

Appendix

Margaret Dore Memo

Reject Rhode Island Bill

H 7297

as of

April 1, 2018

CURRICULUM VITAE

MARGARET K. DORE, ESQ., M.B.A.
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ATTORNEY EXPERIENCE:

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

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

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

The United States Department of Justice, Office of the United States Trustee, Seattle, Washington USA.

Attorney: Government practice, emphasizing bankruptcy. (September 1988 to August 1989)

JUDICIAL CLERKSHIPS:

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

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

ADMITTED TO PRACTICE:

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

PROFESSIONAL MEMBERSHIPS:

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

PUBLICATIONS:

Assisted Suicide and Euthanasia

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

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

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

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

Margaret K. Dore, "Aid in Dying: Not Legal in Idaho; Not About Choice," *The Advocate*, official publication of the Idaho State Bar, Vol. 52, No. 9, pages 18-20, September 2010;

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

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

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

Guardianship, Elder Abuse and Family Law

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

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

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

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

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

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

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

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

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

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

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

AWARDS/RECOGNITIONS:

- Butch Blum Award of Excellence in the Legal Arena, for 2005, in association with *Law & Politics Magazine* (One of nine nominees, only solo practitioner).
- Wendy N. Davis, "Family Values in Flux: Some Lawyers are growing hostile to the 'friendly parent' idea in custody fights," *ABA Journal*, Vol. 87, p. 26, October 2001 (featuring Margaret Dore after victory in Washington State).

PUBLISHED DECISIONS:

- *In re Guardianship of Stamm*, 121 Wn. App. 830, 91 P.3d 126 (2004) (3-0 opinion limiting the admissibility of guardian ad litem testimony);
- *Lawrence v. Lawrence*, 105 Wn. App. 683, 20 P.3d 972 (2001) (3-0 opinion re: the "friendly parent" concept, that its use in a child custody determination would be an abuse of discretion);
- *Kelly-Hansen v. Kelly-Hansen*, 87 Wn. App. 320, 941 P.2d 1108 (1997) (3-0 opinion re: post-dissolution dispute);
- *Jain v. State Farm*, 130 Wn.2d 688, 926 P.2d 923 (1996), (7-2 opinion re: insurance coverage and retroactive application of decisional law); and
- *In Re Alpine Group, Inc.*, 151 B.R. 931 (9th Cir. BAP 1993) (3-0 opinion re: attorney fees in bankruptcy).

EDUCATION:

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

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

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

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

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

AMA Principles of Medical Ethics: I, VII

5.7 Physician-Assisted Suicide

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

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

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

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

- (a) Should not abandon a patient once it is determined that cure is impossible.
- (b) Must respect patient autonomy.
- (c) Must provide good communication and emotional support.
- (d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I, IV

5.8 Euthanasia

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

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

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

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

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

Mercy killing - definition of mercy killing by The Free Dictionary

<http://www.thefreedictionary.com/mercy+killing>

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

mercy killing

n.

Euthanasia.

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mercy killing

n.

(Medicine) another term for euthanasia

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

eu•tha•na•sia (,yu θəˈnei zə, -zi ə, -zi ə)

n.

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

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

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Thesaurus

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

☞ **euthanasia**

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



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Translations

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Go **A-6**

Teen accused of helping friend commit suicide could face trial for murder

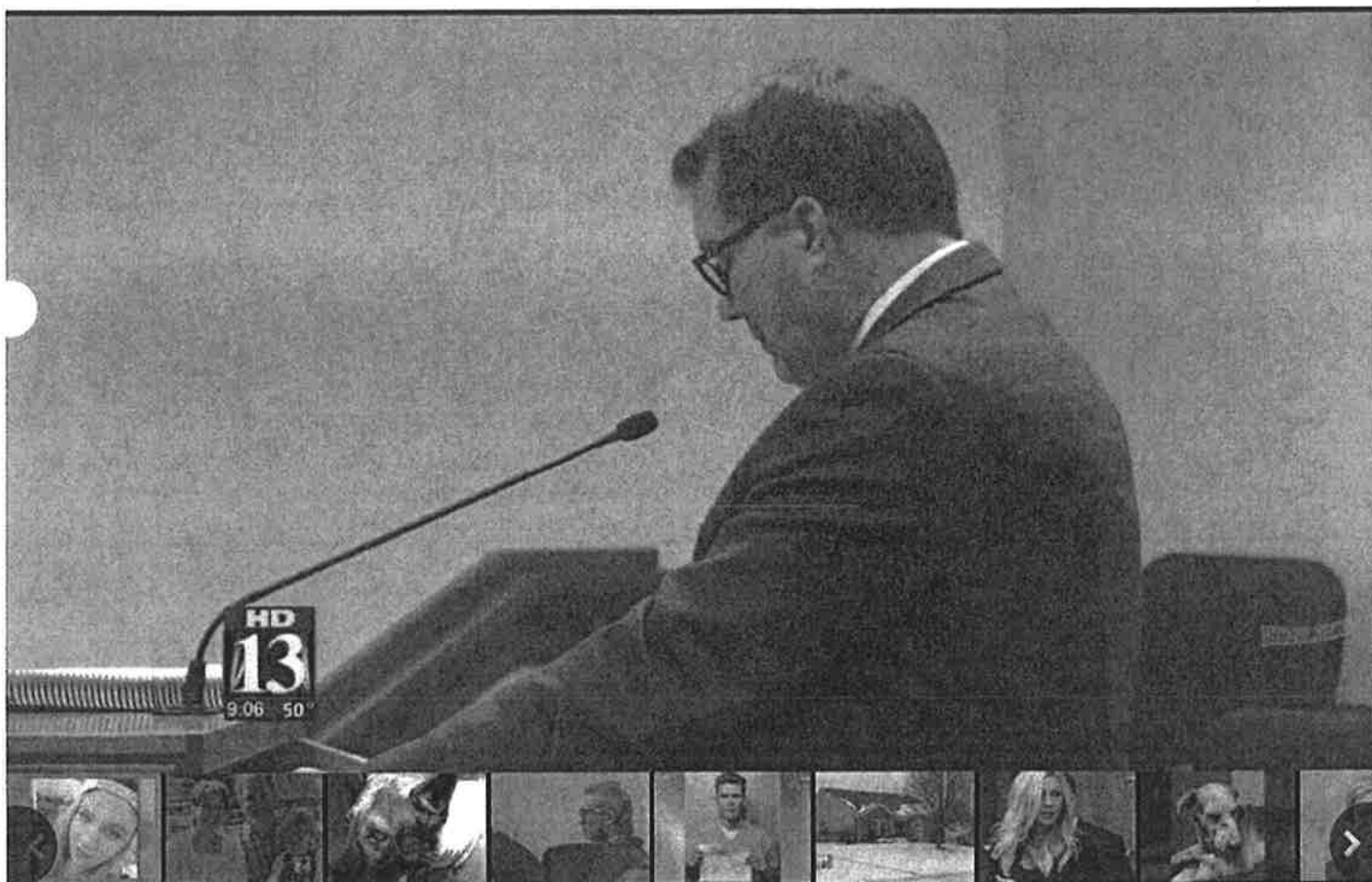
Tribune

BEN WINSLOW

Oct 12th 2017 2:42PM



SHARE



PROVO, Utah (KSTU) -- A judge will decide if a Spanish Fork man will face trial on a murder charge in the suicide of a 16-year-old girl.

