

## **Vote “Yes” on HB 505**

### **Clarify and Simplify the Law of Assisted Suicide; Prevent Legalization of Assisted Suicide**

#### **Questions & Answers**

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## **1. What is HB 505?**

HB 505 is a short two page bill that clarifies and simplifies the offense of aiding or soliciting suicide.<sup>1</sup> The bill's other purpose is to prevent the legalization of assisted suicide in Montana.

## **2. What is assisted suicide?**

Assisted suicide means that someone provides the means and/or information for another person to commit suicide. When a physician is involved, the practice is physician-assisted suicide.<sup>2</sup>

## **3. Why is legalization a bad idea?**

In the two states where assisted suicide is legal (Oregon and Washington), the following problems have emerged:

### **a. People are encouraged to throw away their lives.**

In Oregon and Washington, assisted suicide laws apply to patients predicted to have less than six months to live. Doctor predictions of life expectancy can, however, be wrong.<sup>3</sup> Treatment can also lead to recovery. Consider Oregon resident Jeanette Hall, who was diagnosed with cancer and adamant that she would "do" Oregon's law.<sup>4</sup> Her doctor, Kenneth Stevens, convinced her to be treated instead.<sup>5</sup> Now, 12 years later, "she is thrilled to be alive," says

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<sup>1</sup> A copy of HB 505 is attached hereto at A-1 & A-2. Also available at: <http://data.opi.mt.gov/bills/2013/billpdf/HB0505.pdf>

<sup>2</sup> See e.g., American Medical Association, Code of Medical Ethics, Opinion 2.211, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page>

<sup>3</sup> See e.g., 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. (Attached hereto at A-3 to A-8). Also available at <http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty>

<sup>4</sup> See Affidavit of Kenneth R. Stevens, JR., MD, ¶¶ 3-4, *Leblanc v Canada*, dated September 18, 2012 (Attached hereto at A-9); and Affidavit of Jeanette Hall, ¶3, *Leblanc v Canada*, dated August 17, 2012. (Attached at A-16).

<sup>5</sup> Stevens Affidavit, ¶¶ 5-6 (attached hereto at A-10); and Hall Affidavit, ¶3 (attached hereto at A-16).

Stevens.<sup>6</sup> Hall, herself, says: "If Dr. Stevens had believed in assisted suicide, I would be dead."<sup>7</sup>

With legal assisted suicide, people with many quality years left are encouraged to throw away their lives.

**b. The Oregon and Washington laws are a recipe for elder abuse**

Proponents claim that the assisted suicide laws in Oregon and Washington provide "choice" for patients. These laws, which have similar provisions, are instead a recipe for elder abuse. The most obvious reason is due to a lack of oversight when the lethal dose is administered. No doctor is required to be present, not even a lay witness is required.<sup>8</sup> This creates the opportunity for an heir, or for someone else who will benefit from the patient's death, to administer the lethal dose to the patient without his consent.<sup>9</sup> Even if he struggled, who would know?

For more detail, see Margaret Dore, "'Death with Dignity': What Do We Advise Our Clients?," *Bar Bulletin*, May 2009. (Attached hereto at A-18 to A-20).

**c. Legalization has empowered the Oregon Health Plan to steer patients to suicide**

In Oregon, legalization of assisted suicide has empowered the Oregon Health Plan (Medicaid) to steer patients to suicide. The most well known cases are Barbara Wagner and Randy Stroup.<sup>10</sup> Each wanted treatment.<sup>11</sup> The Plan denied coverage and offered to pay for their

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<sup>6</sup> Stevens Affidavit, ¶6. (Attached at A-10).

<sup>7</sup> Hall Affidavit, ¶1. (Attached hereto at A-17).

<sup>8</sup> See Oregon's entire act at ORS127.800-.897, and Washington's entire act at RCW 70.245.010 et. seq.

<sup>9</sup> The drugs used, Secobarbital and Pentobarbital (nembutal), are water and alcohol soluble and therefore injectable, for example, when a person is asleep. A person could also fail to give consent if he were drunk and/or otherwise cognitively impaired at the time of ingestion. Regarding solubility, see <http://www.drugs.com/pro/seconal-sodium.html> and <http://www.rxlist.com/nembutal-drug.htm>

<sup>10</sup> See Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (attached hereto at A-21 to A-24), also available at <http://abcnews.go.com/Health/story?id=5517492&page=1> and "Letter noting assisted suicide raises questions," KATU TV, July 30, 2008 (attached hereto at A-25 & A-26), also available at <http://www.katu.com/news/specialreports/26119539.html>

<sup>11</sup> Id.

suicides instead.<sup>12</sup> Wagner was devastated.<sup>13</sup> She said “I’m not ready to die.”<sup>14</sup> Stroup said “This is my life they’re playing with.”<sup>15</sup>

Today, the Oregon Health Plan continues to use financial incentives to steer patients to suicide. For more detail, see Dr. Stevens’ affidavit, cited in the footnote below.<sup>16</sup>

**d. Legalization has empowered doctors and nurses to steer patients to suicide**

In Oregon and Washington, steerage also occurs at the individual patient level with doctors and nurses. Kathryn Judson provides this example:

To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. “Think of what it will spare your wife, we need to think of her” he said, as a clincher.

Now, if the doctor had wanted to say “I don’t see any way I can help you, knowing what I know, and having the skills I have” that would have been one thing. If he’d wanted to opine that certain treatments weren’t worth it as far as he could see, that would be one thing. But he was tempting my husband to commit suicide. . . .

We got a different doctor, and David lived another five years or so. But after that nightmare in the first doctor’s office, and encounters with a “death with dignity” inclined nurse, I [became] afraid to leave my husband alone again with doctors and nurses for fear they’d morph from care providers to enemies, with no one around to stop them.<sup>17</sup>

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<sup>12</sup> Id.

<sup>13</sup> Id.

<sup>14</sup> KATU TV *supra*. (Attached hereto at A-25).

<sup>15</sup> ABC News, *supra*. (Attached hereto at A-22).

<sup>16</sup> Affidavit of Kenneth Stevens, MD, ¶¶ 8 to 12. (Attached hereto at A-10 & A-11, & exhibits at A-13)

<sup>17</sup> Kathryn Judson, “I was afraid to leave my husband alone,” Montanans Against Assisted Suicide, at <http://www.montanansagainstaassistedsuicide.org/2013/01/i-was-afraid-to-leave-my-husband-alone.html>, originally published in *The Hawaii Free Press*, February 15, 2011.

**e. Patient stress and fear**

Consider also the letter below by nurse Marlene Deakins, and her brother, Ron Olfert, now deceased from Sanders County. They describe the “unnecessary stress” and “fear” of their brother, Wes Olfert, after he asked a question about assisted suicide in Washington State. They state:

Our brother, Wes Olfert, . . . died in Washington State where assisted suicide is legal. When he was first admitted to the hospital, he made the mistake of asking for information about assisted suicide. We say a mistake, because this set off a chain of events that interfered with his care and caused him unnecessary stress in what turned out to be the last months of his life.

By asking the question, he was given a "palliative care" consult by a doctor who heavily and continually pressured him to give up on treatment before he was ready to do so. It got so bad that Wes actually became fearful of this doctor and asked us and a friend to not leave him alone with her.<sup>18</sup>

**f. In Oregon, other suicides have increased with legalization of physician-assisted suicide**

Oregon’s suicide rate, which excludes suicide under Oregon’s physician-assisted suicide act, is 35% higher than the national average.<sup>19</sup> This rate has been “increasing significantly since 2000.”<sup>20</sup> Just three years prior, Oregon legalized physician-assisted suicide.<sup>21</sup> This increased suicide rate is consistent with a suicide contagion, *i.e.*, legal physician-assisted suicide encouraged other suicides.

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<sup>18</sup> Ron Olfert and Marlene Deakins RN, Letter to the Board of Medical Examiners, “He made the mistake of asking for information about assisted suicide,” June 29, 2012. (Attached hereto at A-27). (Accuracy confirmed by Margaret Dore, the writer of this memo, who spoke with both Ron Olfert and Marlene Deakins). Also, available at <http://www.montanansagainstaassistedsuicide.org/2012/06/dear-board-of-medical-examiners-we-are.html>.

<sup>19</sup> Oregon Health Authority, News Release, *Rising suicide rate in Oregon reaches higher than national average*, September 9, 2010, available at <http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf>. (Attached at A-28). See also “Suicides in Oregon: Trends and Risk Factors,” Oregon Department of Human Services, Public Health Division, September 2010, page 6, (“Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore excluded from this report”). (Attached at A-31).

<sup>20</sup> Oregon Health Authority, *Rising suicide rate*. (Attached at A-28).

