REPORT TO THE 62nd LEGISLATURE FOR THE STATE OF MONTANA

LC 0041

The Montana Patient Protection Act

A bill for an Act entitled:

"An Act prohibiting aid in dying . . ."

Presented by:

Senator Greg Hinkle
SD 7
Address:
5 Gable Road
Thompson Falls, MT 59873-8512
(406) 827-4645
ghinklesd7@gmail.com

As of November 5, 2010

Prepared by:

Margaret Dore
Law Offices of Margaret K. Dore, P.S.

THE MONTANA PATIENT PROTECTION ACT

INDEX

I. INTRODUCTION

The Montana Patient Protection Act will prohibit "aid in dying" (assisted suicide, mercy killing and euthanasia). The Act is based on Montana's public policies to prevent elder abuse and to value all of its citizens.

The Act is a response to the Montana Supreme Court case, *Baxter v. State*.[1] In *Baxter*, the Court gave doctors a potential defense to prosecution for assisting a patient's suicide, but did not legalize the practice by giving them immunity from civil and criminal liability. When making this ruling, the Court overlooked elder abuse and other significant problems with assisted suicide.

Suicide proponents will apparently be submitting a counter bill in an attempt to legalize the practice, which *Baxter* termed "aid in dying."[2]

II. DISCUSSION

A. "Aid in Dying"

The term, "aid in dying," means both euthanasia and assisted

---

[1] *Baxter v. State* 354 Mont. 234, 224 P.3d 1211 (2009). (Excerpts attached in the appendix at A-1, A-8 & A-10).

[2] Representative Dick Barrett, Press Release, July 8, 2010 (stating that his bill will "implement" *Baxter*, but also stating that his bill will provide protection from civil liability, a subject not even addressed by *Baxter*). (Excerpt attached at A-2).

suicide.[3] Euthanasia is also known as "mercy killing."[4] In *Baxter*, the Court described "aid in dying" in terms of a doctor's providing a lethal dose to a patient for the purpose of causing the patient's death, but not directly participating in that death.[5] The Court was describing physician-assisted suicide. The American Medical Association's Code of Medical Ethics states:

> 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).[6]

B. *Baxter* Overlooked Elder Abuse

Baxter's specific holding is that a patient's consent to physician-assisted suicide is a defense to a "charge of homicide

---

[3] *See e.g.*, Craig A. Brandt *et. al.*, Model Aid-in-Dying Act, 75 IOWA L. REV. 125 (1989), available at http://www.uiowa.edu/~sfklaw/euthan.html (notice the letters "euthan" in the link). In the model act, "aid-in-dying" is defined in § 1-102(3) as euthanasia, *i.e.*, "the withdrawal or withholding or other abatement of life-sustaining treatment or the administration of a qualified drug *for the purpose of inducing death.*" (Emphasis added). (Excerpts attached at A-3 through A-5). *See also* video transcript of Barbara Wagner, http://www.katu.com/news/26119539.html?video=YHI&t=a (last visited Nov. 4, 2010) ("'physician aid in dying' [is] better known as assisted suicide"). (Attached at A-6).

[4] http://medical-dictionary.thefreedictionary.com/mercy+killing (defining "mercy killing" as euthanasia). (Attached at A-7).

[5] *See Baxter*, 354 Mont. at 251, ¶ 49 ("In physician aid in dying, the patient-not the physician-commits the final death-causing act by self-administering a lethal dose of medicine"). (Attached at A-8).

[6] A.M.A. Code of Medical Ethics, Opinion 2.211, *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml (last visited Nov. 4, 2010)(Attached at A-9).

against the aiding physician."[7] This holding is based on *Baxter's* determination that assisted suicide is not against public policy.[8] *Baxter*, however, overlooked elder abuse. *Baxter* states that the only person "who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication."[9] *Baxter* thereby overlooked criminal behavior by family members and others who benefit from a patient's death, for example, due to an inheritance.

C. Most States and Canada Have Rejected Assisted Suicide

The majority of states to consider legalizing assisted suicide have rejected it.[10] In 2010, New Hampshire and Canada rejected it by wide margins.[11]

---

[7] *Baxter*, 354 Mont. at 251, ¶ 50, states: "We . . . hold that under § 45-2-211, MCA, "a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply." (Attached at A-8).

[8] *Baxter*, 354 Mont. at 250, ¶ 49. (Attached at A-8).

[9] *Baxter*, 354 Mont. at 239, ¶ 11. (Attached at A-10).

[10] Int'l Task Force, *Attempts to Attempts to Legalize Euthanasia/Assisted Suicide in the United States*, available at http://www.internationaltaskforce.org/pdf/200906_attempts_to_legalize_assisted_suicide.pdf (last visited October 22, 2010)("Between January 1994 and June 2009, there were 113 legislative proposals in 24 states. All were either defeated, tabled for the session, or languished with no action taken.")(Attached at A-11).

[11] On January 13, 2010, the New Hampshire House of Representatives defeated an Oregon style assisted suicide act, 242 to 113. *See* New Hampshire House Record, No. 9, January 13, 2010 regarding HB 304, at http://www.gencourt.state.nh.us/house/caljourns/journals/2010/houjou2010_09.html (last visited Nov. 4 2010). (Attached at A-12). On April 21, 2010, the Canadian Parliament defeated a bill that would have legalized assisted suicide, 228 to 59. *See* Canadian government website at http://bit.ly/Official_Report_C-384 (last visited October 22, 2010) and *How'd They Vote: Bill C-384*, available at http://howdtheyvote.ca/bill.php?id=2053

There are just two states where assisted suicide is legal: Oregon and Washington. These states have statutes that give doctors and others immunity from criminal and civil liability arising out of a patient's suicide.[12] *Baxter*, by contrast, is limited to giving doctors, and only doctors, a potential defense to criminal prosecution.[13] *Baxter* gives no protection against civil liability.[14]

In Montana, proponents have indicated that their legalization bill will be modeled on the Oregon and Washington acts.[15] As discussed below, these acts are a recipe for abuse in which: patient choice is not assured; words do not mean what they appear to say; and euthanasia is not prohibited.

(last visited Nov. 4, 2010). (Attached at A-13).

[12] *See* OR. REV. STAT. § 127.885 § 401 and WASH. REV.CODE ANN. § 70.245.190 (providing doctors and others with civil and criminal immunity). (Excerpts attached at A-14 & A-15).

[13] *See Baxter* in its entirety and Greg Jackson & Matt Bowman, *Analysis of Implications of the Baxter Case on Potential Criminal Liability* (April 2010), available at http://www.montanafamily.org/portfolio/pdfs/Baxter_Decision_Analysis_v2.pdf (last visited October 22, 2010). (Excerpt attached at A-16).

[14] In Montana, legal actions imposing civil liability for a suicide are allowed in two circumstances: (1) causing another to commit suicide; and (2) in a custodial situation where suicide is foreseeable, typically involving a hospital or prison. *Krieg v. Massey*, 239 Mont. 469, 471-3, 781 P.2d 277 (1989). (Excerpts attached at A-17 & A-18). *See also Edwards v. Tardif*, 692 A.2d 1266, 1267 (CT. 1997)(affirming $504,750.07 judgment against doctor and other defendants where doctor proximately caused a patient's suicide by prescribing a large dose of antidepressants). (Excerpt attached at A-19).

[15] Representative Dick Barrett, press and web materials.

D. The Oregon and Washington Acts

1. "Choice" is not assured

The Oregon and Washington acts both have significant gaps so that patient choice is not assured. For example, neither act requires witnesses at the death.[16] Without disinterested witnesses, the opportunity is created for someone to administer the lethal dose to the patient without his consent. Even if he struggled, who would know?

Oregon and Washington are also "Don't Ask, Don't Tell" states. Required official forms and reports do not ask about or report on whether the patient consented at the time of death.[17] Consent at the time of death is also not required by the language of the acts themselves.[18] Contrary to marketing rhetoric, patient "choice" is not assured.

2. "Self-administer"

The Washington act states that patients "self-administer"

---

[16] *See* both acts in their entirety at OR. REV. STAT. § 127.800-.995 (2005) and WASH. REV.CODE ANN. § 70.245.010-904 (2009), available for viewing at http://www.oregon.gov/DHS/ph//pas/ors.shtml and http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245

[17] *Id.* See also ALL official forms and reports for both acts, which can be viewed at http://www.oregon.gov/DHS/ph/pas/index.shtml/shtml and http://www.doh.wa.gov/dwda/ Two of these forms are attached hereto at A-38 and A-43.

[18] Both acts contain provisions requiring that a determination of whether a patient is acting "voluntarily" be made in conjunction with the lethal dose request, not later. *See* Margaret Dore, *"Death with Dignity": A Recipe for Elder Abuse and Homicide (Albeit not by Name)*, 11 Marquette Elder's Advisor 387, 390, at footnote 20 (2010), *available at* http://www.margaretdore.com/pdf/Dore-Elder-Abuse_001.pdf (Entire article attached at A-20 to A-34).

the lethal dose.[19] This does not mean that the patient will necessarily administer the dose to himself. This is because the term, "self-administer," is defined as the patient's "act of ingesting." The Washington act states: "'*Self-administer' means a qualified patient's act of ingesting* medication to end his or her life . . ." (Emphasis added).[20]

In other words, someone else putting the lethal dose in the patient's mouth qualifies as proper administration because the patient will thereby "ingest" the dose.[21] Someone else putting the lethal dose in a feeding tube or IV nutrition bag will also qualify because the patient will thereby "absorb" the dose, i.e., "ingest" it.[22]

Oregon's act does not use the term "self-administer."[23] The act does, however, refer to administration as the "act of

---

[19] *See* WASH. REV. CODE ANN. §§ 70.245.010(7)(11)(12), 70.245.020(1), 70.245.090, 70.245.170 and 70.245.220.

[20] WASH. REV. CODE ANN. § 70.245.010(12). (Attached at A-35).

[21] Neither Act defines "ingest." *See* Washington and Oregon Acts in their entirety, at WASH. REV. CODE ANN. §§ 70.245.010-904 and OR. REV. STAT. §§127.800-995. Dictionary definitions of "ingest" include "*to take* (food, drugs, etc.*) into the body, as by swallowing*, inhaling, *or absorbing*." (Emphasis added). Webster's New World College Dictionary, www.yourdictionary.com/ingest (last visited Nov. 4, 2010). (Attached at A-36).

[22] *See* Webster's New World College Dictionary, defining "ingest" at note 21.

[23] *See* Oregon's act in its entirety, at OR. REV. STAT. §§ 127.800-995, available at http://www.oregon.gov/DHS/ph//pas/ors.shtml

ingesting."[24] Official forms for both acts also refer to administration as "ingestion," "ingesting" and other forms of the word "ingest."[25] With administration defined as mere ingestion, someone else is allowed to administer the lethal dose to the patient.

3. Euthanasia

The Oregon and Washington acts state that they prohibit "euthanasia," which is another name for mercy killing.[26] This prohibition is, however, defined away in the next sentence. For example, the Washington act states:

> Nothing in this chapter authorizes . . . mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute . . . mercy killing [also known as "euthanasia"] . . . ."[27]

---

[24] *See* OR. REV. STAT. § 127.875 § 3.13 (stating "[n]either shall a qualified patient's *act of ingesting* medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy." (Emphasis added)). (Attached at A-37).

[25] *See e.g.* Washington's "Attending Physician's After Death Reporting" form, http://www.doh.wa.gov/dwda/forms/AfterDeathReportingForm.pdf (referring to administration of the lethal dose as "ingestion," "ingesting" and other forms of the word "ingest")(last visited Nov. 4, 2010)(Attached at A-38 to A-42). *See also* "Oregon's Death With Dignity Act Attending Physician Interview" form, http://www.Oregon.gov/DHS/ph/pas/docs/mdintdat.pdf (referring to administration of the lethal dose as "ingestion," "ingesting" and other forms of the word "ingest"). (Last visited November 4, 2010) (Attached at A-43 to A-48).

[26] *See e.g.*, Washington's act, which states: "Nothing in this chapter authorizes . . . mercy killing, or active euthanasia." WASH. REV. CODE ANN. §§ 70.245.180(1). (Attached at A-49). *See also* http://medical-dictionary.thefreedictionary.com/mercy+killing (defining "mercy killing" as euthanasia). (Attached at A-7).

[27] WASH. REV. CODE ANN. §§ 70.245.180(1). (Attached at A-49).

Similarly, the Oregon act states:

> Nothing in [this act] shall be construed to authorize . . . mercy killing or active euthanasia. Actions taken in accordance with [this act] shall not, for any purpose, constitute . . . mercy killing [also known as "euthanasia"] . . . .[28]

E. A Bipartisan Vote Defeats Assisted Suicide

In 2010, a bill modeled on Oregon's act was defeated in the New Hampshire House of Representatives, 242 to 113.[29] New Hampshire Representative Nancy Elliott states:

> [M]any legislators who initially thought that they were for the act became uncomfortable when they studied it further.[30]

In New Hampshire, the House of Representatives is controlled by the Democratic Party.[31] The vote to defeat assisted suicide was bipartisan.[32]

---

[28] OR. REV. STAT. § 127.875 § 3.14. (Attached at A-50).

[29] New Hampshire House Record, regarding HB 304, at note 11 ("This bill is modeled on the Oregon death with dignity law"). (Attached at A-12).

[30] Nancy Elliott, Letter to the Editor, *Right to Die is Prescription for Abuse*, Hartford Courant, May 28, 2010, *available at* http://articles.courant.com/2010-05-28/news/hc-elliott-letter-suicide-0528-20100528_1_new-hampshire-abuse-prescription (last visited Nov. 4, 2010) (Attached at A-52).

[31] *See* New Hampshire website, available at http://www.gencourt.state.nh.us/house/abouthouse/leadership.htm ("Democrat Mary Jane Wallner . . . serves as Majority Leader")(last visited Nov. 4, 2010). (Attached at A-53).

[32] *See* E-mail from New Hampshire General Court Staff with vote breakdown by party; a "yea" vote is a vote to defeat the bill: 242 yeas (100 Democrats; 142 Republicans); 113 nays (93 Democrats; 20 Republicans). (Attached at A-54).

F. Legalization will Create New Paths of Abuse

In Montana, there has been a rapid growth of elder abuse.[33] Nationwide, elder financial abuse is a crime "growing in intensity" with perpetrators often family members, but also strangers and new "best friends."[34] Victims are even murdered for their funds.[35]

Abuse of the elderly is often difficult to detect. This is largely due to the unwillingness of victims to report. A recent article on KULR8.com, states: "often time the victimizer is a family member and the elderly victim doesn't want to get them into trouble."[36]

---

[33] *See* Great Falls Tribune, *Forum will focus on the rapid growth in abuse of elders*, June 10 2009 ("The statistics are frightening, and unless human nature takes a turn for the better, they're almost certain to get worse"). (Attached at A-55). *See also* Nicole Grigg, *Elder Abuse Prevention*, Kulr8.com, June 15, 2010, http://www.kulr8.com/internal?st=print&id=96428934&path=/news/local (last visited October 22, 2010)(attached at A-56); Big Sky Prevention of Elder Abuse Program, What is Elder Abuse, http://www.mtelderabuseprevention.org/whatis.html (last visited October 22, 2010). (Attached at A-57 to A-59).

[34] *See* MetLife Mature Market Institute, "Broken Trust: Elders, Family and Finances, A Study on Elder Abuse Prevention," March 2009, available at http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf (last visited October 22, 2010) (excerpts attached at A-60 to A-68); Miriam Hernandez, "'Black Widows' in court for homeless murders," March 18, 2008, ABC Local, http://abclocal.go.com/kabc/story?section=news/local&id=6027370 (last visited October 2, 2010)(elderly homeless men killed as part of an insurance scam)(attached at A-69); and *People v. Rutterschmidt*, 98 Cal.Rptr.3rd 390 (2009), review granted; issues limited, 102 Cal.Rptr.3d (2009) (regarding this same case).

[35] *See*: MetLife at note 34, at 24; and *People v. Stuart*, 67 Cal. Rptr. 3d 129, 143 (where daughter killed her mother with a pillow, "financial considerations [are] an all too common motivation for killing someone . . .").

[36] Nicole Grigg, at note 33. *See also* Met Life, supra at note 34.

In Montana, preventing elder abuse is official state policy.[37] If assisted suicide would to be legalized, new paths of abuse would be created against the elderly, which is contrary to that policy. Representative Elliott states:

> These acts empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money. There is no assisted suicide bill that you can write to correct this huge problem.[38]

G. "Terminally Ill" Patients Are Not Necessarily Dying

The *Baxter* decision applies to "terminally ill" patients, which is not defined.[39] The Oregon and Washington assisted suicide acts apply to patients with a "terminal disease," which is defined as having less than six months to live.[40] Such patients are not, however, necessarily dying. Doctor prognoses can be wrong.[41] Moreover, treatment can lead to recovery.

---

[37] *See* the "Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act," 52-3-801, MCA; the Protective Services Act for Aged Persons or Disabled Adults, 52-3-201, MCA; and the "Montana Older Americans Act," 52-3-501, et. al., MCA.

[38] Nancy Elliott, *Prescription for Abuse*, at note 30. (Attached at A-52). *See also* Dore, Recipe for Abuse, supra at note 18. (Attached at A-20 to A-34).

[39] *See Baxter*, 354 Mont. at 251, ¶50, and *Baxter* generally.

[40] OR. REV. STAT 127.800 §.1.01(12); WASH. REV. CODE ANN. § 70.245.010(13).

[41] *See* Alison Dayani, *Birmingham man wrongly told he has six [months] to live with terminal cancer*, Birmingham Mail, October 12, 2010 (attached at A-70); and Nina Shapiro, Nina, *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?*, Seattle Weekly, January 14, 2009, *available at* www.seattleweekly.com/2009-01-14/news/terminal-uncertainty

Oregon resident, Jeanette Hall, who was diagnosed with cancer and told that she had six months to a year to live, states:

> I wanted to do our law and I wanted my doctor to help me. Instead, he encouraged me to not give up . . . I had both chemotherapy and radiation. . . .
>
> It is now nearly 10 years later. If my doctor had believed in assisted suicide, I would be dead."[42]

H. Compassion & Choices Wants Assisted Suicide for People Who Are Not Dying

In Montana, the main proponent of assisted suicide is Compassion & Choices, a successor organization to the Hemlock Society.[43] In the *Baxter* litigation, Compassion & Choices proposed a definition of "terminally ill adult patient," as follows: "[An adult] who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time."[44]

Under this definition, young people with chronic conditions such as diabetes or HIV/AIDS, who could "live for decades," are

---

[42] Jeanette Hall, Letter to the Editor, *Second life*, Missoula Independent, June 17, 2010. Author Margaret Dore confirmed accuracy with both Ms. Hall and her doctor. (Attached at A-71).

[43] IAN DOWBIGGIN, A CONCISE HISTORY OF EUTHANASIA 146 (2007)(In 2003, Hemlock changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices). (Attached at A-72).

[44] Compassion & Choices' definition of "terminally ill adult patient" was contained in its answer to a discovery request. *See* Plaintiffs' Responses to State of Montana's First Interrogatories, *Baxter v. Montana*, No 2007-787 (Attached at A-73 & A-74).

classified as "terminally ill."[45] Doctor Richard Wonderly and attorney Theresa Schrempp state:

> [T]his definition is broad enough to include an 18 year old who is insulin dependent or dependent on kidney dialysis, or a young adult with stable HIV/AIDS. Each of these patients could live for decades with appropriate medical treatment. Yet, they are "terminally ill" according to the definition promoted by [Compassion & Choices].[46]

I. Compassion & Choices' True Agenda

Once a patient is labeled "terminal," the argument can be made that his or her treatment should be denied in favor of someone more deserving.[47] This has happened in Oregon where patients labeled "terminal" have not only been denied treatment, they have been offered coverage for assisted suicide instead.[48] The most well-known case involves Barbara Wagner.[49] The Oregon Health Plan refused to pay for a drug to possibly prolong her life and offered to pay for her suicide instead.[50] Wagner did

---

[45] Opinion Letter from Richard Wonderly, MD & Theresa Schrempp, Esq., dated October 22, 2009, available at http://www.euthanasiaprevention.on.ca/ConnMemo02.pdf (Attached at A-75).

[46] Id.

[47] Id.

[48] Id.; video transcript, at note 3. (Attached at A-6).

[49] Id.; Kenneth Stevens, MD, Letter to the Editor, *Oregon doctor responds to recent letter on patient choices*, Montana Standard, July 29, 2010, available at http://www.mtstandard.com/news/opinion/mailbag/article_f50c9694-9a98-11df-9be4-001cc4c002e0.html (Last visited August 15, 2010). (Attached at A-76).

[50] Video transcript, supra at note 3.

not see this as a celebration of her "choice." She said: "I'm not ready, I'm not ready to die."[51]

After Wagner's death, Compassion & Choices's president, Barbara Coombs Lee, published an editorial in *The Oregonian* arguing against Wagner's choice to try and beat her cancer.[52] Coombs Lee also defended the Oregon Health Plan and argued for a public policy change to discourage people from seeking cures.[53] Perhaps not a coincidence, Coombs Lee is a former "managed care executive."[54]

Coombs Lee's editorial, combined with Compassion & Choices' definition of "terminally ill adult patient," provide a glimpse into their true agenda: It's not the promotion of personal choice.[55] Indeed, the opposite would appear to be true.[56]

---

[51] Id.

[52] Barbara Coombs Lee, *Sensationalizing a sad case cheats the public of sound debate*, The Oregonian, November 29, 2008, *available at* http://www.oregonlive.com/opinion/index.ssf/2008/11/sensationalizing_a_sad_case_ch.html (Last visited February 16, 2009). (Attached at A-77 to A-79).

[53] *Id.* She stated: "The burning health policy question is whether we inadvertently encourage patients to act against their own self interest, chase an unattainable dream of cure and foreclose the path of acceptance that curative care has been exhausted . . . Such encouragement serves neither the patients, families, nor the public." (Attached at A-78).

[54] Barbara Coombs Lee, bio, available at http://www.huffingtonpost.com/barbara-coombs-lee// (Last visited October 22, 2010). (Attached at A-80).

[55] Compare: Ian Dowbiggen, at note 43, page 83, regarding Charles Potter of the former Euthanasia Society of America:

> Despite his repeated invocations of individual freedom as a political goal, Potter, a supporter of involuntary eugenics and euthanasia, was no defender of laissez-faire personal choice. . . . If human beings were to be freed from long-standing moral and

J. Steering Patients to Kill Themselves is Contrary to Montana Public Policy

According to a recent report from the Oregon Health Authority, Oregon's suicide rate, which excludes suicide under Oregon's assisted suicide act, is 35% higher than the national average.[57] This rate has been "increasing significantly since 2000."[58] Just three years prior, Oregon legalized assisted suicide.[59] There is at least a statistical correlation between these two events.

Regardless, how can Oregon credibly tell its citizens that suicide is not the answer when it also tells them that suicide is "death with dignity?"

Montana already has one of the highest suicide rates in the

> ethical beliefs, it was to enable them to make the right choices, not any choice whatsoever. Choice did not mean freedom to do what individuals pleased, but empowerment to do what a scientifically grounded humanism taught them to do. (Attached at A-81).

[56] Id.

[57] Oregon Health Authority, News Release, *Rising suicide rate in Oregon reaches higher than national average*, September 9, 2010, available at http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf (Last visited October 13, 2010). (Attached at A-82). An assisted suicide under Oregon's assisted suicide law is not tallied as a "suicide." *See* OR. REV. STAT. 127.880 § 3.14 ("Actions taken in accordance with ORS 127.800 to 127.897 [the Oregon Death With Dignity Act] shall not, for any purpose, constitute suicide . . . under the law"). (Attached at A-50).

[58] Oregon Health Authority, *Rising suicide rate*, at note 57.

[59] *See* 2009 Annual Report, Oregon's Death with Dignity Act, http://www.oregon.gov/DHS/ph/pas/docs/year11.pdf (Last visited October 14, 2010). (Attached at A-83).

"of all ages."[61] Steering citizens to kill themselves is contrary to this policy.