Utah County prosecutors argue that Tyerell Przybycien's actions led Jchandra Brown to kill herself, and he should be tried for first-degree felony murder and a

class B misdemeanor charge of failure to report a body. His defense lawyers argued that Brown was responsible for her own actions.

Przybycien, 18, sat next to his lawyers, looking straight ahead as arguments were made here on Tuesday.

Deputy Utah County Attorney Chad Grunander argued that Przybycien bought the rope, tied the noose and picked the tree. He also took video of the girl's suicide. Her body was found the next day by hunters in Payson Canyon.

Utah has no assisted suicide law, and prosecutors argued Przybycien's actions merited a murder charge. Grunander argued that Przybycien wanted to see someone die.

"He used her suicidal ideations for his own purpose," Grunander told the judge.

"The defendant bragged about getting away with murder."

RELATED: Teen accused of helping friend commit suicide could face murder trial



Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

News sources

POSTED: 11:35 PM PDT September 7, 2011 UPDATED: 4:36 AM PDT July 14, 2011

BEND, Ore. -

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A federal judge twice gave permission for her to travel to Mexico, once in May and again last month.



Former nurse helped instruct man on how to commit suicide, court rules

William Melchert-Dinkel's conviction in death of British man, Mark Drybrough, was affirmed after Minnesota state supreme court reversed ruling last year

Associated Press in Minneapolis

Monday 28 December 2015 14.38 EST

An appeals court on Monday affirmed the conviction of a Minnesota man in the assisted dying of a British man, but reversed his conviction for attempting to assist a Canadian woman's suicide.

The Minnesota court of appeals ruled that there was sufficient evidence to convict William Melchert-Dinkel, 53, of Faribault, of assisting the 2005 death of Mark Drybrough, 32, from Coventry.

It said there was not enough evidence to convict the former nurse of the lesser offense of attempting to assist the 2008 suicide of Nadia Kajouji, 18, of Brampton, Ontario.

Authorities have said that Melchert-Dinkel was obsessed with suicide and hanging, and that he sought out potential victims online, posing as a female nurse and feigning compassion. **A-10**

The appeals court said Melchert-Dinkel gave Drybrough detailed instructions on how to hang himself. But it said he did not give specific instructions to Kajouji when he recommended that she kill herself. She jumped from a bridge into a frozen river in Ottawa, where she was going to college.

The case has been the subject of a long legal fight that narrowed Minnesota's law against assisting suicides. The Minnesota supreme court reversed Melchert-Dinkel's original convictions last year. The justices declared that a state law banning someone from "encouraging" or "advising" suicide was unconstitutional, but upheld part of the law making it a crime to "assist" in a suicide.

Melchert-Dinkel's attorney, Terry Watkins, said they plan yet another appeal to the state supreme court. He said Melchert-Dinkel should have been allowed a jury trial after the supreme court sent the case back to the trial court for further proceedings. The judge declined to allow him to withdraw his waiver of a jury trial from his original trial.

Rice County attorney John Fossum did not immediately return a call seeking comment.

Melchert-Dinkel served nearly six months in jail after his 2014 conviction and remains on 10 years of probation. While he told police he did it "for the thrill of the chase", he apologized at his sentencing and said he had repented.

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Nurses Who Kill

There have been numerous cases of Healthcare Serial Killers (HSKs), as they are preferably known, around the world. Charles Cullen in New Jersey who may have killed over 400 patients within 16 years as a nurse across nine hospitals, Kimberly Saenz also in America who murdered five patients in Texas by injecting them with bleach.

Italian nurse Daniela Poggiali who murdered 38 patients using potassium chloride and took pictures of herself next to the deceased bodies of patients and shared them on social media. Then there is Genene Jones, a paediatric nurse in San Antonio in Texas known to have killed four children by injecting them with drugs.

Most nurses who kill work alone, however a case in Austria saw four nurses in Vienna who worked together between 1983 and 1991. Led by nurses aide Waltraud Wagner at Lainz General Hospital, they killed patients using morphine and later by drowning, holding the patient down, pinching their nose and pouring water down their throat, a truly horrific and terrifying way to die.

Maria Gruber, Irene Leidolf, Stephaniya Mayer, and Waltraud Wagner, collectively known as the 'Lainz Angels of Death', have admitted killing 49 patients but as with many medical serial killers it is feared the true number of patients murdered may be as high as 200. They were caught when a doctor overheard them laughing about their latest victim, starting an investigation which resulted in their arrest in 1989.

When he was finally caught after family members raised concerns and a discovery of false medical records was made, it was believed this doctor murdered up to 250 of his patients between 1975 and 1988. Convicted of murder for 15 of his patients, Dr Harold Shipman was sentenced to life in prison and was recommended never to be released.

He hung himself in his prison cell in 2004. In the UK, the case of Dr Harold Shipman is one which caused shock across the country. A friendly local GP who had been murdering his elderly patients by injecting them with diamorphine and falsifying their medical notes. His choice of patients, their ailing health and his cool and reassuring manner to family members ensured the deaths were attributed to poor health.

RELATED: FBI'S ROBERT RESSLER: THE PSYCHOLOGICAL PROFILING OF SERIAL KILLERS

Studies on Medical Serial Killers

Dr Eindra Khin Khin, Assistant Professor of Psychiatry and Behavioural Sciences at the University of Virginia has highlighted cases of healthcare serial killings have risen since the 1970's. Ten cases were recorded within that decade, by 2001 to 2006 this number had risen to forty cases.

