted,
Melissa Crisostomo, RN, MPH

CPH Testimony

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, February 15, 2017 12:04 AM
To: CPH Testimony
Cc: britteross@hotmail.com
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM

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SB1129

Submitted on: 2/15/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Brittany Ross	Individual	Support	No

Comments: I strongly support giving individuals facing the end of their life the opportunity to choose their journey. This bill allows the choice for a death with dignity, if one so chooses, and also safeguards loved ones and medical professionals who support those making this very difficult choice.

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CPH Testimony

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, February 14, 2017 11:34 PM
To: CPH Testimony
Cc: cissyswanson@gmail.com
Subject: *Submitted testimony for SB1129 on Feb 15, 2017 08:30AM*

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SB1129

Submitted on: 2/14/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Cecilia Swanson	Individual	Support	No

Comments:

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Testimony in opposition to HB 1129---- by Chris Niemczyk -----Feb---2017

Good morning Mr. chairman and members of the committee. I appreciate this opportunity to address you this morning. Once again the issue of Physician Assisted Suicide is being debated before the Hawaii state legislature, more commonly referred to as the Death with Dignity bill. One must ask if anyone exercising this option of hastening their death is any more dignified than those who don't choose this option. Furthermore, is this law even necessary? Is suicide legal?

The advocates of Physician Assisted Suicide argue that this bill will only give those who have been declared terminally ill and have six months or less to live the option to end their lives to alleviate pain and suffering at the end of their life. Ironically in states like Oregon statistics show the five top reasons individuals give in considering Physician Assisted suicide are 1. loss of autonomy 91% , 2. less able to engage in activities 89%, 3. loss of dignity 81%, 4. loss of control and bodily function 51%, and 5. The feeling of being a burden 40%. No one wants anyone to suffer undue pain but Physician Assisted Suicide should never be an option. I believe, as do many others, that there are many other alternatives which should be considered instead of Physician Assisted Suicide. Here I would like to thank the legislators' efforts in past years of making palliative care and pain management more available. This is where the state's focus should remain. The historic emphasis in the past has been on the preservation of life. The Declaration of Independence states that everyone has the right to life liberty and the pursuit of happiness. The whole of essence of the medical profession is to save and to preserve life

Testimony in opposition to HB ---- by Chris Niemczyk -----Feb---2017

LATE

The Honorable Senator Rosalyn Baker, Chair
and Members of the Senate Committee on Commerce, Consumer Protection and Health

RE: In SUPPORT OF SB 1129 – “RELATING TO HEALTH”
Hearing Date: February 15, 2017, 8:30 a.m., Conference Rm. 229

My name is Pauline Sato. Thank you for the opportunity to submit testimony in support of SB 1129, which establishes a death with dignity act under which a terminally ill adult resident may obtain a prescription for medication to end the patient's life.

I have never testified on a bill similar to this before but I feel strongly that the time is now for this bill to become law. Having seen too many of my friends suffer from terminal illness, it is not right to force them to hang on indefinitely to ease someone else's conscience.

I understand that some physicians oppose this, which is their choice. They also have a choice not to have to face this situation with their patients. They can refuse to treat the patient and him or her to go to another doctor. The doctors' and anyone else's personal feelings and beliefs should not interfere with that of someone who has made the very difficult and excruciating decision to end his or her life due to a terminal illness with less than 6 months to live.

Let people make their own decisions about how they want to live the rest of their life. That is the moral thing to do.

I humbly ask you to support the passage of SB 1129. Thank you for the opportunity to testify on this measure.

Aloha,



1173 Alewa Drive
Honolulu, Hawaii 96817

CPH Testimony

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, February 14, 2017 9:57 PM
To: CPH Testimony
Cc: jjamesed@gophawaii.com
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM

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SB1129

Submitted on: 2/14/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Jack James	Individual	Oppose	Yes

Comments: Aloha, I speak in opposition to SB1129. While I understand the compassion of the advocates of SB1129 I am opposed to the legislation for two basic reasons; 1.) the potential abuse of others when the individual that is ill is most vulnerable and 2.) that we do not pinch out the flame of life in those that still have hope in living and may have agreed in a moment of weakness. Thank you for the opportunity to submit my testimony.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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CPH Testimony

From: Tom Tizard <tizard8@hawaii.rr.com>
Sent: Tuesday, February 14, 2017 10:16 PM
To: CPH Testimony
Subject: DEATH WITH DIGNITY

LATE

MOST OF THE SALIENT POINTS ARE COVERED IN OTHER TESTIMONIES...

WHAT HAS NOT BEEN SAID – IS THAT THE REQUESTS IN OREGON HAVE, IN FACT, DECLINED, AT LEAST OVER THE FIRST 10 YEARS...MUCH OF WHICH IS CREDITED TO THE DWD LAW-INSPIRED EFFORTS OF THE MEDICAL COMMUNITY TO PROVIDE GREATER PALLIATIVE CARE!!!

BUT, BOTTOM LINE: IF YOU DON'T WANT DWD, DON'T ASK FOR IT! (BUT DON'T INTERFERE WITH MY RIGHT TO USE IT!)

**THOMAS TIZARD
KAILUA**

Senator Rosalyn H. Baker, Chair
Senator Clarence K. Nishihara, Vice Chair
Senate Committee on Commerce, Consumer Protection and Health

LATE

February 15, 2017

TESTIMONY IN OPPOSITION OF SB 1129 RELATING TO HEALTH; DEATH WITH DIGNITY

Aloha and Mabuhay Chair Baker, Vice Chair Nishihara, and Members of the Committee,

My name is Jeny Bissell, a Registered Nurse of the State of Hawaii Department of Health for almost 30 years. I am writing as a private citizen living in South Maui to express my opposition for SB 1129 to establish a death with dignity act under which a terminally ill adult resident may obtain a prescription for medication to end the patient's life.

The legislation would increase access and availability of lethal drugs to kill a patient. As a Registered Nurse, this method is in violation to our Code of Ethics under the Nurse Practice Act. As immediate past chair of the Prevent Suicide Maui County Task Force, member of the Prevent Suicide Hawaii State Task Force and the Injury Prevention Advisory Committee, physician assisted suicide is not the solution and this measure will send a strong message to the people of Hawaii that suicide is a solution and a promotion. Suicide was the most common cause of fatal injuries among Hawaii residents over the 5-year period 2010-2014, accounting for over one-quarter (908, or 26%) of all fatal injuries. Suicide was the leading cause of injury-related death for most age groups - all but the very young and the very old - outpacing car crashes, homicide, unintentional poisoning and drowning. One person dies by suicide in Hawaii every two days. This measure is opening the door to abuse. Elder abuse is a major public health problem in our state and in the United States with federal estimates that 1/10 older persons are abused, most often by a family member. Placing lethal drugs into the hands of abusers generates an additional major risk to older persons and to vulnerable persons. In fact, allowing physicians to cross the line into killing does not stop with willing patients who request it. A greedy heir or an abusive caregiver can pick up the drugs and either coerce a patient to take them or put them in the patient's food. Who would know if the drugs are freely taken since there is no supervision or tracking of the drugs once they leave the pharmacy? As a facilitator of our Mortality Review Panel(s) in our State, I am concerned about the access and availability of lethal drugs in our household and communities when this become enacted in our state. "Fruit bowl parties" are occurring in our communities that resulted to mortality and morbidity amongst Hawaii's children and youths.

I believe that the enactment of this legislation in our state is wrong, costly, and a burden to our people and our system of care. Instead we should focus and invest on existing system of care, and policies that is effective and culturally meaningful such as and not limited to comfort care, pain management, palliative care, hospice care, and soon to be Kupuna Care.

Thank you for considering my testimony.

Sincerely,
Jeny Bissell, R.N.
484 Kaiwahine Street
Kihei, HI. 96753

February 14, 2017

Senate Committee on Commerce, Consumer Protection and Health
Senator Rosalyn H. Baker, Chair
Senator Clarence K. Nishihara, Vice Chair

LATE

Testimony In Opposition to Senate Bill 1129 Death with Dignity Act

Aloha Honorable Chair Baker, Vice Chair Nishihara and Committee Members,

My name is Michael Bissell, resident of Kihei, Maui since 1987. I am writing this testimony as a private citizen, who with a loving heart on this Valentine's Day strongly oppose Senate Bill 1129. This bill that alters the definition of suicide only because a physician is involved, is falsely presented as compassionate. What a great disservice to the citizens of Hawaii. How is prescribing a death drug that will be self-administered any different than buying the rope for someone to hang themselves? Suicide is suicide. It is not death with dignity, no matter what contrived definitions this bill is desperately fabricating and portraying.

Our State motto translates to "the life of the land is perpetuated by righteousness." This bill SB1129 is the antithesis of our motto, as it outlines in uncaring, perverted details that if you have only six months to live, the compassionate choice is to kill yourself. And, SB1129 defines how this self-administered death won't be called suicide on the death certificate. A bill saying self-administered death is something else doesn't make it so. In fact, hiding the true cause of death works against the bill's premise of death with dignity. There cannot be dignity when falsehoods are present. By the way, what about time of death? Who is responsible for that important detail? It is no wonder that the reporting requirements are nothing but in-house compliance reports with only statistical information to be released to the public.

And contracts, wills and trusts? Since the same death pen that wrote the death prescription, is now used on the death certificate, a self-administered death is not suicide, so those legal documents won't be affected. Unbelievable that we have reached this level of deception, to trick the citizens into believing what is fact to be false and what is false to be fact.

Next, this bill and its variants have lots of commercial ad support. They wouldn't be investing in our State if there wasn't a return, whatever form that return takes on. I placed my trust in you, our elected lawmakers to look after the citizens of our State, not outside lobbyists who have only their investments in mind. They are not invested in compassion, they are only concerned with quotas and statistics. Don't kill our fellow citizens, but instead kill this Bill 1129 instead.

Certainly, there are Hawaii citizens who support this bill. We must work to help them find the compassionate care they believe are lacking. This bill is not their answer. Keep the State of Hawaii the Aloha State, we don't need to join the other Death States. Stop SB1129 now.

Thank you.

Michael Bissell
484 Kaiwahine Street
Kihei, HI 96753

February 14, 2017

Chair Senator Rosalyn H. Baker, Vice-Chair Senator Clarence K. Nishihara
Senate Committee on Commerce, Consumer Protection & Health

**TESTIMONY IN SUPPORT OF S.B. 1129 WITH RECOMMENDED
CHANGES**

Thank you for this opportunity to present testimony in support of SB1120 with a request to consider a major change as follows: **Delete the phrase “terminal disease” and in its place use the phrase “grievous and irremediable medical condition”.**

The proposed legislation is a step forward and may assist some individuals; however, it excludes many other individuals who suffer from debilitating and degenerative neurological disorders such as Alzheimer’s Disease, Huntington’s Disease, and Parkinson’s Disease. These individuals need and deserve the same protection and compassion as those who are considered “terminally” ill.

My husband was diagnosed with Parkinson’s Disease at age 76. At the time of his diagnosis his doctor said, “You may pass away within four years or you may live as long as thirteen more years.” The doctor explained further that a person does not die from Parkinson’s but more than likely from some other related condition like asphyxia, falling (with loss of mobility), mental disorders (dementia, seizures, hallucinating), significant weight loss, and loss of muscle control. My husband endured for the full 13 years, spending the final years of his life in a care home. It was tragic and painful for him and for his family to witness the slow degeneration of this once intelligent and physically competent human being.

It is important to recognize that while Parkinson's is not considered a terminal disease, as of this date **there is no known cure for Parkinson's Disease. Once a person is diagnosed with the disease, he knows he has begun the process under which every part of his body. will degenerate.**

Canada's newly passed legislation, with modifications, is instructive as a way to eliminate any confusion in applying the projected date of natural death. This language offers protection of medical aid in dying where the following requirements are met.

1. An adult with capacity to make decisions about their health care.
2. A voluntary request, without external pressure, for medical aid in dying.
3. Informed consent to receive medical aid in dying is provided only after individuals are advised of the means available to alleviate suffering,
4. A grievous irremediable medical condition exists:

"Grievous irremediable medical condition" means a serious and incurable illness, disease or disability which cannot be reversed and which causes enduring physical or psychological suffering, that is intolerable to the individual and cannot be relieved under conditions acceptable to the individual.

By extending the reach of the current legislative proposal to include those residents facing grievous and irremediable suffering, the Legislature will recognize a class of

long suffering residents who deserve the opportunity to die with dignity

Thank you for the opportunity to present testimony on SB1129.