K. Montana Values All of its Citizens

Montana values all of its citizens, including those who are older or who may have chronic conditions or other disabilities.[62]

III. CONCLUSION

The majority of states to consider assisted suicide have rejected it; only two states allow it. In 2010, the New Hampshire House of Representatives rejected it in a bipartisan vote, 242 to 113. Montana should now follow New Hampshire's lead to reject assisted suicide.

Respectfully submitted this day of Nov. 2010

/s/ see signature next page
Senator Greg Hinkle

* * *

Greg Hinkle was elected to the Montana Senate in 2008. He is a former Chair of the Sanders County Planning Board and a former Sanders County Parks Commissioner. He has been married to Gail Hinkle, an RN, for 36 years. They own a business, Hinkle's

---

suicide in the United States (Kung, et al, 2008) and Montana has been in the top five for the past thirty years"). (Emphasis removed). (Attached at A-84).

[61] 53-21-1101, MCA (regarding a required suicide reduction plan, which is to address reducing suicides by Montanans "of all ages"). (Attached at A-85).

[62] *See*: "Montana Older Americans Act," 52-3-501, et. al., MCA ("The legislature finds that older Montanans constitute a valuable resource of this state"); "Rights of the Physically Disabled," 49-4-202, MCA; Protective Services Act for Aged Persons or Disabled Adults, 52-3-201, MCA; and "Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act, 52-3-801, MCA.

nation.[60] It is a state priority to reduce this rate for persons "of all ages."[61] Steering citizens to kill themselves is contrary to this policy.

K. Montana Values All of its Citizens

Montana values all of its citizens, including those who are older or who may have chronic conditions or other disabilities.[62]

III. CONCLUSION

The majority of states to consider assisted suicide have rejected it; only two states allow it. In 2010, the New Hampshire House of Representatives rejected it in a bipartisan vote, 242 to 113. Montana should now follow New Hampshire's lead to reject assisted suicide.

Respectfully submitted this 6th day of Nov. 2010

Senator Greg Hinkle

---

[60] Montana Strategic Suicide Prevention Plan, Department of Public Health and Human Services, p. 10, at http://www.dphhs.mt.gov/amdd/statesuicideplan.pdf ("For all age groups for data collected in the year 2005, Montana is ranked number one in rate of suicide in the United States (Kung, et al, 2008) and Montana has been in the top five for the past thirty years"). (Emphasis removed). (Attached at A-84).

[61] 53-21-1101, MCA (regarding a required suicide reduction plan, which is to address reducing suicides by Montanans "of all ages"). (Attached at A-85).

[62] See: "Montana Older Americans Act," 52-3-501, et. al., MCA ("The legislature finds that older Montanans constitute a valuable resource of this state"); "Rights of the Physically Disabled," 49-4-202, MCA; Protective Services Act for Aged Persons or Disabled Adults, 52-3-201, MCA; and "Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act, 52-3-801, MCA.

* * *

Greg Hinkle was elected to the Montana Senate in 2008. He is a former Chair of the Sanders County Planning Board and a former Sanders County Parks Commissioner. He has been married to Gail Hinkle, an RN, for 36 years. They own a business, Hinkle's Hardwood Furniture & Home Inspection. They also run a small "all natural" or "organic" ranch raising cattle, sheep and produce for their own consumption. Senator Hinkle served as a Postmaster from 1989 to 1991. He was awarded each year for managing his office under budget. After attending junior college, Senator Hinkle apprenticed in a four year program to become a Journeyman Machinist.

Margaret Dore is an elder law/appellate attorney in Washington state, where assisted suicide is legal. She has been licensed to practice law since 1986. She is a former Law Clerk to the Washington State Supreme Court for then Chief Justice Vernon Pearson. She is a former Law Clerk to the Washington State Court of Appeals to Judge John A. Petrich. She is a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. She is admitted to practice in the United States Supreme Court, the Ninth Circuit Court of Appeals, the United States District Court of Western Washington and the State of Washington. Her publications include: "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, available at http://www.margaretdore.com/pdf/Not_Legal_in_Idaho.pdf. For more information, see www.margaretdore.com

APPENDIX

224 P.3d 1211
354 Mont. 234, 224 P.3d 1211, 2009 MT 449
(Cite as: 354 Mont. 234, 224 P.3d 1211)

H

Supreme Court of Montana.
Robert **BAXTER**, Stephen Speckart, M.D., C. Paul Loehnen, M.D., Lar Autio, M.D., George Risi, Jr., M.D., and Compassion & Choices, Plaintiffs and Appellees,
v.
STATE of Montana and Steve Bullock, Defendants and Appellants.
No. DA 09-0051.

Argued Sept. 2, 2009.
Submitted Sept. 3, 2009.
Decided Dec. 31, 2009.
Rehearing Denied March 3, 2010.

Background: Terminally ill patient and physicians brought action challenging constitutionality of the application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients. The First Judicial District Court, Lewis and Clark County, Dorothy McCarter, Presiding Judge, 2008 WL 6627324, granted patient and physicians summary judgment, finding that patient could use the assistance of physician to obtain a prescription for a lethal dose of medication, and awarded patient attorney fees. State appealed.

Holdings: The Supreme Court, Leaphart, J., held that:
(1) physician aid in dying provided to terminally ill, mentally competent adult patient, was not against public policy for purposes of exception to consent defense, and
(2) patient was not entitled to award of attorney fees.

Affirmed in part, reversed in part, and vacated in part.

Warner, J., concurred and filed opinion.

Nelson, J., specially concurred and filed opinion.

Rice, J., dissented and filed opinion joined by Joe L. Hegel, District Judge sitting in place of Chief Justice.

West Headnotes

[1] Appeal and Error 30 ⚿863

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in General
30k862 Extent of Review Dependent on Nature of Decision Appealed from
30k863 k. In general. Most Cited Cases
Where there is a cross-motion for summary judgment, Supreme Court reviews a district court's decision to determine whether its conclusions were correct. Rules Civ.Proc., Rule 56.

[2] Appeal and Error 30 ⚿984(5)

30 Appeal and Error
30XVI Review
30XVI(H) Discretion of Lower Court
30k984 Costs and Allowances
30k984(5) k. Attorney fees. Most Cited Cases
Supreme Court reviews an award of attorney fees for abuse of discretion.

[3] Constitutional Law 92 ⚿975

92 Constitutional Law
92VI Enforcement of Constitutional Provisions
92VI(C) Determination of Constitutional Questions
92VI(C)2 Necessity of Determination
92k975 k. In general. Most Cited Cases

The Big Sky Country

MONTANA HOUSE OF REPRESENTATIVES

REPRESENTATIVE DICK BARRETT
HOUSE DISTRICT 93

HELENA ADDRESS:
CAPITOL BUILDING
PO BOX 200400
HELENA, MONTANA 59620-0400
PHONE: (406) 444-4800

HOME ADDRESS:
219 AGNES AVE.
MISSOULA, MONTANA 59801
PHONE: (406) 396-3256

COMMITTEES:
TAXATION
TRANSPORTATION
FISH, WILDLIFE AND PARKS

Press Release
Date July 8, 2010

Representative Dick Barrett of Missoula has asked the Montana Legislative Services Division to draft a bill to implement the Supreme Court's ruling in the Baxter case late last year allowing physicians to provide aid in dying when requested by terminally ill patients.

In its ruling, the Court found that there is no public policy opposing physician assistance in dying for the terminally ill, and argued that such a policy would be "incongruous" with existing Montana policies regarding other rights of the terminally ill.

"I believe that the Supreme Court ruled correctly in this case," Barrett says. "In Montana we respect the right of individuals, in consultation with their physicians, to make decisions, such as refusing treatment, that will hasten their deaths. A majority of Montanans believe that we should also respect the right of terminally ill patients to avoid unnecessary suffering and to choose for themselves the time and circumstances of their deaths by taking medications provided by a doctor."

Although they strongly support physician assistance in dying, Montanans are also concerned that some vulnerable individuals may be unduly influenced to request such assistance by family members or caregivers. "The evidence from Oregon, where physician assistance in dying has been available for many years, is that that concern is unfounded," Barrett says. " But Oregon provides a number of safeguards to make sure that only willing patients request aid in dying, and one of the major purposes of the bill I have asked to have drafted will be to provide similar safeguards here, that meet the particular needs of Montana patients and doctors."

A second purpose of the bill will be to provide protection from civil liability or professional sanctions to physicians who wish to honor patients requests under the standards of practice called for in the bill. "It's important to note too that the bill will

Purpose of bill is to legalize assisted suicide, for example, by providing immunity from civil liability, an issue not addressed by Baxter.

Model Act

MODEL AID-IN-DYING ACT

(Drafted by Students at the Iowa Law School

75 Iowa Law Review 125 (1989)

Reporters:

Craig A. Brandt, Patricia J. Cone, Angele L. Fontana, Rachelle M. Hayes, Jody M. Hehr, Janet L. Hoffman, Rebecca Johnson, Janet M. Lyness, Linda J. Messer, Jane E. Robinette, Joyce Shireman, Michael Shubatt, Cheryl K. Smith, Stanley B. Steines, Natalie Spencer and Laura Wilbert

Consultants:

Phillip J. Leonard

Jackie Shane

FOREWORD

This Model Aid-in-Dying Act is the product of an intense year-long seminar addressing the substantive topic of aid-in-dying and the process of researching, debating, negotiating, and drafting legislation. The topic was selected from among a number of possibilities under the more general heading of law and technology. The larger theme is that technological advances accelerate social change. They present society and the law with new and often unanticipated dilemmas. The courts generally are the first to deal with the dilemmas technology creates; however, in this age of statutes, legislatures eventually will, and must, confront the problems technology engenders. Legislatures will have the opportunity to provide a more comprehensive solution to the problems technology has caused than courts are able to provide because courts by their nature are capable of dealing with difficult issues only on a case-by-case basis.

Modern medical technology provides a compelling example of this sort of social and legal challenge. Without providing a cure or any reasonable hope of a cure, and sometimes without providing a tolerable death, technology can sustain biological life, sometimes for many years. Almost everyone knows of someone who has died or is dying a slow or excruciating death or who is kept alive only by artificial means. Current conservative estimates indicate that about 10,000 Americans are in persistent vegetative states. They are condemned to live in comas perhaps for decades with no realistic possibility of recovery.

Although euthanasia [FN1] has been a subject of intense interest for centuries, it did not become a prominent

focus of professional and scholarly discussion until the 1950s. The first court opinions and the beginnings of legislation related to aid-in-dying occurred only in the mid-1970s. The magnitude of societal and legal concerns regarding euthanasia parallels the advances in medical technology that compel those concerns. Although one might wish that the law, or at least legal scholars, would anticipate such events just over the horizon, it appears that the technology always arrives before legal policy makers start thinking seriously about how to control it or respond to the problems it creates.

The ability to sustain life has made the process of dying a focus of increasing concern. It has brought the advent of hospices, books and courses on death and dying, the growth of organizations to support and encourage reform movements, living wills and durable powers of attorney, and various other efforts to regain control of dying from the medical profession and its new technology. It also has brought innumerable cases before the courts of this county, often requiring judges to act as Solomon to determine whether and how a patient should live or die.

All technologically advanced societies, and only technologically advanced societies, have seen this growth of concern surrounding the dying process. Advanced technology has created the dilemma of when to extend life and when to end it. These choices were absent in earlier and less advanced societies when even a pinprick could be life-threatening and pneumonia was likely to be fatal.

This Model Act represents the efforts of seventeen committed law and graduate students who enrolled in a University of Iowa Law School seminar to wrestle with issues integrating technology and its effect on the extension of life and upon death. The seminar's goals were to grapple with the issues as broadly as possible, debate and vote upon alternative social policies and legislative solutions, and draft a detailed and comprehensive statutory scheme governing aid-in-dying.

In a sense, this Model Act really began when students registered for the seminar in the spring of 1988. Students with wide-ranging undergraduate majors, life experiences, backgrounds, and attitudes toward the topic of euthanasia enrolled in the seminar. [FN2] Students were assigned summer readings, and presumably summer thinking: a book on "the right to die," a book on writing style, and a style manual for drafting model legislation. To our surprise, most (but not all) of the anti-aid-in-dying attitudes had faded by an early stage in the autumn debates.

At the start of the fall semester, the class defined a range of topics and issues relating to euthanasia. Students were assigned to research and become experts on various topics and to provide research memoranda to the class. [FN3] Once the research memoranda were completed, the class debated a series of policy issues and by majority vote adopted policy positions to be reflected in their Model Act. [FN4] Thereafter, the basic outline of the Model Act was drawn, and drafting assignments were made. Individuals or small groups of students drafted their respective sections with preliminary comments, and then the class, acting as a drafting committee of the whole, edited and often wholly rewrote the drafts of statutory language. For editing purposes, the statutory language was projected from a computer onto a large screen, permitting group participation in the editing process. The actual drafting, of course, made evident further policy issues and refinements that the class needed to debate and decide.

After the text of the Model Act largely was completed, the class reviewed and debated the concepts, justifications, and explanations to be developed in the comments, and completed the drafting of the comments. Then, class members were assigned to edit comments originally drafted by other class members.

Once a fairly complete draft was in hand, the class sent copies to a wide range of people and groups we thought might be interested and scheduled public hearings. Individuals and representatives of groups from many sides of the euthanasia debate and from around the United States and Canada attended these hearings. Their thoughtful comments, as well as the many other written comments received in the mail, contributed immeasurably to the

The [Act] intentionally is limited in scope. It is not intended to suggest who, if anyone, should receive aid-in-dying. It is hoped that, consistent with current practice, aid-in-dying will be sought only in extreme circumstances. It is not anticipated that receiving aid-in-dying will become the norm or expectation for any particular group in society. The [Act] in no way seeks to discourage any persons from obtaining any medical treatment that they wish to undergo in order to live as long a life as possible. It does not intend to suggest that a person's life is less worthwhile or desirable because of a physical condition or because a person is in the final stages of life. Rather, the [Act] provides a principled mechanism that, in appropriate circumstances, may be used to aid the patient who wishes assistance in the process of dying.

ARTICLE 1

GENERAL PROVISIONS

§ 1-101 SHORT TITLE

This [Act] may be cited as the Aid-in-Dying Act.

§ 1-102 DEFINITIONS

The following words and phrases, whenever used in this [Act], shall have the following meanings, unless the context otherwise requires:

(1) "Activities of daily living" means bathing, dressing, feeding, oral care, skin care, other personal hygiene, toileting, and transfer.

(2) "Adult" is either an emancipated minor or a person [18] years of age or older.

(3) "Aid-in-dying" means the withdrawal or withholding or other abatement of life-sustaining treatment or the administration of a qualified drug for the purpose of inducing death. Euthanasia

(4) "Competence" or "competent" means the ability of a person to make informed health care decisions.

(5) "Conscientious objector" means a person who is opposed to aid-in-dying for any reason.

(6) "Counseling" means a discussion between a counselor and a person demanding or requesting aid-in-dying conducted pursuant to the regulations adopted by the [Department of Health] for the purpose of:

(i) explaining the patient's prognosis;

(ii) assisting the person's understanding of the patient's prognosis;

(iii) ensuring that the person understands that the probable or assured result of providing aid-in-dying to the patient will be the patient's death; and

(iv) exploring with the person the motivations underlying a decision to demand or request aid-in-dying.

(7) "Counselor" is a person who has been trained pursuant to regulations adopted by the [Department of Health] for the purpose of counseling a person demanding aid-in-dying, or demanding or requesting aid-in-dying on behalf of another.

KATU.com - Portland, Oregon
Print this article

Letter noting assisted suicide raises questions

Originally printed at http://www.katu.com/news/26119539.html

By Susan Harding and KATU Web Staff July 30, 2008

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

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

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

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

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

An unfortunate interpretation?

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

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

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

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

mercy killing

Also found in: Dictionary/thesaurus, Legal, Acronyms, Encyclopedia, Wikipedia, Hutchinson

0.01 sec.

mer·cy killing (mûr'sē)
n.
Euthanasia.

mercy killing.
See **euthanasia**, def 1.

mercy killing
the euthanasia of animals for humane reasons is regarded by the veterinary profession as one of its responsibilities to the animal population. When the animal is in a great deal of pain and there is no chance of a favorable outcome, it is thought that the veterinarian is required to carry out euthanasia. In most Western countries this is enshrined in legislation relating to the protection of animals against cruelty. In awkward situations, e.g. when the owner resists or is not available to give consent to euthanasia, it is prudent to get another veterinary opinion if that is possible.

mercy killing
Medical ethics The termination of a person's life as a humane act. See Euthanasia.

A-7

considerations support the award." *United Nat'l Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 2009 MT 269, ¶ 38, 352 Mont. 105, 118, 214 P.3d 1260, 1271. As in *United National*, the equitable considerations here do not support an award of attorney fees. Mr. Baxter is accompanied by other plaintiffs, including four physicians and Compassion & Choices, a national nonprofit organization. The relief herein granted to the Plaintiffs is not incomplete or inequitable without the Montana taxpayers having to pay the attorney fees.

¶ 49 In conclusion, we find nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy. The "against public policy" exception to ***251** consent has been interpreted by this Court as applicable to violent breaches of the public peace. Physician aid in dying does not satisfy that definition. We also find nothing in the plain language of Montana statutes indicating that physician aid in dying is against public policy. In physician aid in dying, the patient-not the physician-commits the final death-causing act by self-administering a lethal dose of medicine.

[14] ¶ 50 Furthermore, the Montana Rights of the Terminally Ill Act indicates legislative respect for a patient's autonomous right to decide if and how he will receive medical treatment at the end of his life. The Terminally Ill Act explicitly shields physicians from liability for acting in accordance with a patient's end-of-life wishes, even if the physician must actively pull the plug on a patient's ventilator or withhold treatment that will keep him alive. There is no statutory indication that lesser end-of-life physician involvement, in which the patient himself commits the final act, is against public policy. We therefore hold that under § 45-2-211, MCA, a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply.

¶ 51 The District Court's ruling on the constitutional issues is vacated, although the court's grant of summary judgment to Plaintiffs/Appellees is affirmed on the alternate statutory grounds set forth above. The award of attorney fees is reversed.

We concur: PATRICIA O. COTTER, JOHN WARNER and BRIAN MORRIS, JJ.Justice JOHN WARNER concurs.
¶ 52 I concur.

¶ 53 The Court's opinion today answers the statutory question: is it, as a matter of law, against the public policy of Montana for a physician to assist a mentally competent, terminally ill person to end their life? The answer provided is: "No, it is not, as a matter of law."

¶ 54 This Court correctly avoided the constitutional issue Baxter desires to present. No question brought before this Court is of greater delicacy than one that involves the power of the legislature to act. If it becomes indispensably necessary to the case to answer such a question, this Court must meet and decide it; but it is not the habit of the courts to decide questions of a constitutional nature unless absolutely necessary to a decision of the case. *See e.g. Ex parte Randolph*, 20 F. Cas. 242, 254 (C.C.Va.1833) (Marshall, Circuit Justice); *Burton v. United States*, 196 U.S. 283, 295, 25 S.Ct. 243, 245, 49 L.Ed. 482 (1905); *State v. Kolb*, 2009 MT 9, ¶ 13, 349 Mont. 10, 200 P.3d 504; ***252***Common Cause of Montana v. Statutory Committee to Nominate Candidates for Commr. of Political Practices*, 263 Mont. 324, 329, 868 P.2d 604, 607 (1994); *Wolfe v. State, Dept. of Labor and Industry, Board of Personnel Appeals*, 255 Mont. 336, 339, 843 P.2d 338, 340 (1992).

¶ 55 This Court has done its job and held that pursuant to § 45-2-211, MCA, a physician who assists a suicide, and who happens to be charged with a crime for doing so, may assert the defense of consent. I join the opinion, and not the thoughtful and thought provoking dissent, because the Legislature has not plainly stated that assisting a suicide is against public policy. This Court must not ****1223** add such a provision by judicial fiat. Section

Baxter

AMA
AMERICAN
MEDICAL
ASSOCIATION

Thursday, November 4 2010

Opinion 2.211 - Physician-Assisted Suicide

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

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

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

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

cause his own death. The District Court further held that the patient's right to die with dignity includes protection of the patient's physician from prosecution under the State's homicide statutes. Lastly, the District Court awarded Mr. Baxter attorney fees. The State appeals.

STANDARDS OF REVIEW

[1][2] ¶ 8 We review an order granting summary judgment de novo using the same standards applied by the District Court under M.R. Civ. P. 56. *Bud-Kal v. City of Kalispell,* 2009 MT 93, ¶ 15, 350 Mont. 25, 30, 204 P.3d 738, 743. Where there is a cross-motion for summary judgment, we review a district court's decision to determine whether its conclusions were correct. *Bud-Kal,* ¶ 15. We review an award of attorney fees for abuse of discretion. *Trs. of Ind. Univ. v. Buxbaum,* 2003 MT 97, ¶ 15, 315 Mont. 210, 216, 69 P.3d 663, 667.

DISCUSSION

¶ 9 The parties in this appeal focus their arguments on the question of whether a right to die with dignity-including physician aid in dying-exists under the privacy and dignity provisions of the Montana Constitution. The District Court held that a competent, terminally ill patient has a right to die with dignity under Article II, Sections 4 and 10 of the Montana Constitution. Sections 4 and 10 address individual ***239** dignity and the right to privacy, respectively. The District Court further held that the right to die with dignity includes protecting the patient's physician from prosecution under Montana homicide statutes. The District Court concluded that Montana homicide laws are unconstitutional as applied to a physician who aids a competent, terminally ill patient in dying.

[3] ¶ 10 While we recognize the extensive briefing by the parties and amici on the constitutional issues, this Court is guided by the judicial principle that we should decline to rule on the constitutionality of a legislative act if we are able to decide the case without reaching constitutional questions. *State v. Adkins,* 2009 MT 71, ¶ 12, 349 Mont. 444, 447, 204 P.3d 1, 5; ****1215***Sunburst Sch. Dist. No. 2 v. Texaco, Inc.,* 2007 MT 183, ¶ 62, 338 Mont. 259, 279, 165 P.3d 1079, 1093. Since both parties have recognized the possibility of a consent defense to a homicide charge under § 45-2-211(1), MCA, we focus our analysis on whether the issues presented can be resolved at the statutory, rather than the constitutional, level.

¶ 11 We start with the proposition that suicide is not a crime under Montana law. In the aid in dying situation, the only person who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication. In that the claims of the plaintiff physicians are premised in significant part upon concerns that they could be prosecuted for extending aid in dying, we deem it appropriate to analyze their possible culpability for homicide by examining whether the consent of the patient to his physician's aid in dying could constitute a statutory defense to a homicide charge against the physician.

Court overlooks criminal behavior by family members etal. e.g. due to an inheritance

¶ 12 The consent statute would shield physicians from homicide liability if, with the patients' consent, the physicians provide aid in dying to terminally ill, mentally competent adult patients. We first determine whether a statutory consent defense applies to physicians who provide aid in dying and, second, whether patient consent is rendered ineffective by § 45-2-211(2)(d), MCA, because permitting the conduct or resulting harm "is against public policy."

[4] ¶ 13 Section 45-5-102(1), MCA, states that a person commits the offense of deliberate homicide if "the person purposely or knowingly causes the death of another human being...." Section 45-2-211(1), MCA, establishes consent as a defense, stating that the "consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense." Thus, if the State prosecutes a physician for providing aid in dying to a mentally competent, terminally ill adult ***240** patient who

Baxter

Attempts to Legalize Euthanasia/Assisted Suicide in the United States

In the United States, Oregon was the first state to legalized physician-assisted suicide. At that time, assisted-suicide advocates predicted that there would be a rapid "domino effect," and other states would soon follow Oregon's lead. But they were wrong. It took fourteen years before another state legalized the practice, and, even then, only after advocates spent a whole year preparing the campaign and raising millions of dollars to insure the victory they so desperately wanted. That state was Washington, the state consultants said was demographically most like Oregon and, therefore, most likely to favor assisted suicide.