In a presentation at the annual meeting of the American Academy of Psychiatry and the Law, Dr Khin Khin showed **the majority of cases took place within a hospital setting (72%), with 20% of cases happening in nursing homes and 6% within the patients homes.** Over half of all cases were carried



A-12 A-12 >

The case of Dr John Bodkin Adams appears to check all boxes, despite his acquittal in 1957 of the murder of patients Edith Morrell and Gertrude Hullett. These wealthy widows both left money and valuables to the physician in their wills.^[34] Bodkin Adams, who had been previously convicted of fraud, was subsequently found guilty of manipulating prescriptions for which his medical license was revoked (and reinstated 4 years later).^[35]

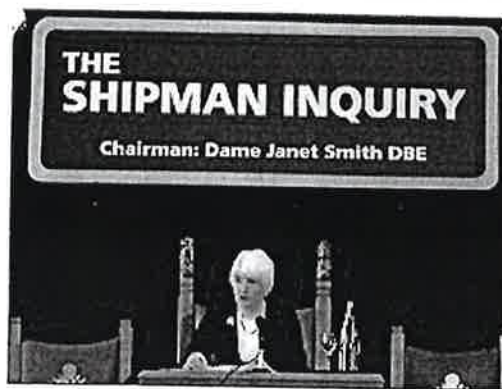
Shortly after joining a medical practice in the wealthy retirement location of Eastbourne on the British south coast, Dr Bodkin Adams became the subject of persistent rumors that focused on the suspicious deaths of his wealthy elderly patients; his use of dangerous drugs, such as heroin and morphine; and his sizeable wealth.^[18,34,35,36]

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Dr Bodkin Adams died a free man in 1983. He was never convicted of murder, despite being suspected in the deaths of up to 132 patients.^[18] After his acquittal, the presiding judge, Lord Justice Patrick Devlin, remarked, "The rigorous standards of the law sometimes allow that the guilty walk free."^[36]

The Most Notorious of Them All

One of the most notorious cases in recent history is that of Dr Harold Shipman, which gained coverage in the medical journals as well as the lay press. On January 31, 2000, the seemingly congenial^[37] Dr Shipman—a general practitioner with a year-long patient waiting list^[38]—was convicted of murdering 15 of his patients and of falsifying one patient's will.^[37,39] He was sentenced to 15 consecutive life sentences and committed suicide in prison on January 13, 2004.^[40] He never admitted to nor spoke of the murders.^[38,40]



Dame Janet Smith. Source: Alamy

A public enquiry chaired by a senior high-court judge, Dame Janet Smith, was initiated in early 2001, becoming the largest forensic investigation in the history of the United Kingdom— involving over 1000 cases and 4 years of work.^[39,40] Dr Shipman, a graduate of Leeds School of Medicine who had practiced in West Yorkshire and in Ryde, Greater Manchester, was found responsible for killing at least 215 patients.^[39] The enquiry voiced serious concerns, but lacked conclusive proof, in a further 62 suspicious deaths.^[40]

In 1998, when he was charged with the death of Kathleen Grundy and of falsifying her will, it is estimated that Dr Shipman was killing at a rate of one patient per week.^[39,40] His victims were mostly women, tended to live alone, and were frequently killed using diamorphine.^[38]

Shipman, who also stole from his victims, was 25 times more likely than comparable GPs to be present at the time of a patient's death.^[37,38]

The unusual rate of death of his patients fueled the suspicions of fellow GPs, a local undertaker, and a taxi driver who had an elderly clientele.^[37,38] The cabbie relayed that "My list of regulars was being cut back all the time...it began to feel wrong, and about 3 or 4 years ago I noticed all those who were dying went to the same doctor."^[38]

Some argued that Dr Shipman was a serial killer who just happened to be a doctor, but Dr Aneez Esmail, writing in the *New England Journal of Medicine*, countered that "it was the very fact that Shipman was a doctor that enabled him to kill and remain undiscovered" and called for more oversight and questioning of physicians.^[40]

The Cullen Law

The "Cullen Law" (officially the Health Care Professional Responsibility and Reporting Enhancement Act) "requires health care facilities to notify the state Division of Consumer Affairs with any information regarding impairment, incompetence or negligence by a health care worker that could endanger patients." It was passed in New Jersey in 2005 after the case of nurse Charles Cullen, who was convicted of killing 29 patients (and is suspected in other cases of suspicious death) in New Jersey and Pennsylvania.^[3,41,42]

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

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

VIII. CONCLUSION

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

{59} IT IS SO ORDERED.

WE CONCUR:

CHARLES W. DANIELS, Chief Justice

PETRA JIMENEZ MAES, Justice

BARBARA J. VIGIL, Justice

JAMES M. HUDSON, District Judge, Sitting by designation

All Citations

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

Morris v. Brandenburg
376 P.3d 836

IN THE STATE OF RHODE ISLAND

IN RE H 7297

DECLARATION OF WILLIAM TOFFLER, MD

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

1. I am a professor of Family Medicine and a practicing physician in Oregon for over 30 years. I write to provide some insight on the issue of physician-assisted suicide, which is legal in Oregon, and which I understand has been proposed for legalization in Rhode Island.
2. Oregon's law applies to persons with a terminal disease who are predicted to have less than six months to live. Our law states:

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

Exhibit A, ORS 127.800 s.1.01(12), attached hereto.

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

4. Attached hereto, as Exhibit B, is an excerpt from the most recent Oregon government statistical report regarding our law. The excerpt lists "diabetes" as an "underlying illness" sufficient for assisted suicide.

5. In Oregon, chronic conditions such as diabetes are sufficient for assisted suicide, if, without treatment such as insulin, the patient has less than six months to live. This is significant when you consider that, without insulin, a typical insulin-dependent 20 year old will live less than a month.

6. Such persons, with insulin, are likely to have decades to live; in fact, most diabetics have a normal life span given appropriate control of their blood sugar.

7. I have also been provided with an excerpt of the proposed Rhode Island bill, which states:

"Terminal condition" means an incurable and irreversible disease which would within reasonable medical judgment, result in death within six (6) months or less.

Exhibit C, H 7297, Sec. 23-4.13-2(10), attached hereto.

8. In my professional judgment, this definition includes insulin dependent diabetes because the final stage of the disease is a failure to produce insulin, such that the affected person is

dependent on insulin to live. The disease at that point is an incurable and irreversible disease that will cause death within six months without treatment.

9. In short, if Rhode Island follows Oregon practice to determine eligibility without treatment, the proposed bill will apply to people with chronic conditions such as insulin dependent diabetes. Such persons, with treatment, can have years or decades to live happy, healthy and productive lives.

Signed under penalty of perjury this 31 day of March 2018, at Portland Oregon.

William L Toffler MD

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
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Oregon Revised Statute

Chapter 127

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

dwda.info@state.or.us

Please browse this page or [download the statute](#) for printing - (or [read the statute at https://www.oregonlegislature.gov](#)). If you are looking for data, you can find it on our [Annual Report](#) page.

127.800 s.1.01. Definitions.