<sup>21</sup> Oregon’s Annual Statistical Report for 2012, page 2 (“Since the law was passed in 1997, . . .”).

**g. Proposals for expansion**

In Washington State, where assisted suicide was legalized four years ago, there has already been a push to expand that law to direct euthanasia of non-terminal people.<sup>22</sup> Indeed, last March, there was a newspaper column suggesting euthanasia for people unable to afford care, which would be *involuntary euthanasia*.<sup>23</sup>

**4. What is the current law of Montana?**

In Montana, persons who cause or fail to prevent another person's suicide can be found civilly liable.<sup>24</sup>

On the criminal side, persons who purposely and/or deliberately assist a suicide can be prosecuted for "aiding or soliciting suicide" and/or homicide. In the case of a doctor offender, there is a potential defense to prosecution based on *Baxter v. State*, 354 Mont. 234 (2009). This case did not, however, legalize assisted suicide. Attorneys Greg Jackson and Matt Bowman state:

[T]he Court's narrow decision didn't even "legalize" assisted suicide. . . . After *Baxter*, assisted suicide continues to carry both criminal and civil liability risks for any doctor, institution, or lay person involved..<sup>25</sup>

**5. Has Montana always prohibited assisted suicide?**

Montana has prohibited assisted suicide since at least 1895. At that time, the Montana

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<sup>22</sup> See Brian Faller, "Perhaps it's time to expand Washington's Death with Dignity Act, *The Olympian*, November 16, 2011, ("To improve the chances of passage, [Washington's] Death with Dignity Act was written to apply only to the choices of the terminally ill . . . This raises the question whether, if the act continues to work as intended, we should extend the choice of voluntary euthanasia to: . . . Persons who are not terminally ill . . .") Available at <http://www.theolympian.com/2011/11/16/1878667/perhaps-its-time-to-expand-washingtons.html>

<sup>23</sup> See Jerry Large, "Planning for old age at a premium," *The Seattle Times*, March 8, 2012 ("After Monday's column, . . . a few [readers] suggested that if you couldn't save enough money to see you through your old age, you shouldn't expect society to bail you out. *At least a couple mentioned euthanasia as a solution.*") (Emphasis added). (Attached hereto at A-32). Also available at <http://seattletimes.nwsources.com/text/2017693023.html>

<sup>24</sup> See *Krieg v. Massey*, 239 Mont. 469, 472-3 (1989) and *Nelson v. Driscoll*, 295 Mont. 363, Para 32-33 (1999). Other cases include *Edwards v. Tardif*, 240 Conn. 610, 692 A.2d 1266 (1997) (affirming a civil judgment against a physician who had prescribed an "excessively large dosage" of barbiturates to a suicidal patient who then killed herself with the barbiturates).

<sup>25</sup> "Analysis of Implications of the Baxter Case on Potential Criminal Liability," Spring 2010, at <http://www.montanansagainstaassistedsuicide.org/p/baxter-case-analysis.html>



legislature enacted a criminal statute prohibiting assisted suicide as a "crime against the public safety."<sup>26</sup> In 1907, 1921 and 1947, this statute was re-codified, but its text remained unchanged.<sup>27</sup> The statute stated:

Every person who deliberately aids, or advises or encourages another to commit suicide is guilty of a felony.<sup>28</sup>

In 1972, Montana held its constitutional convention at which time the Bill of Rights Committee considered and rejected a proposed "right to die."<sup>29</sup> The testimony supporting this proposal had included an argument to legalize physician-assisted suicide.<sup>30</sup> On June 6, 1972, the new constitution was ratified without the proposed right to die.<sup>31</sup> This is the present Constitution of the State of Montana.<sup>32</sup>

In 1973, the assisted suicide statute was re-written and moved to the homicide statutes. This was done as part of the enactment of a new criminal code, which had been drafted by the Criminal Law Commission chaired by Associate Justice Wesley Castles.<sup>33</sup> If the suicide occurred, the offense was homicide.<sup>34</sup> If the suicide did not occur, the offense was "aiding or soliciting suicide."<sup>35</sup> The Criminal Law Commission Comments stated that a victim's consent was not a defense, as follows:

If the conduct of the offender made him the agent of the death, the

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<sup>26</sup> Section 698, Pen. C. 1895.

<sup>27</sup> In 1907, § 698, Pen. C. 1895 was reenacted as § 8529, Rev. C. 1907. In 1921, the statute was reenacted as § 11261, R.C.M. In 1947, the statute was reenacted as § 94-35-215.

<sup>28</sup> Id.

<sup>29</sup> See Margaret Dore, Esq., "Montana Constitution Does Not Include a 'Right to Die,'" Montanans Against Assisted Suicide, updated January 20, 2013. (Attached hereto at A-33)

<sup>30</sup> Id.

<sup>31</sup> Id.

<sup>32</sup> Id.

<sup>33</sup> See Guide to the Montana Criminal Law Commission records 1957-1973, <http://nwda.orbiscascade.org/ark:/80444/xv73546>

<sup>34</sup> See Montana Legislative Services Division, *2012 Annotations to the Montana Code Annotated*, p. 271 (Annotator's Note regarding 45-5-105, MCA).

<sup>35</sup> 45-5-105(1), MCA.

offense is criminal homicide, *notwithstanding the consent or even the solicitations of the victim*. (Emphasis added)<sup>36</sup>

The new code did not, however, provide this clarifying information in the statutes themselves. In 1981, the Legislature added a monetary penalty.<sup>37</sup>

## 6. What about civil liability?

In 1989, the Supreme Court of Montana issued *Krieg v. Massey*, describing that civil liability can be imposed against a person who causes or fails to prevent another person's suicide.<sup>38</sup>

## 7. How did the Montana Supreme Court's decision in *Baxter* come about?

On December 8, 2008, a district court judge issued a decision holding that there is a right to physician-assisted suicide under the Montana State Constitution.<sup>39</sup> On December 31, 2009, the Supreme Court of Montana issued *Baxter v. State*, which vacated that holding.<sup>40</sup> The Court stated: "The District Court's ruling on the constitutional issues is vacated . . ."<sup>41</sup>

The vote to vacate the Constitutional ruling was six justices to one.<sup>42</sup>

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<sup>36</sup> Criminal Law Commission Comments regarding 45-5-105, MCA. (Attached hereto at A-35)

<sup>37</sup> See 45-5-105(2).

<sup>38</sup> *Krieg*, 239 Mont. 469, 472-3 (1989) states:

The general rule . . . is that "[n]egligence actions for the suicide of another will generally not lie since the act or suicide is considered a deliberate intervening act exonerating the defendant from legal responsibility . . .

There are two . . . exceptions to this rule. The first exception deals with causing another to commit suicide . . . The second exception allows the imposition of a duty to prevent suicide but only in a custodial situation where suicide is foreseeable. These situations typically involve hospitals or prisons.

<sup>39</sup> *Baxter v. State*., 354 Mont. 234, ¶¶ 7 & 9, 224 P.3d 1211, 2009 MT 449,

<sup>40</sup> *Id.*, ¶ 51

<sup>41</sup> *Id.*

<sup>42</sup> Justice James Nelson, specially concurring, was the only justice who voted to affirm a constitutional right to physician-assisted suicide under the Montana State Constitution. See his concurrence beginning at ¶ 64. The majority opinion issued by Justice William Leahart vacated the district court's constitutional ruling at ¶ 51 ("The District Court's ruling on the constitutional issues is vacated ...") Leahart was joined by Justices Patricia O. Cotter,

## 8. What else did *Baxter* do?

*Baxter* also held that a patient's consent to assisted suicide is a defense to a homicide charge against an assisting physician.<sup>43</sup> When making this holding, the Court said that it was not bound by the Criminal Law Commission Comments, providing that a victim cannot consent, because the language of the Comments did not appear in the statutes themselves.<sup>44</sup> Again, those Comments state:

If the conduct of the offender made him the agent of the death, the offense is criminal homicide, *notwithstanding the consent or even the solicitations of the victim*. (Emphasis added).<sup>45</sup>

*Baxter* was also based on a determination that assisted suicide is not against Montana public policy.<sup>46</sup> The Court, however, overlooked elder abuse. *Baxter* states that the only person "who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication."<sup>47</sup> *Baxter* thereby overlooked criminal behavior by family members and others who benefit from a patient's death, for example, due to an inheritance. The Court thereby overlooked Montana's explicit public policy to prevent elder abuse.<sup>48</sup>

## 9. Does HB 505 overrule *Baxter*'s consent defense?

Yes. HB 505 does this by amending Montana's existing prohibition against aiding or

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John Warner and Brian Morris. Warner's concurrence, ¶ 54, states "This Court correctly avoided the constitutional issue . . ." The dissent by Justice Jim Rice, joined by Joe L. Hegel, would have gone farther to state that there is no constitutional right to assisted suicide under the Montana State Constitution. See ¶¶ 111-116.