But, since Oregon legalized assisted suicide in 1994, other states have rejected assisted-suicide measures, many multiple times. Between January 1994 and June 2009, there were 113 legislative proposals in 24 states. All were either defeated, tabled for the session, or languished with no action taken.

Here is a listing, by state, of all the ballot initiatives (since 1991) and all the legislative measures (since 1994) to legalize euthanasia and/or assisted suicide in the U.S.

.....

Ballot Initiatives that Passed

Oregon - 1994
Ballot Measure 16 (Oregon Death with Dignity Act) passed on November 8, 1994, by the narrow margin of 51% to 49%. By legalizing physician-assisted suicide, the ballot measure transformed the crime of assisted suicide into a medical treatment.

Washington State - 2008
Ballot Initiative 1000 (Washington Death with Dignity Act) passed on November 4, 2008, by a vote of 58% to 42%. The Washington law is virtually identical to Oregon's assisted-suicide law.

Ballot Initiatives that Were Defeated

Washington State - 1991
Ballot Initiative 119, which would have legalized "aid-in-dying" (euthanasia and physician-assisted suicide), was defeated by a vote of 54% to 46%.

California - 1992
Proposition 161, a ballot initiative that would have legalized euthanasia and physician-assisted suicide failed by a vote of 54% to 46%.

Michigan - 1998
Measure B, which would have legalized physician-assisted suicide, was overwhelmingly rejected by a margin of 71% to 29%.

Maine - 2000
Question 1, the "Maine Death with Dignity Act," patterned after the "Oregon Death with Dignity Act" would have legalized physician-assisted suicide. It was defeated by voters 51% to 49%.

New Hampshire House Record

the ward and to the guardian. If the court does not receive a written report from counsel within 5 days of counsel's appointment, the court shall order an appropriate sanction, which may include substitution of counsel, an order to show cause, or scheduling of a hearing on the propriety of the admission without awaiting a report from counsel.

(5) Upon receipt of a request for a hearing, the court shall schedule a hearing on the admission to a state institution without prior approval of the probate court, at which the guardian shall have the burden of proving, beyond a reasonable doubt, that the placement is in the ward's best interest and is the least restrictive placement available. The hearing shall be held within 10 days, excluding days when the court is closed, from the date that the request is received.

(6) A guardian may not admit a ward to a state institution for more than 60 days for any single admission or more than 90 days in any 12-month period upon certification of a physician or psychiatrist without filing a petition requesting approval of the probate court.

(7) At any time, the ward or counsel for the ward may request a hearing on the admission to a state institution without prior approval of the probate court, at which the guardian shall have the burden of proving, beyond a reasonable doubt, that the placement is in the ward's best interest and is the least restrictive placement available. The hearing shall be held within 15 days, excluding days when the court is closed, from the date that the hearing is requested.

2 Jurisdiction and Venue; Guardianship Proceedings. Amend RSA 464-A:3, II(a) to read as follows:

(a) ***Except as provided in RSA 464-A:25, I(a),*** venue for guardianship proceedings for a proposed ward is in the county where the proposed ward resides, or the county in which the proposed ward is physically present when the proceedings are commenced.

3 Effective Date. This act shall take effect January 1, 2011.

AMENDED ANALYSIS

This bill establishes certain time frames and procedures for probate courts holding hearings on incapacitated persons admitted to state institutions by their guardians.

Majority committee amendment adopted.

Majority committee report adopted and ordered to third reading.

X *HB 304,* relative to death with dignity for certain persons suffering from a terminal condition. **MAJORITY: INEXPEDIENT TO LEGISLATE. MINORITY: REFER FOR INTERIM STUDY.**

Rep. Lucy M. Weber for the Majority of Judiciary: The members of the committee who voted with the majority did so for a variety of different reasons. Some members supported the concept of an individual's right to self-determination, but believed that the bill, as presented, was too flawed to lend itself to appropriate revision. Other members of the committee rejected the premise of the bill entirely. Vote 14-3.

X Rep. Rick H. Watrous for the Minority of Judiciary: This bill is modeled on the Oregon death with dignity law. It would provide terminally ill patients with the option to choose a less painful and more humane way to end their suffering by self-administering prescribed lethal medication. As a matter of personal liberty and compassion, terminally ill New Hampshire citizens should be allowed this choice. The minority believes that an interim study would address concerns regarding this bill.

The question being adoption of the majority committee report of Inexpedient to Legislate.

Reps. Watrous, Weed and Winters spoke against.

Reps. Nancy Elliott and Lucy Weber spoke in favor.

Rep. Rowe spoke in favor and yielded to questions.

Rep. DiFruscia spoke against and yielded to questions.

Rep. Vaillancourt requested a roll call; sufficiently seconded.

YEAS 242 NAYS 113 Bill died.

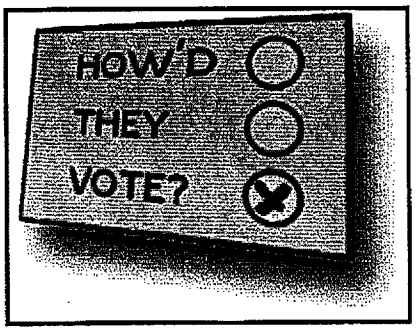
YEAS 242

BELKNAP

Bolster, Peter	Boyce, Laurie	Fields, Dennis	Flanders, Donald
Johnson, William	Merry, Liz	Millham, Alida	Nedeau, Stephen
Pilliod, James	Reever, Judith	Russell, David	St. Cyr, Jeffrey
Swinford, Elaine	Veazey, John	Wendelboe, Fran	

CARROLL

Ahlgren, Christopher	Bridgham, Robert	Buco, Thomas	Chandler, Gene



a resource for political accountability

- **en Français**

- **Find your MP**
- **MP Statistics**
- **Voting History**
- **List of Bills**
- **Downloads**
- **About Us**

Canadian Vote
"Right to Die"
defeated
228 to 59

Bill: **C-384**
40th Parliament, 3rd Session
Tabled by: **Francine Lalonde, Bloc Québécois**
Tabled on: 2010-03-03
Topic: right to die with dignity
Description: An Act to amend the Criminal Code (right to die with dignity)
Status: Negatived on 2010-04-21
More Info: **Library of Parliament**

Votes:

Date	Vote	Yeas	Nays	Paired	Absent
2010-04-21 18:35	**C-384, Second Reading and Referral to Committee**	59	228	4	16

Related Bills:

Date	Bill
2009-05-13	**C-384: 40th Parliament, 2nd Session**
2008-06-12	**C-562: 39th Parliament, 2nd Session**
0000-00-00	**C-407: 38th Parliament, 1st Session**

Report an error on this page

(b) The division shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the division.

(2) The Health Services shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The division shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 s.3.11; 1999 c.423 s.9]

127.870 s.3.12. Effect on construction of wills, contracts and statutes.
(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 s.3.12]

127.875 s.3.13. Insurance or annuity policies.
The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 s.3.13]

127.880 s.3.14. Construction of Act.
Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 s.3.14]

(Immunities and Liabilities) Oregon Act

(Section 4)

127.885 s.4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.
Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other

Inside the Legislature
* Find Your Legislator
* Visiting the Legislature
* Agendas, Schedules and Calendars
* Bill Information
* Laws and Agency Rules
* Legislative Committees
* Legislative Agencies
* Legislative Information Center
* E-mail Notifications (Listserv)
* Civic Education
* History of the State Legislature

Outside the Legislature
* Congress - the Other Washington
* TVW
* Washington Courts
* OFM Fiscal Note Website

Access Washington®
Official State Government Website

RCWs > Title 70 > Chapter 70.245 > Section 70.245.190

70.245.180 << 70.245.190 >> 70.245.200

RCW 70.245.190
Immunities — Basis for prohibiting health care provider from participation — Notification — Permissible sanctions.

(1) Except as provided in RCW 70.245.200 and subsection (2) of this section:

(a) A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner;

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

(c) A patient's request for or provision by an attending physician of medication in good faith compliance with this chapter does not constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator; and

(d) Only willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(2)(a) A health care provider may prohibit another health care provider from participating under chapter 1, Laws of 2009 on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under chapter 1, Laws of 2009. This subsection does not prevent a health care provider from providing health care services to a patient that do not constitute participation under chapter 1, Laws of 2009.

(b) A health care provider may subject another health care provider to the sanctions stated in this subsection if the sanctioning health care provider has notified the sanctioned provider before participation in chapter 1, Laws of 2009 that it prohibits participation in chapter 1, Laws of 2009:

(i) Loss of privileges, loss of membership, or other sanctions provided under the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in chapter 1, Laws of 2009 while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(ii) Termination of a lease or other property contract or other nonmonetary remedies provided by a lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in chapter 1, Laws of 2009 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(iii) Termination of a contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in chapter 1, Laws of 2009 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subsection (2)(b)(iii) prevents:

(A) A health care provider from participating in chapter 1, Laws of 2009 while acting outside the

Washington Act

ANALYSIS OF IMPLICATIONS OF THE *BAXTER* CASE ON POTENTIAL CRIMINAL LIABILITY

By Greg Jackson, Esq. & Matt Bowman, Esq.

for

The Montana Family Foundation

The Montana Supreme Court's assisted suicide decision is remarkable for what it did *not* do. In *Baxter v. State of Montana*, 354 Mont. 234 (2009), the Court did not declare assisted suicide a constitutional right, and it imposed no duty on physicians or hospitals to assist suicides. In fact, the Court's narrow decision didn't even "legalize" assisted suicide. The Court merely allowed a possible consent defense if persons continue to be charged with murder for assisted suicide. Because the Court defined the practice of assisted suicide so benignly, it is an open question whether most assisted suicides would even qualify for the defense. And since Montana law already defines assisted suicide as murder, the legislature doesn't have to make it "illegal"—it can simply declare that a consent defense for assisted suicide is not consistent with Montana public policy. After *Baxter*, assisted suicide continues to carry both criminal and civil liability risks for any doctor, institution, or lay person involved.

Although the parties in *Baxter* focused their arguments on whether "physician aid in dying" is a right under the Montana Constitution, the Court declined to rule on the constitutional issue. Decision ¶ 10. By avoiding the constitution and focusing on mere

Approximately an hour later, Mrs. Young heard a loud "thud." She was not concerned about the noise until the thought occurred to her that Mr. Van Hoose may have climbed up on the chair to get the pistol, and fallen off. She then went back to his apartment and discovered he had killed himself with the pistol.

Did the District Court err in granting summary judgment in favor of defendants?

[1] We begin by emphasizing that summary judgment is never a substitute for a trial on the merits. *Kronen v. Richter* (1984), 211 Mont. 208, 211, 683 P.2d 1315, 1317. It is only appropriate when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Rule 56(c), M.R.Civ.P. Any inferences to be drawn from the factual record must be resolved in favor of the party opposing summary judgment. *Simmons v. Jenkins* (1988), 750 P.2d 1067, 45 St.Rep. 328.

In its summary judgment the District Court relied on the general rule that:

Negligence actions for the suicide of another will generally not lie since the act or suicide is considered a deliberate intervening act exonerating the defendant from legal responsibility, noted the court, but two exceptions to this general rule exist:

a. [W]here the defendant's tortious act causes a mental condition in the decedent that proximately results in an uncontrollable impulse to commit suicide or that prevents the decedent from realizing the nature of his act;

b. [W]here there is a duty to prevent the suicide, the situation typically arising when someone is obligated to exercise custodial care over the eventual decedent, is in a position to know about the latter suicidal potential, and is lax with respect to taking preventive measures.

*472 41 ALR 4th, 353.

The District Court then found that the relationship between Mr. Van Hoose and Mrs. Young was non-custodial and that there was no evidence that Mr. Van Hoose's suicide was a foreseeable event. The court therefore concluded that Mrs. Young owed no duty to prevent Mr. Van Hoose's suicide.

Plaintiff contends that when Mrs. Young entered Mr. Van Hoose's room and attempted to take the pistol away, she imposed upon herself a duty to prevent the suicide. Plaintiff urges that Mrs. Young breached this duty because she was negligent in her intervention. He claims she could have prevented the suicide of Mr. Van Hoose by removing the pistol.

[2][3] It is fundamental that an action for negligence requires 1) a legal duty, 2) a breach of the duty, 3) causation, and 4) ****279** damages. Prosser and Keeton on Torts, § 30, at 164-165 (5th ed.1984); *R.H. Schwartz Const. Specialties v. Hanrahan* (1983), 207 Mont. 105, 672 P.2d 1116. Traditionally, a person is not liable for the actions of another and is under no duty to protect another from harm in the absence of a special relationship of custody or control. If originally, no special relationship existed, but the defendant interjects himself into the situation so as to create a special relationship of control, a duty may be imposed. Prosser and Keeton on Torts, § 56 at 375-377, (5th ed. 1984).

Defendant relies on *Pretty on Top v. Hardin* (1979), 182 Mont. 311, 597 P.2d 58, as authority that no duty arose. That case involved a custodial situation of a jailer and a prisoner. When the prisoner committed suicide the wife claimed the prison had a duty to prevent the suicide. However, in *Pretty on Top* this Court affirmed the district court's grant of summary judgment in favor of defendant since the suicide of the prisoner was not foreseeable. Since foreseeability was lacking we stated that the district court was required to follow the general rule that suicide is an intentional act and grant defendant's motion for summary judgment. *Pretty on Top,* 597 P.2d at 60.

Doctors and others can be civilly liable for causing or failing to prevent the suicide of another in two circumstances.

Kriez v. Massey 239 Mont. 469 (1989)

The same rule applies even more forcefully in the present case. The general rule, as relied upon by the District Court, in the area of civil liability for suicide is that "[n]egligence actions for the suicide of another will generally not lie since the act or suicide is considered a deliberate intervening act exonerating the defendant from legal responsibility ..." 41 ALR 4th, 353. Prosser and Keeton on Torts § 44 at 280-81 (4th ed. 1971); ***473***McPeake v. Cannon Esquire, P.C.* (1989), 381 Pa.Super. 227, 553 A.2d 439; *McLaughlin v. Sullivan* (1983), 123 N.H. 335, 461 A.2d 123. We expressly adopt this rule.

[4] There are two narrow exceptions to this rule. The first exception deals with causing another to commit suicide and is not applicable to the present case. The second exception allows the imposition of a duty to prevent suicide but only in a custodial situation where suicide is foreseeable. These situations typically involve hospitals or prisons. 41 ALR 4th at 353.

[5] The facts of the present case clearly do not fit within this exception to the general rule. As the District Court found, Mrs. Young was not in a custodial relationship with Mr. Van Hoose. He had lived in her apartment less than two days and she had no control over him. Our research has disclosed no cases holding that a landlord tenant relationship is a custodial relationship which would impose a duty to prevent suicide. We agree with the District Court that there are no genuine issues of material fact on the existence of a custodial relationship. The fact that there was no custodial relationship or special circumstances, actually ends our inquiry because no duty can be established.

The District Court, however, went on to determine that the suicide in this case was not foreseeable. Mrs. Young testified that she did not think Mr. Van Hoose should have the gun, but that she did not think he was planning on killing himself. When asked why she put the gun on top of the closet, she said, "I figured he'd leave it alone." She then returned to her own apartment. Plaintiff failed to present any evidence to show that Mr. Van Hoose's suicidal tendencies had been communicated to Mrs. Young. Further, nothing indicates that she had any special training to foresee that Mr. Van Hoose intended suicide. We conclude that no genuine issue of material fact existed regarding foreseeability.

Plaintiff, however, urges that because Mrs. Young "interjected herself into the situation" by taking the gun from Mr. Van Hoose, she imposed a duty upon herself. He contends that she then breached this duty by negligently placing the gun on top of the cabinet rather than removing it. We decline to affirm plaintiff's contention that Mrs. Young's actions created a duty to prevent suicide since, as previously stated, the general rule is that no duty exists in this area absent a custodial relationship or special circumstances. However, even if a duty had arisen, the acts of Mrs. Young placed Mr. Van Hoose in no worse position ****280** than before she took the gun from him. We conclude that there are no genuine issues of material fact on the ***474** issue of negligence. Plaintiff failed to present the District Court with any facts which would establish either a duty or a breach. The general rule that suicide is an intentional act which forecloses civil liability is applicable, and the District Court was correct granting summary judgment in favor of defendants. We affirm the District Court's grant of summary judgment.

TURNAGE, C.J., and HARRISON, SHEEHY and HUNT, JJ., concur.

Mont.,1989.
Krieg v. Massey
239 Mont. 469, 781 P.2d 277

END OF DOCUMENT

Move Krieg v. Massey

198HV(G) Actions and Proceedings
198Hk815 Evidence
198Hk823 Weight and Sufficiency, Particular Cases
198Hk823(14) k. Mental Health Treatment. Most Cited Cases
(Formerly 299k18.80(5) Physicians and Surgeons)
Sufficient evidence established that internist's failure to render adequate care and treatment was proximate cause of patient's suicide, where patient telephoned internist's office complaining of depression, and internist prescribed large dosage of antidepressant over telephone to patient he had never seen without having patient come in for psychiatric evaluation and suicide assessment.

****1267*611** Andrew J. O'Keefe, with whom was Kathryn M. Cunningham, Hartford, for appellants (defendant Jeffrey Ettinger et al.).

Kathryn Calibey, with whom were David W. Cooney and Paul M. Iannaccone, Hartford, for appellee (plaintiff).

Before BORDEN, BERDON, NORCOTT, KATZ and McDONALD, JJ.

BERDON, Associate Justice.

The plaintiff, Craig E. Edwards, as executor of the estate of Agatha M. Edwards, brought this medical malpractice action for damages resulting from the suicide of Agatha M. Edwards (Edwards) against the defendant physicians Daniel Tardif (Tardif), Jeffrey Ettinger (Ettinger), and the defendant Tardif and Ettinger, P.C. (professional corporation). The jury rendered a verdict in favor of the plaintiff against Ettinger and the professional ***612** corporation in the amount of $504,750.07,[FN1] and in favor of Tardif. Ettinger and the professional corporation subsequently moved to set aside the verdict and for judgment notwithstanding the verdict, both of which were denied by the trial court.[FN2] Thereafter, Ettinger and the professional corporation [FN3] filed this appeal.[FN4] We affirm the judgment of the trial court.

FN1. The jury, through interrogatories, found economic damages in the amount of $4750.07, and noneconomic damages in the amount of $500,000.

FN2. Prior to the verdict, the defendants also moved for a directed verdict raising the same legal issues.

FN3. For purposes of this appeal, Ettinger and the professional corporation do not distinguish their liability. Accordingly, we will refer to them jointly as the defendants.

FN4. The plaintiff did not appeal from the verdict in favor of Tardif. The remaining defendants filed this appeal in the Appellate Court, which we transferred to this court pursuant to Practice Book § 4023 and General Statutes § 51-199(c).

****1268** The jury reasonably could have found the following facts. From 1981 to December, 1987, Edwards was treated by Tardif, an internist, for recurring clinical depression. Tardif's initial diagnosis in 1983 was mild depression, for which antidepressant medication was prescribed. In the years following the sudden death of Edwards' husband in 1985, her depression continued and intensified. In June, 1987, she was admitted to Manchester Memorial Hospital due to severe depression and alcohol abuse. While admitted in the hospital, Edwards expressed thoughts of suicide. The discharge diagnosis for Edwards revealed major affective disorder with depression and episodic alcohol abuse disorder.

During the June, 1987 admission, Tardif served as a consultant with respect to Edwards' illness and, subsequently, continued with her treatment. From the time of Edwards' discharge through December, 1987, Tardif's treatment included prescribing the antidepressant medication Tofranil.[FN5] On December 29, 1987, Tardif concluded***613** that Edwards'

Edwards v. Tardif, 692 A.2d 1266, 1266-7 (1997) CT

"DEATH WITH DIGNITY": A RECIPE FOR ELDER ABUSE AND HOMICIDE (ALBEIT NOT BY NAME)

Margaret K. Dore*

INTRODUCTION

Death with Dignity Acts in Oregon and Washington authorize physicians to write life-ending prescriptions for their patients.[1] Oregon's Act went into effect thirteen years ago.[2] Washington's Act was passed as a citizen's initiative in 2008 and went into effect in 2009.[3] Both Acts are touted as providing "choice" and "control" for end-of-life decisions. During Washington's election, the "For Statement" in the voters' pamphlet declared: "Only the patient – and no one else – may administer the [lethal dose]."[4] Washington's Act, however, does not say this

* Margaret Dore is an elder law/appellate attorney admitted to practice in Washington State. She is a past chair of the Elder Law Committee of the ABA Family Law Section. She is also a former law clerk to the Washington State Supreme Court. For more information on Ms. Dore, see www.margaretdore.com. This article is similar to articles previously published in the Washington State *BAR NEWS* and the King County *BAR BULLETIN*.

1. OR. REV. STAT. § 127.815 § 3.01(1)(k) (2009); WASH. REV. CODE ANN. § 70.245.040(1)(k) (West 2009).

2. OR. REV. STAT. §§ 127.800-995. Oregon's Death with Dignity Act was passed as Ballot Measure 16 in 1994 and went into effect in 1997. *See* Death With Dignity Act, *available at* http://www.oregon.gov/DHS/ph/pas/ors.shtml (last visited Jan. 10, 2010).

3. WASH. REV. CODE ANN. § 70.245.903. Washington's Death with Dignity Act was passed as Initiative 1000 on November 4, 2008 and went into effect on March 5, 2009. *See* Washington State Dept. of Health, Ctr. for Health Statistics, *Death with Dignity Act, available at* http://www.doh.wa.gov/dwda/default.htm (last visited Jan. 10, 2010). The full text of the Act is available at http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245 (last visited Jan. 10, 2010).

4. The voters' pamphlet for Initiative 1000 can be viewed on the website for the Washington State Secretary of State, 2008 General Election Voter's Guide –

anywhere. In fact, neither Act even requires the patient's consent when the lethal dose is administered.[5] This problem and other problems are discussed below.

HOW THE ACTS WORK

Both Acts have an application process to obtain the lethal dose, which includes a written request form with two required witnesses.[6] One of these witnesses is allowed to be the patient's heir, who will benefit from the death.[7] Once the lethal dose is issued by the pharmacy, there is no supervision over its administration.[8] The death is not required to be witnessed by disinterested persons.[9] No one is required to be present.[10]

A COMPARISON TO PROBATE LAW

When signing a will, having an heir act as one of the witnesses can support a finding of undue influence. Washington's probate code, for example, states that when one of two witnesses is a taker under the will, there is a rebuttable presumption that the taker/witness "procured the gift by duress, menace, fraud, or

Initiative Measure 1000, *available at* http://wei.secstate.wa.gov/osos/en/Pages/OnlineVoterGuideGeneral2008.aspx?electionid=26#ososTop (last visited April 10, 2010).

5. *See* WASH. REV. CODE ANN. § 70.245.010-904 and OR. REV. STAT. § 127.800-995.

6. WASH. REV. CODE ANN. § 70.245.030(1); OR. REV. STAT. § 127.810 § 2.02(1). *See* the Acts' official lethal dose request forms requiring two witnesses, Washington State Dept. of Health, *Request for Medication to End My Life in a Humane and Dignified Manner* (July 1, 2009), *available at* http://www.doh.wa.gov/dwda/forms/WrittenRequest.pdf; Oregon State Dept. of Health, *Request for Medication to End My Life in a humane and Dignified Manner* (Apr. 2006), *available at* http://www.oregon.gov/DHS/ph/pas/docs/pt-req.pdf/pdf.

7. *See* WASH. REV. CODE ANN. §§ 70.245.030 and 70.245.220; *see also* OR. REV. STAT. §§ 127.810 § 2.02, 127.897 § 6.01 (providing that one of two required witnesses on the lethal dose request form cannot be a patient's heir or other person who will benefit from the patient's death; the other witness may be an heir or other person who will benefit from the death).

8. *See generally* WASH. REV. CODE ANN. §§ 70.245.010-904 and OR. REV. STAT. §§ 127.800-995.