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

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

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

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

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

(Section 2)

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

TOFFLER EXHIBIT A

Characteristics	2017 (N=143)	1998-2016 (N=1,132)	Total (N=1,275)
Residence			
Metro counties (Clackamas, Multnomah, Washington) (%)	55 (38.5)	484 (43.1)	539 (42.6)
Coastal counties (%)	12 (8.4)	80 (7.1)	92 (7.3)
Other western counties (%)	65 (45.5)	471 (41.9)	536 (42.3)
East of the Cascades (%)	11 (7.7)	88 (7.8)	99 (7.8)
Unknown	0	9	9
End of life care			
Hospice			
Enrolled (%)	130 (90.9)	989 (90.1)	1119 (90.2)
Not enrolled (%)	13 (9.1)	109 (9.9)	122 (9.8)
Unknown	0	34	34
Insurance			
Private (%)	36 (31.3)	569 (53.8)	605 (51.6)
Medicare, Medicaid or other governmental (%)	78 (67.8)	474 (44.8)	552 (47.1)
None (%)	1 (0.9)	14 (1.3)	15 (1.3)
Unknown	28	75	103
Underlying illness			
Cancer (%)	110 (76.9)	883 (78.0)	993 (77.9)
Lung and bronchus (%)	23 (16.1)	193 (17.0)	216 (16.9)
Breast (%)	6 (4.2)	86 (7.6)	92 (7.2)
Colon (%)	6 (4.2)	73 (6.4)	79 (6.2)
+ Pancreas (%)	15 (10.5)	74 (6.5)	89 (7.0)
Prostate (%)	10 (7.0)	48 (4.2)	58 (4.5)
Ovary (%)	4 (2.8)	41 (3.6)	45 (3.5)
Other cancers (%)	46 (32.2)	368 (32.5)	414 (32.5)
Neurological disease (%)	20 (14.0)	114 (10.1)	134 (10.5)
Amyotrophic lateral sclerosis (%)	10 (7.0)	90 (8.0)	100 (7.8)
Other neurological disease (%)	10 (7.0)	24 (2.1)	34 (2.7)
Respiratory disease [e.g., COPD] (%)	2 (1.4)	59 (5.2)	61 (4.8)
Heart/circulatory disease (%)	9 (6.3)	40 (3.5)	49 (3.8)
Infectious disease [e.g., HIV/AIDS] (%)	0 (0.0)	13 (1.1)	13 (1.0)
Gastrointestinal disease [e.g., liver disease] (%)	0 (0.0)	8 (0.7)	8 (0.6)
Endocrine/metabolic disease [e.g., diabetes] (%)	1 (0.7)	7 (0.6)	8 (0.6)
Other illnesses (%) ²	1 (0.7)	8 (0.7)	9 (0.7)

TOFFLER EXHIBIT B

1 medication in the ordinary course of business or practice of a profession.

2 (5) "Impaired judgment" means that a person does not sufficiently understand or
3 appreciate the relevant facts necessary to make an informed decision.

4 (6) "Interested person" means:

5 (i) The patient's physician;

6 (ii) A person who knows that they are a relative of the patient by blood, civil marriage,
7 civil union, or adoption;

8 (iii) A person who knows that they would be entitled, upon the patient's death, to any
9 portion of the estate or assets of the patient under any will or trust, by operation of law, or by
10 contract; or

11 (iv) An owner, operator, or employee of a health care facility, nursing home, or
12 residential care facility where the patient is receiving medical treatment or is a resident.

13 (7) "Palliative care" shall have the same definition as in § 23-89-3.

14 (8) "Patient" means a person who is eighteen (18) years of age or older, a resident of
15 Rhode Island, and under the care of a physician.

16 (9) "Physician" means an individual licensed to engage in the practice of medicine as
17 defined in § 5-37-1.

18 (10) "Terminal condition" means an incurable and irreversible disease which would,
19 within reasonable medical judgment, result in death within six (6) months or less.

20 **23-4.13-3. Requirements for prescription and documentation - Immunity.**

21 (a) A physician shall not be subject to any civil or criminal liability or professional
22 disciplinary action if the physician prescribes to a patient with a terminal condition medication to
23 be self-administered for the purpose of hastening the patient's death and the physician affirms by
24 documenting in the patient's medical record that all of the following occurred:

25 (1) The patient made an oral request to the physician in the physician's physical presence
26 to be prescribed medication to be self-administered for the purpose of hastening the patient's
27 death.

28 (2) No fewer than fifteen (15) days after the first oral request, the patient made a second
29 oral request to the physician in the physician's physical presence to be prescribed medication to
30 be self-administered for the purpose of hastening the patient's death.

31 (3) At the time of the second oral request, the physician offered the patient an opportunity
32 to rescind the request.

33 (4) The patient made a written request to be prescribed medication to be self-
34 administered for the purpose of hastening the patient's death that was signed by the patient in the

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

12 million Americans misdiagnosed each year

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

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

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

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

✦ More from Morning Rounds with Dr. LaPook

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

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

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The Stormy Daniels "60 Minutes" interview



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Although it is unknown how many patients will be harmed from diagnostic errors, our previous work suggests that about one-half of diagnostic errors have the potential to lead to severe harm," write the authors in their study. "While this



Greek Freak

A-22

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.

CANADA

C O U R S U P É R I E U R E

PROVINCE DE QUÉBEC

DISTRICT DE TROIS-RIVIÈRES

No. : 400-17-002642-110

GINETTE LEBLANC,

demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,

défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,

mis-en-cause

**AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO
ASSISTED SUICIDE AND EUTHANASIA**

THE UNDERSIGNED, being first duly sworn on oath, STATES:

1. I live in Florence Massachusetts USA. When I was eighteen years old and in my first year of college, I was diagnosed with Amyotrophic Lateral Sclerosis (ALS) by the University of Iowa Medical School. ALS is commonly referred to as Lou Gehrig's disease. I was told that I would get progressively worse (be paralyzed) and die in three to five years.
2. I was a very physical person. The diagnosis was devastating to me. I had played football in high school and was extremely active riding bicycles. I also performed heavy labor including road construction and farm work. I prided myself for my physical strength, especially in my hands.
3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the

AFFIDAVIT OF JOHN NORTON- Page 1

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time. By then, I had twitching in both hands, which were also getting weaker. At some point, I lost the ability to grip in my hands. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor's prescription and support, I would have taken that opportunity.

4. Six years after my initial diagnosis, the disease progression stopped. Today, my condition is about the same. I still can't grip with my hands. Sometimes I need special help. But, I have a wonderful life. I am married to Susan. We have three children and one grandchild. I have a degree in Psychology and one year of graduate school. I am a retired bus driver (no gripping required). Prior to driving bus, I worked as a parole and probation officer. When I was much younger, I drove a school bus. We have wonderful friends. I enjoy singing tenor in amateur choruses. I help other people by working as a volunteer driver.

5. I will be 75 years old this coming September. If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come. I hope that Canada does not legalize these practices.

