

MEMORANDUM

TO: The Colorado Senate State, Veterans, & Military Affairs Committee.

AND TO: The Colorado House Judiciary Committee.

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

RE: Vote "No" on Assisted Suicide and Euthanasia
SB 16-025 and HB 16-1054 (identical bills)

HEARING

DATES: SB 16-025: February 3, 2016, 1:30 pm
HB 16-1054: February 4, 2016, 1:30 pm,

MEMO

DATE: January 30, 2015

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I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.¹ Our law is based on a similar law in Oregon. Both laws are similar to the proposed bills, SB 16-025 and HB 16-1054.²

The proposed bills, which have identical text, are titled the "Colorado End-of-life Options Act." The bills seek to legalize physician-assisted suicide and euthanasia as those terms are traditionally defined. "Eligible" persons may have years, even decades, to live.

The bills are sold as assuring patient choice and control. They are instead stacked against the patient and a recipe for elder abuse. I urge you to reject this measure.

II. FACTUAL AND LEGAL BACKGROUND

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

The American Medical Association (AMA) defines physician-assisted suicide as occurring when "a physician facilitates a patient's death by providing the necessary means and/or

¹ I am an elder law attorney licensed to practice law since 1986. I am also a former Law Clerk to the Washington State Supreme Court and a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. I am president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. See www.margaretdore.com and www.choiceillusion.org

² SB 16-025 and HB 16-1054. are attached hereto beginning at A-1 and A-19, respectively.

information to enable the patient to perform the life-ending act."³ The AMA gives this example:

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

"Assisted suicide" is a general term in which the assisting person is not necessarily a physician. "Euthanasia," by contrast, is the direct administration of a lethal agent with the intent to cause another person's death.⁵

B. Withholding or Withdrawing Treatment Is Not Assisted Suicide or Euthanasia.

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

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

³ The AMA Code of Medical Ethics, Opinion 2.211, Physician-Assisted Suicide. (Attached hereto at A-37).

⁴ Id.

⁵ Opinion 2.21, Euthanasia. (Attached hereto at A-38).

⁶ Nina Shapiro, "Terminal Uncertainty - Washington's new 'Death with Dignity' law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong?," *The Seattle Weekly*, January 14, 2009. (Article attached at A-39; quote attached at A-41).

C. The AMA Rejects Assisted Suicide and Euthanasia.

The AMA rejects assisted suicide and euthanasia, stating they are:

[F]undamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.⁷

D. Elder Abuse.

There are more than 11,000 cases of adult abuse, including elder abuse, reported each year in Colorado.⁸ Elder abuse perpetrators are often family members.⁹ They often start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or coercing victims to sign over deeds to their homes, change their wills or liquidate their assets.¹⁰ Victims may even be murdered.¹¹ Amy Mix, of the AARP Legal Counsel of the Elderly, explains why older people are especially vulnerable:

The elderly are at an at-risk group for a lot of reasons, including, but not limited to

⁷ AMA Code of Medical Ethics, Opns 2.211 and 2.21, supra at A-37 and A-38.

⁸ Denver Human Services, <https://www.denvergov.org/content/denvergov/en/denver-human-services/protection-prevention/adult-protection-elder-abuse.html> (As of January 29, 2016).

⁹ Id. and MetLife Mature Market Institute Study: "Broken Trust: Elders, Family and Finances," March 2009, available at <https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf>

¹⁰ MetLife, supra, at p. 14.

¹¹ Id., p. 24.

diminished capacity, isolation from family and other caregivers, lack of sophistication when it comes to purchasing property, financing, or using computers

[D]efendants are family members, lots are friends, often people who befriend a senior through church We had a senior victim who had given her life savings away to some scammer who told her that she'd won the lottery and would have to pay the taxes ahead of time. . . . The scammer found the victim using information in her husband's obituary.¹²

Elder abuse is prevalent in large part because victims do not report.¹³ "One study estimated that only 1 in 14 cases ever comes to the attention of the authorities."¹⁴ In another study, it was 1 out of 25 cases.¹⁵ According to Denver Human Services, victims are: afraid to speak up, worried about retaliation and embarrassed.¹⁶ Another explanation:

Many who suffer from abuse . . . don't want to report their own child as an abuser.¹⁷

¹² Kathryn Alfisi, "Breaking the Silence on Elder Abuse," *Washington Lawyer*, February 2015. (Attached hereto at A-42 to A-43, quotes at A-43). Also available at <https://www.dcbbar.org/bar-resources/publications/washington-lawyer/articles/february-2015-elder-abuse.cfm>

¹³ See e.g., National Center on Elder Abuse, Administration on Aging, <http://www.ncea.aoa.gov/Library/Data>, p.2

¹⁴ Id.

¹⁵ Id.

¹⁶ Denver Human Services, *supra* at note 8.