Esther Kwon Arinaga

1434 Punahou St. #701, Honolulu, HI 968222

CPH Testimony

From: HONOLULU BUZZ <buzzhonolulu@yahoo.com>
Sent: Tuesday, February 14, 2017 6:20 PM
To: CPH Testimony
Subject: Death With Dignity

LATE

Members of the CPH Committee:
2017

February 14,

I support the right of people who are terminally ill to obtain a physician written prescription for any drugs necessary for such a person to end his or her life. The final stages of cancer, and certain other diseases, can be extremely demeaning and exceedingly painful. When realistic hopes of recovery are no longer there, and all that remains are expensive palliative care which does NOT always take away all the pain, a person should have the right to end his life. There is a major difference between extending a person's life and extending a person's death. Needless and unwanted extending of a dying person's life often causes a person to endure extra months of suffering. Please let this be the year when the unnecessary pain and suffering ends.

Thank you,
Joseph O'Brien
114 N. Kuakini St. # 1604
Honolulu Hawaii 96817
buzzhonolulu@yahoo.com

CPH Testimony

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, February 14, 2017 7:13 PM
To: CPH Testimony
Cc: yvonne.w.m.lau@gmail.com
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM

LATE

SB1129

Submitted on: 2/14/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Yvonne W. M. Lau	Individual	Support	No

Comments: Thank you for the opportunity to testify. As a two time cancer survivor, I want to have the opportunity to decide when to end my life should this disease come back and cause my quality of life to deteriorate to a stage where there is no cure and further pain and suffering is the only thing that remains. I believe this bill provides sufficient protections and would affirmatively allow me to express my desire to end my life and make clear to my family and physicians my intent to end my life should I meet the conditions set forth in this bill. I thank you for your consideration and hope you will pass this bill.

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CPH Testimony

From: Ron Kent <ronkent@hawaii.rr.com>
Sent: Tuesday, February 14, 2017 8:03 PM
To: CPH Testimony
Subject: SB1129

LATE

This bill provides a measure of independence only for those who wish to use it. It doesn't impact people whose religious beliefs don't allow them to use this option.

As long as the individual can independently make the decision to take the medicine it provides a dignified and vital option.

Please support this bill.

Thank you,

Myra Kent

CPH Testimony

From: Danny Rogers <dannyrogers2823@gmail.com>
Sent: Tuesday, February 14, 2017 8:47 PM
To: CPH Testimony
Subject: SB1129

Support
Danny R Rogers

LATE

CPH Testimony

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, February 15, 2017 8:03 AM
To: CPH Testimony
Cc: lynneronderko@gmail.com
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM

SB1129

Submitted on: 2/15/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

LATE

Submitted By	Organization	Testifier Position	Present at Hearing
Lynn Onderko	Individual	Support	No

Comments: Aloha Chair and Committee Members, I am writing in strong support of this bill. Hawaii's terminally ill and those facing the torturous effects of disease should have a humane option to end their life. There are protections in place that make this a well thought out, patient centered, safe choice. I ask that you please do the right thing and move this bill to passage. Mahalo nui, Lynn Robinson-Onderko

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LATE

Vote "No" on SB 1129

SB 1129 legalizes physician-assisted suicide and allows euthanasia as long as actions are taken in "accordance" with the act.

The proposed Oregon style act applies to people with years or decades to live. The act is a recipe for elder abuse.

Highlights:

- Passing the act will encourage people with years, even decades, to live, to throw away their lives.
- The proposed act 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?
- Elder abuse is already a not well controlled problem. Passing the proposed act will make the situation worse, to effectively allow legal murder.
- Physician-assisted suicide, even when voluntary, can be traumatic for patients and families.
- Passage will create a risk of suicide contagion.
- The proposed Oregon-style "oversight" is a sham and will create the opportunity for a non-governmental entity to displace the proper role of government:

Don't Make Oregon and Washington's Mistake.

Vote "No" on SB 1129.

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

Vote "No" on SB 1129

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Vote "No" on SB 1129.

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

TO: The Hawaii State Senate Committee on
Commerce, Consumer Protection and Health

FROM: Margaret Dore, Esq., MBA, President
Choice is an Illusion, a nonprofit corporation¹

RE: Reject SB 1129 (No Assisted Suicide, No
Euthanasia).

- Stop People With Years to Live From Throwing Away Their Lives;
- Prevent Legal Elder Abuse;
- Preserve Government Transparency and Integrity;
- Don't Let Hawaii Become Corrupt Like Oregon;
- Prevent Suicide Contagion

HEARING: Wednesday, February 15, 2017 at 8:30 a.m.
State Capitol, Conference Room 229
415 South Beretania Street
Honolulu HI

MEMO
DATE: February 15, 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

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APPENDIX

I. INTRODUCTION

I am an attorney in Washington State where assisted suicide and euthanasia are legal.¹ Our law is based on a similar law in Oregon. Both laws are similar to the proposed "Death with Dignity" Act set forth in SB 1129.²

The proposed act legalizes physician-assisted suicide and allows euthanasia as long as actions are taken in "accordance" with the act. The act applies to people with years or decades to live. The act is a recipe for elder abuse.

Purported patient protections and government oversight are a sham. I urge you to vote "No" on SB 1129.

II. ASSISTED SUICIDE AND EUTHANASIA

A. Physician-Assisted Suicide

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 The AMA gives this example:

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.margarettdore.com, www.choiceillusion.org and www.hawaiiagainstassistedsuicide.org

² SB 1129 is attached hereto in the Appendix at A-101 to A-126. The proposed act begins at A-102, line 16.

³ The AMA Code of Medical Ethics, Opinion 2.211, attached hereto at A-5.

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

"Assisted suicide" is a general term in which the assisting person is not necessarily a physician.

B. Euthanasia

Euthanasia is also known as "mercy killing" and "lethal injection."⁵ Active euthanasia is the act of putting an animal or person to death painlessly, i.e., via the direct administration of a lethal agent.⁶

Allowing a person to die by withdrawing medical measures ("pulling the plug") may also be termed euthanasia.⁷ The term is not appropriate if the purpose of withdrawing medical measures 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.⁸

⁴ Id.

⁵ See definitions of "mercy killing," "euthanasia" and "lethal injection" attached hereto at A-6 and A-7.

⁶ See definition of "euthanasia" at A-6 (middle of the page).

⁷ Id.

⁸ 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-18, quote at A-20.

III. FEW STATES ALLOW ASSISTED SUICIDE

Assisted suicide was legalized in Oregon and Washington State, in 1997 and 2008, respectively.⁹ Just three other states have enacted similar laws. (Vermont, California and Colorado).

In the last six years, five states have strengthened their laws against assisted suicide: Arizona, Louisiana, Georgia, Idaho and Ohio.¹⁰

Last year, the New Mexico Supreme Court overturned a lower court decision recognizing a right to physician aid in dying, meaning physician-assisted suicide.¹¹ Physician-assisted suicide is no longer legal in New Mexico.

IV. THE ACT APPLIES TO PEOPLE WITH YEARS OR DECADES TO LIVE

The proposed act applies to persons with a "terminal disease," meaning those predicted to have less than six months to

⁹ Oregon's law was originally passed in 1994 as Ballot Measure 16, but did not go into effect until 1997 when it passed again pursuant to Ballot Measure 51. Washington's law was passed by Initiative 1000 in 2008 and went into effect in 2009. The Oregon and Washington laws are sold as limited to physician-assisted suicide. In the fine print, they also allow euthanasia.

¹⁰ See: Associated Press, "Brewer signs law targeting assisted suicide," *Arizona Capitol Times*, 04/30/14, attached at A-24 ("The proposal was prompted by a difficult prosecution stemming from a 2007 assisted suicide"); Associated Press, "La. assisted-suicide ban strengthened," *The Daily Comet*, 04/24/12, attached at A-25); Georgia HB 1114 (attached hereto at A-26); Margaret Dore, "Idaho Strengthens Law Against Assisted Suicide," *Choice is an Illusion*, 07/04/11, at A-27 ("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>

¹¹ *Morris v. Brandenburg*, 376 P.3d 836 (2016). (Excerpt attached at A-28).

live.¹² Such persons may actually have years or decades to live. This is true for three reasons:

A. Treatment Can Lead to Recovery

In 2000, Oregonian Jeanette Hall was given a terminal diagnosis of six months to a year to live, which was based on her not being treated for cancer.¹³ Hall made a settled decision to use Oregon's law, but her doctor convinced her to be treated instead. 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.¹⁴

B. Predictions of Life Expectancy Can Be Wrong

Patients may also have years to live due to misdiagnosis and because predicting life expectancy is not an exact science.¹⁵ Consider John Norton, diagnosed with ALS (Lou Gehrig's disease) at age 18 or 19.¹⁶ He was told that he would get progressively worse (be paralyzed) and die in three to five years.¹⁷ Instead, the disease progression stopped on its own.¹⁸ In a 2012

¹² See SB 1129, Section 2, § -2, p.5, lines 7 to 9. (Attached at A-105).

¹³ Affidavit of Kenneth R. Stevens, JR., MD, ¶¶ 3-7, at A-33 to A-34.

¹⁴ Declaration of Jeanette Hall, ¶ 4, attached hereto at A-40.

¹⁵ See e.g., Jessica Firger, "12 million Americans misdiagnosed each year, CBS NEWS, 4/17/14 (attached at A-41); and Nina Shapiro (at A-18 to A-20).

¹⁶ Affidavit of John Norton, August 15, 2012, attached at A-42 to A-44, ¶3.

¹⁷ Id., ¶ 1.

¹⁸ Id., ¶ 4.

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.¹⁹

C. If Hawaii Follows Oregon's Interpretation of "Terminal Disease," Assisted Suicide and Euthanasia Will Be Allowed for Chronic Conditions Such as Insulin Dependant Diabetes

The proposed act defines "terminal disease," as follows:

"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.²⁰

Oregon's law has an identical definition, as follows:

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

In Oregon, this identical definition is interpreted to include chronic conditions such as "chronic lower respiratory disease" and "diabetes mellitus" (better known as diabetes). This is because the six months to live is determined without treatment.²² Oregon doctor, William Toffler, explains:

In Oregon, people with chronic conditions are "terminal," if without their medications, they have less than six months [to] live.

¹⁹ Id, ¶5.

²⁰ SB 1129, Section 2, § -1, page 5, lines 7-9, attached hereto at A-105.

²¹ Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-47.

²² These conditions are listed in Oregon government reports concerning its law. See, for example, report excerpts attached hereto at A-53 & A-54.

(Emphasis added).²³

Dr. Toffler elaborates:

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. (Emphasis and spacing changed).²⁴

If the proposed act is not rejected and Hawaii follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be allowed for people with chronic conditions such as insulin dependent diabetes. As noted by Dr. Toffler, such persons can have "decades to live."²⁵

V. HOW THE ACT WORKS

The act has an application process to obtain the lethal dose, which includes a written lethal dose request form with two required witnesses.²⁶ One of the witnesses is allowed to be the patient's heir who will financially benefit from the patient's death.²⁷

Once the lethal dose is issued by the pharmacy, there is no

²³ Declaration of William Toffler, MD, ¶ 4, attached at A-45 to A-46.

²⁴ Id., at A-46.

²⁵ Id.

²⁶ See SB 1129 at Section 2, § -22, pages 23 to 25 to view the entire form. (Attached hereto at A-123 to A-125). The declaration of witnesses can be found on page 25, attached hereto at A-125.

²⁷ SB 1129 at A-125, lines 19 to 21.

oversight. No witness, not even a doctor is required to be present when the lethal dose is administered.²⁸

VI. THE ACT

A. The Act Creates a New Path of Elder Abuse, Which is Lethal

1. Elder abuse is a pervasive problem, which includes the financial exploitation and murder of older adults

Elder abuse is a problem in Hawaii and throughout the United States.²⁹ 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.³⁰ Victims may even be murdered.³¹ The State of Hawaii Executive Office on Aging states:

Like other forms of interpersonal violence, elder abuse usually occurs behind closed doors.³²

²⁸ SB 1129 in its entirety, attached at A-101 to A-126.

²⁹ See: State of Hawaii Executive Office on Aging, "Prevention of Elder Abuse Is in Our Hands: A Guide to Identify, Report and Prevent Abuse, Neglect and Exploitation," published July 2014, available at https://www.hawaiiadrc.org/Portals/_AgencySite/Diane/EA-Prevention-07-2014.pdf; 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>

³⁰ Met Life Mature Market Institute, *supra*.

³¹ *Id.*, p. 24.