SWORN BEFORE ME at
MASSACHUSETTS, USA
on, August 16th, 2012

NAME: Heidi Pruzynski
Heidi

A notary in and for the
State of Washington Massachusetts

ADDRESS: 85 Main ST
Florence MA 01062

EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:



JOHN NORTON

AFFIDAVIT OF JOHN NORTON- Page 3

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**BEFORE THE LEGISLATURE OF THE
STATE OF NEW YORK**

IN RE NEW YORK BILLS

**DECLARATION OF KENNETH
STEVENS, MD**

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

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

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

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

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

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

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

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


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

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

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

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

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


Kenneth Stevens, Jr., MD
Sherwood, Oregon

IN RE SOUTH DAKOTA INITIATED MEASURE

DECLARATION OF JEANETTE HALL

I, JEANETTE HALL, declare as follows:

1. I live in Oregon where assisted suicide is legal. Our law was enacted in 1997 via a ballot measure that I voted for.
2. In 2000, I was diagnosed with cancer and told that I had 6 months to a year to live. I knew that our law had passed, but I didn't know exactly how to go about doing it. I tried to ask my doctor, Kenneth Stevens MD, but he didn't really answer me. In hindsight, he was stalling me.
3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!
4. It has now been 17 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 17th day of JULY 2017

State of Oregon - County of Washington

Signed and Attested July 17th, 2017
By Jeanette Hall
[Signature]

Jeanette Hall
Jeanette Hall



Executive summary

The Oregon Death with Dignity Act (DWDA) allows terminally ill Oregonians who meet specific qualifications to end their lives through the voluntary self-administration of a lethal dose of medications, expressly prescribed by a physician for that purpose. The Act requires the Oregon Health Authority, Public Health Division, to collect information about the patients and physicians who participate in the Act and to publish an annual statistical report. In 2017, 218 people received prescriptions under the DWDA. As of January 19, 2018, 143 people had died in 2017 from ingesting the prescribed medications, including 14 who had received the prescriptions in prior years. Characteristics of DWDA patients were similar to those in previous years: most patients were aged 65 years or older (80.4%) and had cancer (76.9%). During 2017, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

2017
Data Summary
printed 2/27/18

FINANCIAL ABUSE OF ELDERS AND OTHER AT-RISK ADULTS

By

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- p. Changes in banks or attorneys used by the elder for many years.
- q. Large, unexplained charges to the elder's credit cards.
- r. Missing or unaccounted for government benefits (*e.g.* monthly checks for Social Security, veterans benefits, SSI or SSDI, or Supplemental Nutrition Assistance (a/k/a "food stamps")).

2. The 2009 MetLife Study suggests the following additional indicators of elder financial abuse. *Id.* at 22-23.

- a. The elder manifests an unusual degree of fear or submissiveness to a caregiver.
- b. Isolation of the elder from family, friends, community, and other stable relationships (*e.g.* the elder is never alone or allowed to discuss finances without the caregiver present).
- c. The elder appears intimidated and threatened (*e.g.* never looks at people directly).
- d. The elder exhibits withdrawn behavior or a disheveled appearance.
- e. The elder expresses anxiety about her ability to meet her financial obligations.
- f. Significant changes in the elder's personal spending patterns (*e.g.* she purchases a new car even though she has not driven in many months or years).
- g. Third parties develop a new close bond with the elder and exert influence over the elder's decisions.
- h. Third parties withhold information from the elder or make false promises.
- i. Third parties suddenly acquire expensive possessions.
- j. Third parties exhibit defensiveness or hostility during appointments or phone calls with the elder.
- k. Third parties are reluctant to leave the side of the elder during appointments.
- l. Unexplained decreases in the number of the elder's bank or investment accounts.
- m. An increase in the number of the elder's credit card accounts.

B. Reporting of elder financial abuse

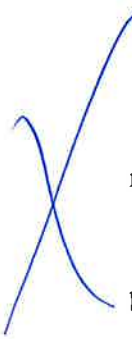
1. The NCEA of the Administration on Aging, in summarizing a series of research studies on the incidence and prevalence of elder abuse and neglect (of all types), concluded that while data from state **Adult Protective Services ("APS")** agencies shows an increase in the reporting of elder abuse, an overwhelming number of cases go undetected, unreported, and untreated each year.

a. One such study estimated that only **one of every 14 cases** of elder abuse ever comes to the attention of the authorities. See www.ncea.aoa.gov/Library/Data/index.aspx, citing Bonnie, R. and Wallace, R. (Eds.), *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America* (Washington, D.C., The National Academies Press 2003) (available at www.hap.edu/openbook.php?isbn-0309084342).

b. Another study found that **for every case of elder abuse referred to social service, law enforcement, or legal authorities 24 cases were not so referred**. See Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University and New York City Department for the Aging (2011), *Under the Radar: New York State Elder Abuse Prevalence Study* (available at <http://ofcs.ny.gov/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf>).

2. Why is elder financial abuse so significantly under-reported? The most cited reason for under-reporting is that the **victims themselves refuse to report the abuse** to relevant authorities. The 2009 MetLife Study suggests some of the following reasons as the basis for an elder's refusal to report her victimization. *Id.* at 21.

- a. The elder does not want her abusing family member to go to jail or to face public embarrassment.

- 
- b. The elder does not want government interference in her personal life.
- c. The elder feels partially responsible for what has happened.
- d. The elder believes that the abuse is simply part of doing business or taking risks.
- e. The elder feels that admitting vulnerability will result in her being placed in a nursing home or other facility.
- f. The elder fears that the abuser will harm her even more if it is reported.
- g. The elder believes that no one will help remedy the abuse, or that any help will be “too little, too late.”
- h. The elder fears that prosecuting the abuse will be prohibitively expensive.
- i. The elder may not recall the abuse because of dementia or other impairments.

3. Another factor underlying the significant under-reporting of elder financial abuse includes the **reluctance of third parties to get involved** for some of the following reasons. *Id.* at 21.

- a. They do not know if they are “mandated reporters” under their state laws. (*See* Section II.B.4, below.)
- b. They do not want to compromise professional relationships.
- c. They are unclear on the issue of “who is the client?” (*i.e.* the elder or her family members).
- d. They wish to avoid adverse publicity to themselves or their organizations.
- e. They do not want to incriminate fellow professionals or employees.
- f. They want to avoid involvement in a criminal investigation or lawsuit.
- g. They are uneducated about business ethics and practices relating to elder financial abuse.
- h. They are untrained on the distinction between “normal aging” and elder abuse.

4. “**Mandatory reporters**” of elder financial abuse can vary significantly from state to state.

a. For example, Georgia law provides that the following persons having reasonable cause to believe that a disabled adult or elder person has been the victim of abuse, other than by accidental means, or has been neglected or exploited, are mandatory reporters of such suspected abuse, neglect, or exploitation.

- (1) Any person required to report child abuse.
- (2) Physical therapists.
- (3) Occupational therapists.
- (4) Day-care personnel.
- (5) Coroners.
- (6) Medical examiners.
- (7) Emergency medical services personnel.
- (8) Certified emergency medical technicians, cardiac technicians, paramedics, or first responders.
- (9) Employees of a public or private agency engaged in professional health related services to elder persons or disabled adults.
- (10) Clergy members (outside of the confessional).