¹⁷ "Adult Abuse Defined," District of Columbia, Department of Human Services, as of January 25, 2016. (Attached hereto at A-44). See also <http://dhs.dc.gov/service/adult-abuse>

E. Assistors Can Have Their Own Agendas.

People who assist a suicide or euthanasia can have their own agendas. In Oregon, there is the Thomas Middleton case, in which legal physician-assisted suicide was part of an elder abuse fraud.¹⁸ Consider also *People v. Stuart* where an adult child killed her parent under circumstances that "dovetailed" with the child's financial interests.¹⁹ The Court observed:

Financial considerations [are] an all too common motivation for killing someone.²⁰

III. THE BILLS

A. Patients May Have Years, Even Decades, to Live.

The proposed bills apply to patients with a "terminal illness."²¹ Such persons may have years, even decades, to live.

¹⁸ See "Sawyer Arraigned on State Fraud Charges," KTVZ.com, 07/14/11, which states:

Middleton deeded his home to the trust and directed [Sawyer] to make it a rental until the real estate market improved.

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than \$200,000, the documents show, and it was deposited into [accounts for Sawyer's benefit]. (Emphasis added)

Attached at A-45.

¹⁹ *People v. Stuart*, 67 Cal.Rptr.3d 129 (2007).

²⁰ *Id.*, at 143.

²¹ The bills apply to "qualified individuals" defined as "terminally ill." See SB 16-025 and HB 16-1054, § 25-48-102(11). (Attached hereto at A-3 and A-21, line 22).

This is true for the following reasons.

1. **People with chronic conditions such as diabetes may be "eligible" for assisted suicide and euthanasia.**

The proposed bills state:

"Terminal illness" means an incurable and irreversible illness that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.²²

Oregon's law has a nearly identical definition of "terminal disease," which states:

"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.²³

In Oregon, this nearly identical definition is interpreted to include chronic conditions such as "chronic lower respiratory disease" and "diabetes mellitus." See the Oregon government report attached hereto at A-52 and A-53 (listing these conditions as an "underlying illness" for the purpose of assisted suicide).²⁴ Oregon doctor William Toffler explains:

Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live.²⁵

²² § 25-48-102(14) (defining "terminal illness"). (Attached at A-4 & A-22).

²³ Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-47.

²⁴ The entire report is attached at A-48 to A-53.

²⁵ Published Letter to the Editor, William Toffler MD, New Haven Register, February 24, 2014, ¶2. (My private copy is attached hereto at A-69. I verified the accuracy of the content with Dr. Toffler).

If Colorado enacts the proposed bills and follows Oregon's lead, assisted suicide will be legalized for people with chronic conditions such as insulin dependent diabetes. Dr. Toffler states:

Such persons, with treatment, could otherwise have years or even decades to live.²⁶

2. Misdiagnosis occurs; predicting life expectancy is not an exact science.

Patients may also have years to live due to misdiagnosis and the fact that predicting life expectancy is not an exact science.²⁷ Consider John Norton, who was diagnosed with ALS (Lou Gehrig's disease) at age 18.²⁸ He was told that he would get progressively worse (be paralyzed) and die in three to five years.²⁹ Instead, the disease progression stopped on its own.³⁰ In a 2012 affidavit, at age 74, he states:

If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.³¹

²⁶ Id.

²⁷ See Jessica Firger, "12 million Americans misdiagnosed each year," CBS NEWS, 4/17/14 (at A-54); and 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*, 1/14/09. (at A-39).

²⁸ Affidavit of John Norton, ¶ 1 (Attached hereto at A-79).

²⁹ Id., ¶ 1.

³⁰ Id., ¶ 4

³¹ Id., ¶ 5

3. Treatment can lead to recovery.

Patients may also have years to live because treatment can lead to recovery. Consider Oregon resident, Jeanette Hall, who was diagnosed with cancer in 2000 and made a settled decision to "do" Oregon's law.³² Her doctor convinced her to be treated instead.³³ In a 2012 affidavit, she states:

This last July, it was 12 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.³⁴

B. "Mandatory" Patient Protections Are Not Necessarily Mandatory Due to Good Faith Immunity.

The proposed bills have an application process to obtain the lethal dose, which features patient protections described in mandatory terms, for example, that the attending physician "shall" refer the patient to a consulting physician.³⁵

These "mandatory" protections may not actually be mandatory due to good faith immunity given to doctors and other participants in patient deaths.³⁶ See below.

³² Affidavit of Kenneth Stevens, MD, attached at A-55 to A-61; Jeanette Hall discussed at A-55 to A-56.

³³ *Id.*

³⁴ Affidavit of Jeanette Hall, ¶¶ 5-9. attached hereto at A-62 to A-63. Jeanette is still alive today, 15 years later.

³⁵ See SB 16-025 and HB 1054, § 25-48-106(1)(d). (Attached at A-6 and A-24, lines 13-25).

³⁶ The bills, § 28-48-115, give doctors and other participants good faith immunity. (Attached hereto at A-14 and A-32).