<sup>43</sup> *Baxter*, 354 Mont. at 251, ¶ 50, states: "We . . . hold that under § 45-2-211, MCA, "a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply."

<sup>44</sup> The Court stated: "[T]he comments analyze language, such as 'agent of death,' that does not even appear in the aid or soliciting statute or anywhere else in the Montana code." *Baxter*, 354 Mont. at 249, ¶ 42.

<sup>45</sup> Criminal Law Commission Comments regarding 45-5-105, MCA. (Attached hereto at A-35)

<sup>46</sup> *Baxter*, 354 Mont. at 250, ¶ 49.

<sup>47</sup> *Baxter*, 354 Mont. at 239, ¶ 11.

<sup>48</sup> See e.g., the Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act, 52-3-801, MCA; the Protective Services Act for Aged Persons or Disabled Adults, 52-3-201, MCA; and the "Montana Older Americans Act," 52-3-501, et. al., MCA.

soliciting suicide in Section 45-5-105, MCA.<sup>49</sup> HB 505 clarifies: (1) that physician-assisted suicide is a form of aiding or soliciting suicide; and (2) that a victim's consent is not a defense.<sup>50</sup>

With these two clarifications, *Baxter's* holding, that consent to physician-assisted suicide is a defense, is overruled.

**10. How does HB 505 simplify existing law?**

HB 505 simplifies existing law by removing the distinction between suicides that occur and suicides that do not occur.<sup>51</sup> If HB 505 is enacted, all assisted suicide offenses will be under Section 45-5-105, "aiding or soliciting suicide."

**11. Does HB 505 give doctors a clear safe harbor?**

Yes. HB 505 provides that the term, "physician-assisted suicide," does not include palliative care or any act to withhold or withdraw treatment authorized under the Rights of the Terminally Ill Act and the statute governing do not resuscitate orders. (Title 50, Chapters 9 & 10). HB 505 states:

The term [physician-assisted suicide] does not include end-of-life palliative care in which a dying person receives medication to alleviate pain that may incidentally hasten the dying person's death or any act to withhold or withdraw life-sustaining treatment authorized pursuant to Title 50, chapters 9 and 10.<sup>52</sup>

**12. Why is HB 505 needed now?**

HB 505 is needed now because the former Hemlock Society, Compassion & Choices, is falsely and aggressively claiming that assisted suicide is legal in Montana.<sup>53</sup> Indeed, they refer to

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<sup>49</sup> See HB 505, attached hereto at A-1, line 14 (striking "but such suicide does not occur").

<sup>50</sup> See HB 505, attached hereto at A-1, line 14 (explicitly including "physician-assisted suicide") and lines 16-17 (adding a new section specifying that consent of the victim is not a defense).

<sup>51</sup> See HB 505, at A-1, line 14.

<sup>52</sup> HB 505, at A-1, lines 26 to 28.

<sup>53</sup> See Ian Dowbiggin, *A Concise History of Euthanasia* 146 (2007) ("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices").

Montana as the “third state” along with Oregon and Washington.<sup>54</sup>

Compassion & Choices has also convinced the Montana Board of Medical Examiners to issue “Position Statement No. 20,” which implies that assisted suicide is legal in Montana.<sup>55</sup> Moreover and based on that statement, Compassion & Choices is actively recruiting doctors via direct mailings to perform assisted suicides. One of their mailings states:

Physicians can provide prescriptions to such patients without the fear that doing so could give rise to criminal or disciplinary sanction.<sup>56</sup>

A lie or half truth repeated enough times becomes the truth. If nothing is done, the idea that committing suicide is a good thing, or that pushing your parents and relatives towards death is acceptable, will, at some point, become normalized. Moreover, with the aggressiveness of Compassion & Choices, they could attempt a test suicide at any time, possibly before the next legislative session. This is similar to how legalization of assisted suicide and euthanasia took hold in the Netherlands. This is why HB 505 is needed now.

### 13. Why should legislators vote “Yes”?

With a yes vote on HB 505, the law will be clarified to overrule *Baxter* and to undermine the claim that assisted suicide is “already legal” in Montana. There will be a clear tool for law enforcement and other interested parties to stop the propaganda. There will be a clear means to protect Montana citizens, especially the elderly.

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### Biographies:

**Margaret Dore** is a lawyer in Washington State where assisted suicide is legal. She is a former Law Clerk to the Washington State Supreme Court and also to the Washington State Court of

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<sup>54</sup> For example, their website states:

Montana is one of three states where citizens are free to choose aid in dying [assisted suicide] with no risk to the doctors . . .

Attached hereto at A-36.

<sup>55</sup> See Letter from Compassion & Choices at A-37 (describing the Board’s position statement). See original statement attached hereto at A-41. The current version is attached hereto at A-42.

<sup>56</sup> A copy of this mailing and other similar documents are attached hereto at A-37 through A- 44.

Appeals. She worked for a year as an attorney with the United States Department of Justice. She has her own law practice. Ms. Dore is also President of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide. She was an amicus curie in Montana's assisted suicide case, *Baxter v. State*. For more information, see [www.margaretdore.com](http://www.margaretdore.com) and [www.choiceillusion.org](http://www.choiceillusion.org)

**Bradley D. Williams** is President of Montanans Against Assisted Suicide, a Nonprofit, Public Benefit Corporation based in Hamilton, MT. He can be reached at 406 531 0937 and [bradley@montanansagainstassistedsuicide.org](mailto:bradley@montanansagainstassistedsuicide.org) For more information, see [www.montanansagainstassistedsuicide.org](http://www.montanansagainstassistedsuicide.org)

63rd Legislature

HB0505.01

## HOUSE BILL NO. 505

INTRODUCED BY K. KERNS

ABILL FOR AN ACT ENTITLED: "AN ACT CLARIFYING THE OFFENSE OF AIDING OR SOLICITING SUICIDE;  
CLARIFYING THAT PHYSICIAN-ASSISTED SUICIDE IS A FORM OF AIDING OR SOLICITING SUICIDE;  
CLARIFYING THAT THE CONSENT OF A VICTIM IS NOT A DEFENSE TO AIDING OR SOLICITING SUICIDE;  
PROVIDING DEFINITIONS; AMENDING SECTION 45-5-105, MCA; AND PROVIDING AN IMMEDIATE  
EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

**Section 1.** Section 45-5-105, MCA, is amended to read:

**"45-5-105. Aiding or soliciting suicide.** (1) A person who purposely aids or solicits another person to commit suicide, ~~but such suicide does not occur,~~ including physician-assisted suicide, commits the offense of aiding or soliciting suicide.

(2) The consent of a victim is not a defense to the provisions of this section, and 45-2-211 does not apply.

~~(2)~~(3) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed \$50,000, or both.

(4) For purposes of this section, the following definitions apply:

(a) "Aid" means to facilitate, assist, or help.

(b) (i) "Physician-assisted suicide", also known as physician aid-in-dying, means any act by a physician of purposely aiding or soliciting another person to end the person's life, including prescribing a drug, compound, or substance, providing a medical procedure, or directly or indirectly participating in an act with the purpose of aiding or soliciting suicide.

(ii) The term does not include end-of-life palliative care in which a dying person receives medication to alleviate pain that may incidentally hasten the dying person's death or any act to withhold or withdraw life-sustaining treatment authorized pursuant to Title 50, chapters 9 and 10.

(c) "Solicit" has the meaning provided in 45-2-101."

63rd Legislature

HB0505.01

1        NEW SECTION. **Section 2. Effective date.** [This act] is effective on passage and approval.

2

3        NEW SECTION. **Section 3. Applicability.** [This act] applies to offenses committed on or after [the  
4 effective date of this act].

5

- END -





## Terminal Uncertainty

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

By Nina Shapiro

published: January 14, 2009

Nina Shapiro



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

Details:

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

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

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

That was almost four years ago.

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

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

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

series of vacations, including a cruise to the Caribbean, a trip to Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it

descended and tipped over, sending everybody crawling out.

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

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

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

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

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

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

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

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

In the world of hospice care, this finding is disturbing because it indicates that many patients aren't

being referred early enough to take full advantage of services that might ease their final months. "That's what has frustrated hospices for decades," says Wayne McCormick, medical director of Providence Hospice of Seattle, explaining that hospice staff frequently don't get enough time with patients to do their best work.

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

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

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

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

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

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

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

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

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

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

It's been like this for years. A decade ago, after clearing a jungle of blackberries off a lot he had bought

adjacent to his secluded ranch house south of Tacoma, Bud came down with a case of pneumonia. "Well, no wonder he's so sick," Heidi recalls the chief of medicine saying at the hospital where he was brought. "He's in congestive heart failure."