Characteristics	2016	1998–2015	Total
	(N=133)	(N=994)	(N=1,127)
Lethal medication			
Secobarbital (%)	86 (64.7)	582 (58.6)	668 (59.3)
Pentobarbital (%)	0 (0.0)	386 (38.8)	386 (34.3)
Phenobarbital (%)	39 (29.3)	17 (1.7)	56 (5.0)
Other (combination of above and/or morphine) (%)	8 (6.0)	9 (0.9)	17 (1.5)
End of life concerns⁴	(N=133)	(N=994)	(N=991)
Losing autonomy (%)	119 (89.5)	906 (91.6)	1,025 (91.4)
Less able to engage in activities making life enjoyable (%)	119 (89.5)	888 (89.7)	1,007 (89.7)
Loss of dignity (%) ⁵	87 (65.4)	680 (78.8)	767 (77.0)
Losing control of bodily functions (%)	49 (36.8)	475 (48.1)	524 (46.8)
Burden on family, friends/caregivers (%)	65 (48.9)	408 (41.3)	473 (42.2)
Inadequate pain control or concern about it (%)	47 (35.3)	249 (25.2)	296 (26.4)
Financial implications of treatment (%)	7 (5.3)	31 (3.1)	38 (3.4)
Health-care provider present (collected since 2001)	(N=133)	(N=924)	(N=1,057)
When medication was ingested ⁶			
Prescribing physician	14	149	163
Other provider, prescribing physician not present	14	256	270
No provider	5	86	91
Unknown	100	433	533
At time of death			
Prescribing physician (%)	13 (10.1)	136 (15.0)	149 (14.4)
Other provider, prescribing physician not present (%)	14 (10.9)	281 (31.0)	295 (28.5)
No provider (%)	102 (79.1)	489 (54.0)	591 (57.1)
Unknown	4	18	22
Complications⁶	(N=133)	(N=994)	(N=1,127)
Difficulty ingesting/regurgitated	3	27	30
None	24	530	554
Unknown	106	437	543
Other outcomes			
Regained consciousness after ingesting DWDA medications ⁷	0	6	6

Oregon Drugs,
See above

Washington State

Table 3. Death with Dignity Act process for the participants who have died

	2016		2015 ¹		2014 ¹	
	Number	%	Number	%	Number	%
Family and Psychiatric/Psychological involvement						
Referred for psychiatric/psychological evaluation ²	11	5	8	4	6	4
Patient informed family of decision ³	221	94	170	94	146	88
Medication⁴						
Secobarbital	77	32	106	52	112	64
Pentobarbital	2	1	2	1	64	36
Secobarbital/Pentobarbital Combination	0	0	0	0	0	0
Phenobarbital	1	<1	92	46	0	0
Phenobarbital/Chloral Hydrate Combination	106	44				
Chloral Hydrate	1	<1				
Morphine sulfate	52	22	0	0	0	0
Other	1	<1	1	1	0	0
Timing						
Duration of patient-physician relationship ⁵						
<25 weeks	125	53	100	51	62	43
25 weeks – 51 weeks	25	11	15	8	18	13
1 year or more	84	36	80	40	57	40
Unknown	2	1	2	1	6	4
Range (min – max)	<1 wk – 31 yrs		<1 wk – 2 yrs		<1 wk – 23 yrs	
Duration between first oral request and death ²						
<25 weeks	209	89	163	84	145	87
25 weeks or more	24	10	32	16	15	9
Unknown	3	1	0	0	7	4
Range (min – max)	2 wks – 112 wks		2 wks – 95 wks		2 wks – 57 wks	

Notes:

¹ Data published in 2014 and 2015 reports

<http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx>.

² Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 236 of the 240 participants in 2016 who died.

³ Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 234 of the 240 participants in 2016 who died.

⁴ Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 240 participants in 2016 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.

⁵ Data are collected from the After Death Reporting form. At the time of publication, data are available for 236 of the 240 participants in 2016 who died.

Washington State Druggist - See a Save

RCW 70.245.010**Definitions.**

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

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

Washington State
Death with Dignity
Act

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ingest definition

in·gest (in-jest')

transitive verb

to take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing

Origin: < L *ingestus*, pp. of *ingerere*, to carry, put into < *in-*, into + *gerere*, to carry

Related Forms:

- **Ingestion** in-ges'tion *noun*
- **Ingestive** in-ges'tive *adjective*

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in·gest (in-jest')

transitive verb in-gest·ed, in-gest·ing, in-gests

1. To take into the body by the mouth for digestion or absorption. See Synonyms at [eat](#).
2. To take in and absorb as food: "*Marine ciliates ... can be observed ... ingesting other single-celled creatures and harvesting their chloroplasts*" (Carol Kaesuk Yoon).

Origin: Latin *ingerere*, *ingest-* : *in-*, in; see [in-](#)² + *gerere*, to carry.

Related Forms:

- **In-gest'i-ble** *adjective*
- **Ingestion** in-ges'tion *noun*
- **Ingestive** in-ges'tive *adjective*

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define in the spirit of



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in (or in the) spirit

phrase of spirit

1. in thought or intention though not physically.
"he couldn't be here in person, but he is with us in spirit"

Translations, word origin, and more definitions

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A force or principle believed to animate living beings. b. A force or principle believed to animate humans and often to endure after departing from the body of a person at death; the soul. 2. **Spirit** The Holy **Spirit**.

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

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Spirit definition, the principle of conscious life; the vital principle in humans, animating the body or mediating between body and soul. See more.



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Original article

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

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ABSTRACT

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

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

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

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

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1. Introduction

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

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

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

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Financial abuse and exploitation is increasing and the elderly are the most common victims. Older adults are often lonely. They may be a widow or widower. With age, friends could be fewer. Children may be trying to help but often are busy with their own daily affairs. The elderly adult physical and cognitive functions are not as good as when they were younger. Older adults are vulnerable and often trusting of others. The perfect victim predators take advantage of. At ElderCare of RI we work to eliminate opportunities for abuse and to stop financial abuse and exploitation when it occurs.

Factors increasing the likelihood of becoming a victim of elder abuse and exploitation:

1. Loss of a spouse
2. Loss of friends
3. Sickness both physical and cognitive
4. Loneliness

Who are the perpetrators:

Children

Relatives

Caregivers

Financial advisors

Identity theft

Mail scams

Telephone scams

Unsolicited emails

IRS scams

Here are nine warning signs to watch for in older adults which may indicate financial abuse and exploitation is occurring.

1. Taking a large amount out of the bank or other cash accounts
2. Making numerous withdrawals of smaller amounts.
3. Writing a large check to someone you do not know.
4. Changing power of attorney or beneficiaries on insurance or investment accounts.
5. Bouncing checks or bills going unpaid.
6. Making unusual or unnecessary purchases.
7. Agreeing to make unnecessary home repairs.

NEWS RELEASE



Date: Sept. 9, 2010

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

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

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

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.

Suicides in Oregon Trends and Risk Factors

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



[Oregon suicide report issued in September 2010. Data through 2007. Excerpts attached].

Executive Summary

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

Key Findings

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%).

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.