³² State of Hawaii Executive Office on Aging, *supra* at note 29, page 4.

Elder abuse is prevalent in part because victims do not report it. The Executive Office on Aging states:

- [Victims f]eel ashamed and embarrassed, particularly if a family member is the abuser.
- [They are] afraid that if they report, the abuse will get worse.³³

2. "Even if the patient struggled,
'who would know?'"

The act has no required oversight at the death.³⁴ In addition, the drugs used are water and alcohol soluble, such that they can be administered to a restrained or sleeping person without consent.³⁵ 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. . . . Even if a patient struggled, "who would know?" (Emphasis added).³⁶

³³ Id., p.5.

³⁴ See the proposed act in its entirety, attached hereto at A-102 to A-126.

³⁵ The drugs used for assisted suicide in Oregon and Washington include Secobarbital and Pentobarbital (Nembutal), which are water and alcohol soluble, such that they can be injected without consent. See "Secobarbital Sodium Capsules, Drugs.Com, at <http://www.drugs.com/pr/seconal-sodium.html> and <http://www.drugs.com/pro/nembutal.html> See also Oregon's government report, page 6, attached at A-53 (listing these drugs).

³⁶ 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](http://www.margaretdore.com/info/October%20Letters.pdf)

B. The Act Does Not Require That Administration of the Lethal Dose Be Voluntary

The proposed act does not require administration of the lethal dose to be voluntary. The act repeatedly describes a request for the lethal dose in voluntary terms.³⁷ The issue, however, is whether administration of the lethal dose is required to be voluntary and on this point, the act is silent.³⁸ The bill's preamble, which is not part of the act, implies voluntary administration.³⁹ But, the act itself, which is what matters, is silent on the subject. With no requirement in the act that administration of the lethal dose be voluntary, patients are not protected. The act must be rejected.

C. The Act Merely Requires That Actions Be Taken in "Accordance" With the Act; In Washington State, This Means That the Act Was "Used"

The proposed act says that actions taken in accordance with the act shall not constitute mercy killing, which is another word for euthanasia.⁴⁰ The act states:

Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing [euthanasia], or homicide, under the

³⁷ See the act, Section 2, §§ -2, 3, 4, 5, 12 & 22. (Attached hereto at A-105 to A-107, A-110, A-112 and A-125)

³⁸ See the Act in its entirety, attached hereto at A-102 to A-126.

³⁹ See SB 1129, Section 1, p. 1, lines 1 to 6. (Attached hereto at A-101).

⁴⁰ See definitions at A-6 (defining mercy killing as "euthanasia").

law. (Emphasis added).⁴¹

Washington's law has nearly identical language, as follows:

Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing [euthanasia], or homicide, under the law.⁴²

In Washington State, this nearly identical language requires the death certificate to list a natural death without regard to whether there was compliance with patient protections. The only relevant inquiry is whether Washington's law was "used." Washington's "Death Certificate Instructions for Medical Examiners, Coroners and Prosecuting Attorneys," state:

If you know the decedent used [Washington's law], you must comply with the strict requirements of the law when completing the death record:

1. The underlying terminal disease must be listed as the cause of death.
2. The manner of death must be marked as "Natural."
3. The cause of death section may not contain any language that indicates that [Washington's law] was used, such as:
 - a. Suicide
 - b. Assisted suicide
 - c. Physician-assisted suicide
 - d. Death with Dignity
 - e. I-1000 [Washington's law was passed by I-

⁴¹ The act, Section 2, § -17, p. 15, lines 18 to 20, attached at A-115.

⁴² RCW 70.245.180(1). (Attached hereto at A-127).

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- f. Mercy killing
- g. Euthanasia
- h. Secobarbital or Seconal
- i. Pentobarbital or Nembutal (Emphasis added; spacing changed.)⁴³

If the proposed act is enacted and Hawaii follows Washington State, death certificates for deaths occurring under the act will list a natural death without regard to whether there was compliance with patient protections and without disclosing the actual cause of death simply because the act was "used." Prosecution will not be possible because the cause of death will not be "suicide, assisted suicide, mercy killing [euthanasia], or homicide, under the law."⁴⁴

D. Euthanasia Is Not Authorized, But Nonetheless Allowed

The proposed act states:

Nothing in this chapter 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.⁴⁵

As noted above, however, the act also states:

Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing [euthanasia], or homicide. (Emphasis

⁴³ Washington State Department of Health "Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with the Death with Dignity Act." (Attached hereto at A-78).

⁴⁴ The act, Section 2, § -17, p. 15, lines 18 to 20. (Attached at A-115).

⁴⁵ Id., lines 15-18.

added).⁴⁶

With this language, the act does not "authorize" euthanasia, also known as mercy killing, but nonetheless allows it when actions are taken in accordance with the act. Euthanasia, also known as mercy killing, is in substance allowed under the proposed act.

E. If Hawaii Follows Oregon's Interpretation of "Not a Public Record," the Department of Health Will Be Insulated from Review, Even by Law Enforcement and Perhaps By the Legislature

The proposed act charges the Department of Health with issuing an annual statistical report based on data collected pursuant to the act.⁴⁷ The act also states:

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. (Emphasis added).⁴⁸

Oregon's law has an identical 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 inspection by the public. (Emphasis added).⁴⁹

In Oregon, this identical provision is interpreted to bar release of information about individual cases, to everyone,

⁴⁶ Id, lines 18 to 20.

⁴⁷ SB 1129, Section 2, § -14(d), page 14, lines 1-14. (Attached at A-114).

⁴⁸ Id., § -14(c), lines 9-11.

⁴⁹ ORS 127.865 s.3.11 (Attached hereto at A-81)

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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.... ⁵⁰

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).⁵¹

If the Hawaii enacts the proposed act, which on this point is identical to Oregon's law, 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. Will the Legislature have access? That would seem to be an open question.

F. If Hawaii Follows Oregon's Data Collection Protocol, Patient Identities Will Not Be Recorded in Any Manner and Source Documentation Will Be Destroyed

Oregon's website describes the data collection protocol for its annual reports, as follows:

⁵⁰ Oregon Data Release Policy, copy attached hereto at A-70.

⁵¹ E-mail from Alicia Parkman to me, January 4, 2012, attached at A-63.

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).⁵²

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).⁵³

The significance is that Oregon's annual reports are unverifiable. If Hawaii, based on its identical statutory language, follows Oregon, Hawaii's annual reports will also be unverifiable.

VII. COMPASSION & CHOICES

Passage of the proposed act is being spearheaded by the suicide promotion group, Compassion & Choices. In Oregon, this organization has used Oregon's law to disable and largely displace the Department of Health as the entity overseeing Oregon's law. See below.

A. **Compassion & Choices is the Former Hemlock Society; Its Mission Is to Promote Suicide**

Compassion & Choices was formed in 2004 as the result of a

⁵² Oregon Health Authority, Frequently Asked Questions, attached at A-71.

⁵³ E-mail from Alicia Parkman to Margaret Dore, 01/04/12, attached hereto at A-63.

merger/takeover of two other organizations.⁵⁴ One of these organizations was the former Hemlock Society, originally formed by Derek Humphry.⁵⁵

In 2011, Humphry was the keynote speaker at Compassion & Choices' annual meeting here in Washington State.⁵⁶ He was also in the news as a promoter of mail-order suicide kits.⁵⁷ This was after a depressed 29 year old man used one of the kits to kill himself.⁵⁸ Compassion & Choices' newsletter, promoting Humphry's presentation, references him as "the father of the modern movement for choice."⁵⁹ Compassion & Choices' mission is to promote suicide.

⁵⁴ 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-128 and available at <https://choiceisanillusion.files.wordpress.com/2016/10/humphry-keynote.pdf>

⁵⁵ Id.

⁵⁶ Compassion & Choices Newsletter, regarding Humphry's October 22, 2011 speaking date, at <https://choiceisanillusion.files.wordpress.com/2016/10/humphry-keynote.pdf> (Attached hereto at A-128.)

⁵⁷ See Jack Moran, "Police kick in door in confusion over suicide kit," *The Register-Guard*, September 21, 2011 ("A spotlight was cast on the mail-order suicide kit business after a 29-year-old Eugene man committed suicide in December using a helium hood kit. The Register-Guard traced the \$60 kit to [the company, which] has no website and does no advertising; clients find [the] address through the writings of Humphry.") (Emphasis added). (Attached hereto at A-129 & A-130).

⁵⁸ Id.

⁵⁹ Compassion & Choices Newsletter, at A-128, <https://choiceisanillusion.files.wordpress.com/2016/10/humphry-keynote.pdf>

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B. In Oregon, Compassion & Choices, a Non-Governmental Entity, has Largely Displaced the Department of Health as the Agency Overseeing Oregon's Law

1. 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 reject its then pending assisted suicide measure.⁶⁰ 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).⁶¹

Four days later, Oregon doctors Stevens and Toffler published a follow up article agreeing with the Editorial Board.⁶² They also stated:

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

⁶⁰ 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

⁶¹ Id.

⁶² Kenneth Stevens MD and William Toffler MD, "Assisted suicide: Conspiracy and control," *The Oregonian*, September 24, 2008. (Attached hereto at A-91).

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. . . .⁶³

2. In Oregon, a police officer assigned to my client's case was not able to get information from the State of Oregon; he obtained it from Compassion & Choices.

In 2010, I had client who wanted to know if his father had died under Oregon's Act. I referred him to an Oregon attorney, Isaac Jackson, who asked the police to investigate. Jackson's subsequent declaration describes how the officer was unable to get information from the State of Oregon. Jackson states:

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. (Emphasis added)⁶⁴

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. The State had been unwilling to provide this information.

In Oregon, Compassion & Choices, a non-governmental entity,

⁶³ Id.

⁶⁴ Isaac Jackson, Declaration of Testimony, ¶ 8, 09/18/12, at A-66.
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has largely displaced the Department of Health as the agency overseeing Oregon's law.

C. Senator Jennifer Fielder on Compassion & Choices: "Beware of Vultures"

In 2013, Montana State Senator Jennifer Fielder published an article titled "Beware of Vultures," discussing the motives of Compassion & Choices.⁶⁵ The article states:

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

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

When considering the financial aspects of assisted suicide, it is clear that millions, maybe billions of dollars, are intertwined with the issue being marketed as "Compassion and Choices". Beware.⁶⁶

VIII. OTHER CONSIDERATIONS

A. 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

⁶⁵ Published as Communication from Your State Senator, "Beware of Vultures," by Montana State Senator Jennifer Fielder, Sanders County Ledger, <http://www.sclledger.net>, page 2, 6-4-13 (Word processing version attached hereto at A-131 to A-132).

⁶⁶ Id.
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Switzerland.⁶⁷ 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.⁶⁸

B. My Clients Suffered Trauma in Oregon and Washington State

In Oregon and Washington State, I have had two cases where there was trauma suffered in connection with legal assisted suicide.⁶⁹

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

In the other case, it's not clear that administration of the lethal dose was voluntary. My client was told that his father had two suicide parties; that at the first party, his father had

⁶⁷ "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-72)

⁶⁸ Id., at A-72.

⁶⁹ To protect the privacy of the persons involved, I am not identifying which case occurred in which state.

refused to take the lethal dose; that at the second party, his father had ingested the lethal dose while intoxicated. The person who related this information later changed his story.

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

C. In Oregon, Other Suicides Have Increased With Legalization of Physician-Assisted Suicide

In Oregon, other (conventional) suicides have steadily increased with legalization of physician-assisted suicide. To learn more, please read my suicide contagion memo regarding Montana.⁷⁰

D. The Felony for Undue Influence Is Illusory and Unenforceable

The act has a felony for undue influence, which is not defined and has no elements of proof. The proposed act states:

A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of the request, shall be guilty of a class A felony.
(Emphasis added).⁷¹

The act also allows the patient's heir to be one of two witnesses on the lethal drug request form.⁷² In the context of a

⁷⁰ Attached hereto at A-133. For a more recent version, with attachments, please go to this link:
http://www.choiceillusiondc.org/2017/01/in-oregon-other-suicides-have-increase-d_21.html

⁷¹ SB 1129, Section 2, § -19, page 2, lines 3-6, attached at A-122

⁷² Id, § -22, page 25, lines 7 to 21, attached hereto at A-125.

will, this situation can be used to prove undue influence.⁷³

How do you prove that undue influence occurred when the act does not define it, and the act also allows conduct normally used to prove it? You can't. The felony for undue influence is illusory and unenforceable.

X. CONCLUSION

Passing the act will encourage people with years, even decades, to live, to throw away their lives.