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

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

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

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

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

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

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

Given these two studies, it's no surprise that in Oregon some people who got a prescription for lethal medication on the basis of a six-month prognosis have lived longer. Of the 341 people who put themselves to death as of 2007 (the latest statistics available), 17 did so between six months and two

years after getting their prescription, according to state epidemiologist Katrina Hedberg. Of course, there's no telling how long any of the 341 would have lived had they not killed themselves. The Department of Health does not record how long people have lived after getting prescriptions they do not use, so there's no telling, either, whether those 200 people outlived their prognosis. Compassion & Choices of Oregon, which independently keeps data on the people whom it helps navigate the law, says some have lived as long as eight years after first inquiring about the process (although it doesn't track whether they ever received the medication and a six-month prognosis).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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CANADA

C O U R S U P É R I E U R E

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**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

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**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*

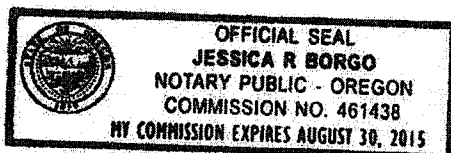
A notary in and for the  
State of Oregon

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

CANADA

C O U R S U P É R I E U R E

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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 JEANETTE HALL  
OPPOSING ASSISTED SUICIDE**

THE UNDERSIGNED, being first duly sworn under oath, states:

1. I live in Oregon where physician-assisted suicide is legal. Our law was enacted in 1997 via a ballot initiative that I voted for.
2. In 2000, I was diagnosed with cancer and told that I had 6 months to a year to live. I knew that our law had passed, but I didn't know exactly how to go about doing it. I tried to ask my doctor, Ken Stevens MD, but he didn't really answer me. In hindsight, he was stalling me.
3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!

Affidavit of Jeanette Hall - Page 1

\\Server\Root\DOX\ASE Files\Leblanc\Jeanette Hall Affidavit.wpd

4. This July, it was 12 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 17<sup>th</sup> day of August 2012

Jeanette Hall  
Jeanette Hall

SWORN BEFORE ME at  
OREGON, USA  
on, August 17, 2012

NAME: Sheena Marie Leslie

JEANETTE HALL

A notary in and for the  
State of Oregon

ADDRESS: 15405 SW 116th Ave  
Tigard, OR 97224

EXPIRY OF COMMISSION:  
September 28, 2015

PLACE SEAL HERE:



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## **‘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.<sup>1</sup> 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].”<sup>2</sup> 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.<sup>3</sup> The Act allows one of these witnesses to be the patient's heir.<sup>4</sup> The Act also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient's heir.<sup>5</sup> 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."<sup>6</sup>

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

### **"Self-administer"**

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

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."<sup>8</sup> 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.<sup>9</sup> But what if the doctors are wrong? This is the point of a recent article in *The Seattle Weekly*: Even patients with cancer can live years beyond expectations<sup>10</sup>. 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].<sup>11</sup>

### 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](http://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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## Death Drugs Cause Uproar in Oregon

By SUSAN DONALDSON JAMES

Aug. 6, 2008 —

[abcnews.go.com](http://abcnews.go.com)



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

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

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

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

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

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

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

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

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

### Letter's Impact 'Devastating'

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

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

"I'm not too good today," said Wagner, a Springfield great-grandmother. "But I'm opposed to the [assisted suicide] law. I haven't considered it, even at my lowest point."

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

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

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

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

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

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

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

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

### Playing With 'My Life'

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

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

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

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

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

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

The health plan takes "no position" on the physician-assisted suicide law, according to spokesman Jim Sellers.

The terminally ill who qualify can receive pain medication, comfort and hospice care, "no matter what the cost," he said.

But Sellers acknowledged the letter to Wagner was a public relations blunder and something the state is "working on."

"Now we have to review to ensure sensitivity and clarity," Sellers told ABCNews.com "Not only is the patient receiving bad news, but insensitivity on top of that. This is something that requires the human touch."

Sellers said that from now on insurance officials will likely "pick up the phone and have a conversation," he said.

But a 1998 study from Georgetown University's Center for Clinical Bioethics found a strong link between cost-cutting pressures on physicians and their willingness to prescribe lethal drugs to patients -- were it legal to do so.

The study warns that there must be "a sobering degree of caution in legalizing [assisted death] in a medical care environment that is characterized by increasing pressure on physicians to control the cost of care."

Cancer drugs can cost anywhere from \$3,000 to \$6,000 a month. The cost of lethal medication, on the other hand, is about \$35 to \$50.

Advocates for the proposed Washington law say that while offering death benefits but not health care can be perceived as a cost-cutting, "respectable studies" say otherwise.

"The reason is that hospice care, where most patients are at the end of life is relatively inexpensive," Anne Martens, spokesman for Washington's Death With Dignity Initiative, told ABCNews.com.

But even those who support liberal death laws say Wagner's predicament is reflective of insurance attitudes nationwide.

### **Case Is Not Unique**

"Her case is hardly unique," said Michigan lawyer Geoffrey Fieger, who defended Dr. Jack Kevorkian's crusade to legalize physician-assisted deaths. "In the rest of the country insurance companies are making these decisions and are not paying for suicide," Fieger told ABCNews.com. "Involuntary choices are foisted on people all the time by virtue of denials."

"I am surprised there hasn't been a revolt in this country," he said. "It happens every day and people are helpless."

Indeed, one executive suffering from a rare and potentially fatal form of liver cancer is fighting his insurance company for coverage. Oncologists from a major teaching hospital in New York City have prescribed Sutent -- a medication that costs about \$4,000 a month and could extend his life expectancy.

"Most of my objections are that some second rate guy on the staff of the insurance company is second-guessing one of the foremost authorities and trumping his judgment," said the 57-year-old executive, who didn't want his name used to protect his privacy.

"I am fortunate to have the financial resources and the ability to fight these people who would rather these you die," he told ABCNews.com.

Dr. Jonathan Groner, clinical professor of surgery at OSU College of Medicine and Public Health in Columbus, Ohio, said some patients may want to prolong their lives for a life-cycle event, like a birth or wedding.

"A course of chemo would not cure, but would subdue the cancer long enough to be meaningful," he told ABCNEWS.com. "There are many people with slow-growing but nonetheless metastatic cancer for whom death, while inevitable, is many years away."

"The problem with the Oregon plan is it sounds like administrators, not physicians, are making treatment decisions," he said. "And if a patient can get assisted death paid for but not cancer treatment, the choice is obvious."

Derek Humphry, founder of the Hemlock Society and author of "Final Exit," who helped write the Oregon Death With Dignity Law, said only about 30 people a year choose an assisted death, which must be approved by two doctors.

"It's purely optional and the patient and doctor can walk away from it," the 78-year-old told ABCNEWS.com. "It's not the mad rush our enemies predicted and for our residents it has worked out well."

His own wife, Jean, was diagnosed with fast-growing breast cancer in 1975 and asked him to help find drugs to help her die. At 42, she chose to take them and ended her life.

Humphry says the Oregon Health Plan's approach to coverage is sound.

"People cling to life and look for every sort of crazy cure to keep alive and usually they are better off not to have done it," he said.

Meanwhile Wagner has faith in her medicine, not assisted death. Now, at the request of her doctor, the pharmaceutical company Genentech is giving her Tarceva free of charge for one year.

"The doctor did say it would put a lid on the cancer and I am hopeful," she said.

Wagner's daughter Susie May says her mother is a fighter. "I think we all knew that this is her last hope," she said.

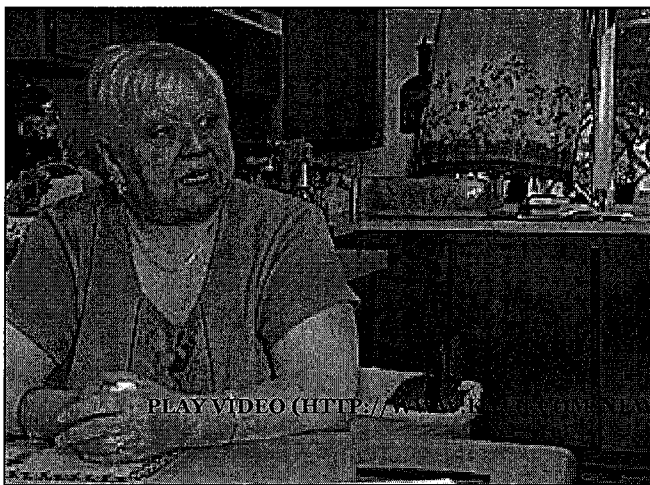
Even Wagner's ex-husband, Dennis Wagner of Springfield, has weighed in on the ethical dilemma.