Public Health Division

Suicides in Oregon: Trends and Risk Factors -2012 Report-

Oregon Violent Death Reporting System
Injury and Violence Prevention Program
Center for Prevention and Health Promotion

Note to Readers:
Data collected through 2010
Report Excerpts attached hereto

**Oregon
Health
Authority**

Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all Oregonians in 2010. The financial and emotional impacts of suicide on family members and the broader community are devastating and long lasting. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data of the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Key Findings

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

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

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

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

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

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

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

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

Executive Summary

Suicide is one of Oregon's most persistent public health problems. Suicide is the second leading cause of death among Oregonians aged 15 to 34 years, and the eighth leading cause of death among all Oregonians in 2012. The financial and emotional impacts of suicide on family members and the broader community are devastating and long-lasting.

This report provides the most current suicide statistics in Oregon. We analyzed mortality data from 1981 to 2012 and Oregon Violent Death Reporting System (ORVDRS) data from 2003 to 2012. This report presents findings of suicide trends and associated factors in Oregon. These data can inform prevention programs, policy, and planning.

Key Findings

In 2012, the age-adjusted suicide rate among Oregonians was 17.7 per 100,000, 42 percent higher than the national average.

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

Suicide rates among adolescents aged 10 through 17 years has increased since 2011 after decreasing from 1990 to 2010.

Suicide rates among adults aged 45 to 64 years rose more than 50 percent from 18.1 per 100,000 in 2000 to 28.7 per 100,000 in 2012; the rate increased more among females than among males.

Suicide rates among males aged 65 years and older decreased approximately 18 percent from nearly 50 per 100,000 in 2000 to 42 per 100,000 in 2012.

From 2003 to 2012:

Males were 3.6 times more likely to die by suicide than females. The highest suicide rate occurred among males aged 85 years and older (72.4 per 100,000). Non-Hispanic white males had the highest suicide rate among all racial / ethnic groups (27.1 per 100,000).

Approximately 25 percent of suicides occurred among veterans. Male veterans had almost twice the suicide rate than non-veteran males (45.5 vs. 29.0 per 100,000). Veteran suicide victims were reported to have more physical health problems than non-veteran males.

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

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2018

A N A C T

RELATING TO HEALTH AND SAFETY- LILA MANFIELD SAPINSLEY
COMPASSIONATE CARE ACT

Introduced By: Representatives Ajello, O'Grady, Knight, Carson, and Donovan

Date Introduced: January 25, 2018

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

1 SECTION 1. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby
2 amended by adding thereto the following chapter:

3 CHAPTER 4.13

4 LILA MANFIELD SAPINSLEY COMPASSIONATE CARE ACT

5 23-4.13-1. Short title.

6 This chapter shall be known and may be cited as the "Lila Manfield Sapinsley
7 Compassionate Care Act".

8 23-4.13-2. Definitions.

9 As used in this chapter:

10 (1) "Bona fide physician-patient relationship" means a treating or consulting relationship
11 in the course of which a physician has completed a full assessment of the patient's medical history
12 and current medical condition, including a personal physical examination.

13 (2) "Capable" means that a patient has the ability to make and communicate health care
14 decisions to a physician, including communication through persons familiar with the patient's
15 manner of communicating if those persons are available.

16 (3) "Health care facility" shall have the same meaning as in § 23-17-2.

17 (4) "Health care provider" means a person, partnership, corporation, facility, or
18 institution, licensed or certified or authorized by law to administer health care or dispense

1 medication in the ordinary course of business or practice of a profession.

2 (5) "Impaired judgment" means that a person does not sufficiently understand or
3 appreciate the relevant facts necessary to make an informed decision.

4 (6) "Interested person" means:

5 (i) The patient's physician;

6 (ii) A person who knows that they are a relative of the patient by blood, civil marriage,
7 civil union, or adoption;

8 (iii) A person who knows that they would be entitled, upon the patient's death, to any
9 portion of the estate or assets of the patient under any will or trust, by operation of law, or by
10 contract; or

11 (iv) An owner, operator, or employee of a health care facility, nursing home, or
12 residential care facility where the patient is receiving medical treatment or is a resident.

13 (7) "Palliative care" shall have the same definition as in § 23-89-3.

14 (8) "Patient" means a person who is eighteen (18) years of age or older, a resident of
15 Rhode Island, and under the care of a physician.

16 (9) "Physician" means an individual licensed to engage in the practice of medicine as
17 defined in § 5-37-1.

18 (10) "Terminal condition" means an incurable and irreversible disease which would,
19 within reasonable medical judgment, result in death within six (6) months or less.

20 **23-4.13-3. Requirements for prescription and documentation - Immunity.**

21 (a) A physician shall not be subject to any civil or criminal liability or professional
22 disciplinary action if the physician prescribes to a patient with a terminal condition medication to
23 be self-administered for the purpose of hastening the patient's death and the physician affirms by
24 documenting in the patient's medical record that all of the following occurred:

25 (1) The patient made an oral request to the physician in the physician's physical presence
26 to be prescribed medication to be self-administered for the purpose of hastening the patient's
27 death.

28 (2) No fewer than fifteen (15) days after the first oral request, the patient made a second
29 oral request to the physician in the physician's physical presence to be prescribed medication to
30 be self-administered for the purpose of hastening the patient's death.

31 (3) At the time of the second oral request, the physician offered the patient an opportunity
32 to rescind the request.

33 (4) The patient made a written request to be prescribed medication to be self-
34 administered for the purpose of hastening the patient's death that was signed by the patient in the

1 presence of two (2) or more subscribing witnesses at least one of whom is not an interested
2 person as defined in § 23-4.13-2, who were at least eighteen (18) years of age, and who
3 subscribed and attested that the patient appeared to understand the nature of the document and to
4 be free from duress or undue influence at the time the request was signed.

5 (5) The physician determined that the patient:

6 (i) Was suffering a terminal condition, based on the physician's physical examination of
7 the patient and the physician's review of the patient's relevant medical records;

8 (ii) Was capable;

9 (iii) Was making an informed decision;

10 (iv) Had made a voluntary request for medication to hasten their death; and

11 (v) Was a Rhode Island resident.

12 (6) The physician informed the patient in person, both verbally and in writing, of all the
13 following:

14 (i) The patient's medical diagnosis;

15 (ii) The patient's prognosis, including an acknowledgement that the physician's prediction
16 of the patient's life expectancy was an estimate based on the physician's best medical judgment
17 and was not a guarantee of the actual time remaining in the patient's life, and that the patient
18 could live longer than the time predicted;

19 (iii) The range of treatment options appropriate for the patient and the patient's diagnosis;

20 (iv) If the patient was not enrolled or participating in hospice care, all feasible end-of-life
21 services, including palliative care, comfort care, hospice care, and pain control;

22 (v) The range of possible results, including potential risks associated with taking the
23 medication to be prescribed; and

24 (vi) The probable result of taking the medication to be prescribed.

25 (7) The physician referred the patient to a second physician for medical confirmation of
26 the diagnosis, prognosis, and a determination that the patient was capable, was acting voluntarily,
27 and had made an informed decision.