9. *Id.*

10. *Id.*

undue influence."[11]

Other states have similar laws. Consider *Burns v. Kabboul*, which states: "[i]t will weigh heavily against the proponent [of the will] on the issue of undue influence when the proponent was . . . present at [its] dictation . . . ."[12] The lethal dose request process, which allows an heir to act as a witness on the request form, does not promote patient choice. It invites coercion.

A RELAXED STANDARD OF COMPETENCY

In Washington, patients signing the lethal dose request form are required to be "competent."[13] In Oregon, patients are required to be "capable."[14] Regardless of the term used, this is a relaxed standard *in which someone other than the patient is allowed to speak for the patient.* For example, the Washington Act states: "'Competent' means . . . a patient has the ability to make and communicate an informed decision . . . , *including communication through persons familiar with the patient's manner of communicating* . . . ."[15]

There is no requirement that the person speaking for the patient be a designated agent such as an attorney-in-fact.[16] The person could be an heir or a new "best friend."[17]

Regardless, without a requirement of strict competency,

11. WASH. REV. CODE ANN. § 11.12.160(2).

12. Burns v. Kabboul, 595 A.2d 1153, 1163 (Pa. Super. Ct. 1991).

13. WASH. REV. CODE ANN. § 70.245.010(11) (defining a "qualified patient" as a "competent adult.")

14. OR. REV. STAT. § 127.800 § 1.01(11) (defining a "qualified patient" as a "capable adult.")

15. WASH. REV. CODE ANN. § 70.245.010(3) (emphasis added). The Oregon Act has similar language. *See* OR. REV. STAT. § 127.800 § 1.01(3) (stating "'[c]*apable' means* . . . a patient has the ability to make and communicate health care decisions . . . , *including communication through persons familiar with the patient's manner of communicating* . . . ." (Emphasis added).

16. *See generally* WASH. REV. CODE ANN. §§ 70.245.010-904 and OR. REV. STAT. §§ 127.800-995.

17. *Id.* For a discussion of new "best friends" and other signs of elder financial abuse, see METLIFE MATURE MARKET INSTITUTIONS, STUDY: BROKEN TRUST: ELDERS, FAMILY, AND FINANCES: A STUDY ON ELDER FINANCIAL ABUSE PREVENTION, March 2009, at 22-23, *available at* http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf.

both Acts set the stage for undue influence by heirs and others who will benefit from the patient's death.[18]

NO MENTAL STANDARD OF CONSENT REQUIRED AT THE TIME OF ADMINISTRATION

Neither Act requires that the patient be competent, capable, or even aware when the lethal dose is administered.[19] There is also no language requiring the patient's consent at the time of administration.[20] Without these requirements, when the lethal dose is administered, the Acts again set the stage for undue influence and worse.

"DOCTOR SHOPPING"

Under both Acts, the initial decision as to whether the patient is "competent" or "capable" is made by the doctor who will be prescribing the lethal dose (the "attending physician").[21] As a safeguard, this doctor is required to obtain a second opinion from a "consulting physician."[22] In practice, this requirement is

18. *See e.g.*, MONT. CODE ANN. § 28 2-407(2) (2009) (defining undue influence as "taking an unfair advantage of another's weakness of mind"); Burns v. Kabboul, 595 A.2d at 1162 (describing "weakened intellect" as a factor for undue influence).

19. Both Acts only address whether the patient is "competent" or "capable" in conjunction with the lethal dose request, and not later at the time of administration. *See* WASH. REV. CODE ANN. §§ 70.245.010(3)(5)(11), 70.245.020(1), 70.245.030(1), 70.245.040(1)(a)(d), 70.245.050, 70.245.120(3)(4), 70.245.220 (regarding "sound mind"); OR. REV. STAT. §§ 127.800 § 1.01(3)(5)(11), 127.805 § 2.01(1), 127.810 § 2.02(1), 127.815 § 3.01(1)(a)(d), 127.820 § 3.02, 127.855 § 3.09(3), 127.855 § 3.09(3), 127.897 § 6.01 (regarding "sound mind.")

20. Both Acts contain provisions requiring that a determination of whether a patient is acting "voluntarily" be made in conjunction with the lethal dose request, not later. *See* WASH. REV. CODE ANN. §§ 70.245.020(1), 70.245.030(1), 70.245.040(1)(a)(d), 70.245.050, 70.245.120(3)(4), 70.245.220; OR. REV. STAT. §§ 127.805 § 2.01(1), 127.810 § 2.02(1), 127.815 § 3.01(1)(a)(d), 127.820 § 3.02, 127.855 § 3.09(3), 127.855 § 3.09(4), 127.897 § 6.01.

21. WASH. REV. CODE ANN. § 70.245.040(1)(a); OR. REV. STAT. § 127.815 § 3.01(1)(a).

22. WASH. REV. CODE ANN. § 70.245.040(1)(d) (requiring the attending physician to refer the patient to a consulting physician to confirm that the patient is "competent"); OR. REV. STAT. § 127.815 § 3.01(1)(d) (requiring the attending physician to refer the patient to a consulting physician "for a determination that the patient is capable . . . .")

circumvented through "doctor shopping." Dr. Charles Bentz describes the following incident:

> [My patient's cancer specialist] asked me to be the "second opinion" for his suicide . . . I told her that assisted-suicide was not appropriate for this patient and that I did NOT concur . . . [A]pproximately two weeks later my patient was dead from an overdose prescribed by this doctor . . . .[23]

In other words, the prescribing doctor asks multiple doctors to give the second opinion until one agrees to do so.

"SELF-ADMINISTER" DOES NOT NECESSARILY MEAN THAT A PATIENT ADMINISTERS THE LETHAL DOSE TO HIMSELF

Both acts imply that patients administer the lethal dose to themselves. There is, however, nothing in either Act that requires this. There is no language that "only" the patient can administer the lethal dose to himself.[24]

The Washington Act instead states that the patient may "self-administer" the dose.[25] In an Orwellian twist, the term "self-administer" does not mean that administration will necessarily be by the patient. "Self-administer" is instead defined as the patient's "act of ingesting." The Washington Act states: "'*Self-administer' means a qualified patient's act of ingesting* medication to end his or her life . . ." (Emphasis added).[26]

In other words, someone else putting the lethal dose in the patient's mouth qualifies as proper administration because the patient will thereby "ingest" the dose.[27] Someone else putting

23. Charles Bentz, *Don't Follow Oregon's Lead: Say No to Assisted Suicide*, HAWAII REPORTER, Feb. 13, 2009, at ¶¶ 3, 4, http://www.hawaiireporter.com/story.aspx?4048b066-5612-4ede-86d6-c7fd385703d1 (last visited Jan. 10, 2010).

24. *See supra* at Introduction, note 5 and accompanying text. *See also* WASH. REV. CODE ANN. §§ 70.245.010-904 and OR. REV. STAT. §§127.800-995.

25. *See* WASH. REV. CODE ANN. §§ 70.245.010(7)(11)(12), 70.245.020(1), 70.245.090, 70.245.170, 70.245.220.

26. WASH. REV. CODE ANN. § 70.245.010(12).

27. Neither Act defines "ingest." *See* WASH. REV. CODE ANN. §§ 70.245.010-904 and OR. REV. STAT. §§127.800-995. Dictionary definitions include "*to take* (food, drugs, etc.) *into the body, as by swallowing*, inhaling, *or absorbing*" (emphasis added). WEBSTER'S NEW WORLD COLLEGE DICTIONARY, www.yourdictionary.com/ingest

the lethal dose in a feeding tube or IV nutrition bag will also qualify because the patient will thereby "absorb" the dose, *i.e.*, "ingest" it.[28]

Oregon's Act does not use the term "self-administer."[29] The Act does, however, refer to administration as the "act of ingesting."[30] Official forms for both Acts also refer to administration as "ingestion," "ingesting," and other forms of the word "ingest."[31] With administration defined as mere ingestion, someone else is allowed to administer the lethal dose to the patient.

BOTH ACTS ALLOW INVOLUNTARY KILLING

In summary, someone other than the patient is allowed to administer the lethal dose.[32] The Acts contain no requirement that the patient be competent, capable, or even aware when the lethal dose is administered.[33] There is no requirement that the patient consent when the lethal dose is administered.[34]

Intentionally killing an incompetent or unaware person, or intentionally killing some other person without his consent, is homicide.[35] Both Acts, however, allow this result as long as the

(last visited Jan. 23, 2010).

28. WEBSTER'S NEW WORLD COLLEGE DICTIONARY, *supra* note 27.

29. *See* OR. REV. STAT. §§ 127.800-995.

30. OR. REV. STAT. § 127.875 § 3.13 (stating "[n]either shall a qualified patient's *act of ingesting* medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy." (Emphasis added)).

31. *See* Washington State Dept. of Health, *Attending Physician's After Death Reporting Form, available at* http://www.doh.wa.gov/dwda/forms/AfterDeath ReportingForm.pdf (referring to administration of the lethal dose as "ingestion," "ingesting," and other forms of the word "ingest"); *see also* Oregon Dept. of Human Servs., *Oregon's Death With Dignity Act Attending Physician Interview Form, available at* http://www.Oregon.gov/DHS/ph/pas/docs/mdintdat.pdf (referring to administration of the lethal dose as "ingestion," "ingesting," and other forms of the word "ingest.")

32. *Supra* notes 24-31 and accompanying text.

33. *Supra* notes 19-20 and accompanying text.

34. *Id.*

35. *Cf.* WASH. REV. CODE ANN. §§ 9A.32.010 (defining "homicide"), 9A.32.020 (regarding "premeditation"), 9A.32.030 (defining "murder in the first degree") and OR. REV. STAT. § 163.005 (defining "criminal homicide.")

action taken is "in accordance with" the Act. For example, Washington's Act states: "Actions taken in accordance with this chapter do not, for any purpose, constitute . . . homicide, under the law."[36]

THE ACTS' OFFICIAL REPORTS AND FORMS PROVIDE FURTHER SUPPORT THAT THE ACTS ALLOW INVOLUNTARY KILLING

Under both Acts, physicians and pharmacists who participate in the lethal dose request process are required to complete official forms. The data collected is summarized in annual statistical reports, which are displayed on official web sites.[37]

None of these official forms and reports ask about, or report on, patient competency, consent, or awareness at the time of administration, or whether the patient administered the lethal dose to himself.[38] These factors are not relevant to compliance with either Act.

COUNTER ARGUMENTS

Proponents sometimes argue that "only" the patient can administer the lethal dose because both Acts prohibit mercy killing and active euthanasia (another name for mercy killing).[39] This argument is word play. The prohibition against mercy killing and euthanasia is defined away in the next sentence. For example, the Washington Act states: "Nothing in this chapter authorizes . . . mercy killing, or active euthanasia. Actions taken

36. WASH. REV. CODE ANN. § 70.245.180(1); OR. REV. STAT. § 127.880 § 3.14 (stating that "[a]ctions taken in accordance with [this Act] shall not for any purpose, constitute . . . homicide, under the law.")

37. Oregon Dep't of Human Servs., *Death With Dignity Act, available at* http://www.oregon.gov/DHS/ph/pas/ (last visited Mar. 22, 2010); Washington State Dep't of Health Ctr. For Health Statistics, *Death with Dignity Act, available at* http://www.doh.wa.gov/dwda (last visited Mar. 22, 2010).

38. *Id.*

39. WEBSTER'S NEW WORLD COLLEGE DICTIONARY, http://www.yourdictionary.com/mercy-killing (last visited Apr. 3, 2010) (defining "mercy killing" as "euthanasia.")

in accordance with this chapter do not, for any purpose, constitute . . . mercy killing [also known as 'euthanasia'] . . . ."[40]

Proponents may also argue that patient consent is required because patients may rescind the request for the lethal dose "at any time."[41] A provision that a patient "may" rescind is not, however, the same thing as a right to give consent when the lethal dose is administered. Consider, for example, a patient who obtained the dose on a "just-in-case" basis without consenting to taking it. If such patient would later become incompetent, be sedated, or simply be sleeping, he would not have the ability to rescind. Without the right to consent, someone else could, nonetheless, administer the lethal dose to him. Without the right to consent, the patient's promised control over the "time, place, and manner" of his death is an illusion.

Finally, proponents may argue that the Acts protect patients due to provisions that impose civil and criminal liability.[42] None of these provisions penalize administration of the lethal dose without the patient's consent.[43]

NO WITNESS AT THE DEATH

If, for the purpose of argument, the Acts do not "allow" a patient's death without his consent, patients are, nonetheless, unprotected from this result due to the lack of required witnesses at the death.[44] Without witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he

40. WASH. REV. CODE ANN. § 70.245.180(1); OR. REV. STAT. § 127.880 § 3.14 (stating that "[n]othing in [this chapter] shall be construed to authorize . . . mercy killing or active euthanasia. *Actions taken in accordance with [this chapter] shall not, for any purpose, constitute . . . mercy killing* [also known as 'euthanasia'] . . . ." (Emphasis added)).

41. WASH. REV. CODE ANN. § 70.245.100; OR. REV. STAT. § 127.845 § 3.07.

42. WASH. REV. CODE ANN. § 70.245.200; OR. REV. STAT. § 127.890 § 4.02.

43. *Id.*

44. *See* Washington and Oregon Acts in their entirety. WASH. REV. CODE ANN. §§ 70.245.010-904; OR. REV. STAT. §§ 127.800-995 (lacking a requirement that administration be witnessed by a disinterested party or anyone at all).

struggled, who would know? The lethal dose request would provide the alibi.

This scenario would seem especially significant for patients with money. A California case, *People v. Stuart*, states: "[F]inancial considerations [are] an all too common motivation for killing someone . . . ."[45]

OFFICIAL COVER

In Washington, a further alibi is provided by a reporting requirement that medical examiners, coroners, and even prosecuting attorneys treat the death as "natural."[46] Any death certificate not complying with this requirement is to be rejected by the Washington State Registrar.[47] In Oregon, the Act does not require the death to be treated as natural.[48] This is, however, local practice.[49]

ILLUSORY LIABILITY FOR UNDUE INFLUENCE

Both Acts impose criminal, but not civil liability for undue influence in connection with the lethal dose request.[50] Undue influence is a civil concept, which is not capable of being criminally enforced.

Neither Act defines undue influence or provides elements of proof.[51] Undue influence is, regardless, a traditionally

45. People v. Stuart, 67 Cal. Rptr. 3d 129, 143 (Cal. App. 2007).

46. *See* Washington State Dep't of Health, *Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with the Death with Dignity Act* (revised Apr. 8, 2009), *available at* http://www.doh.wa.gov/dwda/forms/MEsAndCoroners.pdf.

47. *Id.*

48. OR. REV. STAT. §§ 127.800-995.

49. *See* Bentz, *supra* note 23, at ¶ 4.

50. WASH. REV. CODE ANN. § 70.245.200(2) (stating that "[a] person who coerces or exerts undue influence on a patient to request medication to end the patient's life . . . is guilty of a Class A felony.") The Oregon statute has nearly identical language. *See* OR. REV. STAT. § 127.890 § 4.02(2) (stating that "[a] person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life . . . shall be guilty of a Class A felony.")

51. *See* Washington and Oregon Acts in their entirety. WASH. REV. CODE ANN. §§70.245.010-904; OR. REV. STAT. §§ 127.800-995.

equitable concept "not susceptible of precise definition . . . ."[52] For example, in Washington, the test for undue influence consists of multiple nonexclusive factors.[53] With this situation, the "crime" of undue influence is too undefined and/or vague to be enforced.[54]

Both Acts also allow conduct that would generally provide proof of undue influence (allowing an heir to act as a witness on the lethal dose request form).[55] How do you prove beyond a reasonable doubt that undue influence occurred when the Act prohibiting undue influence also specifically allows conduct used to prove undue influence? It is hard to say. The purported criminal liability is, regardless, illusory.

THE ANNUAL REPORTS ARE CONSISTENT WITH ELDER ABUSE

As noted above, both Acts require annual statistical reports.[56] Washington has generated one report.[57] In Oregon, there have been twelve reports.[58]

52. Mark Reutlinger, *Washington Law of Wills and Intestate Succession*, WASHINGTON BAR ASSOCIATION 88 (2006).

53. Estate of Lint, 957 P.2d 755, 764 (Wash. 1998) (stating the test for undue influence:

> The most important of such facts are (1) that the beneficiary occupied a fiduciary or confidential relation to the testator; (2) that the beneficiary actively participated in the preparation or procurement of the will; and (3) that the beneficiary received an unusually or unnaturally large part of the estate. Added to these may be other considerations, such as the age or condition of health and mental vigor of the testator, . . .)

54. *See* City of Tacoma v. Luvene, 827 P.2d 1374, 1384 (Wash. 1992) (stating that prohibited conduct must be defined "with sufficiently specificity to put citizens on notice of what conduct they must avoid . . ."); *see also* Mays v. State, 68 P.3d 1114, 1120-21 (Wash. App. 2003) (holding a statute unconstitutionally vague where "reasonably intelligent persons must guess at its meaning.")

55. *Supra* notes 6-12 and accompanying text.

56. WASH. REV. CODE ANN. § 70.245.150(3); OR. REV. STAT. § 127.865 § 3.11(3).

57. Washington State Dep't of Health, *Washington State Department of Health 2009 Death with Dignity Act Report* (2009), *available at* http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf.

58. Oregon has generated twelve annual reports. Oregon Dep't of Human Servs., *Death with Dignity Annual Reports, available at* http://www.oregon.gov/DHS/ph/pas/ar-index.shtml (last visited Apr. 15, 2010).

In Oregon and Washington, the annual reports do not track income or net worth.[59] They do, however, show that the majority of people who have died under the Acts have been well-educated and covered by private insurance.[60] Typically, people with these attributes would be those with money, *i.e.*, the middle class and above. The statistics also show that the majority of persons dying have been age sixty-five or older.[61]

These statistics can be explained by older persons with money feeling a "duty to die" so as to pass on funds to their heirs.[62] The statistics are also consistent with elder abuse. A recent MetLife Mature Market Institute Study states that "[e]lders' vulnerabilities and larger net worth make them a prime target for financial abuse . . . [v]ictims may even be murdered by perpetrators who just want their funds and see them as an easy mark."[63]

THE BARBARA WAGNER SCENARIO

The statistics, which also show poor people dying, are also consistent with the "Barbara Wagner" scenario. Wagner was an

59. *Id.*; *see* Washington State Dep't of Health, *supra* note 57.

60. In Oregon, 67.3% of the 460 people who died as of the most recent report, had some college or higher education; in Washington, 61% of the 47 people who died had some college or higher education. *See* Oregon Dep't Of Human Servs., *Table 1: Characteristics and End-of-Life care of 460 DWDA Patients Who Died After Ingesting a Lethal Dose of Medication, By Year, Oregon, 1998-2009, available at* http://www.oregon.gov/DHS/ph/pas/docs/yr12-tbl-1.pdf [hereinafter *Table 1*]. *See also* Washington State Dep't of Health, *supra* note 57, at 5. To date, 507 people have died in Oregon and Washington combined, of which 355 (70%) have had private insurance.

61. *Table 1*, *supra* note 60; Washington State Dep't of Health, *supra* note 57, at 5.

62. *See, e.g.*, Licia Corbella, *If Doctors Who Won't Kill are 'Wicked,' the World Is Sick*, THE CALGARY HERALD, Jan. 10, 2009, *available at* http://www.canada.com/calgaryherald/news/story.html?id=83835868-7f89-40bd-b16e-8bc961d41b39 (last visited Jan. 10, 2010); *see* Dr. Margaret White, *Letter in Response to Nurses, Undertakers, and the Duty to Die*, THE TIMES, July 30, 2009, *available at* http://www.timesonline.co.uk/tol/comment/letters/article6732198.ece (stating "I am happy here in the nursing home with no wish to die, but were voluntary euthanasia to be made legal I would feel it my absolute duty to ask for it as I now have 19 descendents who need my legacy.")

63. MetLife Mature Market Institutions, *supra* note 17, at 4, 24.

indigent resident of Oregon who had lung cancer.[64] The Oregon Health Plan refused to pay for a drug to possibly prolong her life and offered to pay for her assisted suicide instead.[65] Unable to afford the drug, she was steered to suicide.[66]

CITIZENS ARE "BURDENS"

In both Washington and Oregon, the official reporting forms include a check-the-box question with seven possible "concerns" that contributed to the lethal dose request.[67] These concerns include the patient's feeling that he was a "burden."[68] The prescribing doctor is instructed: "Please check 'yes,' 'no,' or 'don't know' depending on whether or not you believe that a concern contributed to the request."[69]

In other states, a person being described as a "burden" is a warning sign of abuse. For example, Sarah Scott of Idaho Adult Protection Services describes the following "warning sign": "*Suspect behavior by the caregiver . . . [d]escribes the vulnerable adult as a burden* or nuisance."[70]

The recommendation is that when such "warning signs" exist, a report should be made to law enforcement and/or to the local adult protective services provider.[71] Washington and

64. For articles discussing Wagner, see Margaret Datiles, *A Price on your Head*, WASH. TIMES, Nov. 2. 2008, *available at* http://www.washingtontimes.com/news/2008/nov/02/a-price-on-your-head/ (last visited Jan. 15, 2010); Susan Donaldson James, *Death Drugs Cause Uproar in Oregon* 1, ABC NEWS, Aug. 6, 2008, *available at* http://www.abcnews.go.com/Health/Story?id=5517492&page= (last visited Jan. 15, 2010); and Katu.com, *Letter Noting Assisted Suicide Raises Questions* (July 30, 2008), *available at* http://www.katu.com/news/26119539.html?video=YHI&t=a (last visited Jan. 15, 2010) (video transcript of Barbara Wagner).

65. *Id.*

66. *Id.*

67. *See Attending Physician's After Death Reporting Form, supra* note 31, at question 7; *see also Oregon's Death With Dignity Act Attending Physician Interview Form, supra* note 31, at Question 13.

68. *Id.*

69. *Id.*

70. Sarah Scott, *Adult Protection: Safeguarding Every Person's Basic Human Right to a Safe and Decent Life, Regardless of Age, Regardless of Condition* 3 (on file with author) (emphasis added).

71. *Id.* (stating that these "'warning signs' should . . . serve as indicators that a problem may exist and a report should be made to law enforcement or to the local

Oregon, by contrast, instruct its doctors to check a "burden" box.

Washington and Oregon promote the idea that its citizens are burdens, which justifies the prescription of lethal drugs to kill them. Washington's and Oregon's Acts do not promote patient "control," but officially sanctioned abuse of vulnerable adults.

INDIVIDUAL "OPT OUTS" ARE NOT ALLOWED

Neither state's Act allows patients to opt out of its provisions. The Washington Act states that any provision that affects whether a person may make or rescind a lethal dose request "is not valid."[72] Oregon's Act has a similar provision.[73] So, if a person knows he gets talked into things, and he doesn't want to get talked into requesting the lethal dose, committing suicide and/or facilitating his own homicide, he is not allowed to make legal arrangements to try and prevent it. So much for personal "choice" and "control."

PEOPLE COMMIT SUICIDE ANYWAY

It should be remembered that patients have the "choice" to commit suicide without legalization. Vermont resident, Kelly Bartlett, states "[s]uicide advocates talk about the 'right to suicide,' forgetting that patients . . . already can and do commit suicide."[74]

Adult Protection service provider.")

72. WASH. REV. CODE ANN. § 70.245.160(1) (stating that "*[a]ny provision in a contract, will, or other agreement,* whether written or oral, *to the extent the provision would affect whether a person may make or rescind a request for medication* to end his or her life in a humane and dignified manner, *is not valid.*" (Emphasis added)).

73. OR. REV. STAT. § 127.870 § 3.12(1) (stating "*[n]o provision in a contract, will, or other agreement,* whether written or oral, *to the extent the provision would affect whether a person may make or rescind a request for medication* to end his or her life in a humane and dignified manner, *shall be valid.*" (Emphasis added)).

74. Kelly Bartlett, *Letter to Editor in Response to Legalizing Suicide Draws in Others*, BURLINGTON FREE PRESS, Dec. 9, 2008 (on file with author).