"My reaction is pretty typical," he told ABCNews.com. "I am sick and tired of the dollar being the bottom line of everything. We need to put human life above the dollar."

Rana Senol of ABC News Research contributed to this report.

## Letter noting assisted suicide raises questions

By Susan Harding and KATU Web Staff | Published: Jul 30, 2008 at 5:30 PM PST (2008-07-31T1:30:00Z) | Last Updated: Nov 20, 2008 at 10:57 PM PST (2008-11-21T6:57:23Z)



Barbara Wagner

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

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

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

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

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

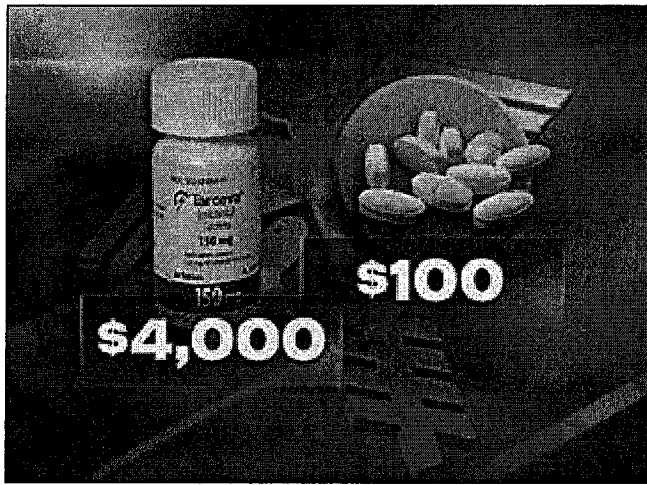
### An unfortunate interpretation?

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

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

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

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



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

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

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

#### **Health plan hasn't evolved?**

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

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

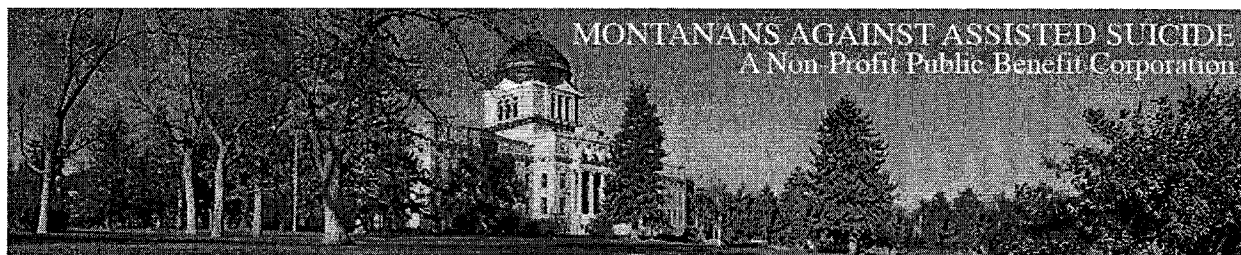
Yet the Oregon Health Plan only offers coverage for chemo that cures cancer - not if it can prolong a patient's life.

"We are looking at today's ... 2008 treatment, but we're using 1993 standards," Fryefield said. "When the Oregon Health Plan was created, it was 15 years ago, and there were not all the chemotherapy drugs that there are today."

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

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





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#### A RECIPE FOR ELDER ABUSE



Julie's Sign: No assisted suicide. No assisted elder abuse. Preserve choice for seniors.

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#### VOICES FROM OREGON AND WASHINGTON WHERE ASSISTED SUICIDE IS LEGAL

- "I was afraid to leave my husband alone"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "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 simply said 'Thank you.'"
- "He made the mistake of asking for information about assisted suicide"
- "Dr. Stevens, you saved my life!"

#### CHOICE IS AN ILLUSION



Click on the banner to learn about the fight against assisted suicide in other states

#### MAJOR TOPICS

FRIDAY, JUNE 29, 2012

## "He made the mistake of asking for information about assisted suicide"

Dear Board of Medical Examiners:

We are disturbed to hear that the Board has been asked to legalize assisted suicide in Montana. We are writing to express our extreme objection to this development.

Our brother, Wes Olfert, recently died in Washington State where assisted suicide is legal. When he was first admitted to the hospital, he made the mistake of asking for information about assisted suicide. We say a mistake, because this set off a chain of events that interfered with his care and caused him unnecessary stress in what turned out to be the last months of his life.

By asking the question, he was given a "palliative care" consult by a doctor who heavily and continually pressured him to give up on treatment before he was ready to do so. It got so bad that Wes actually became fearful of this doctor and asked us and a friend to not leave him alone with her.

Justified or not, Wes was afraid that the doctor would do something to him or have him sign something if she would find him alone. In fact, even though he was on heavy doses of narcotic pain medications and not in a clear state of mind to sign documents without someone to advocate for him, this palliative care MD actually did try to get him to sign a DNR or "Do Not Resuscitate" form without his Durable POA or any family member present. Fortunately, his close friend / POA arrived at that moment in time to stop this from happening.

Some of the other doctors and staff members seemed to also write Wes off once they learned that he had asked about assisted suicide.

We object to any move by this Board to legalize assisted suicide in Montana.

We also question whether this Board would have the authority to do so. Thank you.

Ron Olfert  
 Marlene Deakins, RN  
 Sanders County, MT

Posted by Admin at 5:57 PM

#### WELCOME!

Legal physician-assisted suicide encourages people with years to live to throw away their lives.

Legal physician-assisted suicide is a recipe for elder abuse.

In Oregon, legalization allows the Oregon Health Plan to steer citizens to suicide.

In Oregon, other suicides have increased with legalization.

For more information, see Quick Facts About Assisted Suicide.

#### JOIN BRADLEY WILLIAMS IN THE FIGHT AGAINST ASSISTED SUICIDE

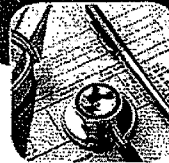


Click on photo to watch Bradley Williams speak against assisted suicide

#### PRINT OUR HANDOUTS!

- Quick Facts About Assisted Suicide
- "Aid in Dying" Whose Choice?
- Talking Points
- US Overview (Idaho article)
- Terminal Uncertainty
- Laws Against Assisted Suicide are Constitutional

OREGON HEALTH AUTHORITY



# NEWS RELEASE

**Date:** Sept. 9, 2010

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

## **Rising suicide rate in Oregon reaches higher than national average:**

***World Suicide Prevention Day is September 10***

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

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

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

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

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

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

The report also included the following findings:

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

**Oregon Health Authority**

**DHS**  
Oregon Department of Human Services

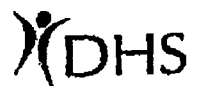
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# Suicides in Oregon Trends and Risk Factors

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

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 | Independent. Healthy. Safe.

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

## Executive Summary

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

### Key Findings

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

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

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

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

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

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

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

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

## Introduction

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

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

## Methods, data sources and limitations

X 11 Suicide is a death resulting from the intentional use of force against oneself. In this report, suicide deaths are identified according to International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of deaths on death certificates. Suicide was considered with code of X60-84 and Y87.0.<sup>4</sup> Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore are excluded from this report.

<sup>1</sup> Injury in Oregon, 2008 Annual Report. [http://www.oregon.gov/DHS/ph/lpe/docs/report2008v2\\_2.pdf](http://www.oregon.gov/DHS/ph/lpe/docs/report2008v2_2.pdf). Accessed on March, 26, 2010.

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

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

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

# The Seattle Times

Jerry Large

Low-graphic news index | Mobile site

Thursday, March 8, 2012 - Page updated at 06:30 p.m.

**Jerry Large**

## Planning for old age at a premium

**By Jerry Large**

**Seattle Times staff columnist**

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

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

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

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

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

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

The only certainty is that nothing is universally true.

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

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

At least a couple mentioned euthanasia as a solution.

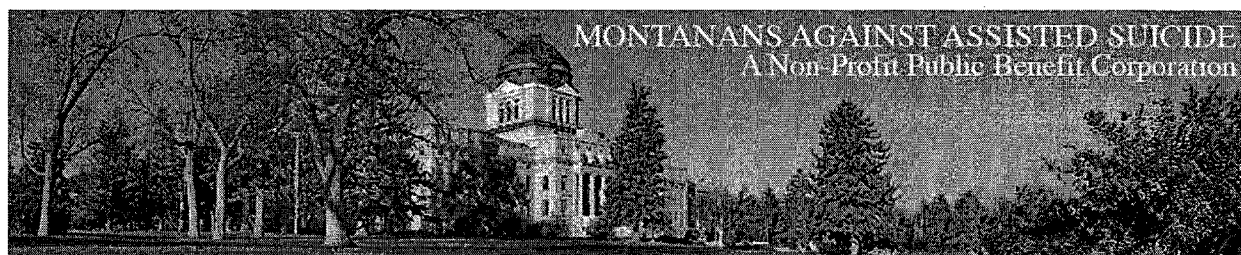
But most readers were glad the topic was raised. Out of sight, out of mind is no way to deal with something so important.