The proposed act 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, regardless, allowed to occur in private without a doctor or witness present. If the patient objected or struggled, who would know?

Elder abuse is already a not well controlled problem. Passing the proposed act will make the situation worse, to effectively allow legal murder.

Physician-assisted suicide, even when voluntary, can be traumatic for patients and families. Passage will create a risk of suicide contagion. The proposed Oregon-style "oversight" is a sham and will create the opportunity for a non-governmental entity to displace the proper role of government.

⁷³ See e.g., Washington State's probate statute: When one of two witnesses is a taker under the will, there is a rebuttal presumption that the taker/witness "procured the gift by duress, menace, fraud, or undue influence." (Attached hereto at A-87).

For all of these reasons, I urge you to vote "No" on SB 1129.
Don't make Washington and Oregon's mistake. Thank you.

Respectfully submitted this 15th day of February 2017



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Attachments

Margaret Dore Memo

Reject SB 1129

as of

February 15, 2017

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Lanz & Danielson, Seattle, Washington USA.

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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.
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- United States District Court, Western District of Washington 1988-present.
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- American Bar Association, 2001 to present.
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- 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;

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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).

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Resources » Medical Ethics » AMA Code of Medical Ethics » Opinion 2.211

Opinion 2.211 - Physician-Assisted Suicide

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

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

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

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

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mercy killing

n.

(Medicine) another term for euthanasia

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

eu•tha•na•sia (,yu θə'net̩ zə, -z̩'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 *euthanasia* easy death]

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Thesaurus

Legend: ≡ Synonyms ↔ Related Words ≠ Antonyms

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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



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lethal injection

noun

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

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(<http://www.thedailybeast.com/articles/2012/06/13/pets-or-predators-10-things-about-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.

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

Pokémon Words (<http://blog.dictionary.com/catch-the-real-words-in-this-pokemon-quiz/>)

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.

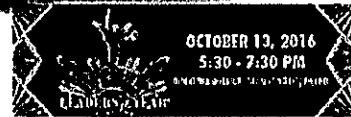
Curtis also once kept a patient on life support against his better judgment because her family insisted. "I thought she would live days to weeks," he says of the woman, who was suffering from septic shock and multiple organ failure. Instead she improved enough to eventually leave the hospital and come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

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X

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.

X

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

Brewer signed the bill on Wednesday.

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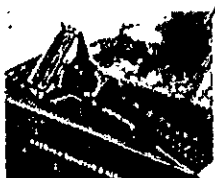
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La. assisted-suicide ban strengthened

The Associated Press

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

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

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

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

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

Georgia General Assembly

2011-2012 Regular Session - HB 1114

Homicide; offering to assist in commission of suicide; repeal certain provisions

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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

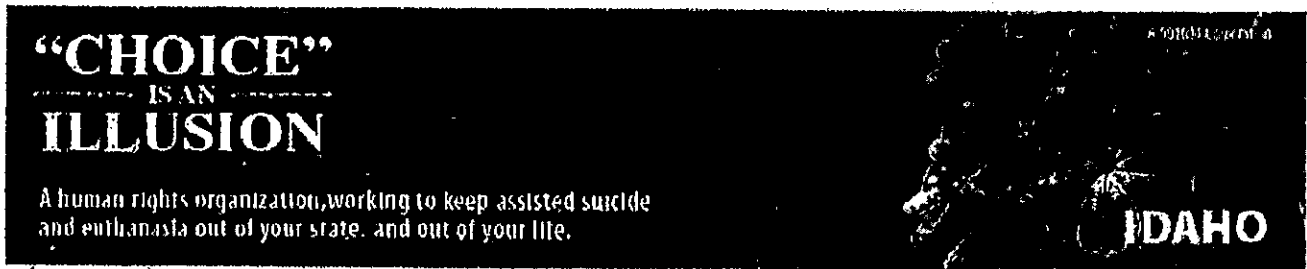
May/01/2012 - Effective Date
 May/01/2012 - Act 639
 May/01/2012 - House Date Signed by Governor
 Apr/10/2012 - House Sent to Governor
 Mar/29/2012 - Senate Agreed House Amend or Sub
 Mar/29/2012 - House Agreed Senate Amend or Sub As Amended
 Mar/27/2012 - Senate Passed/Adopted By Substitute
 Mar/27/2012 - 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)



Idaho Home Idaho Strengthens Law Idaho Bar Articles Letters to the Editor



MONDAY JULY 4, 2011

Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

Donate Now

VOICES AGAINST ASSISTED SUICIDE AND EUTHANASIA

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

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

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

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

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

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

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

LINKS

- Montana's Campaign Against Assisted Suicide (Following Idaho's Lead)

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LABELS

- 18-4017 (1)
assisted suicide (1)
common law (1)
Compassion and Choices (1)
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

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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

[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,

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

the aforementioned legitimate government interests. If we were to recognize an absolute, fundamental right to physician aid in dying, constitutional questions would abound regarding legislation that defined terminal illness or provided for protective procedures to assure that a patient was making an informed and independent decision. Regulation in this area is essential, given that if a patient carries out his or her end-of-life decision it cannot be reversed, even if it turns out that the patient did not make the decision of his or her own free will.

VIII. CONCLUSION

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

{59} IT IS SO ORDERED.

WE CONCUR:

CHARLES W. DANIELS, Chief Justice

PETRA JIMENEZ MAES, Justice

BARBARA J. VIGIL, Justice

JAMES M. HUDSON, District Judge, Sitting by designation

All Citations

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

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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.

X
"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

X
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 expectations¹⁰. The article states:

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

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

Conclusion

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

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

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

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

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

4 id.

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

6 RCW 11.88.160(2).

7 RCW 70.245.010(12).

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

9 RCW 70.245.010(11) & (13).

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

11 id.

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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*

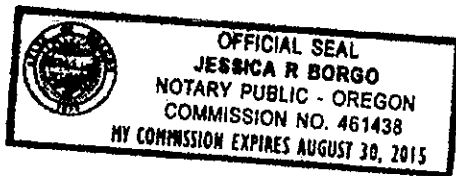
A notary in and for the
State of Oregon

ADDRESS: *16100 Sw Tualatin - Sherwood Rd*

EXPIRY OF COMMISSION: *Aug, 30, 2015*

PLACE SEAL HERE: *Jessica Borgo*

Ken Stevens MD
Ken Stevens, MD



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

STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

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

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

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

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

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

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

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

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

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

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

Ventricular assist devices are not covered for destination therapy.

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

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

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

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

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

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

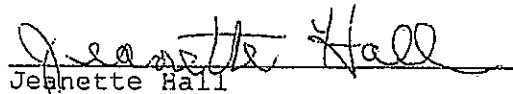
- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal

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



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

12 million Americans misdiagnosed each year

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

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

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

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

→ More from Morning Rounds with Dr. LaPook

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

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



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A-41

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

AFFIDAVIT OF JOHN NORTON- Page 1

E:\ASE Files\Leblanc\John Norton Affidavit.wpd

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 16th, 2012

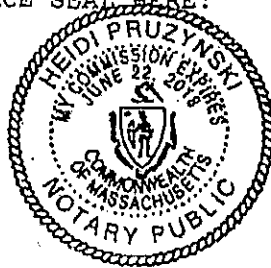
NAME: Heidi Pruzynski
Heidi Pruzynski

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:



[Handwritten signature]

JOHN NORTON

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."

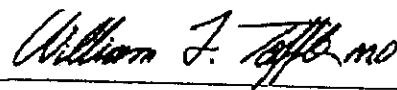
X 4. In Oregon, people with chronic conditions are "terminal," if

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

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.

Contact Us

dwda.info@state.or.us

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

127.800 s.1.01. Definitions.

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

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

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

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

(Section 2)

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

OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY

Oregon Public Health Division
February 4, 2016

For more information:

<http://www.healthoregon.org/dwd>

Contact: DWDA.info@state.or.us

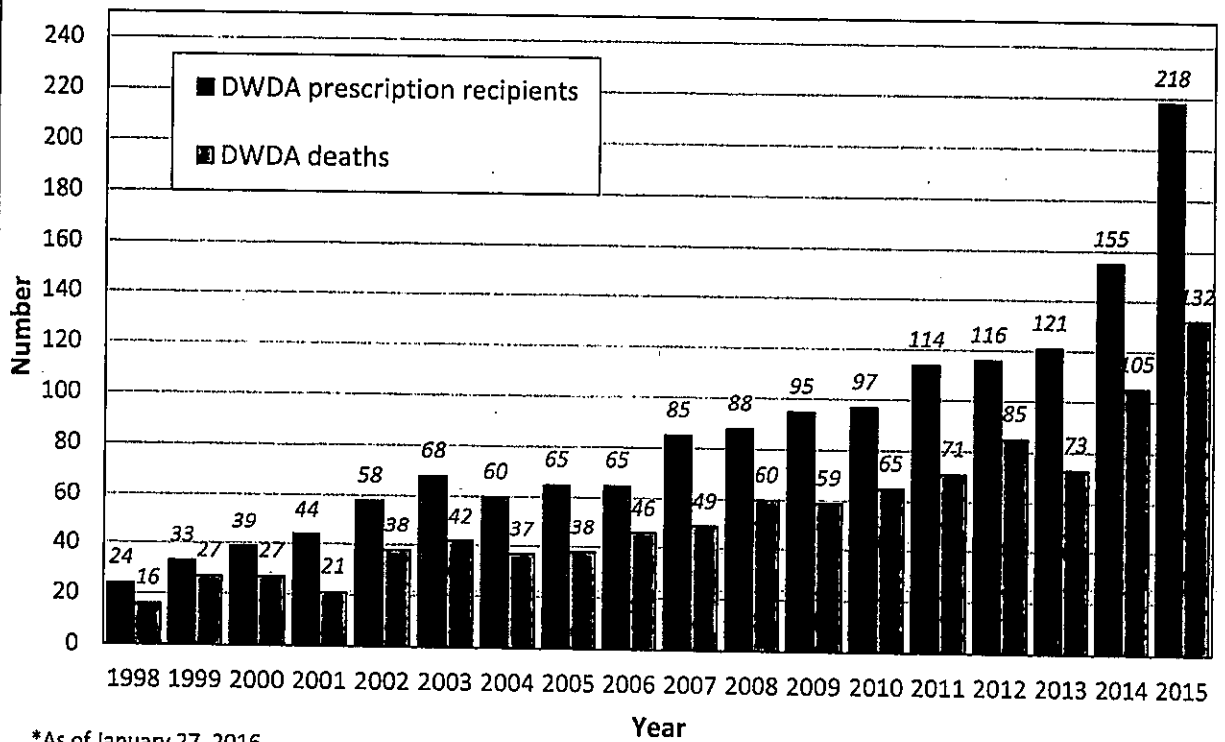


TOFFLER EXHIBIT B

Introduction

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

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



*As of January 27, 2016

Participation Summary and Trends

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

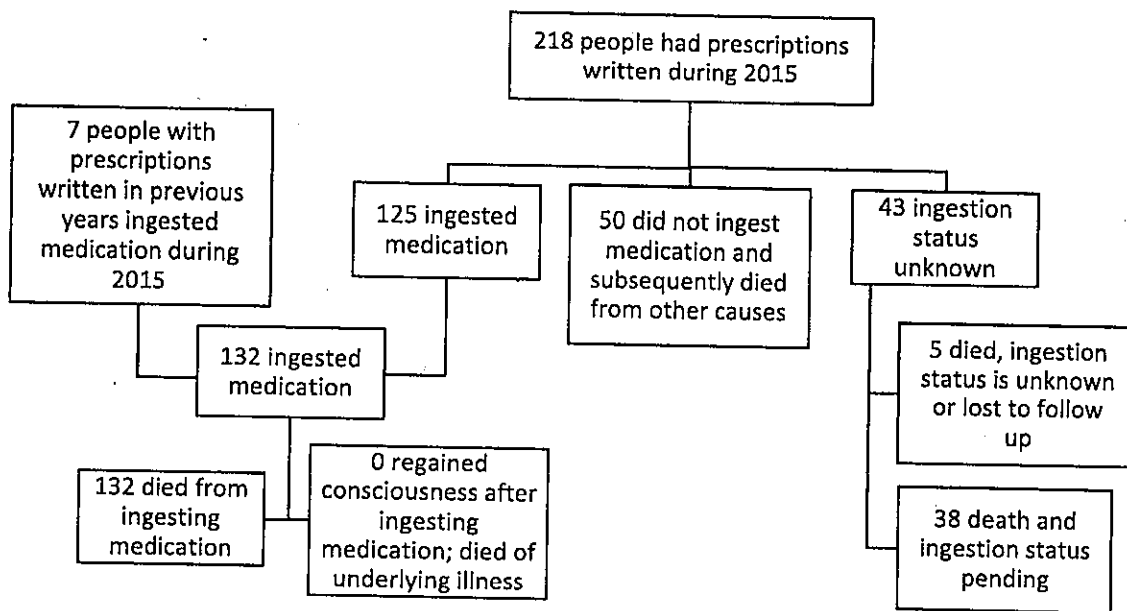
Since the law was passed in 1997, a total of 1,545 people have had prescriptions written under the DWDA, and 991 patients have died from ingesting the medications. From 1998 through 2013, the number of prescriptions written annually increased at an average of 12.1%; however, during 2014 and