THE BIG PICTURE

SIGNING THE FORM WILL LEAD TO A LOSS OF CONTROL

By signing the lethal dose request form, the patient takes an official position that if he dies suddenly, no questions should be asked. He will be unprotected against others in the event he obtains the dose on a "just-in-case" basis or changes his mind and decides that he wants to live. This would seem especially important for older people with money. There is, regardless, a loss of control.

PROGNOSES CAN BE WRONG

Both Acts apply to adults determined by an "attending physician" and a "consulting physician" to have a disease expected to produce death within six months.[75] But, what if the doctors are wrong? This is the point of a 2008 *Seattle Weekly* article.[76] The article states: "Since the day [the patient] was given two to four months to live, [she] has gone with her children on a series of vacations. . . . '[w]e almost lost her because she was having too much fun, not from cancer' [her son] chuckles."[77]

CONCLUSION

Death with Dignity Acts in Oregon and Washington State are not about patient "choice" and "control." These laws instead enable people to pressure others to an early death or to even cause that death on an involuntary basis. What was previously

75. WASH. REV. CODE §§ 70.245.040(1)(a), 70.245.050, 70.245.010(13); OR. REV. STAT. §§ 127.815 § 3.01(a), 127.820 § 3.02, 127.800 § 1.01(12).

76. Nina Shapiro, *Terminal Uncertainty: Washington's New "Death with Dignity" Law Allows Doctors to Help People Commit Suicide -- Once They've Determined That the Patient Has Only Six Months to Live. But what if they're wrong?*, THE SEATTLE WEEKLY, Jan. 14, 2009, *available at* http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/ (last visited Jan. 10, 2010).

77. *Id.*

"homicide" is now "death with dignity." Elderly persons with money, *i.e.*, the middle class and above, appear to be especially at risk. Don't let "death with dignity" come to your state.

POSTSCRIPT

Shortly after Washington's Act was passed in 2008, a Montana district court held that there was a constitutional right to physician assisted suicide, which was vacated by the Supreme Court of Montana on December 31, 2009.[78] *Per that decision, physician-assisted suicide is, instead, decriminalized under certain narrow conditions.*[79] *The court held that "a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply."*[80]

On January 13, 2010, a proposed Death with Dignity Act similar to the Oregon and Washington Acts was defeated in the New Hampshire State House, 242 to 113.[81]

Between January 1994 and June 2009, there were 113 legislative proposals to legalize physician-assisted suicide and/or euthanasia in twenty-four states, all of which were defeated, tabled for the session, and/or languished with no action taken.[82]

78. *See* Baxter v. State, 224 P.3d 1211, 1222, ¶ 51 (Mont. 2009).

79. *See* Greg Jackson. & Matt Bowman, *Analysis of Implications of the Baxter Case on Potential Criminal Liability for the Montana Family Foundation* (April 2010), *available at* http://www.montanafamily.org/portfolio/pdfs/Baxter_Decision_Analysis_v2.pdf.

80. *Id. See Baxter*, 224 P.3d at 1214, 1221, ¶¶ 11, 50. The court also commented that the only person who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication." The court thereby overlooked the issue of elder abuse perpetrated by family members, new "best friends," and others.

81. *See* H.R. 304, 161st Leg., 2d Sess. (N.H. 2010), *available at* http://www.gencourt.state.nh.us/ (last visited Apr. 11, 2010).

82. Int'l Task Force on Euthanasia & Assisted Suicide, *Attempts to Legalize Euthanasia/Assisted Suicide in the United States* (2009), *available at* http://www.internationaltaskforce.org/pdf/200906_attempts_to_legalize_assisted_suicide.pdf.

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 Act

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***

in·gest (ĭn–jĕst')

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***

(b) The division shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the division.

(2) The Health Services shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The division shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 s.3.11; 1999 c.423 s.9]

127.870 s.3.12. Effect on construction of wills, contracts and statutes.
(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 s.3.12]

127.875 s.3.13. Insurance or annuity policies.
The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 s.3.13]

127.880 s.3.14. Construction of Act.
Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 s.3.14]

(Immunities and Liabilities)

(Section 4)

Oregon Act

127.885 s.4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.
Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other

Washington State Department of Health

ATTENDING PHYSICIAN'S AFTER DEATH REPORTING FORM

**MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47856, Olympia, WA 98504-7856**

Dear Physician:

The Washington Death with Dignity Act requires physicians who write a prescription for a lethal dose of medication under the Act to report to the Department of Health information that documents compliance with the law. The attending physician shall complete this form within thirty calendar days of a patient's ingestion of a lethal dose of medication obtained pursuant to the act or death from any other cause, whichever comes first. If you do not know the answers to any of the following questions, please contact the family or patient's representative.

All individual information will be kept strictly confidential. Aggregate information will be provided on an annual basis. If you have questions about these instructions, please call 360-236-4324.

Physician's Name: _____

Date: ___/___/___

Patient Name: _____

Date of Patient's Death: __/___/___

County of Death: _____

1. What was the patient's underlying illness?

   _____

   _____

2. On what date did you begin caring for this patient?

   ___/___/___ (Mo/Da/Yr)

3. On what date was the patient first told about their underlying medical condition?

   ___/___/___ (Mo/Da/Yr)

4. On what date was the patient told they have a terminal disease – meaning an incurable and irreversible disease that will within reasonable medical judgment produce death within six months?

   ___/___/___ (Mo/Da/Yr)

Washington Reporting Form
- questions regarding "ingestion"
- no questions regarding Patient consent to administration at the time of such administration.

5. What type of health-care coverage did the patient have for their underlying illness? (*Check all that apply.*)
   - ☐ 1 Medicare
   - ☐ 2 Medicaid
   - ☐ 3 Military/CHAMPUS
   - ☐ 4 V.A.
   - ☐ 5 Indian Health Service
   - ☐ 6 Private insurance
   - ☐ 7 No insurance
   - ☐ 8 Had insurance, don't know type
   - ☐ 9 Unknown

6. When the patient initially requested a prescription for the lethal dose of medication, was the patient receiving hospice care?
   - ☐ 1 Yes
   - ☐ 2 No, refused care
   - ☐ 3 No, other (specify) _____
   - ☐ 9 Unknown

7. Seven possible concerns that may have contributed to the patient's decision to request a prescription for the lethal dose of medication are shown below. Please check "Yes," "No," or "Don't know," depending on whether or not you believe that concern contributed to the request.

   A concern about:

   ...the financial cost of treating or prolonging his or her terminal condition.
   ☐ Yes ☐ No ☐ Don't Know

   ...the physical or emotional burden on family, friends, or caregivers.
   ☐ Yes ☐ No ☐ Don't Know

   ...his or her terminal condition representing a steady loss of autonomy.
   ☐ Yes ☐ No ☐ Don't Know

   ...the decreasing ability to participate in activities that made life enjoyable.
   ☐ Yes ☐ No ☐ Don't Know

   ...the loss of control of bodily functions, such as incontinence and vomiting.
   ☐ Yes ☐ No ☐ Don't Know

   ...inadequate pain control at the end of life.
   ☐ Yes ☐ No ☐ Don't Know

   ...a loss of dignity.
   ☐ Yes ☐ No ☐ Don't Know

8. On what date was the prescription for a lethal dose of medication written or phoned in?

   ___/___/___ (Mo/Da/Yr)

9. What medication was prescribed and what was the dosage?

   _____

   _____

10. On what date was the lethal dose of medication dispensed to the patient?
    ___/___/___ (Mo/Da/Yr) ☐ Not Dispensed ☐ Unknown

11. Did the patient ingest the lethal dose of medication?

- ☐ 1 Yes
- ☐ 2 No (If NO, then please skip to question 22)

12. Were you with the patient when they took the lethal dose of medication?

- ☐ 1 Yes
- ☐ 2 No, did not offer to be present at the time of ingestion
- ☐ 3 No, offered to be present, but the patient declined
- ☐ 8 No, other (specify):_____

If no: Was another physician or trained health care provider or volunteer present when the patient ingested medication?

- ☐ 1 Yes, another physician
- ☐ 2 Yes, a trained health-care provider/volunteer (specify):

_____

- ☐ 3 No
- ☐ 9 Unknown

13. Were you with the patient at the time of death?

- ☐ 1 Yes
- ☐ 2 No

If no: Was another physician or trained health care provider or volunteer present at the patient's time of death?

- ☐ 1 Yes, another physician
- ☐ 2 Yes, a trained health-care provider/volunteer
- ☐ 3 No
- ☐ 9 Unknown

If no: How were you informed of the patient's death?

- ☐ 1 Family member called M.D.
- ☐ 2 Friend of patient called M.D.
- ☐ 3 Another physician
- ☐ 4 Hospice R.N.
- ☐ 5 Hospital R.N.
- ☐ 6 Nursing home/Assisted-living staff
- ☐ 7 Funeral home
- ☐ 8 Medical Examiner
- ☐ 9 Other (specify):_____

14. Did the patient take the lethal dose of medication according to the prescription directions?

- ☐ 1 Yes
- ☐ 2 No

If no: Please list the medications the patient took (other than those reported in item 10), the dosages, and the reason for not following the prescription directions.

_____

_____

_____

☐ 9 Unknown

15. Were there any complications after the ingestion of the lethal dose of medication, for example, vomiting, seizures, or regaining consciousness?

☐ 1 Yes

Please Describe:

_____

_____

_____

☐ 2 No
☐ 9 Unknown

16. Was the Emergency Medical System activated for any reason after the ingestion of the lethal dose of medication?

☐ 1 Yes

Please describe:

_____

_____

_____

☐ 2 No
☐ 9 Unknown

17. What was the time between ingestion of the lethal dose of medication and unconsciousness?

Minutes: _____ or Hours: _____ ☐ Unknown

18. What was the time between ingestion of the lethal dose of medication and death?

Minutes: _____ or Hours: _____ ☐ Unknown

If the patient lived longer than six hours:

Do you have any observations on why the patient lived for more than six hours after ingesting the medication? _____

_____

_____

_____

19. *Immediately* prior to ingestion of the lethal dose of medication, what was the patient's mobility? (ECOG scale)

☐ 0 Fully active, no restrictions on pre-disease performance.
☐ 1 Restricted in strenuous activity, but ambulatory and able to carry out work.
☐ 2 Ambulatory and capable of all self-care, but no work activities; up and about more than 50% of waking hours.
☐ 3 Capable of only limited self-care; in bed or chair more than 50% of waking hours.
☐ 4 Completely disabled, no self-care, totally confined to bed or chair.
☐ 9 Unknown

X **20.** Where did the patient ingest the medication?

- ☐ 1 Private home
- ☐ 2 Assisted-living residence (including foster care)
- ☐ 3 Nursing home
- ☐ 4 Acute care hospital in-patient
- ☐ 5 In-patient hospice resident
- ☐ 6 Other (specify) _____
- ☐ 9 Unknown

X **21.** At the time of ingestion of the lethal dose of medication, was the patient receiving hospice care?

- ☐ 1 Yes
- ☐ 2 No, refused care
- ☐ 3 No, other (specify) _____
- ☐ 9 Unknown

22. What is your medical specialty? (*Check all that apply.*)

- ☐ 1 Family Practice
- ☐ 2 Internal Medicine
- ☐ 3 Oncology
- ☐ 4 Other (specify) _____

23. How many years have you been in practice, not including any training periods, such as residency or fellowship?

Years: ____

24. And lastly, do you have any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

_____

_____

_____

Original Signature of Physician: _____

FOR OFFICIAL USE ONLY

CASE ID NUMBER: ☐ DWDA ☐ ILLNESS ☐ OTHER

PHYSICIAN ID NUMBER:

Case ID: _____-_____ Attending ID: _____ _____ _____ _____ _____ ☐ **DWD** ☐ **Illness**
For ODPE use only.

Oregon Death with Dignity Act
Attending Physician Follow-up Form

Dear Physician:

The Death with Dignity Act requires physicians who write a prescription for a lethal dose of medication to complete this follow-up form within **10 calendar days** of a patient's death, whether from ingestion of the lethal dose of medications obtained under the Act or from any other cause.

For DHS to accept this form, it must be signed by the Attending (Prescribing) Physician, whether or not he or she was present at the patient's time of death.

This form should be mailed to the address on the last page. *All information is kept strictly confidential.* If you have any questions, call: 971-673-1150.

Date: ____/____/____ **Patient's Name:** _____

Name of Attending (Prescribing) Physician: _____

_____

Did the patient die from ingesting the lethal dose of medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink? **If unknown, please contact the family or patient's representative.**

☐ 1 **Death with Dignity** (lethal medication) → ***Please sign below and go to page 2.***

Attending (Prescribing) Physician Signature _____

☐ 2 **Underlying illness** → ***There is no need to complete the rest of the form. Please sign below.***

Attending (Prescribing) Physician Signature _____

☐ 3 **Other** → ***There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death andsign.***

Please specify: _____
_____
_____

Attending (Prescribing) Physician Signature _____

Oregon Reporting Form
— questions regarding "ingestion"
— no questions regarding patient consent to administration at the time of such administration.

X **PART A and PART B should only be completed if the patient died from ingesting the lethal dose of medication.**

Please read carefully the following to determine which situation applies to you. Check the box that indicates your scenario, and complete the remainder of the form accordingly.

☐ The Attending (Prescribing) Physician was present at the time of death.

→ The Attending (Prescribing) Physician must complete this form in its entirety and sign Part A and Part B.

☐ The Attending (Prescribing) Physician was not present at the time of death, but another licensed health care provider was present.

→ The licensed health care provider must complete and sign Part A of this form. The Attending (Prescribing) Physician must complete and sign Part B of the form.

☐ Neither the Attending (Prescribing) Physician nor another licensed health care provider was present at the time of death.

→ Part A may be left blank. The Attending (Prescribing) Physician must complete and sign Part B of the form.

PART A: To be completed and signed by the Attending (Prescribing) Physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the lethal dose of medication?

"Took" does not necessarily mean a voluntary act. See the definition of "ingest" at A-36: "to take (food, drugs, etc.) into the body, as by swallowing, inhaling or absorbing."

- ☐ 1 Yes
- ☐ 2 No

X **If no:** Was another physician or trained health care provider or volunteer present when the patient ingested the lethal dose of medication?

- ☐ 1 Yes, another physician
- ☐ 2 Yes, a trained health-care provider/volunteer
- ☐ 3 No
- ☐ 9 Unknown

2. Was the attending physician at the patient's bedside at the time of death?

- ☐1 Yes
- ☐ 2 No

If no: Was another physician or a licensed health care provider or volunteer present at the patient's time of death?

- ☐ 1 Yes, another physician or licensed health care provider
- ☐ 3 No
- ☐ 9 Unknown

3. On what day did the patient consume the lethal dose of medication?

____/____/____ (month/day/year) ☐9 Unknown

4. On what day did the patient die after consuming the lethal dose of medication?

____/____/____ (month/day/year) ☐9 Unknown

X **5.** Where did the patient ingest the lethal dose of medication?

- ☐ 1 Private home
- ☐ 2 Assisted-living residence (including foster care)
- ☐ 3 Nursing home
- ☐ 4 Acute care hospital in-patient
- ☐ 5 In-patient hospice resident
- ☐ 6 Other (specify) _____
- ☐ 9 Unknown

X **6.** What was the time between lethal medication ingestion and unconsciousness?

Minutes: _____ or Hours: _____ ☐ Unknown

X **7.** What was the time between lethal medication ingestion and death?

Minutes: _____ or Hours: _____. ☐ Unknown

X *If the patient lived longer than six hours*, are there any observations on why the patient lived for more than six hours after ingesting the lethal dose of mediation? _____

_____

_____

8. Were there any complications that occurred after the patient took the lethal dose of medication? For example: vomiting, seizures, or regaining consciousness?

- ☐ 1 Yes – vomiting, emesis
- ☐ 2 Yes – seizures
- ☐ 3 Yes – regained consciousness
- ☐ 4 No complications
- ☐ 5 Other – please describe: _____
- ☐ 9 Unknown

X **9.** Was the Emergency Medical System activated for any reason after ingesting the lethal dose of medication?

- ☐ 1 Yes - please describe: _____
- ☐ 2 No
- ☐ 9 Unknown

X **10.** At the time of ingesting the lethal dose of medication, was the patient receiving hospice care?

- ☐ 1 Yes
- ☐ 2 No, refused care
- ☐ 3 No, never offered care
- ☐ 4 No, other (specify) _____
- ☐ 9 Unknown

11. And lastly, are there any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

_____

_____

_____

_____

_____

Signature of Attending (Prescribing) Physician present at time of death:

_____

Name of Licensed Health Care Provider present at time of death if not Attending (Prescribing) Physician:

_____

Signature of Licensed Health Care Provider

_____

PART B : To be completed and signed by the Attending (Prescribing) Physician

12. On what date did the attending physician begin caring for this patient?
____/____/____ (month/day/year)

13. On what date was the prescription written for the lethal dose of medication?
____/____/____ (month/day/year)

14. When the patient initially requested a prescription for a lethal dose of medication, was the patient receiving hospice care?

- ☐ 1 Yes
- ☐ 2 No, refused care
- ☐ 3 No, never offered care
- ☐ 4 No, other (specify) _____
- ☐ 9 Unknown

15. Seven possible concerns that may have contributed to the patient's decision to request a prescription for lethal medication are shown below. Please check "yes," "no," or "Don't know," depending on whether or not you believe that concern contributed to the request.

A concern about...

...the financial cost of treating or prolonging his or her terminal condition.
☐ Yes ☐ No ☐ Don't Know

...the physical or emotional burden on family, friends, or caregivers.
☐ Yes ☐ No ☐ Don't Know

...his or her terminal condition representing a steady loss of autonomy.
☐ Yes ☐ No ☐ Don't Know

...the decreasing ability to participate in activities that made life enjoyable.
☐ Yes ☐ No ☐ Don't Know

...the loss of control of bodily functions, such as incontinence and vomiting.
☐ Yes ☐ No ☐ Don't Know

...inadequate pain control at the end of life.
☐ Yes ☐ No ☐ Don't Know

...a loss of dignity.
☐ Yes ☐ No ☐ Don't Know

16. What type of health-care coverage did the patient have for their underlying illness?
(*Check all that apply.*)

- ☐ 1 Medicare
- ☐ 2 Oregon Health Plan/Medicaid
- ☐ 3 Military/CHAMPUS
- ☐ 4 V.A.
- ☐ 5 Indian Health Service
- ☐ 6 Private insurance (e.g., Kaiser, Blue Cross, Medigap)
- ☐ 7 No insurance
- ☐ 8 Had insurance, don't know type
- ☐ 9 Unknown

17. Are there any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

_____

_____

_____

_____

_____

Signature of Attending (Prescribing) Physician:

_____

Please mail this document to:
Center for Health Statistics
Oregon Department of Human Services
P. O. Box 14050
Portland, OR 97293-0050
Copies of this form are available at: http://oregon.gov/DHS/ph/pas/pasforms.shtml

RCW 70.245.180
Authority of chapter — References to practices under this chapter — Applicable standard of care.

(1) Nothing in this chapter authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide." Consistent with RCW 70.245.010 (7), (11), and (12), 70.245.020(1), 70.245.040(1)(k), 70.245.060,70.245.070 , 70.245.090, 70.245.120 (1) and (2), 70.245.160 (1) and (2), 70.245.170, 70.245.190(1) (a) and (d), and70.245.200 (2), state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication.

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

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

(b) The division shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the division.

(2) The Health Services shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The division shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 s.3.11; 1999 c.423 s.9]

127.870 s.3.12. Effect on construction of wills, contracts and statutes.
(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 s.3.12]

127.875 s.3.13. Insurance or annuity policies.
The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 s.3.13]

127.880 s.3.14. Construction of Act.
Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 s.3.14]

(Immunities and Liabilities)

(Section 4)

Oregon Act

127.885 s.4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.
Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other

Right To Die Is Prescription For Abuse

May 28, 2010

I am a state representative in New Hampshire, where we recently voted down an Oregon-style "death with dignity" act. The vote was 242 to 133 (nearly 70 percent). I disagree with Barbara Coombs Lee that such legislation brings "choice" to elders [Opinion, May 16, "Elders Deserve Choices, Not Just A Bitter End"].

In New Hampshire, many legislators who initially thought that they were for the act became uncomfortable when they studied it further. Contrary to promoting "choice" for older people, these acts are a prescription for abuse. These acts empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money. There is no assisted-suicide bill that you can write to correct this huge problem.

Do not be deceived.

Nancy Elliott, Merrimack, N.H.

Find more stories about

- New Hampshire

FEATURED ARTICLES

Town News Briefing
June 27, 2006

Seniors' Main Issue: War
October 25, 2004

A Crisis Worsening With Age
December 25, 2000

NH House Leadership

Speaker of the House

State Rep. Terie Norelli was elected Speaker of the House for the 2007-2008 biennium on December 6, 2006. This is her sixth term in the House, and she is the first female Democratic Speaker of the New Hampshire House of Representatives. Rep. Linda Foster of Mont Vernon serves as Deputy Speaker of the House.

The Speaker's duties are varied. Not only does the Speaker preside over a House session (preserving order while enforcing and interpreting the House parliamentary rules), it is also the Speaker's responsibility to make committee appointments and refer more than 1,000 bills to the appropriate committee for review. The only time the Speaker votes is to break a tie.

Majority and Minority Leaders

The primary responsibilities of the Majority and Minority leaders are: to organize and develop party positions; to provide channels of communications between the party and the Speaker and work closely with the various groups within their party. Democrat Mary Jane Wallner of Concord serves as Majority Leader. The Republican Leader is Sherman Packard of Londonderry.

Delivered-To: margaretdore@margaretdore.com
Authentication-Results: mx.google.com; spf=neutral (google.com: 216.177.20.245 is neither permitted nor denied by best guess record for domain of Dave.Nadeau@leg.state.nh.us) smtp.mail=Dave.Nadeau@leg.state.nh.us
Subject: NH Vote on HB304
Date: Mon, 23 Aug 2010 16:10:45 -0400
X-MS-Has-Attach:
X-MS-TNEF-Correlator:
Thread-Topic: NH Vote on HB304
Thread-Index: ActC/0VpIoAIIuLJRMiWqWQg4jWwhQ==
From: "Nadeau, David" <Dave.Nadeau@leg.state.nh.us>
To: <margaretdore@margaretdore.com>
Cc: "Kelly, Stan (stan.kelly@leg.state.nh.us)" <Stan.Kelly@leg.state.nh.us>

Hi Margaret!
Here is the information you requested:

The vote breakdown for HB304 for the roll call taken on 1/13/2010 is as follows:

YEA
DEMOCRATS 100
REPUBLICANS 142
242

NAY
DEMOCRATS 93
REPUBLICANS 20
113

] votes to defeat the bill

] votes in favor of the bill

TOTAL VOTING:
DEMOCRATS 193
REPUBLICANS 162
355

Bipartisan Vote to defeat Oregon-style bill.

NOT VOTING:
EXCUSED
DEM 20
REP 11
NOT EXCUSED
DEM 8
REP 4
PRESIDING DEM 1 (Speaker of the House)
44

VACANT SEATS 1

TOTAL 400

David E. Nadeau
Asst. Manager, Senior Software Engineer
General Court Information Systems

greatfallstribune.com
GREAT FALLS, MONTANA

June 10, 2009

Forum will focus on the rapid growth in abuse of elders

The statistics are frightening, and unless human nature takes a turn for the better, they're almost certain to get worse.

We're talking about the numbers of seniors who fall victim to abuse, exploitation or neglect — *in Montana.*

The graphic at right shows a substantial year-over-year increase in cases — 22 percent for abuse, for example — but the numbers over the past decade in our nine-county region are even more dramatic.

Abuse cases nearly doubled, and exploitation and neglect cases both tripled from 1998 to 2008.

The state division of Adult Protective Services expects the trend to worsen.

"I anticipate that the economic stresses ... the increase in gambling addiction, the increase in child support payment enforcement and the unrealistic lifestyle expectation of the younger generation will contribute to the increased referrals," said division Director Rick Bartos.

Sheer numbers of seniors will contribute further as baby boomers age — the so-called "golden years" also are the years of increased vulnerability.