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

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

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Laws Against Assisted Suicide are Constitutional Baxter Case Analysis Letter to Physicians About Us Oregon Studies are Invalid

SB 220 Tabled! Quick Facts About Assisted Suicide Montana Constitution Does Not Include a "Right to Die"

#### A RECIPE FOR ELDER ABUSE



Julie's Sign: No assisted suicide. No assisted elder abuse. Preserve choice for seniors.

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#### VOICES FROM OREGON AND WASHINGTON WHERE ASSISTED SUICIDE IS LEGAL

- "I was afraid to leave my husband alone"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "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 simply said 'Thank you.'"
- "He made the mistake of asking for information about assisted suicide"
- "Dr. Stevens, you saved my life!"

#### CHOICE IS AN ILLUSION



Click on the banner to learn about the fight against assisted suicide in other states

#### MAJOR TOPICS

## Montana Constitution Does Not Include a "Right to Die"

By Margaret Dore  
Updated January 20, 2013

In 1972, Montana held its Constitutional Convention. At that time, the Bill of Rights Committee was charged with drafting a declaration of rights for the new constitution.

On February 2, 1972, the Committee received "Delegate Proposal 103," which proposed "the right to be born and the right to be die." [1]

On February 3, 1972, the Committee held a hearing on the "right to die." [2] According to the Committee Minutes, "Mrs. Joyce Franks presented the theory to the Committee that all persons should be able to choose his own death with dignity." [3] The record also includes her seven page written submission, titled "Bill of Rights Speech." [4] In this document, she proposed wording for a constitutional right to die; she discussed her father's long and painful death, and the right to die in terms of physician-assisted suicide and/or euthanasia. [5]

Other persons also submitted testimony, for and against. [6]

On February 9, 1972, the Bill of Rights Committee rejected Proposal #103, the "Right to Die." [7]

On February 12, 1972, Joe Roberts appeared before the Committee in support of the right to die. [8] He noted the reason for the Committee's rejection of the right to die, as follows:

"[T]he consensus of the delegates I have talked to indicated that while they were sympathetic to Mrs. Frank's personal tragedy, they were afraid of the implications of stating broadly a Right to Die in the Montana Constitution. [9]

On March 18, 1972, the Committee's "Declaration of Rights" was adopted by the full convention without the

#### WELCOME!

Legal physician-assisted suicide encourages people with years to live to throw away their lives.

Legal physician-assisted suicide is a recipe for elder abuse.

In Oregon, legalization allows the Oregon Health Plan to steer citizens to suicide.

In Oregon, other suicides have increased with legalization.

For more information, see Quick Facts About Assisted Suicide.

#### JOIN BRADLEY WILLIAMS IN THE FIGHT AGAINST ASSISTED SUICIDE



Click on photo to watch Bradley Williams speak against assisted suicide

#### PRINT OUR HANDOUTS!

- Quick Facts About Assisted Suicide
- "Aid in Dying" Whose Choice?
- Talking Points
- US Overview (Idaho article)
- Terminal Uncertainty
- Laws Against Assisted Suicide are Constitutional

- Updated Quick Facts About Assisted Suicide
- MAAS Files New Lawsuit Against Board
- Physician-assisted suicide is not legal in Montana.
- Legal analysis of failed bill to legalize assisted suicide, SB 167
- Baxter case analysis

#### BLOG ARCHIVE

##### ▼ 2013 (20)

###### ► February (9)

###### ▼ January (11)

Physician-assisted suicide runs risk of invisible ...

Assisted suicide would exacerbate problem of elder...

Oregon doctor could not save patient from assisted...

Oregon Assisted Suicide Law is Not Safe According ...

"Dr. Stevens, you saved my life!"

Oregon Doctor's Letter to Medical Society

"I was afraid to leave my husband alone"

Updated Quick Facts About Assisted Suicide

Assisted Suicide is a Bipartisan Issue

Quick Facts About Assisted Suicide

Assisted Suicide & Cross Aisle Alliances

##### ► 2012 (64)

##### ► 2011 (23)

right to die.[10]

Today, the Committee's Declaration of Rights is Article II of the Montana Constitution.[11]

With this history, there is no right to die in the Montana Constitution: it was proposed; advocated by Mrs. Franks and other persons; and rejected.

\* \* \*

- [1] Delegate Proposal 103 can be viewed at <http://maasdocuments.files.wordpress.com/2012/09/archived-del-proposal-103-rtd.pdf>
- [2] See Committee Minutes for February 3, 1972 (listing the "Subject of Hearing" as "18 year old vote, proposal #13 [and] Right to Die"), available at [http://maasdocuments.files.wordpress.com/2012/09/archived-rtd-test-feb-3-hearing-7\\_0011.pdf](http://maasdocuments.files.wordpress.com/2012/09/archived-rtd-test-feb-3-hearing-7_0011.pdf)
- [3] Minutes, page 2 (middle of the page), available at [http://maasdocuments.files.wordpress.com/2012/09/archived-rtd-test-feb-3-hearing-7\\_0011.pdf](http://maasdocuments.files.wordpress.com/2012/09/archived-rtd-test-feb-3-hearing-7_0011.pdf)
- [4] Mrs. Franks' testimony form and seven page document are available at <http://maasdocuments.files.wordpress.com/2012/10/archived-mrs-franks-materials-02-03-721.pdf>
- [5] In Mrs. Franks' materials, it's not clear whether she is talking about "physician-assisted suicide" in which the patient commits the life ending act, or "euthanasia" in which the patient's death is directly caused by another person. See her materials at <http://maasdocuments.files.wordpress.com/2012/10/archived-mrs-franks-materials-02-03-721.pdf>
- [6] Kenneth Henry wrote: "Euthanasia. I wish to support the idea." Stella Fila\_\_\_\_\_ opposed "abortion on demand" and "euthanasia." See this link: <http://maasdocuments.files.wordpress.com/2012/09/archived-documents-put-in-record-2-3-72.pdf>
- [7] See Committee Minutes for February 9, 1972, pp. 1 & 2 ("The following decisions were made: . . . #103-Out . . ."), available at <http://maasdocuments.files.wordpress.com/2012/09/archived-rtd-103-rejected-2-9-72.pdf>
- [8] See Mr. Roberts' testimony form at this link: <http://maasdocuments.files.wordpress.com/2012/09/archived-joe-roberts-test-in-minutes-for-4-12-72.pdf>
- [9] The above quote is from the first paragraph of Mr. Roberts' written remarks, which can be viewed on the page after the testimony form at this link: <http://maasdocuments.files.wordpress.com/2012/09/archived-joe-roberts-test-in-minutes-for-4-12-72.pdf>
- [10] To see the text of the Declaration of Rights submitted to the full Convention, along with a preamble, go here: [http://maasdocuments.files.wordpress.com/2012/09/archived-bill-rts-final-3-18-72\\_001.pdf](http://maasdocuments.files.wordpress.com/2012/09/archived-bill-rts-final-3-18-72_001.pdf) To see the Convention's roll vote, go here: <http://maasdocuments.files.wordpress.com/2012/09/archived-conv-vote-3-18-72.pdf>
- [11] The entire Montana Constitution can be

- Not Legal in MT
- What People Mean When They Say They Want to Die
- Bullet Points Handout

#### STOP ASSISTED SUICIDE



Click on the flag to learn how you can help stop assisted suicide in Montana

#### LABELS

- aid in dying (48)
- American Medical Association (5)
- assisted suicide (76)
- Barbara Coombs Lee (3)
- Barbara Wagner (6)
- Baxter (24)
- Blewett (15)
- Bradley Williams (25)
- Bumperstickers (1)
- Carol Mungus (1)
- Charles Bentz MD (4)
- Choice is an Illusion (1)
- Compassion and Choices (9)
- Constitutional Right (1)
- contagion (2)
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- Craig Charlton (5)
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- death with dignity (20)
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- Derek Humphry (2)
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- Elder abuse (43)
- Essmann (3)
- euthanasia (8)
- FBI (1)
- Gabor Benda (1)
- George Risi (1)
- Georgia (1)
- Glucksberg (1)
- Greg Hinkle (5)
- Greg Jackson (15)
- Hawaii (1)
- Helium Hood (2)
- Hemlock Society (6)



the safety or rights of others, the instructions taken as a whole are correct. For while the former may, standing alone, be inaccurate or even erroneous, yet as qualified and explained by other portions of the charge, in pari materia, it fully and fairly submitted the case to the jury. *St. v. Bosch*, 125 M 566, 242 P2d 477 (1952).