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			
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

TOPFLER EXHIBIT B

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Underlying illness			
Malignant neoplasms (%)			
Lung and bronchus (%)	95 (72.0)	667 (77.9)	762 (77.1)
Breast (%)	23 (17.4)	154 (18.0)	177 (17.9)
Colon (%)	9 (6.8)	64 (7.5)	73 (7.4)
Pancreas (%)	7 (5.3)	54 (6.3)	61 (6.2)
Prostate (%)	7 (5.3)	56 (6.5)	63 (6.4)
Ovary (%)	5 (3.8)	35 (4.1)	40 (4.0)
Other (%)	3 (2.3)	33 (3.9)	36 (3.6)
Amyotrophic lateral sclerosis (%)	41 (31.1)	271 (31.7)	312 (31.6)
Chronic lower respiratory disease (%)	8 (6.1)	71 (8.3)	79 (8.0)
Heart disease (%)	6 (4.5)	38 (4.4)	44 (4.5)
HIV/AIDS (%)	9 (6.8)	17 (2.0)	26 (2.6)
Other illnesses (%) ²	0 (0.0)	9 (1.1)	9 (0.9)
Unknown	14 (10.6)	54 (6.3)	68 (6.9)
DVWA process			
Referred for psychiatric evaluation (%)	0	3	3
Patient informed family of decision (%) ³	5 (3.8)	47 (5.5)	52 (5.3)
Patient died at	126 (95.5)	729 (93.2)	855 (93.5)
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			
Less able to engage in activities making life enjoyable (%)	(N=132)	(N=859)	(N=991)
Losing autonomy (%)	127 (96.2)	758 (88.7)	885 (89.7)
Loss of dignity (%) ⁵	121 (92.4)	782 (91.5)	903 (91.6)
Losing control of bodily functions (%)	98 (75.4)	579 (79.3)	677 (78.7)
Burden on family, friends/caregivers (%)	46 (35.7)	428 (50.1)	474 (48.2)
Inadequate pain control or concern about it (%)	63 (48.1)	342 (40.0)	405 (41.1)
Financial implications of treatment (%)	37 (28.7)	211 (24.7)	248 (25.2)
Unknown	3 (2.3)	27 (3.2)	30 (3.1)
Health care provider present (collected 2001-present)			
When medication was ingested ⁶	(N=132)	(N=789)	(N=921)
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

Drugs Used

Drugs used

See page 7
next page
Footnote 2
at A.54

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Compliments	(N=132)	(N=859)	(N=991)
Regurgitated	2	22	24
Other	2	1	3
None	23	506	529
Unknown	105	330	435
Other circumstances			
Regained consciousness after ingesting DWDA medications ⁷	0	6	6
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	45	47	46
Median	15-517	15-1009	15-1009
Range	131	859	990
Number of patients with information available	1	0	1
Number of patients with information unknown	5	5	5
Minutes between ingestion and unconsciousness ⁶	2-15	1-38	1-38
Median	25	506	531
Range	107	353	460
Number of patients with information available	25	25	25
Number of patients with information unknown	5mins-34hrs	1min-104hrs	1min-104hrs
Minutes between ingestion and death ⁶	25	511	536
Median	107	348	455
Range (minutes - hours)			
Number of patients with information available			
Number of patients with information unknown			

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

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.

X 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

Margaret K. Dore

Margaret Dore <margaretdore@margaretdore.com>

RE: Death with Dignity Act

1 message

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

Wed, Jan 4, 2012 at 7:57 AM

Thank you for your email regarding Oregon's Death with Dignity Act. For all of your questions, the answer is no. Since our office is charged with maintaining absolute confidentiality, our policy is to never release identifying information. We can neither confirm nor deny participation of any individual patient or physician. We have been contacted by law enforcement and legal representatives in the past, but have not provided identifying 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?
2. Would your office release copies of completed reporting forms in answer to a request by law enforcement?
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

DECLARATION OF TESTIMONY

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

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

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

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

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

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

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

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

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

///

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

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

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

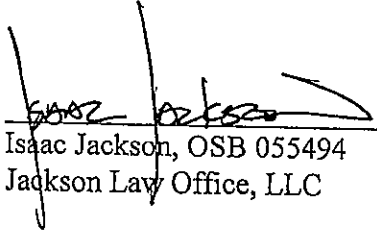
The Death with Dignity Act requires that the Oregon Health Authority collect information pertaining to compliance (ORS 127.865 (2)) and to make available to the public an annual statistical report (ORS 127.865 (3)).

The Oregon Health Authority's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation. Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.

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

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

Dated Sept. 18 2012


Isaac Jackson, OSB 055494
Jackson Law Office, LLC

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

JOHN R. KROGER
Attorney General



MARY H. WILLIAMS
Deputy Attorney General

DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

RECEIVED
11/4/10

November 3, 2010

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

Re: Death with Dignity Act Records Request

Dear Mr. Jackson:

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

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

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

Please contact me if you have additional questions.

Sincerely,

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

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



Oregon

Theodore R. Kulungoski, Governor

RECEIVED
713

1/29/10

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

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

Legal Name First [redacted] Middle [redacted] Last [redacted]		Sex Male	Age [redacted]	State of Foreign Birth Oregon	County of Death [redacted]	Death Date [redacted] 2010
Social Security Number [redacted]		Vital Record District [redacted]		Was Decedent Ever in U.S. Armed Forces? [redacted]		
Residence County [redacted]	State at Foreign Birth Oregon	Spouse's Name Prior to First Marriage [redacted]	Zin Code + 4 [redacted]			
Place of Birth [redacted]	Telephone Number Not Available	Relationship to Decedent [redacted]	Mother's Name Prior to First Marriage [redacted]			
Decedent's Residence [redacted]	Facility Name [redacted]	City/Town/Village/Location of Death [redacted]	State Oregon	Zin Code + 4 [redacted]		
Method of Disposition Donation and cremation		Name and Complete Address of Funeral Facility [redacted] Cremation Center				
Date of Disposition [redacted]	Registrar's Signature [redacted]	Death Certificate Signature [redacted]	CR License Number [redacted]	Death Date [redacted] 2010		
Cause of Death IMMEDIATE CAUSE [redacted] cancer		Autopsy? No		Were autopsy findings available to complete the cause of death? [redacted]		
Due to (or as a consequence of) [redacted]		Time of injury [redacted]		Approximate Interval Onset to Death [redacted] years		
Other significant conditions contributing to death [redacted]		Place of injury [redacted]		Injury at Work? [redacted]		
Manner of Death Natural		Disease: [redacted]		If transportation injury, specify: [redacted]		
Name and Address of Coroner [redacted]		Physician [redacted]		Date of Death [redacted] 2010		
Name and Title of Attending Physician [redacted]		Other than Coroner [redacted]		Physician's License Number [redacted]		
Medical Certificate [redacted]		Title of Coroner M.D.		[redacted]		

TO BE COMPLETED BY FUNERAL FACILITY

TO BE COMPLETED BY MEDICAL CERTIFIER



THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE REGISTERAR.

DATE ISSUED: [redacted] 2010

THIS COPY IS NOT VALID WITHOUT OREGON STATE SEAL AND SIGNATURE OF REGISTERAR.

EX-1013

Google traduction

Articles de presse sur la qualité et les problèmes de santé en Oregon

Options ▼



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

Frequently Asked Questions

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



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Original article

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

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ABSTRACT

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

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

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

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

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1. Introduction

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

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

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient's home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient's home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.

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E-mail address: birgit.wagner@medizin.uni-leipzig.de (B. Wagner).



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ac·cord·ance

/əˈkɔrdns/

noun

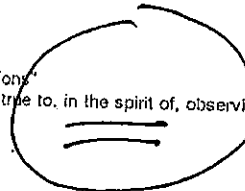
noun: accordance

In a manner conforming with.

"the product is disposed of in accordance with federal regulations"

synonyms: in agreement with, in conformity with, in line with, true to, in the spirit of, observing, following, heeding

"a ballot held in accordance with union rules"



Handwritten note: "in the spirit of"

Origin

OLD FRENCH

acorder
bring to an agreement

OLD FRENCH

acordance

accordance

ENGLISH

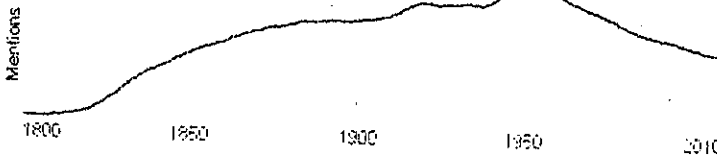
accord

Middle English

Middle English: from Old French *acordance*, from *acorder* 'bring to an agreement' (see *accord*).

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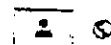
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1: an animating or vital principle held to give life to physical organisms. 2: a supernatural being or essence: asa capitalized: holy spiritb: soul 2ac: an often malevolent being that is bodiless but can become visible; specifically: ghost 2d: a malevolent being that enters and possesses a human being.

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

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

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

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

The Washington State Registrar will reject any death certificate that does not properly adhere to the requirements of the Death with Dignity Act.¹ If a death certificate contains any reference to actions that might indicate use of the act, the Local Registrar and Funeral Director will be instructed, under RCW 70.58.030, to obtain a correction from the medical certifier before a permit to proceed with disposition will be issued.

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

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

West Western Rosslyn

- A report of the outcome and determinations made during counseling, if performed;
- The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and

A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 s.3.09]

127.860 s.3.10. Residency requirement.

Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:

- Possession of an Oregon driver license;
- Registration to vote in Oregon;
- Evidence that the person owns or leases property in Oregon; or
- 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.

a) The Health Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

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.

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 available for inspection by the public.

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.

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.

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 such 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 actions.

Except as provided in ORS 127.890:

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.

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.

A 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.

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1/20/2014

Law Offices of Margaret K. Dore, P.S. Mail - Re: Record Retention Policy

Margaret K. Dore

Margaret Dore <margaret.dore@margaretdore.com>

Re: Record Retention Policy

1 message

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

Mon, Jun 27, 2011 at 4:18 PM

Hello Ms. Dore,

X 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 >>>

1/20/2014

Law Offices of Margaret K. Dore, P.S. Mail - Re: Record Retention Policy

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

RCW 11.12.160

Interested witness—Effect on will.

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

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

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

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

[1994 c 221 § 16; 1965 c 145 § 11.12.160. Prior: 1917 c 156 § 38; RRS § 1408; prior: Code 1881 § 1331; 1863 p 209 § 67; 1860 p 171 § 34.]

NOTES:

Effective dates—1994 c 221: See note following RCW 11.94.070.

*In Washington State,
having 1 or 2 witnesses on
a will se an heir creates
a presumption of
duress, menace, fraud,
or undue influence.*

Assisted suicide: Conspiracy and control

By Rick Attig, The Oregonian

on September 24, 2008 at 7:01 PM, updated September 24, 2008 at 7:10 PM

We applaud The Oregonian's recommendation that Washington voters reject I-1000, the physician-assisted suicide measure.

We must comment on two realities: first, the group controlling assisted suicide in Oregon is also the group controlling what the public is told; second, the claim that Oregon is a leader in improved end-of-life care because of assisted suicide is inaccurate.

The editorial board correctly notes "a coterie of insiders run the program, with a handful of doctors and others deciding what the public may know".

The group promoting assisted suicide, so-called "Compassion and Choices (C&C)", are like the fox in the proverbial chicken coop; this case the fox is reporting its version to the farmer regarding what is happening in the coop. Members of C&C authored and

claim they are the stewards of Oregon's assisted suicide law. They call it "their law". They have arranged and participated in 74ths of Oregon's assisted suicide cases. Their medical director reported she'd participated in more than 100 doctor-assisted suicides as of March 2005. A physician board-member reported in 2006 that he'd been involved with over forty such patients. Their executive director reported in September 2007 that he has attended more than 36 assisted suicide deaths. He has been involved in preparing the lethal solution. Yet, he is not a doctor.