To help area residents and officials prepare and cope with these seemingly inevitable trends, an organization called the Elder Abuse Prevention Forum will sponsor a public meeting at the Rainbow Assisted Living Community from 1-7 p.m. Friday, which happens to be National Elder Abuse Prevention Day.

The public is invited, and there's no charge.

Speakers will include Sgt. Jeff Newton, Great Falls Police Department; Jim Francetich, Adult Protective Services; Sheriff Dave Castle; County Attorney John Parker; and District Judge Dirk Sandefur.

There also will be 30 booths from vendors who serve seniors. The forum is a grass-roots coalition of groups and individuals.

ELDER ABUSE PREVENTION

TOOLS
- 3 COMMENTS
- EMAIL THIS ARTICLE
- PRINT THIS ARTICLE
- YOUNEWS™
- DIGG THIS!
- SAVE TO DELICIOUS
- POST TO FACEBOOK
- SHARE ON TWITTER

By Nicole Grigg
Story Published: Jun 15, 2010 at 5:15 PM MDT
(Story Updated: Jun 16, 2010 at 10:26 AM MDT)

MULTIMEDIA
WATCH THE VIDEO

BILLINGS - Elderly people across the country are victims of abuse on a daily basis. A Billings organization was one of the first in the nation to spread awareness of this often unseen abuse.
There are many warning signs to look for if your loved one is being victimized and different types of abuse. There's physical, emotional, psychological, and sexual.

Social worker Nikki Nielsen is talking about the different forms of elder abuse. She's handling 40 cases right now in Billings. Big Sky Senior Services works to prevent abuse, neglect and financial exploitation of seniors age 60 and older.

"Someone's relative coming and saying they are going to help out and in fact they end up getting hold of the person's bank account and unfortunately wiping out their savings they saved up all their lives," is the most common cases Nielsen said she sees.

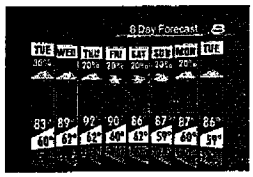
Only one in ten cases of elder abuse is actually reported. More than 900 cases of abuse were reported in Montana last year. Director of Big Sky services Denise Armstrong said financial exploitation is the fastest growing form of abuse because elders are so trustworthy.

"I encourage all seniors to review their bank statements every single month. Protect your identification and if someone calls asking for your account number or social security number never give out your information over the phone. The other thing we always say if it sounds to good to be true, then it is too good to be true," said Armstrong.

Armstrong said one reason elder abuse is so underreported is that often time the victimizer is a family member and the elderly victim doesn't want to get them in trouble.

Next article
Helping Disabled Adults

YOUR WEATHER AUTHORITY



84.0 °F
Current Temp

Partly Cloudy

Wind : North at 10.4 mph
Humidity : 25 %
Pressure : 29.89 in

More Weather

SKY CAM

AP VIDEO


BP's Hayward to Leave As CEO; Russia Job on Tap
Play


Gibbs: Leaked Documents a Potential Threat
Play


Swaths of Washington in Dark After Huge Storm
Play

ON DEMAND

Facebook
Become a part of KULR8 News!!

Twitter
Follow KULR-8 on Twitter!

E-Newsletters
Top stories, weather, and breaking news!

CAST YOUR VOTE

Do you believe the Wall Street Reform Law will keep another economic meltdown from happening?

- Yes
- No

Submit

MOST POPULAR

- Heights Fire
- Greenhouse Concert
- Emergency Landing
- Bison Attack Investigation
- Garage Sales Bring in Money
- Local Couple Sues State
- Body Identified
- Big Night for City Council
- Pedestrian Fatal

What is Elder Abuse

Physical Abuse • Neglect and Abuse by Caregiver
Psychological/Emotional Abuse • Abandonment
Self-Neglect • Sexual Abuse • Financial Abuse
• Signs of Distress • Two Case Studies

Physical Abuse

Any physical pain or injury that is willfully inflicted upon an elder by a person who has care of or custody of, or who stands in a position of trust with that elder, constitutes physical abuse. This includes, but is not limited to, direct beatings, sexual assault, unreasonable physical restraint, and prolonged deprivation of food or water.

Possible Indicators of Physical Abuse

- Cuts, lacerations, puncture wounds
- Bruises, welts, discoloration
- Any injury incompatible with history
- Any injury which has not been properly addressed
- Poor skin condition or poor skin hygiene
- Absence of hair and /or hemorrhaging below the scalp
- Dehydration and/or malnourished without illness-related cause
- Weight loss
- Burns: may be caused by cigarettes, caustics, acids, friction from ropes or chains, or other objects
- Soiled clothing or bed

Neglect and Abuse by Caregiver [Back to Top]

The failure of any person having the care or custody of an elder to provide that degree of care which a reasonable person in a like position would provide constitutes neglect. This includes, but is not limited to:

1. Failure to assist in personal hygiene or the provision of clothing for an elder
2. Failure to provide medical care for the physical and mental health needs of an elder
3. Failure to protect an elder from health and safety standards

Possible Indicators of Neglect by Caregiver:

- Dirt, fecal/urine smell, or other health and safety hazards in elder's living environment
- Rashes, sores, lice on elder

- Inadequate clothing
- Elder is malnourished or dehydrated
- Elder has an untreated medical condition

Possible Indicators of Abuse by Caregiver:

- The elder may not have been given an opportunity to speak for him or herself, or see others without the presence of the caregiver.
- Attitude of indifference or anger toward the dependent person, or the obvious absence of assistance
- Family members or caregiver blames the elder
- Aggressive behavior by caregiver toward the elder (threats, insults, harassment)
- Previous history of abuse of others
- Problem with alcohol or drugs
- Inappropriate display of affection by the caregiver
- Flirtations, coyness, etc. as possible indicators of inappropriate sexual relationship
- Social isolation of family, or isolation or restriction of activity of the older adult within the family unit by the caregiver
- Conflicting accounts of incidents by family, supporters, or victim
- Unwillingness or reluctance by the caregiver to comply with service providers in planning and implementing care-plan
- Inappropriate or unwarranted defensiveness by caregiver

Psychological/Emotional Abuse [Back to Top]

The willful infliction of mental suffering, by a person in a position of trust with an elder, constitutes psychological/emotional abuses. Example of such abuse are: verbal assaults, threats, instilling fear, humiliation, intimidation, or isolation of an elder.

Abandonment [Back to Top]

Abandonment constitutes the desertion or willful forsaking of an elder by a person having the care and custody of that elder, under circumstances in which a reasonable person will continue to provide care or custody.

Self-Neglect [Back to Top]

Failure to provide for self through inattention or dissipation. The identification of this type of cause depends on assessing the elder's ability to choose a lifestyle versus a recent change in the elder's ability to manage.

Sexual Abuse [Back to Top]

The non-consensual sexual contact of any kind with an elderly person.

Financial Abuse [Back to Top]

Financial Exploitation means the initial depletion of bank account, credit accounts or other resources for the benefit or advantage of the offender.

Possible indicators of Financial Abuse:

- Unusual or inappropriate activity in bank accounts
- Signatures on checks, etc. that do not resemble the older person's signature, or signed when the elder person cannot write
- Power of attorney given, or recent changes or creation of will, when the person is incapable of making such decisions
- Unusual concern by caregiver that an excessive amount of money is being expended on the care of the person
- Numerous unpaid bills, overdue rent, when someone is supposed to be paying the bills for a dependent elder
- Placement in nursing home or residential care facility which is not commensurate with alleged size of estate

- Lack of amenities, such as TV, personal grooming items, appropriate clothing, that the estate can well afford

An elderly person may be at risk for abuse, neglect and/or exploitation if:

- The level of care they are receiving is inconsistent with their resources or needs
- They seem nervous or afraid of the person accompanying or 'helping' them
- Someone displays sudden attention or affection for the elder
- Someone promises life-long care in exchange for property
- They are unable to remember signing documents or making financial transactions
- Someone is attempting to isolate them from family or other support
- Property is transferred to someone else or is reported missing
- They seem confused about transactions or withdrawals from their account
- They seem coerced into making transactions
- The elder or the acquaintance gives implausible explanations of finances or expenses
- Sudden changes in the elder's appearance or self-care
- The elder becomes emotionally or physically withdrawn
- A professional 'assisting' them behaves or responds questionably

Financial exploitation of our elderly is a growing problem and is under reported by the victim's family or caregivers. Financial exploitation means the intentional depletion of bank account, credit accounts or other resources for the benefit or advantage of the offender. Victims of financial exploitation may live in the community or in a health care facility; may be in poor health or have a diminished mental capacity and can be easily swayed. The motivation of the offender to steal will probably fall into one of two categories; greed or desperation.

Financial abuse robs many elderly victims of their homes, life savings and possessions, as well as their dignity and independence. The damage is devastating because it comes at a time when the elderly victim is least likely to recover what they have lost.

To help prevent the depletion of an elder's financial assets, Big Sky Prevention of Elder Abuse Program formed a Task Force that developed an effective training model for reporting suspect situations. This Financial Exploitation Training Manual, Video and PowerPoint includes forms, procedures and remedies for reporting to the appropriate authorities when abuse is detected and is available to the public.

Signs of Distress [Back to Top]

- Unkempt lawns/walks
- Disheveled personal appearance
- Loss of hearing, vision, weight, difficulty moving about
- Increased withdrawal, isolation
- Disorientation, forgetfulness, confusion
- Any marked change in overall ability to function>

Two Case Studies

[Back to Top]

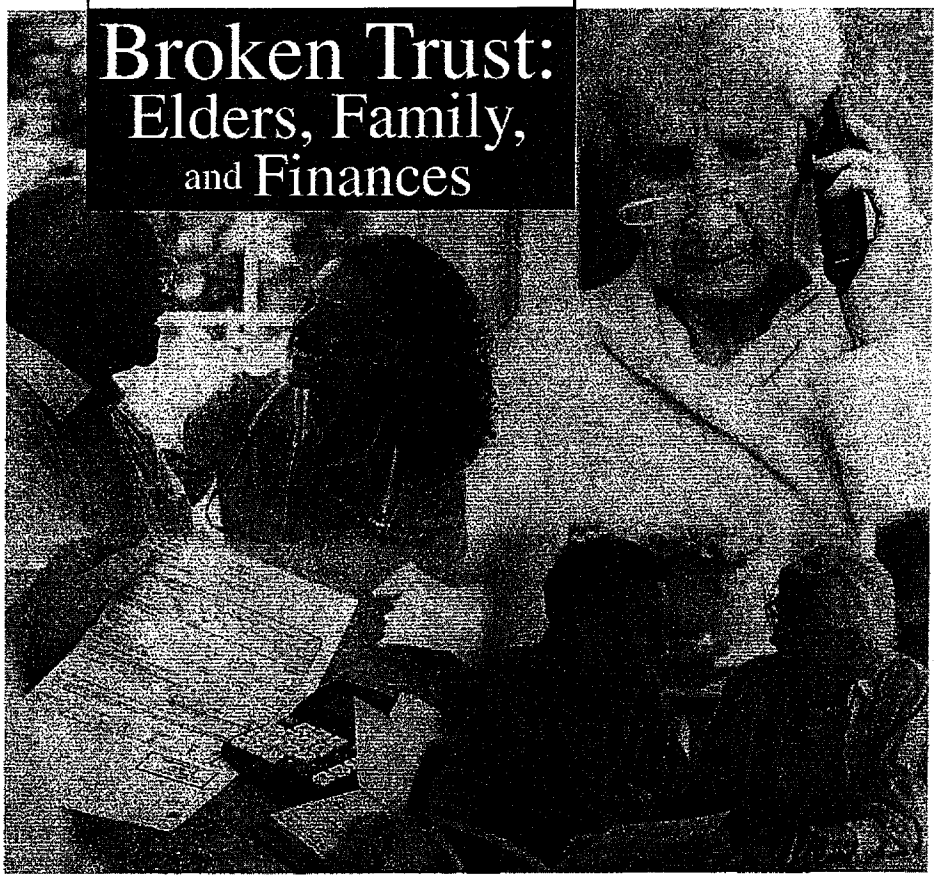
Medical Neglect

A call was received concerning an elderly man residing in an unlicensed care home. Harold was placed in the home by a relative when his care needs became too great for her to manage. Harold exhibits dementia, hearing impairment, and incontinence of urine. He ambulates with a walker and is prone to falls.

After slipping in the bathroom one evening, Harold sustained a five-inch laceration to his right calf. The care provider transported Harold to the emergency room where the cut was sutured. Care instructions and recommendations for follow-up treatment were given. Several weeks passed and Harold was seen again in the emergency room. The

STUDY

Broken Trust: Elders, Family, and Finances



A Study on Elder Financial Abuse Prevention

by the MetLife Mature Market Institute, the National Committee for the Prevention of Elder Abuse, and the Center for Gerontology at Virginia Polytechnic Institute and State University

MARCH 2009

MetLife
Mature Market
INSTITUTE

http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

Executive Summary

This study from the MetLife Mature Market Institute (MMI), the National Committee for the Prevention of Elder Abuse, and the Center for Gerontology at Virginia Polytechnic Institute and State University provides a comprehensive understanding about the extent and implications of elder financial abuse in all its various manifestations—personal, institutional, and societal. Through an extensive review of available information on elder abuse, this research enhances the understanding of the complexities surrounding elder financial abuse, the current magnitude of the issue, reasons why this issue is likely to grow, and some recommendations of ways to potentially mitigate this complex and devastating crime.

While difficult to present any comprehensive or consensus definition of elder financial abuse, this study considers elder financial abuse as "the unauthorized use or illegal taking of funds or property of people aged 60 and older." It is perpetrated by those who gain, and then violate, the trust of an older person. They can be as close as a family member, neighbor, or friend, or as distant as an invisible voice on the telephone or an e-mail from the other side of the globe.

Key Findings:

- While underreported, the annual financial loss by victims of elder financial abuse is estimated to be at least $2.6 billion dollars
- Elders' vulnerabilities and larger net worth make them a prime target for financial abuse
- The increased aging of the population, social changes, and technology advances will lead to a dramatic increase in the opportunity for a growing level of elder financial abuse
- The perpetrators of elder financial abuse are typically not strangers and most are people who have gained the trust of the older individual, including business and service professionals and family members
- The victims of elder financial abuse come from all walks of life, and this type of abuse affects elders regardless of gender, race, or ethnicity

With good reason, financial elder abuse has been characterized by some experts as "the crime of the 21st Century."[1]

–J.F. Wasik, Journalist

[1] http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

Prevalence of Elder Financial Abuse

Both researchers and practitioners acknowledge that estimates of elder financial abuse represent only the most overt cases, thus significantly underestimating the incidence of financial abuse of elders living in the community. Even less definitive information is available about the prevalence of financial abuse in residential long-term care settings.

Estimates of the occurrence of elder financial abuse vary considerably. The source of information about this abuse is one reason for the variation, as some estimates are predicated on anecdotal information of what people are seeing and reporting at best, while others are founded on a "sentinel approach" (i.e., purposefully selected reporters) to estimating the size of the problem. For example, the 1996 National Incidence Study conducted by the National Center on Elder Abuse found that elder financial abuse constituted 30.2% of 70,942 substantiated cases of elder abuse.[15] According to reports from the Santa Clara County Financial Abuse Specialist Team (FAST) in California, there may be as many as five million elders financially abused yearly.[16] Reports to authorities of its occurrence range from one report for every four or five cases to one report in 100 instances.

The Perpetrators of Elder Financial Abuse

In the review of NAPSA/NCEA Newsfeeds from April 2008 through June 2008, the media reported a total dollar value of elder financial abuse of approximately $396,654,700, with the largest percentage of cases involving close associates of the victim—families, friends, caregivers, and neighbors—as the perpetrator of the abuse, accounting collectively for almost 40% of reported cases. The largest single category included a variety of financial professionals, attorneys, and fiduciary agents.

Table 2: Perpetrators by Type

PERPETRATOR	TOTAL	PERCENTAGE
Trusted Professionals	48	18.0
Family	45	16.9
Caregiver (non-agency)	29	10.9
Caregiver (agency)	25	9.3
Skilled Nursing Facility/Assisted Living	20	7.5
Medicaid/Medical Fraud	18	6.7
Befriending ("Sweetheart Scam")	15	5.6
Home Repair Scam (includes travelers/handyman)	15	5.6
Stranger	14	5.3
Contractors	12	4.5
Criminal (robbery, burglary, rape, drugs, etc.)	8	3.0
Neighbor—Friend	8	3.0
Con Man	5	1.9
Phone Scam	4	1.5
Total	**266***	**99.8%****

***Does not equal 100 due to rounding.*
Number and percentage distribution of perpetrators of financial abuse—from Newsfeeds April 1, 2008—June 30, 2008 (n=266)
**Note, 266 is the number of cases that provided perpetrator information. Total number of cases was 269; total number of articles addressing elder financial abuse in any form was 357 of total of 1,007 articles.*

[12] http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

Elder Financial Abuse by Family Members

Family members, even more so than strangers, financially exploit their elderly relatives. Although there is no definitive estimate of the number of older adults who experience financial abuse by family members, community service providers and other professionals agree that cases actually reported to authorities represent only the very "tip of the iceberg." Like King Lear, when people in their later years encounter health problems that diminish their physical or cognitive capacities, they usually first turn to family members for assistance and support.

In most situations, family members nobly assume their caregiving role; but in others, family members—sons, daughters, grandchildren, nieces, and nephews—take advantage of the elders' dependencies and become perpetrators of financial abuse. Approximately 60% of substantiated Adult Protective Services (APS) cases of financial abuse involve an adult child, compared to 47% for all other forms of abuse.[17]

The elder's grandchildren and other relatives are almost equally as likely to be perpetrators of financial abuse (9.2% and 9.7%, respectively). In the primary literature, male and female relatives are equally likely to be financial abusers of older adults. However, the media-reported instances revealed that elder financial abuse was 2.5 times more likely to be committed by sons than daughters. Overall, 45 incidents (16.9%) of elder financial abuse described in the media involved immediate relatives. Family perpetrators often misuse their powers of attorney to steal money from bank accounts, obtain credit cards to make unauthorized purchases, and embezzle large sums of money by refinancing the elder's home, among other examples of financial abuse.[18]

It is unknown what factors contribute to the likelihood of family members financially exploiting their elderly relatives, as no rigorous research has been done. Scholars and practitioners speculate that, like perpetrators of other types of elder abuse, family members who exploit their elders are dependent upon them for their own survival (e.g., shelter and finances) and their actions may be influenced by problems with alcohol, drug abuse, and gambling, and many may suffer from antisocial behavior disorders.

Tensions and inequalities between the elder and family member, perhaps stemming from the relative's dependency and mental health issues, enhance the likelihood of financial abuse. For example, an unemployed adult child living in the home of a parent might be more likely to exploit the elder than an adult child with a steady income and their own place of residence, or one generation abused another and then the "abuser role" is reversed.[19]

American Bar Association

ABANet

An American Bar Association report noted an ongoing case where a mother gave her son her power of attorney. The mother then sold her home, moved in with the son, and gave the proceeds to her son to build an addition to the son's house where she could live. The son subsequently claimed that the contractors he paid did not do the work on the house. The son then dropped the mother off at a local hospital and refused to bring her home.

After staying in the hospital for about two and a half months, a nursing home was finally located for placement for her. However, because the mother is now impoverished after giving her assets to her son, Medicaid is taking the position that the transfers to the son were disqualifying for Medicaid coverage eligibility purposes, and the placement may very well become disrupted.

The Brooklyn Tab

June 25, 2008

A 68-year-old man with experience in owning a business and making investments was allegedly scammed out of $26,500 by a man who promised him a $500 a week return on his money. Mr. J had hoped to supplement his and his wife's Social Security income with that money. When Mr. J requested a formal written proposal, the alleged perpetrator was unable to provide one.

Mr. J then requested that his money be returned. This resulted in getting "every excuse in the book" from the alleged perpetrator, but no check. Finally an attorney was retained, a check was provided, but it bounced. Mr. J still has not received his $26,500, nor has he received a $500 a week return on it.

financial abuse include neighbors, apartment managers, home health aides, ministers, those with power of attorney, and guardians.

They initially extended helping hands to the elders and gradually are overcome by greed; contractors and handymen who ripped off the elders with bogus charges; phony financial planners and professional con artists who provided "free" services for elders to gain their trust and then defrauded them later; and others who befriended the elders to take advantage of them.

One trait perpetrators of elder financial abuse have in common is that they exhibit excellent persuasion skills. They are very good at cultivating relationships and convincing older adults that they are worthy of their trust and money. In general, perpetrators are not bound by conventional norms or business ethics, and rationalize their criminal and abusive behavior.

The *Sarasota Herald Tribune* (June 12, 2008) estimated that since 2000, southwest Florida elders alone have lost at least $350 million to swindlers. Individuals involved in exploiting older adults may use "undue influence"—the substitution of one person's will for the true desires of another.[25] In these cases, the perpetrator uses his or her role and power to exploit the trust, dependency, or fear to gain psychological control over the older adult's decision-making, usually for financial gain. Some are career professionals in the business of defrauding others, while others are initially in a position of trust who apparently are overcome by greed. They encourage their elderly victims to make an immediate decision or commitment to purchase products or services, which effectively limits the opportunity for consultation with others.

As the elderly population grows, so too does their presence on the Internet. The Federal Trade Commission reported that in 2004, elders who filed complaints about Internet fraud each lost an average of $1,280 to individuals and businesses operating Internet scams.[26] Common Internet scams used with older adults are "phishing" and identity theft. Using carefully crafted e-mail messages that appear to be from legitimate and reputable banks, companies, and government agencies, the perpetrators often use scare tactics such as threats of account closures to lure in their elderly victims.

As the newest demographic to venture in cyberspace, older adults are generally least educated about the dangers and intricacies of phishing and other fraudulent practices.[27-28]

"Elder financial abuse is a crime growing in intensity and, especially now, with the plummeting economy, elders will be unable to recover from such losses."

–Pamela Teaster, President, National Committee for the Prevention of Elder Abuse

[16] http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

"Approximately 60% of substantiated Adult Protective Services (APS) cases of financial abuse involve an adult child, compared to 47% for all other forms of abuse."

Table 4: Relationship of Perpetrator to Victim

NON-INSTITUTIONAL PERPETRATORS

Family: including "fictive kin" (i.e., non-relatives considered to be "like" family), son/daughter, grandson/granddaughter, niece/nephew, and other relatives

Family, Caregivers, and Friends		**82**
Family		45
Son	18	
Daughter	7	
Nephew/Niece	7	
Granddaughter/Grandson	6	
Other Relatives	6	
Fictive Kin	1	
Caregiver (non-agency)		29
Neighbor/Friend		8
Others		**65**
Befriended ("Sweetheart Scam")	15	
Stranger	14	
Contractors	12	
Handyman/Chores/Caretaker	9	
Con Man	5	
Home Repair Scam	4	
Phone Scams	4	
"Travelers"	2	
Criminal		**8**
Robber/Burglar	4	
Transient	2	
Serial Rapist	1	
Drugs	1	

INSTITUTIONAL PERPETRATORS

Trusted Professionals		**48**
Financial	33	
Attorneys/Paralegal	11	
Pastor/Minister	2	
Executors/Trustees	1	
CPA	1	
Other		**63**
Caregiver (agency/facility)	25	
SNF/ALF/Personal Care Home Owner/Operator/Business Manager	20	
Medicare/Medicaid Fraud	15	
Health Care Fraud	1	
Hearing Aid Business	1	
Therapist	1	

http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

double over the next 15 years.[36] Non-family members, paid and unpaid, are providing more care as well.

- **Recognizing Diversity Within and Across Cultures Is Necessary for Implementing Effective Prevention, Investigation, and Intervention Efforts**

Due to a rapidly increasing population of different races and ethnicities, perceptions of the problem are as different as its remedies.

For example, what one culture considers elder financial abuse may not be the belief of another, which also affects when it is acceptable and who is acceptable to involve in intervention strategies.