Evidence in a manslaughter prosecution showing that defendant driver, blinded by bright lights of an approaching car, drove off the highway into a shallow depression filled with a pile of rocks hidden by brush, causing the car to sideswipe a tree, was insufficient to sustain conviction on theory of criminal negligence. *St. v. Bast*, 116 M 829, 151 P2d 1009 (1944).

Conviction of involuntary manslaughter in the commission of a lawful act required a higher degree of negligence than to establish liability in a civil case; it required aggravated, culpable, or gross negligence or recklessness, a disregard for human life, or an indifference to consequences such a departure from the conduct of an ordinarily prudent or careful man under the circumstances as to be incompatible with a proper regard for human life. *St. v. Powell*, 114 M 571, 138 P2d 949 (1943).

The negligent handling of a loaded firearm causing or contributing to the death of another person could be found to support a conviction of involuntary manslaughter. *St. v. Kuum*, 55 M 436, 178 P 288 (1919).

**Double Jeopardy:** Prosecution for involuntary manslaughter under 94-2507, R.C.M. 194 (since repealed), was not barred by defendant's prior conviction upon guilty pleas to driving while intoxicated and operating motor vehicle with improper brakes arising from same accident. *St. v. McDonald*, 158 M 307, 491 P2d 711 (1971).

#### Failure to Provide:

Where wife died from subdural hematoma after a period of unconsciousness, husband's failure to summon medical assistance for period of 28 hours was not such degree of culpable negligence as to support a conviction of involuntary manslaughter under 94-2507, R.C.M. 194 (now MCA, 45-5-104), where unconsciousness appeared to have been from intoxication, wife appeared to be breathing well, and friend advised only bed rest. *St. v. Decker*, 157 M 361, 45 P2d 695 (1971).

Husband's failure to provide medical attention for wife for 2 days after she fell and sustained serious injuries was such culpable negligence as to support conviction for involuntary manslaughter, even though wife protested that she did not need attention, where she was in semicomatose condition and obviously did need attention. *St. v. Mally*, 139 M 599, 366 P2d 8 (1961), followed in *State ex rel. Kuntz v. District Court*, 2000 MT 22, 298 M 146, 995 P2d 951, 1 St. Rep. 111 (2000).

Failure of parents to provide food for baby, with resulting death from starvation, the baby weighing only 10 ounces more at 5 months than at birth, was such culpable negligence as to show a disregard for human life or an indifference to consequences and would support a conviction of involuntary manslaughter even without an intention to cause death. *St. v. Bischoff*, 131 M 15 308 P2d 969 (1957).

#### Intent:

Willful or evil intent was not an element of involuntary manslaughter under 94-2507, R.C.M. 1947 (now MCA, 45-5-104). *St. v. Pankow*, 134 M 519, 333 P2d 1017 (1959); *St. v. Messerly*, 1 M 62, 244 P2d 1054 (1952); *St. v. Souhrada*, 122 M 377, 204 P2d 792 (1949).

In prosecution for involuntary manslaughter under 94-2507, R.C.M. 1947 (now MCA, 45-5-104), the issue was one of criminal negligence rather than intent, and instruction that "intent is not an element of involuntary manslaughter" was proper. *St. v. Souhrada*, 122 M 377, 204 P2d 792 (1949).

### 45-5-105. Aiding or soliciting suicide.

#### Criminal Law Commission Comments

Source: New.

If the conduct of the offender made him the agent of the death, the offense is criminal homicide notwithstanding the consent or even the solicitations of the victim. See sections 94-5-101 through 94-5-105 [now MCA, 45-5-102 through 45-5-104].

Rather than relying on aiding or soliciting an attempted homicide, this section sets forth specific formula to make such acts punishable. The rationale behind the felony sentence for substantive offense of aiding or soliciting suicide is that the act typifies a very low regard for human life.

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## Montana

What We Do > On the Ground > Montana



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### NEWS

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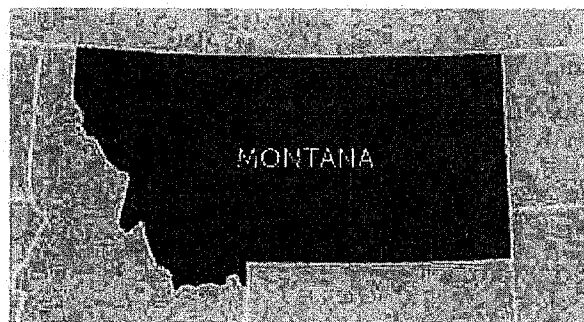
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**X** Montana is one of three states where citizens are free to choose aid in dying with no risk to the doctors or loved ones who support their choice.

The Montana Supreme Court held in December 2009 that the Montana State Constitution protects a peaceful death with dignity, making Montana the third state to provide its residents with legal aid in dying in the successful Baxter et al v. Montana case.



Despite the landmark Baxter decision and subsequent Board of Medical Examiners' policy backing this freedom, opponents threaten to undermine the right every legislative session. Compassion & Choices' on-the-ground advocates have fended them off for two years, and during this session we need your help.

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# compassion & choices Montana

Support. Educate. Advocate. Choice & Care at the End of Life.

June 5, 2012

Dear Montana Physician,

Montanans are independent. Montanans are thoughtful. They believe in privacy. That's why the Montana constitution is written to guarantee personal privacy and dignity. Terminally ill Montanans are guaranteed the right to choice, privacy and dignity at the end of life. On December 31, 2009, the Montana Supreme Court ruled terminally ill Montanans have the right to choose aid in dying under state law. The court's decision set clear boundaries for this intervention: the patient must be terminally ill and mentally competent, and the physician may provide, but not administer, a prescription for life-ending medication. Only the patient may administer this medication. Physicians can provide prescriptions to such patients without fear that doing so could give rise to criminal or disciplinary sanction.

Compassion & Choices Montana has been working tirelessly with medical professionals and citizen activists to educate the public, implement the practice with appropriate safeguards and protect the right of Montanans to die with dignity. Recently, the Montana Board of Medical Examiners (BME) adopted a new policy further establishing aid in dying as a medical intervention to be governed, as with all other medical interventions, by professional practice standards. Specifically the BME Policy states:

*"The Montana Board of Medical Examiners has been asked if it will discipline physicians for participating in aid-in-dying. This statement reflects the Board's position on this controversial question."*

*The Board recognizes that its mission is to protect the citizens of Montana against the unprofessional, improper, unauthorized and unqualified practice of medicine by ensuring that its licensees are competent professionals. 37-3-101, MCA. In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct as defined by the laws and rules pertinent to the Board."*

([http://bsd.dll.mt.gov/license/bsd\\_boards/med\\_board/board\\_page.asp](http://bsd.dll.mt.gov/license/bsd_boards/med_board/board_page.asp))

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X **Physician Advisory Council for Aid in Dying**

Compassion & Choices Montana's End-of-Life Consultation service is actively helping patients, families and medical practitioners understand aid in dying and navigate the emotional and clinical landscape of terminal illness. We are currently in the process of forming the Montana Physician Advisory Council for Aid in Dying (PACAID) with the primary goal of helping physicians empower terminally ill patients in Montana with the ability to control their suffering and choose their manner of death. To accomplish this goal, members of PACAID will:

1. Adopt best-practice guidelines for aid-in-dying practice in Montana.
2. Serve as a prescribing physician.
3. Advise physicians, hospices and requesting patients.
4. Shepherd affirmative policy through local medical organizations.

We need your help. Please consider joining the Montana Physician Advisory Council for Aid in Dying. To learn more, ask questions or get involved, please call Patrick Johnson at 406-552-2916 or email at [PJohnson@compassionandchoices.org](mailto:PJohnson@compassionandchoices.org).

Sincerely,

*Judy Neall Epstein, ND*

Judy Neall Epstein, ND  
Clinical Director  
End-of-Life Consultation Program  
Compassion & Choices

*Eric Kress*

Eric Kress, MD  
Chair  
Montana Physician Advisory Council for  
Aid in Dying

Enclosure: PACAID Recruitment Flyer

# Physician Advisory Council for Aid in Dying

Helping physicians empower terminally ill patients in Montana with the ability to control their suffering and choose their manner of death.

## End-of-Life Care in Montana

The State of Montana authorizes a range of end-of-life care options, including but not limited to:

- Discontinuing life-prolonging modalities such as dialysis, pacemakers, antibiotics, or other medication;
- Providing palliative support to a patient who elects to stop eating and drinking;
- Administering palliative sedation upon the request of the patient;
- Providing medication to provide peace of mind that peaceful dying is achievable.