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. As such, we believe the initials "C&C" of this organization more properly reflect its repeated public behavior ---that is, "Conspiracy & Control".

Regardless of one's perspective on assisted suicide, all citizens should be concerned about the controlling influence of this death-promoting organization. In all other areas of medicine, we are striving for increased transparency---not conspiracy and control.

What about assisted suicide causing improved end-of-life care?

There is improved end-of-life care in Oregon. In training physicians, we have sought to improve patient-physician communication, and improve patient care at many levels. We have made improvements. However, similar improvements have occurred in other states that have not legalized assisted suicide. Many states do better than Oregon in this area. The latest data ranks Oregon 9th (not 1st) in Medicare-age hospice-utilization; 4 of the top 5 states have criminalized assisted-suicide. The Wisconsin Pain Policies Studies Group issues grades regarding states' pain-policies. While Oregon & Washington both have high grades on their pain-policies, an OHSU study documented that after 4 years of assisted suicide in Oregon there was a decline in end-of-life pain-control. This doesn't prove that the pain-control decline was due to assisted suicide. At the same time, the data doesn't support the claim that legalization of assisted suicide improved care at the end-of-life.

In summary, we should all be wary of the false "C&C" claims.

A-91

JAN 25 2017

A BILL FOR AN ACT

RELATING TO HEALTH.

*Preamble
Not part
of the
Act.*

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature finds that some states have
2 enacted laws that allow their mentally competent adult residents
3 who have a terminal illness with a confirmed prognosis of six or
4 fewer months to live to voluntarily request and receive a
5 prescription medication so that they can die in a peaceful,
6 humane manner. These laws, labeled "death with dignity laws,"
7 are based on the concept that the terminally ill person should
8 have the ability to make reasoned end-of-life decisions and
9 determine how much pain and suffering to endure.

10 The legislature also finds that Oregon's death with dignity
11 act has been in effect since 1997. Similar laws are also in
12 effect in California, Colorado, Vermont, and Washington. This
13 act is modeled on the Oregon statute and includes safeguards to
14 protect patients from misuse. These safeguards include
15 confirmation by two physicians of the patient's diagnosis,
16 prognosis, mental competence, and voluntariness of the request;
17 multiple requests by the patient: an oral request followed by a



1 signed written request that is witnessed by two people, one of
2 whom must be unrelated to the patient, and a subsequent oral
3 restatement of the request; and two waiting periods between the
4 requests and the writing of the prescription. At all times the
5 patient retains the right to rescind the request and is under no
6 obligation to fill the prescription or ingest the medication.

7 The legislature concludes that terminally ill residents of
8 the State have a right to determine their own medical treatment
9 at the end of their lives.

10 The purpose of this Act is to enact a death with dignity
11 act.

12 SECTION 2. The Hawaii Revised Statutes is amended by
13 adding a new chapter to be appropriately designated and to read
14 as follows:

15 "CHAPTER

16 DEATH WITH DIGNITY ACT

17 § -1 Definitions. The following terms shall mean as
18 follows:

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



1 "Attending physician" means the physician who has primary
2 responsibility for the care of the patient and treatment of the
3 patient's terminal disease.

4 "Capable" means that in the opinion of a court or in the
5 opinion of the patient's attending physician or consulting
6 physician, psychiatrist, or psychologist, a patient has the
7 ability to make and communicate health care decisions to health
8 care providers.

9 "Consulting physician" means a physician who is qualified
10 by specialty or experience to make a professional diagnosis and
11 prognosis regarding the patient's disease.

12 "Counseling" means one or more consultations as necessary
13 between a state licensed psychiatrist or psychologist and a
14 patient for the purpose of determining that the patient is
15 capable and not suffering from a psychiatric or psychological
16 disorder or depression causing impaired judgment.

17 "Department" means the department of health.

18 "Health care provider" means a person licensed, certified,
19 or otherwise authorized or permitted by the law of this State to
20 administer health care or dispense medication in the ordinary



1 course of business or practice of a profession, and includes a
2 health care facility.

3 "Informed decision" means a decision by a qualified
4 patient, to request and obtain a prescription to end the
5 qualified patient's life in a humane and dignified manner, that
6 is based on an appreciation of the relevant facts and after
7 being fully informed by the attending physician of:

- 8 (1) The medical diagnosis;
- 9 (2) The prognosis;
- 10 (3) The potential risks associated with taking the
11 medication to be prescribed;
- 12 (4) The probable result of taking the medication to be
13 prescribed; and
- 14 (5) The feasible alternatives, including but not limited
15 to comfort care, hospice care, and pain control.

16 "Medically confirmed" means the medical opinion of the
17 attending physician has been confirmed by a consulting physician
18 who has examined the patient and the patient's relevant medical
19 records.

20 "Patient" means a person who is under the care of a
21 physician.



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1 "Physician" means a doctor of medicine or osteopathy
2 licensed to practice medicine by the Hawaii medical board.

3 "Qualified patient" means a capable adult who is a resident
4 of the State and has satisfied the requirements of this chapter
5 in order to obtain a prescription for medication to end the
6 qualified patient's life in a humane and dignified manner.

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

10 § -2 Written request for medication; initiated. (a) An
11 adult who is capable, is a resident of the State, and has been
12 determined by the attending physician and consulting physician
13 to be suffering from a terminal disease, and who has voluntarily
14 expressed the adult's wish to die, may make a written request
15 for medication for the purpose of ending the adult's life in a
16 humane and dignified manner in accordance with this chapter.

17 (b) No person shall qualify under this chapter solely
18 because of age or disability.

19 § -3 Form of the written request. (a) A valid request
20 for medication under this chapter shall be in substantially the
21 form described in section -22, signed and dated by the

re: request not administration of the lethal dose.



1 patient and witnessed by at least two individuals who, in the
2 presence of the patient, attest that to the best of their
3 knowledge and belief the patient is capable, acting voluntarily,
4 and is not being coerced to sign the request.

re: request, not administrator

5 (b) One of the witnesses shall be a person who is not:

- 6 (1) A relative of the patient by blood, marriage, or
7 adoption;
- 8 (2) A person who at the time the request is signed would
9 be entitled to any portion of the estate of the
10 qualified patient upon death under any will or by
11 operation of law; or
- 12 (3) An owner, operator or employee of a health care
13 facility where the qualified patient is receiving
14 medical treatment or is a resident.

15 (c) The patient's attending physician at the time the
16 request is signed shall not be a witness.

17 (d) If the patient is a patient in a long term care
18 facility at the time the written request is made, one of the
19 witnesses shall be an individual designated by the facility and
20 having qualifications specified by the department of human
21 services by rule.



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1 § -4 Attending physician responsibilities. (a) The
2 attending physician shall:

3 (1) Make the initial determination of whether a patient
4 has a terminal disease, is capable, and has made the
5 request voluntarily; *re: request, not administration*

6 (2) ~~Request that~~ the patient demonstrate residency;

7 (3) To ensure that the patient is making an informed
8 decision, inform the patient of:

9 (A) The medical diagnosis;

10 (B) The prognosis;

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

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

15 (E) The feasible alternatives, including but not
16 limited to comfort care, hospice care, and pain
17 control;

18 (4) Refer the patient to a consulting physician for
19 medical confirmation of the diagnosis, and for a
20 determination that the patient is capable and acting
21 voluntarily; *re: request, not administration*

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- 1 (5) Refer the patient for counseling if appropriate;
- 2 (6) Recommend that the patient notify next of kin;
- 3 (7) Counsel the patient about the importance of having
- 4 another person present when the patient takes the
- 5 medication prescribed pursuant to this chapter and of
- 6 not taking the medication in a public place;
- 7 (8) Inform the patient that the patient has an opportunity
- 8 to rescind the request at any time and in any manner,
- 9 and offer the patient an opportunity to rescind at the
- 10 time of the patient's second oral request made
- 11 pursuant to section -9;
- 12 (9) Verify, immediately prior to writing the prescription
- 13 for medication under this chapter, that the patient is
- 14 making an informed decision;
- 15 (10) Fulfill the medical record documentation requirements
- 16 of section -12;
- 17 (11) Ensure that all appropriate steps are carried out in
- 18 accordance with this chapter prior to writing a
- 19 prescription for medication to enable a qualified
- 20 patient to end the qualified patient's life in a
- 21 humane and dignified manner; and



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1 (12) Either:

2 (A) Dispense medications directly, including
3 ancillary medications intended to facilitate the
4 desired effect to minimize the patient's
5 discomfort; provided that the attending physician
6 is registered as a dispensing physician with the
7 Hawaii medical board, has a current Drug
8 Enforcement Administration certificate, and
9 complies with any applicable administrative rule;
10 or

11 (B) With the patient's written consent:

12 (i) Contact a pharmacist of the patient's choice
13 and inform the pharmacist of the
14 prescription; and

15 (ii) Transmit the written prescription
16 personally, by mail, or electronically to
17 the pharmacist, who will dispense the
18 medications to either the patient, the
19 attending physician, or an expressly
20 identified agent of the patient.



1 (b) Notwithstanding any other provision of law, the
2 attending physician may sign the patient's death certificate.

3 § -5 Consulting physician confirmation. Before a
4 patient is qualified under this chapter, a consulting physician
5 shall examine the patient and the patient's relevant medical
6 records and confirm, in writing, the attending physician's
7 diagnosis that the patient is suffering from a terminal disease,
8 and verify that the patient is capable, is acting voluntarily,
9 and has made an informed decision.

part
of
request
process

re: request for

10 § -6 Counseling referral. If, in the opinion of the
11 attending physician or the consulting physician, a patient may
12 be suffering from a psychiatric or psychological disorder or
13 depression causing impaired judgment, either physician shall
14 refer the patient for counseling. No medication to end a
15 patient's life in a humane and dignified manner shall be
16 prescribed until the person performing the counseling determines
17 that the patient is not suffering from a psychiatric or
18 psychological disorder or depression causing impaired judgment.

lethal
dose,
not
administra-
tion.

19 § -7 Informed decision. No person shall receive a
20 prescription for medication to end the person's life in a humane
21 and dignified manner unless the person has made an informed



1 decision. Immediately prior to writing a prescription for
2 medication under this chapter, the attending physician shall
3 verify that the patient is making an informed decision.

4 § -8 Family notification. The attending physician shall
5 recommend that the patient notify the next of kin of the
6 patient's request for medication pursuant to this chapter. A
7 patient who declines or is unable to notify next of kin shall
8 not have the patient's request denied for that reason.

9 § -9 Written and oral requests. To receive a
10 prescription for medication to end one's life in a humane and
11 dignified manner, a qualified patient shall have made an oral
12 request and a written request, and reiterate the oral request to
13 the qualified patient's attending physician not less than
14 fifteen days after making the initial oral request. At the time
15 the qualified patient makes the second oral request, the
16 attending physician shall offer the patient an opportunity to
17 rescind the request.

18 § -10 Right to rescind request. A patient may rescind
19 the request at any time and in any manner without regard to the
20 patient's mental state. No prescription for medication under
21 this chapter may be written without the attending physician



1 having offered the qualified patient an opportunity to rescind
2 the request made pursuant to section -9.

3 § -11 **Waiting periods.** Not less than fifteen days shall
4 elapse between the patient's initial oral request and the
5 writing of a prescription under this chapter. Not less than
6 forty-eight hours shall elapse between the patient's written
7 request and the writing of a prescription under this chapter.

8 § -12 **Medical record; documentation requirements.** The
9 following shall be documented or filed in the patient's medical
10 record:

11 (1) All oral requests by a patient for medication to end
12 the patient's life in a humane and dignified manner;

13 (2) All written requests by a patient for medication to
14 end the patient's life in a humane and dignified
15 manner;

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

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

regarding request process



regarding request, not administration of the lethal dose



1 (5) A report of the outcome and determinations made during
2 counseling, if performed;

3 (6) The attending physician's offer to the patient to
4 rescind the patient's request at the time of the
5 patient's second oral request made pursuant to section
6 -9; and

7 (7) A note by the attending physician indicating that all
8 requirements under this chapter have been met and
9 indicating the steps taken to carry out the request,
10 including a notation of the medication prescribed.