- **Artful and Designing Ways to Financially Abuse Elders Are Increasingly Varied**

Technologies such as the Internet are opening up new and "creative" ways to financially abuse elders. Increasingly, an elder's identity is universally available to others through online purchases, Internet dating, and virtual social networks. Systems to address the problem have not caught up with its growing variety and complexity, such as the growing instances of Internet-based fraud of older consumers.[37]

Houston Chronicle

June 9, 2008

More than 80 older adults of various ages were the victims of securities fraud perpetrated by an attorney over an extended period of time. The amount of money involved was over $10 million, and the attorney asked for probation at his sentencing hearing. He was sentenced to 20 years in prison.

Restitution for a portion of the amount taken was realized by selling his assets, and victims were reimbursed on a pro-rata basis. When he has completed his sentence, he must pay nearly $4 million additional in restitution.

"The older population owns the largest proportion of wealth in the U.S. People over 50 years of age control at least 70% of the net worth of the nation's households."

http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

Scholars, practitioners, and policymakers are all grappling with often complex legal, financial, medical, and familial issues surrounding elder financial abuse. As a result, information about, and documentation of, the problem and practices to prevent and alleviate such abuse are scattered across multiple disciplines and sources. The resulting absence of a comprehensive knowledge base impedes the development of preventive practices, interventions, and policies that strive to eliminate elder financial abuse and maximize individual autonomy and quality of life of older adults.

The Tip of the Iceberg: Why Victims Do Not Report

A significant reason for the underestimation of the occurrence of elder financial abuse is the victims themselves do not report elder financial abuse for a variety of reasons. Among the multitude of reasons uncovered, the victims:

- Do not want government interference in their personal lives
- Do not want their adult child or other family member going to jail or facing public embarrassment
- Feel responsible for what has happened
- Do not realize that they have been financially abused
- Believe financial abuse is a consequence of "doing business" or taking risks
- Fear that they will be placed in a nursing home or other facility
- Do not think anyone will really help them, even if they expose the abuse
- Worry that the perpetrator might harm them even more
- Think resolution will come too late to be of any good
- Believe they will lose even more money to costs of pursuing the financial abuse

Financial and other professionals who deal with elders generally feel a responsibility to help protect their elderly clients from harm or abuse of any kind. However, they often fail to get involved when they suspect elder financial abuse because they:

- Do not know if they are mandated reporters in some states
- Do not want to compromise professional relationships (confidentiality vs. mandatory reporting)
- Are not clear who their client is (older adult or their family members)
- Are not able to determine the actual mental capacity of their older clients, a determination that affects decisions made by them and on their behalf
- Want to avoid adverse publicity to themselves and their organizations
- Do not understand business ethics and practices in relation to elder financial abuse
- Do not want to incriminate a fellow professional
- Want to avoid involvement in a criminal investigation and potential lawsuit

http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

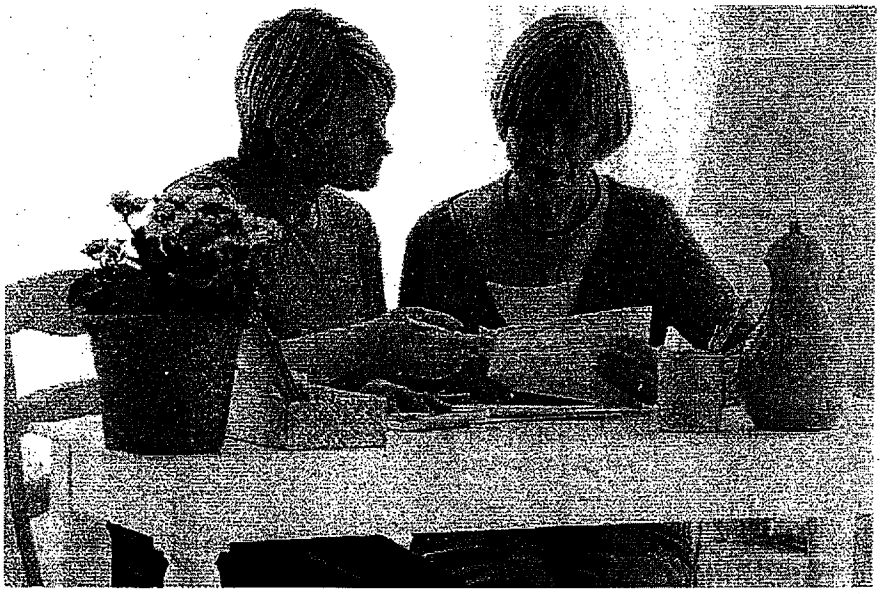
Lasting Impact of Elder Financial Abuse

Perhaps elder financial abuse has received limited attention, both in the popular press and in the research literature, because it is not regarded as visible, life-threatening, or newsworthy as is the physical or sexual abuse of elders. Still, elder financial abuse affects elders and their families in significant and long-lasting ways by putting enormous emotional duress on the elder, increasing their risk of depression, decreasing their quality of life, and increasing unnecessary institutionalization.[40]

A National Institute of Justice study revealed that 20% of victims suffered financial or credit problems, with 14% subsequently suffering health effects.[41] Some scholars contend that the impact of elder financial abuse has the same effect as being a victim of a violent crime, reporting that at least one victim likened this kind of abuse to being raped. If restitution is offered for elder financial abuse, it may come too late to be of any help to an elder, who may well have passed away before any ever reaches him or her.

Elder financial abuse can impact an elder by eradicating nearly all of his or her financial resources. Unlike younger people, an older adult will have little to no ability to recoup these losses over time. Also, even if the courts order restitution, it may take years to receive it, and the victim may well pass away before it ever reaches him or her. Victims may even be murdered by perpetrators who just want their funds and see them as an easy mark.

Loss of finances limits choices in health care and other services. They may be unable to afford needed medications. Restricted choices can reduce or completely destroy an elder's independence. Moreover, such losses can result in shame, guilt, or general mistrust escalating into paranoia or depression. Untreated or undetected depression can cause death by passive or active suicide.[42-43]



[24] http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

Local

'Black Widows' in court for homeless murders

Tuesday, March 18, 2008

Olga Rutterschmidt and Helen Louise Golay have been awaiting trial for two years. (KABC Photo / KABC)

TAGS: local, miriam hernandez

Comment Now Email Print Report a typo

LOS ANGELES (KABC) -- The trial began Tuesday for two elderly women dubbed the "Black Widows." They're accused of murdering homeless men for millions of dollars in insurance money.

In a very lengthy opening statement, the prosecution detailed how it says the defendants laid out a plan to collect more than $2 million in life insurance.

Prosecutors say 75-year-old Olga Rutterschmidt and 77-year-old Helen Louise Golay befriended two homeless men, 73-year-old Paul Vados and 51-year-old Kenneth McDavid. They claim Rutterschmidt and Golay offered to pay the men rent for studio apartments in exchange for their signature on life insurance policies.

Authorities say the women then had rubber stamps made of those signatures and completed 19 additional life insurance policies, making themselves the sole beneficiaries.

Police allege the defendants staged two separate hit-and-run incidents in secluded alleyways in Los Angeles, killing Vados and McDavid and then collecting $2.8 million.

During opening statements, the prosecution showed jurors grim coroner's photos of McDavid at the crime scene. Prosecutors also presented a timeline that showed within four minutes of McDavid being struck, Golay called for a tow truck to get rid of the vehicle involved.

Deputy District Attorney Truc Do detailed a nefarious plot: Selecting homeless men Kenneth McDavid and Paul Vados, paying their rent, taking out dozens of insurance policies, claiming to be a cousin or fiancee, then to cash in on their claim, allegedly running them over with a car.

The D.A. flashed surveillance photos of a silver station wagon entering a dark alley, stopping for four minutes, going into reverse, then accelerating. Documents were shown linking the car to Golay.

Investigators tracked the car down, allegedly finding the DNA of Kenneth McDavid on the undercarriage.

Attorney Gloria Allred represents McDavid's family, who may later sue for damages.

"It is the first time they are hearing an explanation from the prosecution in such detail," said Allred.

But a surprise appearance in the news conference outside the court: Defense attorney for Helen Golay, Roger Jon Diamond cautioned against a rush to judgment.

"I intervened to make sure that the press covers this case properly," said Diamond, Golay's attorney.

"And what are you concerned about, that we've said on behalf of the victims, that they're in pain, that they're devastated by the loss of their brother? What's wrong with that? That's true," said Allred to Diamond. "He's dead. He's never coming back."

"The issue is who caused the death," replied Diamond.

Evidence of fraud surfaced in an undercover video. Investigators recording the two women talking after their arrest.

"Did you read the accusation?" says Rutterschmidt. "Why did you get all those insurances? You were too greedy, that's the problem."

"Be quiet, be careful what you say," replies Golay. "All they are after is mail fraud."

Rutterschmidt, referring to their claim as next of kin: "I was the cousin, you were the fiancée. Baloney."

Hot Topics » Jobs (http://www.jobs-midlands.com/)
Cerys Edwards (http://www.birminghammail.net/news/top-stories/2010/10/09/horrific-car-smash-survivor-cerys-edwards-returns-home-four-years-after-crash-97319-27433942/)
CrimeFiles (http://www.birminghammail.net/news/crime-news/)
Treyc Cohen (http://www.birminghammail.net/news/birmingham-mail-indepth/the-x-factor-2010/)
High School admissions (http://www.birminghammail.net/birmingham-schools/schools-admissons/)

Birmingham man wrongly told he has six to live with terminal cancer

Oct 12 2010
(http://www.birminghammail.net/news/top-stories/2010/10/12/)
by Alison Dayani
(http://www.birminghammail.net/authors/alison-dayani/), Birmingham Mail

Comments (5) (#sitelife-commentsWidget-bottom)
Recommend (#none)

A BIRMINGHAM man who claims he was told he had just six months to live sold many of his precious possessions before discovering he wasn't going to die.

Malcolm McMahon sold most heirlooms left by his parents, gave away his dog, cashed in premium bonds, made a will and put his house up for sale – only to find out his life was not at risk after all.

Mr McMahon, 55, from Erdington, claimed the terminal cancer diagnosis caused emotional turmoil for his girlfriend and relatives, who had already suffered the death of his mother and brother to lung cancer in recent years.

He also revealed he considered suicide, so he would not go through the heartache his late brother Robert faced. And he was "so low", he was caught drink driving days after his visit to the GP – and ultimately given a 22-month driving ban.

STREET TALK

by Cathrine L. Walters

Asked Tuesday morning in downtown Missoula.

Q: This week arts editor Erika Fredrickson profiles Missoula singer-songwriter Ethan Thompson, whose band wrote the winning jingle for a competition hosted by Folgers. In your opinion, what's the best part of waking up?
Follow-up: What advertising slogan or jingle do you find catchiest?

David Winterburn: I'm a medical marijuana patient so I like to have a little medicine to start my day. It's more of a spiritual awakening. Cold one: For all you do, this Bud's for you.

Teri Gonzalez: Having a whole new day, heart beating, still have my soul and the opportunity to make a smile and not a frown. Git 'er done: Just do it.

Becky Douglas: There are no rules for what I have to do. We live in a liberated country. Being a woman and a momma, I have every option open to me and I really appreciate that. **Deconstructing America:** Saving wood for good. I'm the co-owner of Heritage Timber, and we take down old buildings and sell the reclaimed wood.

John Teten: Besides Folgers in my cup? I can't think of anything good about waking up. Maybe fresh sunshine on a hot day with an unannounced bucket of water in my face. Pickled: That's the tastiest crunch I've ever heard!

Second life

I am a retired office worker, who lives in Oregon where assisted suicide is legal. Our law was enacted via a ballot initiative, which I voted for. I write in response to your article about Sen. Hinkle's bill to prohibit assisted suicide in Montana (see "etc.," June 10, 2010).

In 2000, I was diagnosed with colon cancer and told that I had six 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, but he didn't really answer me.

I did not want to suffer. I wanted to do our law and I wanted my doctor to help me. Instead, he encouraged me to not give up and ultimately I decided to fight. I had both chemotherapy and radiation. I am so happy to be alive!

It is now nearly 10 years later. If my doctor had believed in assisted suicide, I would be dead. I thank him and all my doctors for helping me choose "life with dignity." I also agree with Sen. Hinkle that assisted suicide should not be legal. Don't make Oregon's mistake.

Jeanette Hall
King City, Ore.

Die free or live?

I am a state representative in New Hampshire where we recently voted down an Oregon-style assisted suicide bill. The vote was 242–133 (nearly 70 percent). I write in response to your editorial. I disagree that assisted suicide necessarily brings "choice."

In New Hampshire, many legislators who initially thought that they were for the bill, became uncomfortable when they studied it further. Contrary to promoting "choice," it was a prescription for abuse. These laws empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money. There is *no* assisted suicide law that you can write to correct this huge problem. Do not be deceived.

Nancy Elliott
Merrimack, N.H.

Another side of Israel

The only thing new in Ochenski's anti-Israel rant (see "Israel's enablers," June 3, 2010) is that he saved the "some of my best friends are Jewish" line for the end of his column. Most racists, homophobes and anti-Semites who want to express their negativity about an issue or a group usually begin their case with "Some of my best friends are black," "I have a friend who is gay," or "My Jewish coworker." The list goes on ad nauseam.

He rants about U.S. aid for Israel. Who would you rather the U.S. give aid: Iran? Syria? Yemen? North Korea?

Why did this so-called humanitarian aid flotilla decide to take this venture the day before Netanyahu was supposed to meet with President Obama? Did you ever stop to consider that this was a setup?

I suggest Mr. Ochenski take a trip to Israel. He might find a very progressive country where gays do not have to deal with a "Don't ask, don't tell" policy. He would find a country that allows its Arab minorities to serve in the Knesset. He might also find that there is a country that elected a woman prime minister before we elected a woman president. Oops! I forgot. We have never elected a woman president. But then gays, lesbians and women do not enjoy the same rights in other Middle Eastern countries as they do in Israel. Israel, with all of its internal differences, secular and religious, is a very progressive, open society.

> **"If my doctor had believed in assisted suicide, I would be dead."**

Here's one more idea: Read *The Jerusalem Post*. With little effort you will find Israel, a country of six million surrounded by 550 million Arabs, engaging in serious humanitarian discussions. There is a loud group in Israel voicing that the people of Gaza need to be treated better. This is in spite of thousands of missiles that neighboring Gaza launched into Israel. Meanwhile, the IDF does what soldiers do in a democracy, i.e. defend their tiny country so its people can engage in dissent.

In fact, when it comes to dissent the people of Israel may reflect the famous statement better than we Americans: "I may disagree with what you have to say, but I shall defend to the death your right to say it."

Edward Brown
Missoula

Hydatid hysteria

One way to save the humans? Educate yourself.

It is hard to believe that years after the irresponsible introduction of wolves infected with the parasite *Echinococcus granulosus* tapeworm into Montana, most people still don't know about this potentially fatal disease. Known as Hydatid disease, infected people develop cysts of tiny tape worm heads in their liver, lungs or brain. They have to be removed surgically, and if they are in the brain, they are inoperable and fatal. This disease has caused the confirmed deaths of over 300 Alaskans since 1950.

I recently found this information published in *The Outdoorsman*, the December 2009 edition. It is titled, "Two-Thirds of Idaho Wolf Carcasses Examined Have Thousands of Hydatid Disease Tapeworms." Now *E. granulosus* has been confirmed in two-thirds of the wolves examined by Fish and Game experts participating in a study evaluating the lower intestines of those wolves found in both Idaho and Montana. What has not been confirmed is how many coyotes, dogs, cattle and even humans it has infected. With a higher population density in Idaho and Montana than Alaska, the previously foreign disease has a new host; unsuspecting lower-48ers who have been deceived by their Fish and Game, and are now at risk of contracting and dying from the disease. Where are the warnings? They never came from the people responsible for "introducing" the infected wolves from Canada and Alaska.

Why the deception? And why wasn't anything mentioned about the disease in the latest cover article in the *Independent*? (See "One way to save the wolf? Hunt it," May 20, 2010.) It's because the people pushing for the wolves know that if the public found out about the dangers of high wolf populations infecting deer, elk, moose, coyotes, dogs and even people with this disease, there would be a public outcry over the recent population explosion of wolves in the state. All I can say now is, do the research yourself. Find out about *Echinococcus granulosus* and decide if you want wolves running around in your backyard.

Jacob Chessin Wustner
Missoula

Letters Policy: The Missoula *Independent* welcomes hate mail, love letters and general correspondence. Letters to the editor must include the writer's full name, address and daytime phone number for confirmation, though we'll publish only your name and city. Anonymous letters will not be considered for publication. Preference is given to letters addressing the contents of the *Independent*. We reserve the right to edit letters for space and clarity. Send correspondence to: Letters to the Editor, Missoula *Independent*, 317 S. Orange St., Missoula, MT 59801, or via e-mail: editor@missoulanews.com.

A-71

A-71

to win legislative approval of assisted suicide. When added to their earlier defeats in Washington State (1991) and California (1992), these setbacks augur poorly for the movement in the early twenty-first century.

The lone exception is Oregon, the only American state to vote in favor of assisted suicide. However, studies of how the Oregon law functions point to a cautionary conclusion. According to some critics, a "culture of silence and secrecy" surrounds the Oregon law.[3] The Oregon Health Division relies entirely on doctors' reporting of cases of euthanasia, and typically only after the fact. The state does not attempt to verify data provided by physicians. If it did, it might discover that, despite its safeguards, abuses still occur involving patients with psychiatric disease who are given lethal prescriptions, as reported to the American Psychiatric Association in 2004. And, according to right-to-die activists, the requirement that two physicians approve of each assisted suicide is no obstacle to arranging one. Barbara Coombs Lee of Compassion in Dying told the *Washington Post* in 1998: "if I get rebuffed by one doctor, I can go to another" to get the necessary signatures.[4] Yet, leading physicians such as Marcia Angell, former executive editor of the *New England Journal of Medicine*, believe Oregon's law is still too restrictive and that too few people are using it.

Studies of the Oregon statute indicate that, where assisted suicide is a legal option, palliative care services are deficient and underutilized. These and other findings warn that right-to-die legislation can lead to a reduction in the quality of health care for society's most vulnerable and needy patients.

END-OF-LIFE CHOICES

A telltale sign of the euthanasia movement's decline in America was the 2003 change in name of the Hemlock Society to End-of-Life Choices. In 2004, End-of-Life Choices merged with Compassion in Dying to form Compassion and Choices. Derek Humphry had stepped down as leader of Hemlock in 1992. By then his very public troubles with Ann Wickett had made him more a liability than an asset to the group. Since his departure from Hemlock, he has concentrated on lecturing, research, and writing about euthanasia. The 2003 name change reflects the mounting recognition among right-to-die groups in the early twenty-first century that advocacy of assisted suicide or voluntary active euthanasia does not resonate with most Americans. The name End-of-Life Choices mirrored the growing emphasis in health-care policy on better pain management and counseling of terminally ill patients and their families about treatment options. When

it comes to end-of-life choices, Americans appear to want information, education, and consultation more than legislation.

In other words, as the new century opened, the ESA's old dream was in tatters. To longtime activists such as Humphry, it looked less and less likely that they would see euthanasia legalized. There was always the chance that an additional state would follow Oregon and enact a physician-assisted suicide law. But even if that happened, a stampede of other states in the same direction was distinctly unlikely.

These shifts in America's overall mood regarding euthanasia indicate how marginalized Jack Kevorkian and George Exoo had become. Their grandstanding was both cause and effect of the robust opposition to euthanasia from voters, legislators, and the courts. Their actions reflected their desperation, their own realization that legalized euthanasia was unlikely to be achieved through the normal political and legal channels. Their tactics tended to backfire, because for every individual won over to their way of thinking about death and dying, another two or three were so appalled that they became more firmly than ever anti-euthanasia.

This is essentially the lesson learned by the St. Petersburg, Florida, hard-rock band Hell on Earth. In 2004, the band announced it would let a disabled fan kill himself on stage as a way to promote assisted suicide. The suicide never took place, and many regarded it as little more than a publicity stunt for the band. But the controversy sparked by the band provoked the Florida state legislature into passing a bill that banned suicide as a form of entertainment.

PROVOKING CHANGE

In Canada, right-to-die activists had appeared to be winning the battle of public opinion as the twentieth century came to a close. Suicide had been decriminalized in Canada in 1974. But the country's Criminal Code was amended to outlaw assisted suicide. By the early 1990s, the nation's eyes were on thirty-four-year-old Sue Rodriguez who, after Canada's Supreme Court ruled the country's law against assisted suicide did not violate any of her constitutional rights, publicly announced her wish to find a doctor who would help to kill her before her Lou Gehrig's disease did. John Hofsess, who had founded the Canadian Right-to-Die Society in 1991 to (as he put it) "provoke change" along the lines of Derek Humphry's Hemlock Society, agreed to help Rodriguez find such a doctor if she permitted him to publicize her case. His plan was to dare the government into bringing

Mark S. Connell
CONNELL LAW FIRM
502 W. Spruce
P.O. Box 9108
Missoula, MT 59807
Ph: (406) 327-1517

Kathryn L. Tucker
Compassion & Choices
2066 NW Irving
Portland, OR 97209
Ph: (503) 841-5237

Attorneys for Plaintiffs

MONTANA FIRST JUDICIAL DISTRICT COURT,
LEWIS AND CLARK COUNTY

ROBERT BAXTER, STEVEN STOELB, STEPHEN SPECKART, M.D., C. PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D. and COMPASSION & CHOICES,

Plaintiffs,

v.

STATE OF MONTANA and MIKE MCGRATH, ATTORNEY GENERAL,

Defendants.

Judge: Dorothy McCarter
Cause No. ADV 2007-787

PLAINTIFFS' RESPONSES TO STATE OF MONTANA'S FIRST DISCOVERY REQUESTS

Plaintiffs respond to Defendant State of Montana's First Discovery Requests as follows:

INTERROGATORY NO. 1: Define "aid in dying" as it is used in the Complaint, including the specific medication(s) and process(es) involved, any differences between the type, dose, and amount of medication prescribed for palliative care and "aid in dying," the resulting

person understands what he or she is doing and the probable consequences of his or her acts. Mental competence will be determined by the person's attending physician based upon the physician's professional judgment and assessment of the relevant medical evidence.

INTERROGATORY NO. 4: Define "terminally ill adult patient" as it is used in the Complaint, including the specific class that Plaintiff Patients' purport to represent, the diseases that may qualify for terminal illness, expected terminal prognosis, who will determine the diagnosis and prognosis, and any other objective standards that delimit the definition.

ANSWER: The term "terminally ill adult patient", as used in the complaint, means a person 18 years of age or older who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time. This definition is not limited to any specific set of illnesses, conditions or diseases. The patient plaintiffs in this case represent the class of Montana citizens who are mentally competent, adult, terminally ill under this definition, and wish to avail themselves of the right to aid in dying. The patient's diagnosis and prognosis will be determined by his or her attending physician.

INTERROGATORY NO. 5: Define "a dying process the patient finds intolerable" as it is used in the Complaint, including any objective standards that delimit the definition.

ANSWER: This is a subjective determination made by the individual patient based upon his or her medical condition and circumstances, symptoms, and personal values and beliefs.

INTERROGATORY NO. 6: Define how a patient seeking "aid in dying" "requests such assistance" as it is described in the Complaint.

Richard Wonderly, M. D.
Theresa Schrempp, Esq.
3841 48th Avenue NE
Seattle, WA 98105
(206) 525-1223

Alex Schadenberg
Executive director
Euthanasia Prevention Coalition
P. O. Box 25033
London, ON N6C 6A8

October 22, 2009

Dear Mr. Schadenberg:

We are a physician and an attorney in Washington State where assisted suicide is regrettably legal. We write to comment on the lawsuit in Connecticut which seeks to legalize "aid in dying" for "terminally ill patients."