28 (8) The physician either verified that the patient did not have impaired judgment or
29 referred the patient for an evaluation by a psychiatrist, psychologist, or clinical social worker,
30 licensed in Rhode Island, for confirmation that the patient was capable and did not have impaired
31 judgment.

32 (9) If applicable, the physician consulted with the patient's primary care physician with
33 the patient's consent.

34 (10) The physician informed the patient that the patient may rescind the request at any

1 time and in any manner and offered the patient an opportunity to rescind after the patient's second
2 oral request.

3 (11) The physician ensured that all required steps were carried out in accordance with this
4 section and confirmed, immediately prior to writing the prescription for medication, that the
5 patient was making an informed decision.

6 (12) The physician wrote the prescription no fewer than forty-eight (48) hours after the
7 last to occur of the following events:

8 (i) The patient's written request for medication to hasten their death;

9 (ii) The patient's second oral request; or

10 (iii) The physician's offering the patient an opportunity to rescind the request.

11 (13) The physician either:

12 (i) Dispensed the medication directly, provided that at the time the physician dispensed
13 the medication, they were licensed to dispense medication in Rhode Island, had a current Drug
14 Enforcement Administration certificate, and complied with any applicable administrative rules; or

15 (ii) With the patient's written consent:

16 (A) Contacted a pharmacist and informed the pharmacist of the prescription; and

17 (B) Delivered the written prescription personally or by mail or electronically to the
18 pharmacist, who dispensed the medication to the patient, the physician, or an expressly identified
19 agent of the patient.

20 (14) The physician recorded and filed the following in the patient's medical record:

21 (i) The date, time and detailed description of all oral requests of the patient for
22 medication to hasten their death;

23 (ii) All written requests by the patient for medication to hasten their death;

24 (iii) The physician's diagnosis, prognosis, and basis for the determination that the patient
25 was capable, was acting voluntarily, and had made an informed decision;

26 (iv) The second physician's diagnosis, prognosis, and verification that the patient was
27 capable, was acting voluntarily, and had made an informed decision;

28 (v) The physician's attestation that the patient was enrolled in hospice care at the time of
29 the patient's oral and written requests for medication to hasten their death or that the physician
30 informed the patient of all feasible end-of-life services;

31 (vi) The physician's verification that the patient either did not have impaired judgment or
32 that the physician referred the patient for an evaluation and the person conducting the evaluation
33 has determined that the patient did not have impaired judgment;

34 (vii) A report of the outcome and determinations made during any evaluation which the

1 patient may have received;

2 (viii) The date, time, and detailed description of the physician's offer to the patient to
3 rescind the request for medication at the time of the patient's second oral request; and

4 (ix) A note by the physician indicating that all requirements under this section were
5 satisfied and describing all of the steps taken to carry out the request, including a notation of the
6 medication prescribed.

7 (15) After writing the prescription, the physician promptly filed a report with the
8 department of health documenting completion of all of the requirements under this section.

9 (b) This section shall not be construed to limit civil or criminal liability for gross
10 negligence, recklessness, or intentional misconduct.

11 **23-4.13-4. No duty to aid.**

12 A patient with a terminal condition who self-administers a lethal dose of medication shall
13 not be considered to be a person exposed to grave physical harm under § 11-56-1, and no person
14 shall be subject to civil or criminal liability solely for being present when a patient with a
15 terminal condition self-administers a lethal dose of medication pursuant to this chapter, or for not
16 acting to prevent the patient from self-administering a lethal dose of medication pursuant to this
17 chapter, or for not rendering aid to a patient who has self-administered medication pursuant to
18 this chapter.

19 **23-4.13-5. Limitations on actions.**

20 (a) A physician, nurse, pharmacist, or other person shall not be under any duty, by law or
21 contract, to participate in the provision of a lethal dose of medication to a patient.

22 (b) A health care facility or health care provider shall not subject a physician, nurse,
23 pharmacist, or other person to discipline, suspension, loss of license, loss of privileges, or other
24 penalty for actions taken in good faith reliance on the provisions of this chapter or refusals to act
25 under this chapter.

26 (c) Except as otherwise provided in this chapter herein, nothing in this chapter shall be
27 construed to limit liability for civil damages resulting from negligent conduct or intentional
28 misconduct by any person.

29 **23-4.13-6. Health care facility exception.**

30 A health care facility may prohibit a physician from writing a prescription for a dose of
31 medication intended to be lethal for a patient who is a resident in its facility and intends to use the
32 medication on the facility's premises, provided the facility has notified the physician in writing of
33 its policy with regard to the said prescriptions. Notwithstanding the provisions of § 23-4.13-5(b),
34 any physician who violates a policy established by a health care facility under this section may be

1 subject to sanctions otherwise allowable under law or contract.

2 **23-4.13-7. Insurance policies; prohibitions.**

3 (a) A person and their beneficiaries shall not be denied benefits under any life insurance
4 policy, as defined in § 27-4-0.1, for actions taken in accordance with this chapter.

5 (b) The sale, procurement, or issue of any medical malpractice insurance policy or the
6 rate charged for the policy shall not be conditioned upon or affected by whether the physician is
7 willing or unwilling to participate in the provisions of this chapter.

8 **23-4.13-8. No effect on palliative sedation.**

9 This chapter shall not limit or otherwise affect the provision, administration, or receipt of
10 palliative sedation consistent with accepted medical standards.

11 **23-4.13-9. Protection of patient choice at end-of-life.**

12 A physician with a bona fide physician-patient relationship with a patient with a terminal
13 condition shall not be considered to have engaged in unprofessional conduct under § 5-37-5.1 if:

14 (1) The physician determines that the patient is capable and does not have impaired
15 judgment; and

16 (2) The physician informs the patient of all feasible end-of-life services, including
17 palliative care, comfort care, hospice care, and pain control; and

18 (3) The physician prescribes a dose of medication that may be lethal to the patient; and

19 (4) The physician advises the patient of all foreseeable risks related to the prescription;
20 and

21 (5) The patient makes an independent decision to self-administer a lethal dose of the
22 medication.

23 **23-4.13-10. Immunity for physicians.**

24 A physician shall be immune from any civil or criminal liability or professional
25 disciplinary action for actions performed in good faith compliance with the provisions of this
26 chapter.

27 **23-4.13-11. Safe disposal of unused medications.**

28 The department of health shall adopt rules providing for the safe disposal of unused
29 medications prescribed under this chapter.

30 **23-4.13-12. Statutory construction.**

31 Nothing in this chapter shall be construed to authorize a physician or any other person to
32 end a patient's life by lethal injection, mercy killing, or active euthanasia. Action taken in
33 accordance with this chapter shall not be construed for any purpose to constitute suicide, assisted
34 suicide, mercy killing, or homicide under the law. This section shall not be construed to conflict

1 with section 1553 of the Patient Protection and Affordable Care Act, Pub.L. No. 111-148, as

2 amended by the Health Care and Education Reconciliation Act of 2010, Pub.L. No. 111-152.

3 SECTION 2. This act shall take effect upon passage.

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