11 § -13 Residency requirement. Only requests made by
12 residents of this State under this chapter shall be granted.
13 Factors demonstrating state residency include but are not
14 limited to:

- 15 (1) Possession of a Hawaii driver license;
16 (2) Registration to vote in Hawaii;
17 (3) Evidence that the person owns or leases property in
18 Hawaii; or
19 (4) Filing of a Hawaii tax return for the most recent tax
20 year.



1 § -14 Reporting requirements. (a) The department shall
2 annually review a sample of records maintained pursuant to this
3 chapter.

4 (b) The department shall require any health care provider
5 upon dispensing medication pursuant to this chapter to file a
6 copy of the dispensing record with the department.

7 (c) The department shall adopt rules to facilitate the
8 collection of information regarding compliance with this
9 chapter. Except as otherwise required by law, the information
10 collected shall not be a public record and may not be made
11 available for inspection by the public.

12 (d) The department shall generate and make available to
13 the public an annual statistical report of information collected
14 under subsection (c).

15 § -15 Effect on construction of wills, contracts, and
16 statutes. (a) No provision in a contract, will, or other
17 agreement, whether written or oral, to the extent the provision
18 would affect whether a person may make or rescind a request for
19 medication to end the person's life in a humane and dignified
20 manner, shall be valid.



1 (b) No obligation owing under any currently existing
2 contract shall be conditioned or affected by the making or
3 rescinding of a request, by a person, for medication to end the
4 person's life in a humane and dignified manner.

5 § -16 Insurance or annuity policies. The sale,
6 procurement, or issuance of any life, health, or accident
7 insurance or annuity policy or the rate charged for any policy
8 shall not be conditioned upon or affected by the making or
9 rescinding of a request, by a person, for medication to end the
10 person's life in a humane and dignified manner. Neither shall a
11 qualified patient's act of ingesting medication to end the
12 qualified patient's life in a humane and dignified manner have
13 an effect upon a life, health, or accident insurance or annuity
14 policy.

15 § -17 Construction of chapter. Nothing in this chapter
16 shall be construed to authorize a physician or any other person
17 to end a patient's life by lethal injection, mercy killing, or
18 active euthanasia. Actions taken in accordance with this
19 chapter shall not, for any purpose, constitute suicide, assisted
20 suicide, mercy killing or homicide, under the law.



1 § -18 Immunities; basis for prohibiting health care
2 provider from participation; notification; permissible
3 sanctions. - (a) Except as provided in section -19:

4 (1) No person shall be subject to civil or criminal
5 liability or professional disciplinary action for
6 participating in good faith compliance with this
7 chapter, including being present when a qualified
8 patient takes the prescribed medication to end the
9 qualified patient's life in a humane and dignified
10 manner;

11 (2) No professional organization or association, or health
12 care provider, may subject a person to censure,
13 discipline, suspension, loss of license, loss of
14 privileges, loss of membership, or other penalty for
15 participating or refusing to participate in good faith
16 compliance with this chapter;

17 (3) No request by a patient for or provision by an
18 attending physician of medication in good faith
19 compliance with this chapter shall constitute neglect
20 for any purpose of law or provide the sole basis for
21 the appointment of a guardian or conservator; and



1 (4) No health care provider shall be under any duty,
2 whether by contract, by statute, or by any other legal
3 requirement, to participate in the provision to a
4 qualified patient of medication to end the qualified
5 patient's life in a humane and dignified manner. If a
6 health care provider is unable or unwilling to carry
7 out a patient's request under this chapter, and the
8 patient transfers the patient's care to a new health
9 care provider, the prior health care provider shall
10 transfer, upon request, a copy of the patient's
11 relevant medical records to the new health care
12 provider.

13 (b) Notwithstanding any other provision of law, a health
14 care provider may prohibit another health care provider from
15 participating in actions covered by this chapter on the premises
16 of the prohibiting provider if the prohibiting provider has
17 notified the health care provider of the prohibiting provider's
18 policy regarding participation in actions covered by this
19 chapter. Nothing in this subsection shall prevent a health care
20 provider from providing health care services to a patient that



1 do not constitute participation in actions covered by this
2 chapter.

3 (c) Notwithstanding subsection (a)(1) to (a)(4), a health
4 care provider may subject another health care provider to the
5 following sanctions if the sanctioning health care provider has
6 notified the sanctioned provider prior to participation in
7 actions covered by this chapter that it prohibits the
8 participation:

9 (1) Loss of privileges, loss of membership, or other
10 sanction provided pursuant to the medical staff
11 bylaws, policies, and procedures of the sanctioning
12 health care provider if the sanctioned provider is a
13 member of the sanctioning provider's medical staff and
14 participates in actions covered by this chapter while
15 on the health care facility premises of the
16 sanctioning health care provider, but not including
17 the private medical office of a physician or other
18 provider;

19 (2) Termination of lease or other property contract or
20 other nonmonetary remedies provided by lease contract,
21 not including loss or restriction of medical staff



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1 privileges or exclusion from a provider panel, if the
2 sanctioned provider participates in actions covered by
3 this chapter while on the premises of the sanctioning
4 health care provider or on property that is owned by
5 or under the direct control of the sanctioning health
6 care provider; or

7 (3) Termination of contract or other nonmonetary remedies
8 provided by contract if the sanctioned provider
9 participates in actions covered by this chapter while
10 acting in the course and scope of the sanctioned
11 provider's capacity as an employee or independent
12 contractor of the sanctioning health care provider.

13 Nothing in this paragraph shall be construed to
14 prevent:

15 (A) A health care provider from participating in
16 actions covered by this chapter while acting
17 outside the course and scope of the provider's
18 capacity as an employee or independent
19 contractor; or

20 (B) A patient from contracting with the patient's
21 attending physician and consulting physician to



1 act outside the course and scope of the
2 provider's capacity as an employee or independent
3 contractor of the sanctioning health care
4 provider.

5 (d) A health care provider that imposes sanctions pursuant
6 to subsection (c) shall follow all due process and other
7 procedures the sanctioning health care provider may have that
8 are related to the imposition of sanctions on another health
9 care provider.

10 (e) For the purposes of this section:

11 "Notify" means a separate statement in writing to the
12 health care provider specifically informing the health care
13 provider prior to the provider's participation in actions
14 covered by this chapter of the sanctioning health care
15 provider's policy regarding participation in actions covered by
16 this chapter.

17 "Participate in actions covered by this chapter" means to
18 perform the duties of an attending physician, the consulting
19 physician function pursuant to section -5, or the counseling
20 referral function pursuant to section -6. The term does not
21 include:



1 (1) Making an initial determination that a patient has a
2 terminal disease and informing the patient of the
3 medical prognosis;

4 (2) Providing information about this chapter to a patient
5 upon the request of the patient;

6 (3) Providing a patient, upon the request of the patient,
7 with a referral to another physician; or

8 (4) A patient contracting with the patient's attending
9 physician and consulting physician to act outside of
10 the course and scope of the provider's capacity as an
11 employee or independent contractor of the sanctioning
12 health care provider.

13 (f) Action taken pursuant to sections -4 to -6 shall
14 not be the sole basis for disciplinary action under section 453-
15 8.

16 (g) This chapter shall not be construed to allow a lower
17 standard of care for patients in the community where the patient
18 is treated or a similar community.

19 § -19 Prohibited acts; penalties. (a) A person who,
20 without authorization of the patient wilfully alters or forges a
21 request for medication or conceals or destroys a rescission of



1 that request with the intent or effect of causing the patient's
2 death shall be guilty of a class A felony.

3 (b) A person who coerces or exerts undue influence on a
4 patient to request medication for the purpose of ending the
5 patient's life, or to destroy a rescission of the request, shall
6 be guilty of a class A felony.

7 (c) It shall be a class A felony for a person without
8 authorization of the principal to wilfully alter, forge,
9 conceal, or destroy an instrument, the reinstatement or
10 revocation of an instrument, or any other evidence or document
11 reflecting the principal's desires and interests, with the
12 intent and effect of causing a withholding or withdrawal of
13 life-sustaining procedures or of artificially administered
14 nutrition and hydration that hastens the death of the principal.

15 (d) Except as provided in subsection (c), it shall be a
16 misdemeanor for a person without authorization of the principal
17 to wilfully alter, forge, conceal, or destroy an instrument, the
18 reinstatement or revocation of an instrument, or any other
19 evidence or document reflecting the principal's desires and
20 interests with the intent or effect of affecting a health care
21 decision.



1 (e) Nothing in this section shall limit any further
2 liability for civil damages resulting from other negligent
3 conduct or intentional misconduct by any person.

4 (f) The penalties in this chapter are cumulative and do
5 not preclude criminal penalties applicable under other law for
6 conduct which is inconsistent with this chapter.

7 § -20 Claims by governmental entity for costs incurred.
8 Any governmental entity that incurs costs resulting from a
9 person terminating the person's life pursuant to this chapter in
10 a public place shall have a claim against the estate of the
11 person to recover costs and reasonable attorney fees related to
12 enforcing the claim.

13 § -21 Severability. Any section of this chapter that is
14 held invalid as to any person or circumstance shall not affect
15 the application of any other section of this chapter that can be
16 given full effect without the invalid section or application.

17 ~~§~~ -22 Form of the request. A request for a medication
18 as authorized by this chapter shall be in substantially the
19 following form:

20 "REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED
21 MANNER



1 I, _____, am an adult of sound mind.

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

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

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

11 INITIAL ONE:

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

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

16 _____ I have no family to inform of my decision.

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

19 I understand the full import of this request and I expect
20 to die when I take the medication to be prescribed. I further
21 understand that although most deaths occur within three hours,



1 my death may take longer and my physician has counseled me about
2 this possibility.

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

5 Signed: _____

6 Dated: _____

*re:
request -
Not
administrations*

7 DECLARATION OF WITNESSES

8 We declare that the person signing this request:

- 9 (a) Is personally known to us or has provided proof of
- 10 identity;
- 11 (b) Signed this request in our presence;
- 12 (c) Appears to be of sound mind and not under duress or to
- 13 have been induced by fraud, or subjected to undue
- 14 influence when signing the request; and
- 15 (d) Is not a patient for whom either of us is the
- 16 attending physician.

*1 of 2 witnesses
on the lethal
drug
request form
is not allowed to
be an heir
who will
financially
benefit from
the patient's
death. The
other witness
can be.*

17 _____ Witness 1 Date _____

18 _____ Witness 2 Date _____

19 NOTE: One witness shall not be a relative (by blood,
20 marriage, or adoption) of the person signing this request, shall
21 not be entitled to any portion of the person's estate upon death



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1 and shall not own, operate, or be employed at a health care
2 facility where the person is a patient or resident. If the
3 patient is an inpatient at a long-term care facility, one of the
4 witnesses shall be an individual designated by the facility."

5 SECTION 3. This Act does not affect rights and duties that
6 matured, penalties that were incurred, and proceedings that were
7 begun before its effective date.

8 SECTION 4. This Act shall take effect upon its approval.

9

INTRODUCED BY:

Karl Rhoad

Russell E. Puder
Michelle R. Sidani
Katherine J. Grouse



RCW 70.245.180

Authority of chapter—References to practices under this chapter—Applicable standard of care.

(1) Nothing in this chapter authorizes 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 this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide." Consistent with RCW 70.245.010 (7), (11), and (12), 70.245.020(1), 70.245.040(1)(k), 70.245.060, 70.245.070, 70.245.090, 70.245.120 (1) and (2), 70.245.160 (1) and (2), 70.245.170, 70.245.190(1) (a) and (d), and 70.245.200(2), state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication.

(2) Nothing contained in this chapter shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist or psychologist, or other health care provider participating under this chapter.

[2009 c 1 § 18 (Initiative Measure No. 1000, approved November 4, 2008).]

*Washington State
RCW 70.245.180*

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Derek Humphry to be Keynote Speaker at 2011 Annual Meeting



This year our keynote speaker will be Derek Humphry, the author of *Final Exit* and the founder of the Hemlock Society USA in 1980. Derek is generally considered to be the father of the modern movement for choice at the end of life in America.

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

Derek is a British journalist and author who has lived in the United States since 1978, the same year he published the book *Jean's Way* describing his first wife's final years of suffering from cancer and his part in helping her to die peacefully. The public response to the book caused him to start the Hemlock Society USA in 1980 from his garage in Santa Monica. Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion In Dying to become Compassion & Choices.

In 1991 he published *Final Exit*. Much to his surprise, it became the national #1 bestseller within six months. Since then it has been translated into 12 languages and is now in its fourth edition.