The terms "aid in dying" and "terminally ill" imply that legalization would apply only to dying patients. Don't count on it. In Montana, where there is another lawsuit involving "aid in dying", assisted suicide advocates define the phrase "terminally ill patient" as follows:

> [A] person 18 years of age or older who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time.
> (*See,* Enclosed Interrogatory Responses from Montana Plaintiffs)

Shockingly, this definition is broad enough to include an 18 year old who is insulin dependent or dependent on kidney dialysis, or a young adult with stable HIV/AIDS. Each of these patients could live for decades with appropriate medical treatment. Yet, they are "terminally ill" according to the definition promoted by advocates of assisted suicide. (Compassion & Choices)

Once someone is labeled "terminal," an easy justification can be made that their treatment or coverage should be denied in favor of someone more deserving. In Oregon, where assisted suicide has been legal for years, "terminal" patients have not only been denied coverage for treatment, they have been offered assisted suicide instead. The most well-known cases involve Barbara Wagner and Randy Stroup, reported at http://www.abcnews.go.com/Health/comments?type=story&id=5517492.

Those who believe that assisted suicide promotes free choice may discover that is does anything but.

Very truly yours,

Theresa Schrempp, Attorney at Law

Richard Wonderly M. D.

Richard Wonderly M. D.
Enclosure
H:\Schrempp\MISC\Schadenbergltr.doc

Letter: Oregon doctor responds to recent letter on patient choice

By Kenneth Stevens, MD | Posted: Thursday, July 29, 2010 12:00 am

I have been a cancer doctor in Oregon for more than 40 years. This letter is in response to Patricia Lewis who argues that legal assisted suicide promotes patient "choice" (July 16 letter).

In Oregon, the combination of assisted-suicide legalization and prioritized medical care based on prognosis has created a danger for my patients on the Oregon Health Plan (Medicaid). The plan limits medical care and treatment for patients with a likelihood of a 5 percent or less than five-year survival.

My patients in that category, who, say, have a good chance of living another two years and who want to live, cannot receive surgery, chemotherapy or radiation therapy to obtain that goal. The plan guidelines state that the plan will not cover "chemotherapy or surgical interventions with the primary intent to prolong life or alter disease progression." The plan will, however, cover the cost of the patient's suicide. If the patient takes the plan's "suggestion," the plan won't even have to pay for comfort care.

Under Oregon's law, a patient is not supposed to be eligible for voluntary suicide until they are deemed to have six months or less to live. In the well publicized cases of Barbara Wagner and Randy Stroup, neither of them had such diagnoses, nor had they asked for suicide. The plan, nonetheless, offered them suicide. Neither Wagner nor Stroup saw this event as a celebration of their "choice." Wagner stated: "It was horrible ... I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won't give you the medication to live."

In Oregon, the mere presence of legal assisted-suicide steers patients to suicide even when there is not an issue of coverage. One of my patients was adamant she would use the law. I convinced her to be treated. Ten years later she is thrilled to be alive. Don't make Oregon's mistake.

Kenneth Stevens, MD

13680 SW Morgan Road

Sherwood, OR

A-76

Sensationalizing a sad case cheats the public of sound debate

Posted by rattig November 29, 2008 19:30PM

In the crucial period leading up to Washington State's vote on an Oregon-style Death with Dignity law, this newspaper published a story featuring Barbara Wagner. A sensational story, an easy media "gotcha" on Oregon's Medicaid program, it completely missed the deeper questions crucial to public understanding of end-of-life care and our national healthcare debate.

President of Choice
Compassion & Choices
Criticizing Wagner's
"Choice"

Barbara Coombs Lee

Readers will recall Wagner as a 64-year-old Springfield resident with end stage lung cancer, a life-long smoker enrolled in the Oregon Health Plan (OHP). Over several years the OHP had paid for extensive cancer treatment and it continued to pay for Wagner's healthcare until her death.

When it became clear that first and second-line therapies had failed and her prognosis was grim, Ms. Wagner's oncologist recommended a costly, third-line cancer drug called Tarceva. Research indicates that 8 percent of advanced lung cancers respond to Tarceva, with a chance to extend life from an average of 4 months to 6 months. The likelihood of no response to the drug is 92 percent, yet 19 percent of patients develop toxic side effects like diarrhea and rash. Based on the low indicators of effectiveness, Oregon Health Plan denied coverage.

The irresistible ingredients of sensationalism included a distraught patient, a doctor deeply opposed to Death with Dignity and an insensitive letter of payment denial. The media was called in and the rest is history.

As a publicly funded service, Oregon Health Plan aims to do the greatest good it can. It assigns a high priority to preventive care, health maintenance, and treatments that offer a near-certain cure. Elective, cosmetic or ineffective, "futile" care is not covered. Futile care is defined as any treatment without at least a 5 percent chance of 5 year survival. "We can't cover everything for everyone," said the medical director of OHP. "Taxpayer dollars are limited for publicly funded programs. We try to come up with policies that provide the most good for the most people."

The OHP letter denying one ineffective treatment did not close the door on all care. It included a long list of appropriate end-of-life care that OHP would pay for, including hospice, medical equipment, palliative services and state-of-the-art pain and symptom management. Yes, the list included medication prescribed under the Oregon Death with Dignity Act.The media juxtaposed denial of Tarceva with coverage for aid in dying in a sensational, emotional manner, suggesting the two were related. Many stories ensued about supposedly callous bureaucrats refusing to prolong life but agreeing to shorten it. It made for a catchy story ... but not truthful journalism.

Was it true that Ms. Wagner was harmed in any manner? Or that Tarceva was an efficacious option?

Ms. Wagner received Tarceva, anyway, when the drug's manufacturer, Genentech, responding to the media firestorm and provided it at no cost. News stories never mentioned that when Wagner bet on the remote chance to prolong life, she probably turned her back on hospice care, widely recognized as the gold standard for end-of-life care. Sadly, it turned out Tarceva didn't help Wagner and she lived only a short time after starting the drug.

While the media widely reported OHP's denial of this expensive experimental treatment, we worry the media missed the important issues inherent in the story.

What do patients like Wagner really understand about the "last hope" treatments their doctors offer? Do doctors inform patients of the true statistical chance these therapies will prolong life, or the chance of toxic side effects that diminish the quality of the short life that remains? Might Wagner have been better served, and perhaps even lived longer, if her doctors had referred her to hospice instead of recommending a drug so toxic and so unlikely to extend her life? How many times do patients lose out on the real hope and comfort hospice offers because they are encouraged to grasp for the small hope of largely ineffective chemotherapy? Do financial incentives play a role in whether physicians recommend long-shot chemotherapy instead of comprehensive comfort care?

While the OHP decision was closely scrutinized, there was no scrutiny of realistic options considered or not considered and the decision-making process. The burning health policy question is whether we inadvertently encourage patients to act against their own self interest, chase an unattainable dream of cure, and foreclose the path of acceptance that curative care has been exhausted and the time for comfort care is at hand. Such encouragement serves neither patients, families, nor the public.

Barbara Roberts, Oregon's wise and gentle former governor, tells in her first book the story of how she and her husband Frank reacted to the news that he had entered the terminal stage of prostate cancer. She describes how immediately after disclosing the grim prognosis, the doctor announced he was setting up an appointment for chemotherapy! Frank asked two crucial questions, "Will this treatment extend my life?" and "For how long." And when the answers, balanced against the likely toxic side effects, didn't add up to how Frank envisioned his last days on earth, he declined the doctor's recommended treatment.

Roberts writes that chemotherapy seemed, "a medical misjudgment encouraged by a culture in denial and a medical profession equally in denial and unwilling to treat death as normal." Frank said "no" to treatment. But he said "yes" to life and began the "hard work of acceptance" of what is means to be mortal.

In order for society to overcome its collective denial of mortality, we desperately need a public dialogue that shuns superficial sensationalism and leads us to, and through, the hard questions. We're Oregonians. We can handle it.

Coombs Lee is president of the group Compassion & Choices.

Categories:

Comments

LetDocDecide says...

My wife was diagnosed with Stage IIIb lung cancer (which really should have been stage IV) in April 2006. The diagnosing surgeon anounced that there was no hope, and that my wife would only live a short time. In fact, the prognosis for my wife suggested she had a 1%-2% chance of surviving 2 years. Thankfully, we had an ambitious Oncologist that thought the surgeon's opinion was wrong.

While it is easy to armchair quarterback the appropriateness of health care treatments. You can be the one that tells my 8 and 10 year old sons that their mother should not receive Tarceva because it is an "experimental treatment". The efficacy of all chemotheray treatments are ALL poor. The first line chemo treatment (carboplaten/Paclitaxel) that my wife received had only a 35% likelyhood of a positive response. That was 2 years and 8 months ago and she is still kicking. Her response to Tarceva has been an exceptional one, resulting in a significant reduction of the size and number of tumors in her remaining right lung. After a 3rd tier chemo treatment failed 3 months ago, Tarceva is probably the only reason she is spending Christmas day with me and my boys. In fact, I expect that she will continue having a positive response to the Tarceva for at least a couple of months. Anyone with a loved one with a terminal disease would appreciate the added time.

On the topic of cost and side effects, the side-effects of Tarceva (rash and diahrea) are nothing compared to the side effects of the Taxane or platinum chemotherapy drugs (severe anemia, reduced white blood counts and platelet levels, severe nausia, body PAIN, etc..).

In addition to these benefits, the cost of Tarceva (about $4000/month) is NOT HIGHER than the cost of chemotherapy (about $8000 per treatment every 3 weeks). It is expensive to treat cancer, period. It is unclear to me whether the author of this news story is appealing for the denial of all cancer treatments, or just Tarceva. If that is the case, they can tell the family of the next Stage IIIb/IV lung cancer patient that treatment is not worth the cost. What the hell, perhaps we should just Euthanize all cancer patients at the time of dianosis to save a little money.

I believe that the spiralling costs of health care are not caused by the compassionate treatment of those with terminal diseases. The real culprits are 1)the fact that to many individuals that have no health insurance use emergency care at a huge cost premium over preventative care; 2) People have had no incentive to use healthy lifestyles as a preventative; 3) Many people with insurance are not smart shoppers when it comes to health care. This leads to people having expensive diagnostic procedures like MRI and CT scans inappropriately.

We need to wakeup, do a little research into the available treatments for our ailments, and determine if the increased public cost for not insuring everyone and using more preventative health care.

Respectfully
Bob

Posted on 12/25/08 at 12:16AM
Footer

Barbara Coombs Lee
Get Barbara Coombs Lee's RSS Feed

Barbara Coombs Lee is President of Compassion & Choices, a nonprofit organization dedicated to expanding and protecting the rights of the terminally ill. She practiced as a nurse and physician assistant for 25 years before beginning a career in law and health policy. Since then she has devoted her professional life to individual choice and empowerment in health care. As a private attorney, as counsel to the Oregon State Senate, as a managed care executive and finally as Chief Petitioner for Oregon's Death with Dignity Act, she has championed initiatives that enable individuals to consider a full
range of choices and be full participants in their health care decisions.

@@compandchoices Submit Query

There is no info on Twitter for this entry for that keyword

Blog Entries by Barbara Coombs Lee

Five States Give Patients Choice

Posted September 27, 2010 | 11:33 AM (EST)

"There's nothing more we can do." For too long, for too many, medical professionals have used these words when they believe they cannot cure their patients. Facing, as each of us must, the nearness of death, terminally ill patients too often speak of abandonment by...

Read Post

Medical Society of New York Fights Palliative Care Information Act Despite Mounting Evidence

2 Comments | Posted September 3, 2010 | 04:33 PM (EST)

The ink of Governor Paterson's signature is barely dry on New York's Palliative Care Information Act (PCIA), drafted and sponsored by Compassion & Choices and its New York affiliate, yet evidence mounts daily for its vast and dramatic impact on end-of-life care. I predict this bill...

Read Post

New York's Palliative Care Information Act: A Sea Change in End-of-Life Care

2 Comments | Posted August 19, 2010 | 07:01 PM (EST)

Word came Sunday night from Compassion & Choices New York that Governor Paterson had signed our bill, the Palliative Care Information Act, (PCIA) and it would take effect in 180 days. Hooray!! We hope and trust this event marks the beginning of the end for endemic medical habits that...

Read Post

Compassion & Choices Membership: Something to be Proud Of

Posted July 14, 2010 | 03:15 PM (EST)

Recently Capitol Hill staffers pulled Compassion & Choices into federal politics, suggesting the new Administrator of the Centers for Medicare and Medicaid Services, Donald Berwick, should be called before Congress to answer accusations that he is a member, or affiliated somehow with C&C. "Are you now,...

minority in favor of euthanasia, but they also reinforced what critics of the VELS contended: that many of Millard's VELS colleagues were not content to limit euthanasia to only consenting, informed, and dying adults. The small but vocal Roman Catholic press in Britain again and again attacked Millard and VELS. Letitia Fairfield, a Catholic and senior medical officer for the London County Council (and sister of author Rebecca West), warned that if the VELS bill ever passed, the mentally handicapped would be "murdered" and homes for the aged poor would become "slaughter-houses." As the *Catholic Herald* put it in 1934, "the people who advocate euthanasia always advocate it for somebody else."[13]

THE EUTHANASIA SOCIETY OF AMERICA

The Euthanasia Society of America (ESA), founded in 1938 and headquartered in New York City, was the brainchild of two people, the wealthy New Yorker Ann Mitchell and the ex-Unitarian minister Charles Potter. Mitchell was a highly eccentric and abrasive individual whose emotional problems led to a stay in a U.S. psychiatric hospital (1934–1936) and likely contributed to her death in 1942 when she threw herself out the window of a Miami hotel. Her difficulties living with psychosis convinced her that euthanasia was a relief for the many other Americans suffering from mental illness, whether they requested it or not. She believed that mental diseases were chiefly due to heredity, and this naturally made her sympathetic to eugenics. In a lively and sometimes hair-raising correspondence with Millard, she talked of the seeming necessity of breeding human beings "as carefully as we do animals." She welcomed the coming of World War II because, she claimed, it gave both the United States and Britain an opportunity to do some serious "biological house cleaning." Mitchell's frank views were shared by few members of the ESA, but she was indulged because her financial contributions to the cause were sorely needed.[14]

Convinced of the need to legalize voluntary and involuntary euthanasia, Mitchell was thrilled in 1936 when she learned that both had been ardently defended by clergyman Charles Potter (1885–1962). Potter, born in Marlboro, Massachusetts, and ordained a Baptist minister in 1908, made headlines across the country for backing birth control, the equality of women, the League of Nations, and the abolition of capital punishment. In 1913, he joined the Unitarian ministry, but even that church proved to be too doctrinaire for his tastes. By the early 1930s, Potter had embraced humanism, founding the First Humanist Society of New York in 1929. Other

members of the First Humanist Society included Columbia Univers philosopher John Dewey, scientists Albert Einstein and Julian Huxley, a author Thomas Mann. By 1937, the society and its branch organizations England, France, Australia, and Russia numbered some 15,000 membe The First Humanist Society, Potter boasted, had no creed, clergy, or pray

Potter's efforts to promote humanism coincided with the signing of t 1933 Humanist Manifesto, a document chiefly scripted by two Unitari ministers, Curtis W. Reese and John H. Dietrich, and signed by Potter a sixty Unitarian pastors. Their ideal was a universal church of human based on firm ethical commitments. Rejecting all notions of a transcende tal God or an order of divine truth outside mankind, they believed in t sweeping improvability of human nature through scientifically based soc engineering, and in whatever social causes freed individuals from traditior moral codes that limited human choice. These ideals led prominent Ame icans such as John Dewey to sign the manifesto. Dewey's emphasis on t development of the individual and learning through experience as keys the growth of democracy dovetailed with the postulates of the Human Manifesto.[15]

To Potter, legalized euthanasia was an obvious humanist cause. He a gued that permitting euthanasia emancipated humanity from mainstrea value systems that forbade people from exercising their autonomy and d veloping their personalities to the fullest, even on their deathbed. Peop who freely chose euthanasia, Potter believed, were examples of true d mocracy in action. Euthanasia also curtailed human suffering, according Potter. His experience as a "marryin' and buryin' parson" had exposed hi to dying parishioners who pleaded with him to be put out of their mise They deserved the liberty to receive medical help in dying, Potter co cluded.

Despite his repeated invocations of individual freedom as a politic goal, Potter, a supporter of involuntary eugenics and euthanasia, was no d fender of laissez-faire personal choice. This was less of a contradiction th it appears. Although he and other Unitarians and humanists attacked trad tional codes of conduct for blocking human freedom, they were not libe tarians. If human beings were to be freed from long-standing moral and et ical beliefs, it was to enable them to make the right choices, not any choi whatsoever. Choice did not mean freedom to do what individuals please but empowerment to do what a scientifically grounded humanism taug them to do.

Potter's deep faith in the liberating influence of science accounts for h belief in humanism and explains why he could condone coercive eugeni



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.

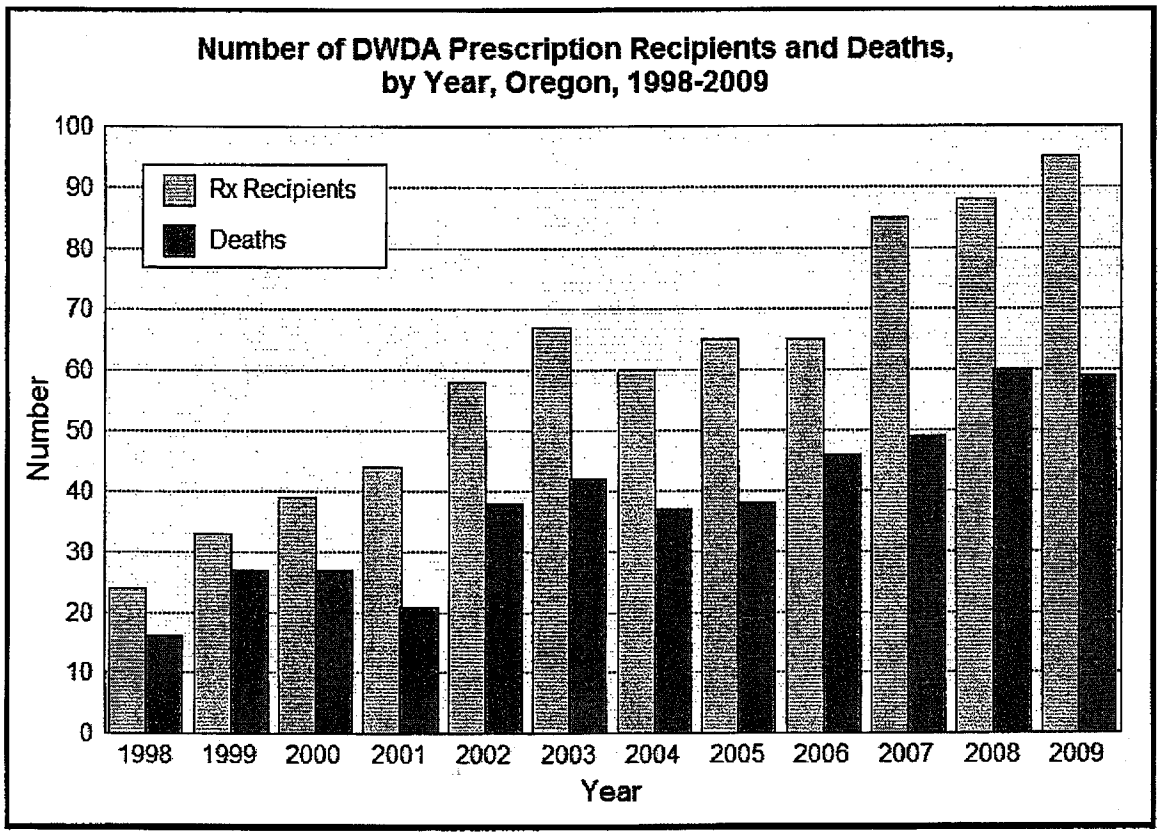
The report also included the following findings:

- 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.
-

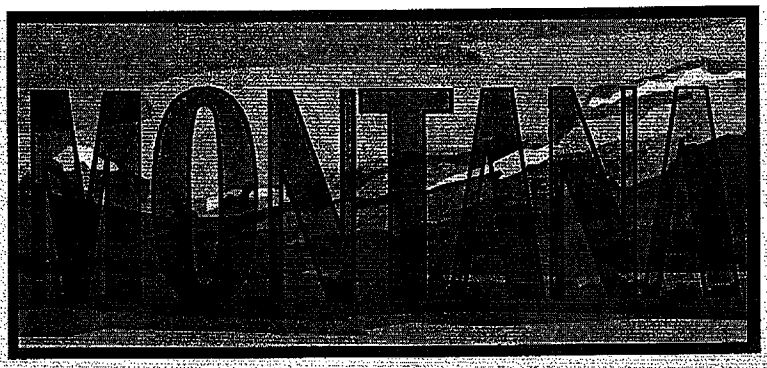
A-82

2009 Summary of Oregon's Death with Dignity Act

Oregon's Death with Dignity Act (DWDA), which was enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2009 are listed below. For more detail, please view the figures and tables on our web site at http://oregon.gov/DHS/ph/pas/index.shtml.



- During 2009, 95 prescriptions for lethal medications were written under the provisions of the DWDA compared to 88 during 2008 (Figure). Of these, 53 patients took the medications, 30 died of their underlying illness, and 12 were alive at the end of 2009. In addition, six patients with earlier prescriptions died from taking the medications, resulting in a total of 59 DWDA deaths during 2009. This corresponds to an estimated 19.3 DWDA deaths per 10,000 total deaths.



Suicide continues to be a major public health issue in the state. Montana has been at or near the top in the nation for the rate of suicide for nearly three decades. In the past seven years, the rate of suicide in Montana is 19.50 per 100,000 people (the national average has been around 11 per 100,000). Since 2000, 1,087 Montana residents have completed suicide for an average of 180 people per year.

- For all age groups for data collected for the year 2005, **Montana is ranked number one in rate of suicide in the United States** (Kung, et al, 2008) and Montana has been in the **top five** for the past **thirty years**.
- Between 2000 and 2005, suicide was the number **two** cause of death for children **ages 10-14**, adolescents **ages 15-24**, and adults **ages 25-34**, behind only unintentional injuries (CDC, 2008)
- **Alcohol** and **drug impairment**, a sense of **hopelessness**, underlying **mental illness**, and a **societal stigma against depression**, all contribute to the high rate of youth suicide in Montana.
- In 2005, **25.6% of high school students in Montana** reported they felt so **sad or hopeless almost every day for two weeks or more** that they stopped doing some of their usual activities (Montana YRBS, 2007)
- Between 2000 and 2005, the highest rate of suicide in Montana was among **American Indians** (21.47 per 100,000) followed by Caucasians (19.33 per 100,000).
- **Firearms** (66%), hanging (13%), and drugs (10%) are the most common means of suicide in Montana.

2000 - 2006, Montana
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0, *U03

Number of Deaths	Cumulative Population	Age-Adjusted Rate
1,258	6,442,943	19.50

A-84

C
West's Montana Code Annotated Currentness
Title 53. Social Services and Institutions
Chapter 21. Mentally Ill
Part 11. Suicide Prevention Program

53-21-1101. Suicide prevention officer--duties

(1) The department of public health and human services shall implement a suicide prevention program by January 1, 2008. The program must be administered by a suicide prevention officer attached to the office of the director of the department.

(2) The suicide prevention officer shall:

(a) coordinate all suicide prevention activities being conducted by the department, including activities in the addictive and mental disorders division, the health resources division, and the public health and safety division, and coordinate with any suicide prevention activities that are conducted by other state agencies, ~~including~~ the office of the superintendent of public instruction, ~~the department of~~ corrections, the department of military affairs, and the university system;

(b) develop a biennial suicide reduction plan that addresses reducing suicides by Montanans of all ages;

(c) direct a statewide suicide prevention program with activities that include but ~~are not limited to~~:

(i) conducting statewide public awareness campaigns utilizing both paid and free media and including input from government agencies, school representatives from elementary schools through higher education, mental health advocacy groups, and other relevant nonprofit organizations;

(ii) initiating, in partnership with Montana's tribes and tribal organizations, a public awareness program that is culturally appropriate and that utilizes the modalities best suited for Indian country;

(iii) seeking opportunities for research that will improve understanding of suicide in Montana and provide increased suicide-related services;

(iv) training for medical professionals, military personnel, school personnel, social service providers, and the general public on recognizing the early warning signs of suicidality, depression, and other mental illnesses; and

A-85