The medical practice of aid in dying for terminally ill patients is becoming more established, as evidenced by the increasing number of states where aid in dying is openly available and by the growing number of professional medical organizations that support open access to aid in dying: the American College of Legal Medicine (ACLM), the American Medical Women's Association (AMWA), the American Medical Student Association (AMSA); the American Academy of Hospice and Palliative Medicine (AAHPM) has shifted its stand from oppositional to neutral.

## Montana Physicians Are Authorized to Provide Aid in Dying Subject to Professional Best-Practice Standards

The *Baxter* decision, handed down by the Montana Supreme Court on December 31, 2009, affirmed that aid in dying is legal in Montana. The Court's decision specified that a patient must: (1) have a terminal illness; (2) be within six months of death; and (3) be of sound mind.

In response to the *Baxter* decision, the Board of Medical Examiners (BOME) issued a formal statement on January 20, 2012 clarifying the Board will treat aid in dying as it would any other medical procedure or intervention when evaluating physician conduct. The BOME statement entrusts physicians in Montana to set the standard of care for aid in dying as they have with other end-of-life practices.

## Physician Advisory Council for Aid in Dying

The primary goal of the Montana Physician Advisory Council for Aid in Dying (PACAID) is to help physicians empower terminally ill patients to control their suffering and choose the manner and timing of death. To accomplish this goal, members of Montana PACAID will:

1. Adopt best-practice guidelines for aid-in-dying medical practice in Montana. Montana law entrusts physicians to set the standard of care for aid in dying as they have with other end-of-life practices. Physicians have established standards of practice in Oregon and Washington. Members of the Montana PACAID will help physicians adopt these standards and integrate aid in dying into end-of-life care in Montana.

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**2. Advise physicians, hospices and requesting patients.** As the medical practice of aid in dying matures in Montana, physicians will receive increased requests. Hospices and individual hospice workers will benefit from information, guidance and emotional support from knowledgeable and supportive colleagues. All will need reassurance that what they are doing conforms to a medical best-practice standard, which shields them from criminal conviction and professional discipline.

**3. Serve as a prescribing physician.** Patients will need support and direction to talk with their physicians about aid in dying. Members of the PAC with current licenses and prescribing privileges for controlled substances can serve a consulting role as a prescribing physician.

**4. Shepherd affirmative policies through local medical organizations.** Members of PACAID will work with the Montana medical organizations to encourage adoption of affirmative policies and documented support of the medical practice of aid in dying.

**5. Develop, grow and lead the Physician Coalition for Aid in Dying.** The Physician Coalition for Aid in Dying will be a network of supportive physicians that will:

- a. Lend their names and reputations to this effort by helping the public and medical community understand aid in dying as an available option in the palliative continuum at the end of life;
- b. Inform physicians of Compassion & Choices' End-of-Life Consultation program for support and information, for their patients and themselves;
- c. Educate medical providers and answer their concerns about prescribing or referring patients to prescribing physicians;
- d. Serve as a prescribing physician;
- e. Develop relationships with pharmacists so prescriptions can be filled locally; and
- f. Provide professional education through grand rounds.

**Please Join the Montana Physician Advisory Council for Aid in Dying**

To learn more, please call Patrick Johnson at 406.552.2916 or email at [PJohnson@compassionandchoices.org](mailto:PJohnson@compassionandchoices.org)

A.40

## Physician Aid In Dying

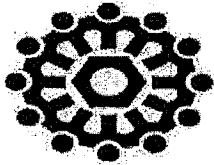
In *Baxter v. State of Montana*, 354 Mont. 234, 224 P.3d 1211, the Montana Supreme Court ruled that the Rights of the Terminally Ill Act, 50-9-101, MCA, et seq., and the consent defense found in 45-2-211, MCA shield a physician from liability for acting in accordance with a patient's end-of-life wishes if an adult, mentally competent terminally ill patient consents to the physician's aid-in-dying. As a result of this decision, the Montana Board of Medical Examiners has been asked if it will discipline physicians for participating in such aid-in-dying. This statement reflects the Board's position on this controversial question.

The Board recognizes that its mission is to protect the citizens of Montana against the unprofessional, improper, unauthorized and unqualified practice of medicine by ensuring that its licensees are competent professionals. 37-3-101, MCA. In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct as defined by the laws and rules pertinent to the Board."

*implies that physician  
"aid in dying" (assisted  
suicide) is a "medical  
procedure or intervention."*

*This is the original "Position Statement  
No. 20" adopted on Jan 10, 2012.*

*A.41*



Montana Department of  
**LABOR & INDUSTRY**  
Business Standards Division  
Montana Board of Medical Examiners



**Physician Aid in Dying  
(as of March 16, 2012)**

The Montana Board of Medical Examiners has been asked if it will discipline physicians for participating in aid-in-dying. This statement reflects the Board's position on this controversial question.

The Board recognizes that its mission is to protect the citizens of Montana against the unprofessional, improper, unauthorized and unqualified practice of medicine by ensuring that its licensees are competent professionals. 37-3-101, MCA. In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct as defined by the laws and rules pertinent to the Board."

Adopted January 20, 2012  
Revised March 16, 2012

refers to "physician aid-in-dying" (physician-assisted suicide) as a "medical procedure or intervention."

*This statement was  
enacted as "Position  
Statement No. 20."*



282.  
George Risi, M.D. - Stephen Speckart, M.D.  
P.O. Box 1348 • Helena, MT 59624

March 8, 2012

Dr.

↑  
*Compassion & Choices  
mailbox.*

RE: BME Position on Aid in Dying

Dear Dr.

X As you may be aware, in 2009 the Montana Supreme Court ruled that no basis exists to prosecute a physician for providing aid in dying. Aid in dying refers to the medical practice of a physician providing a prescription to a mentally competent, terminally ill adult patient for medication that the patient may choose to ingest to achieve a peaceful death if they find their suffering unbearable. We were involved in that case, known as *Baxter v. Montana*.

X The court's decision did not address the question of whether a physician providing aid in dying had reason to fear disciplinary action. We are writing to share with you the important news that the Board of Medical Examiners recently adopted a position statement on aid in dying, advising:

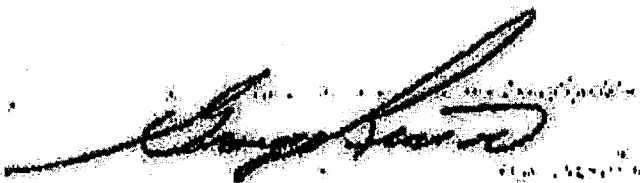
"In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct..."

Physicians willing to provide this option can safely do so within the bounds recognized in *Baxter v. Montana* and professional practice standards.

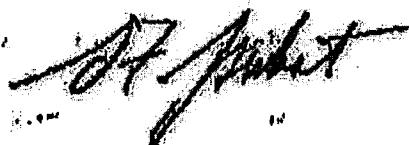
Enclosed please find a copy of the Board of Medical Examiners position statement. If you would like more information or resources to best support your patients at the end-of-life, please contact Compassion & Choices' End-of-Life Consultation program at 800.247.7421.

Sincerely,

Doctors:



George Risi, M.D.



Stephen Speckart, M.D.

<sup>1</sup>Baxter v. State of Montana, 354 Mont. 234, 224 P.3d 1211(2009).

<sup>2</sup>Montana Board of Medical Examiners Position on Aid in Dying.

A-43

**From:** Gabor Benda [mailto:gabendamd@yahoo.com]

**Sent:** Wednesday, March 14, 2012 7:49 PM

**To:** Marquand, Ian

**Cc:** Connor, Maggie; DLI BSD Medical Examiners; bradley@montanansagainstassistedsuicide.org

**Subject:** Postion Statement 20

Dear Sirs,

I am writing to Implore you to remove your position statement regarding the physician assisted suicide status in Montana. With this statement, you are suggesting that this procedure is already legal, and perhaps even endorsed by the Board. I was appalled to receive a letter just last week from 2 "Physicians" clearly recruited by the Compassion & Caring group, who quoted your position statement, and reassured the physicians of Montana, that they are on solid ground to proceed with physician assisted suicide requests. Please do not be an accomplice in this arena in denegrating our noble profession to the level of compromising the special nature of a human life. Physicians should not be participating in life ending procedures anywhere, let alone in our fine state of Montana, and I am dismayed to see a special interest group manipulating our state's Medical Board.

I am a Board Certified Family Medicine physician here in Bozeman, MT since 1989, and I know that the bulk of my colleagues here would agree with my position. Please retract your position statement, and help us instead to preserve the dignity of our profession.

Sincerely,

Gabor Benda, MD

931 Highland Blvd Suite 3360

Bozeman, MT 59715

gabendam@yahoo.com

A. 44