Although not affiliated with – and sometimes even at odds with – Compassion & Choices, Derek is still actively involved in the movement. Always interesting and sometimes controversial, Derek will provide our supporters and their guests with his perspective about the evolution of the movement for choice at the end of life in



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Police kick in door in confusion over suicide kit.



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Byline: Jack Moran The Register-Guard

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

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

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

They soon learned the man was not home.

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

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

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

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

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

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

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

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

The FBI's investigation involving The Gladd Group is ongoing. Since the May raid on the home of the company's owner, 91-year-old Charlotte Hydom, 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 Hydom'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 Hydom'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 will conduct the 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 Humphry, who has no website and does no advertising; clients find her address through the writings of Humphry.

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

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

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

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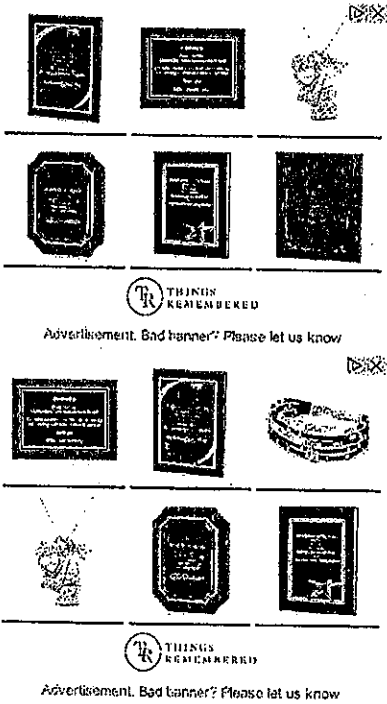
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Beware of Vultures: Senator Jennifer Fielder on Compassion & Choices

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

By Senator Jennifer Fielder

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

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

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

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

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

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

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

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

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

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

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

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

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

* * *

Published as Communication from Your State Senator, "Beware of Vultures," by Montana State Senator Jennifer Fielder, Sanders County Ledger, <http://www.sclledger.net>, page 2, 6-4-13. Senator Fielder lives in Thompson Falls MT, representing Montana State Senate District 7.

**MONTANA DOESN'T NEED MORE SUICIDE:
SAY "NO" TO THE OREGON EXPERIENCE**

By Margaret Dore, Esq., MBA
October 12, 2016

Since the passage of Oregon's law allowing physician-assisted suicide, other suicides in Oregon have steadily increased. This is consistent with a suicide contagion in which the legalization of physician-assisted suicides has encouraged other suicides. In Oregon, the financial and emotional impacts of suicide on family members and the broader community are devastating and long-lasting.¹

A. Suicide is Contagious

It is well known that suicide is contagious. A famous example is Marilyn Monroe.² Her widely reported suicide was followed by "a spate of suicides."³

With the understanding that suicide is contagious, groups such as the National Institute of Mental Health and the World Health Organization have developed guidelines for the responsible reporting of suicide, to prevent contagion. Key points include that the risk of additional suicides increases:

[W]hen the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.⁴

B. Physician-Assisted Suicide in Oregon

In Oregon, prominent cases of physician-assisted suicide include Lovelle Svart and Brittany Maynard.

Lovelle Svart died in 2007.⁵ *The Oregonian*, which is Oregon's largest paper, violated

¹ Shen X., Millet L., *Suicides in Oregon: Trends and Associated Factors. 2003-2012*, Oregon Health Authority, Portland Oregon, p.3, Executive Summary. (Excerpts attached hereto at A-56 to A-58)

² Margot Sanger-Katz, "The Science Behind Suicide Contagion," *The New York Times*, August 13, 2014. (Attached hereto at A-59).

³ Id., page 1.

⁴ "Recommendations for Reporting on Suicide," The National Institute of Mental Health. (Attached hereto at A-60). See also "Preventing Suicide: A Resource for Media Professionals," World Health Organization, at http://www.who.int/mental_health/prevention/suicide/resource_media.pdf

⁵ Ed Madrid, "Lovelle Svart, 1945 - 2007," *The Oregonian*, September 28, 2007. (Attached at A-61)

the recommended guidelines for the responsible reporting of suicide by explicitly describing her suicide method and by employing "dramatic/graphic images." Indeed, visitors to the paper's website were invited "to hear and see when Lovelle swallowed the fatal dose."⁶ There are still photos of her online, lying in bed, dying.⁷

Brittany Maynard reportedly died from physician-assisted suicide in Oregon, on November 1, 2014. Contrary to the recommended guidelines, there was "repeated/extensive coverage" in multiple media, worldwide.⁸ This coverage is ongoing, especially in Colorado, where her image is now being used to promote a pending ballot initiative (Prop. 106).

C. The Young Man Wanted to Die Like Brittany Maynard

A month after Ms. Maynard's death, Dr. Will Johnston was presented with a twenty year old patient during an emergency appointment.⁹ The young man, who had been brought in by his mother, was physically healthy, but had been acting oddly and talking about death.¹⁰

Dr. Johnston asked the young man if he had a plan.¹¹ The young man said "yes," that he had watched a video about Ms. Maynard.¹² He said that he was very impressed with her and that he identified with her and that he thought it was a good idea for him to die like her.¹³ He also told Dr. Johnston that after watching the video he had been surfing the internet looking for suicide drugs.¹⁴ Dr. Johnston's declaration states:

He was actively suicidal and agreed to go to the hospital, where he stayed for five weeks until it was determined that he was

⁶ Id.

⁷ Id.

⁸ The worldwide coverage of Ms. Maynard in multiple media started with an exclusive cover story in People Magazine. A copy of the cover is attached hereto at A-64. Other media included TV, radio, print, web and social media.

⁹ Declaration of Williard Johnston, MD, May 24, 2015. (Attached hereto at A-65 to A-66).

¹⁰ Id.

¹¹ Id.

¹² Id.

¹³ Id.

¹⁴ Id.

sufficiently safe from self-harm to go home.¹⁵

The young man had wanted to die like Brittany Maynard.

D. In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide

Oregon government reports show the following positive correlation between the legalization of physician-assisted suicide and an increase in other suicides. Per the reports:

Oregon legalized physician-assisted suicide "in late 1997."¹⁶

By 2000, Oregon's conventional suicide rate was "increasing significantly."¹⁷

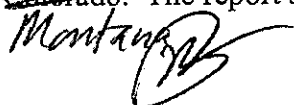
By 2007, Oregon's conventional suicide rate was 35% above the national average.¹⁸

By 2010, Oregon's conventional suicide rate was 41% above the national average.¹⁹

By 2012, Oregon's conventional suicide rate was 42% above the national average.²⁰

E. The Financial and Emotional Cost of Suicide in Oregon

Oregon's most recent report, for 2012, describes the cost of suicide as "enormous" for Oregon, a smaller population state than ~~Colorado~~. The report states:



¹⁵ Id.

¹⁶ Oregon Death with Dignity report, attached hereto at A-35.

¹⁷ Oregon Health Authority News Release, September 9, 2010, at <http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf> ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached hereto at A-67).

¹⁸ Suicides in Oregon: Trend and Risk Factors, issued September 2010 (data through 2007). (Excerpts attached hereto at A-68 to A-70).

¹⁹ "Suicides in Oregon: Trends and Risk Factors, 2012 Report (data through 2010). (Excerpts attached hereto at A-71 to A-73).

²⁰ "Suicides in Oregon: Trends and Associated Factors, 2003-2012 (data through 2012). (Excerpts attached at A-56 to A-58).

Suicide is the second leading cause of death among Oregonians aged 15 to 34 year, and the eighth leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 201[2] alone, self-inflicted injury hospitalization charges in Oregon exceeded \$54 million; and the estimate of total lifetime cost of suicide in Oregon was over \$677 million. The loss to families and communities broadens the impact of each death.²¹

F. The Significance for Montana

In Montana, the law on assisted suicide is governed by the Montana Supreme Court decision, *Baxter v. State*, 354 Mont. 234 (2009). *Baxter* gives doctors who assist a patient's suicide a potential defense to criminal prosecution. *Baxter* does not legalize assisted suicide by giving doctors or anyone else immunity from criminal and civil liability. Under *Baxter*, a doctor cannot be assured that a suicide will qualify for the defense.

Some assisted suicide proponents nonetheless claim that *Baxter* has legalized assisted suicide in Montana. More importantly, some doctors are assisting suicides in Montana.

Montana already has a higher suicide rate than Oregon.²² If *Baxter* is not overturned and/or the law clarified that assisted suicide is not legal, the suicide problem in Montana will only get worse. Montana does not need the Oregon experience.

²¹ Id., attached at A-57.

²² CDC Centers For Disease Control and Prevention, Age Adjusted Suicide Rates by State, US, 2012. (Attached hereto at A-71)

C:\Users\Margaret\Documents\DOX\WASE2016 *MontanaMontana Doesn't Need the Oregon Experience.mpd

To the honorable:
Senator Rosalyn H Bake, Chair
Senator Clarence K Nishihara, Vice Chair

LATE

From: 509-531-1111 cell
Suzanne Sullivan
1777 Ala Moan Blvd #2609
Honolulu, Hi 96815

RE: SB 1129

Positons: No to SB 1129

Against assisted suicide- no matter how you package it as dying with compassion or ?

Government should not be in the business of playing God, or determining when a life takes its first breath or last. This terrifies me that a government would want to do this.

My husband was told he had 5 years to live over 15 years ago. He is completely healthy now, but did have quite a few years of up and downs.

If he had taken his life his grandkids would not have been blessed ,and I would have lost a mate early.

He still works and contributes to society. He has value and gives back to many organizations!

Respect life!,
Respect the Kupuna. Hawaii has in its culture the sacredness of the elderly
Respect the disabled.

Just because a person may not be fully functioning does not mean their life has NO value.

So who is to determine when someone's life has value or not?

So who is to determine when a person is of sound mind?

So who is to determine if a teen is just wanting to kill themselves? Just let them? NO

So who is to determine that the life is too costly for our society to support?

So who is to determine that the 100 pills or so will work for a depressed person?

So who will pay for the pills? Who pays if more damage is done to a person resulting in more care?

So who will pay for the burial and expenses?

A society which kills itself, is destroying itself.

NO to SB1129

Suzanne Sullivan
2/10/17

baker4 - Mary Kate

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, February 15, 2017 8:05 AM
To: CPH Testimony
Cc: dannyrogers2823@gmail.com
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM

LATE

SB1129

Submitted on: 2/15/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
danny r rogers	Individual	Support	No

Comments: Quality of life should be at the discretion of each individual. When it has deteriorated to wear the "person" cannot or does not desire to struggle through pain, suffering then alternatives should be at his/her discretion.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Please approve Death with Dignity – it's time!

We are more humane to our animals... not always... but in this particular case.

The option to die a peaceful death at the time and place of their choosing provides the terminally ill with invaluable peace of mind at an extremely private time of their lives.

Suffering not required. God provided us relief! Government should not prevent us basic human rights over our own body.

The latest Hawaii poll (Fall of 2016) revealed that "eight out of 10 Hawaii voters (80%) agreed that a mentally capable adult who is dying of a terminal disease that cannot be cured should have the legal option to request prescription medicine from their doctor, and use that medication to end their suffering in their final stages of dying." A majority of Catholics (82%) and those associated with the Christian Fellowship (83%) said terminally ill adults definitely or probably should have this legal option.

SB1129 is modeled on the historic Oregon statute and includes all of the proven safeguards to protect patients from misuse. The Oregon law has been in effect since 1997 without a single incident of misuse.

Today, 22 other states are considering medical aid in dying legislation.

» SUGGESTED AMENDMENT SB1129 reads (Page2, line 14): "These safeguards include confirmation by two physicians of the patient's diagnosis, prognosis, mental competence, and voluntariness of the request ...". NOTE: "voluntariness" is a legal and philosophical concept referring to a choice being made of a person's free will, as opposed to being made as the result of coercion or duress]. Due to Hawaii's geographical makeup, we suggest this paragraph be amended to read: "... by at least one consulting physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease."

Mahalo for your effort to see this legislation passed in 2017.

Please!

baker4 - Mary Kate

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, February 15, 2017 10:30 AM
To: CPH Testimony
Cc: denis2654@hawaiiantel.net
Subject: Submitted testimony for SB1129 on Feb 15, 2017 08:30AM

LATE

SB1129

Submitted on: 2/15/2017

Testimony for CPH on Feb 15, 2017 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Lawrence Denis III	Individual	Oppose	No

Comments: Hi from Waikoloa. I'm writing to urge you to not allow physician assisted suicide in our state, no matter what euphemistic name it is cloaked. Let's not play God. Thank you, Lawrence Denis

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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