The bills do not define "good faith."³⁷ Common meanings include an honest intent to act, even when there is a lack of compliance with legal technicalities. Consider, for example, this legal dictionary definition:

[Good faith means an] honest intent to act without taking an unfair advantage over another person or to fulfill a promise to act, even when some legal technicality is not fulfilled. (Emphasis added).³⁸

With good faith immunity, doctors and other participants in a patient's death are not required to follow a particular patient protection (a "legal technicality") as long as they are in good faith. If the attending physician failed to send the patient to a consulting physician, as required by the bills, this could be viewed as a legal technicality not required as long as the attending physician acted in good faith - if for example, he says that he did it to save the patient money.

With good faith immunity, "mandatory" patient protections may not be mandatory.

C. Someone Else Is Allowed to Speak for the Patient.

The bills require that the patient be "capable."³⁹ Capable is a specially defined term that allows someone else to speak for

³⁷ See SB 16-025 and HB 16-1054 in their entirety, at A-1 through A-36.

³⁸ <http://dictionary.law.com/Default.aspx?selected=819> (Attached at A-46).

³⁹ The bills, § 25-48-102(11), define a "qualified individual" as "capable." (Attached at A-3 and A-21, lines 22-23).

the patient as long as he or she "familiar with the [patient's] manner of communicating." The bills refer to the patient as a "terminally ill individual." The bills state:

"Capable" means that, in the opinion of a "terminally ill individual's attending physician, consulting physician, psychiatrist, or licensed mental health professional, a terminally ill individual has the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the individual's manner of communicating"⁴⁰

Being familiar with a patient's "manner of communicating" is a very minimal standard. Consider, for example, a doctor's assistant who is familiar with a patient's "manner of communicating" in Spanish, but she, herself, does not understand Spanish. That, however, would be good enough for her to speak for the patient to obtain the lethal dose. The patient's heir, or a complete stranger, would also be allowed to speak for the patient -- as long as they were familiar with the patient's manner of communicating.

With other people allowed to speak for the patient,

⁴⁰ SB 16-025 and HB 16-1054, § 25-48-102(5), states:

"Capable" means that, in the opinion of a terminally ill individual's attending physician, consulting physician, psychiatrist, or licensed mental health professional, a terminally ill individual has the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the individual's manner of communicating if that person is available. (Attached hereto at A-1 and A-19).

including a stranger, mistake and overreaching are invited.
Patient choice and control are not guaranteed.

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

Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer prescription drugs to a patient.⁴¹ Common examples include parents who administer drugs to their children and adult children who administer drugs to their parents.⁴² This is normal practice.⁴³

The proposed bills define the lethal dose as a "medication" and say that the patient "may choose to self-administer" it.⁴⁴ The bills do not say that administration of the lethal dose "must" be by self-administration.⁴⁵

With self-administration not mandatory under the bills, generally accepted medical practice allows someone else to administer the lethal dose to the patient.⁴⁶ With someone else allowed to administer the lethal dose, patient choice and control are once again, not guaranteed.

⁴¹ Declaration of Dr. Kenneth Stevens, MD, 01/06/16, at A-69, ¶¶ 9-10.

⁴² Id.

⁴³ Id.

⁴⁴ See § 25-48-102 (2) (referring to the lethal dose as "medication" and stating that the patient "may choose to self-administer").

⁴⁵ See SB 16-025 and HB 16-1054 in their entirety, at A-1 through A-36.

⁴⁶ Cf. Dr. Stevens' declaration at A-66.
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E. Allowing Someone Else to Administer the Lethal Dose to the Patient is Euthanasia.

Allowing someone else to administer the lethal dose is euthanasia under generally accepted medical terminology. The AMA Code of Ethics, Opinion 2.21, states:

Euthanasia is the administration of a lethal agent by another person to a patient (Emphasis added).⁴⁷

F. The Bills Do Not Prohibit Euthanasia.

The bills, § 25-48-120, appear to prohibit euthanasia, also known as "mercy killing" and "lethal injection." This apparent prohibition is, however, defined away in the next sentence. The bills state:

Nothing in this article authorizes a physician or any other person to end an individual's life by lethal injection, mercy killing, or euthanasia. Actions taken in accordance with this article do not, for any purpose, constitute . . . mercy killing [another term for lethal injection and euthanasia] (Emphasis added).⁴⁸

⁴⁷ Attached at A-38.

⁴⁸ The bills, § 25-48-120, state in their entirety:

Nothing in this article authorizes a physician or any other person to end an individual's life by lethal injection, mercy killing, or euthanasia. Actions taken in accordance with this article do not, for any purpose, constitute suicide, assisted suicide, mercy killing, [another term for lethal injection and euthanasia] homicide, or elder abuse under the "Colorado Criminal Code", Title 18, C.R.S.

Attached hereto at A-17 and A-35.

G. There Is No Oversight at the Death.

If for the purpose of argument, the bills do not allow euthanasia, patients are still at risk to the actions of other people. This is because the bills do not require a doctor or even a witness to be present when the lethal dose is administered.⁴⁹ There is a complete lack of oversight at the death.

Without oversight, the opportunity is created for someone else to administer the lethal dose to the patient without his or her consent. Even if the patient struggled, who would know? And in case, I'm being too subtle, the drugs used are water and alcohol soluble, such that they can be administered to a sleeping or restrained person.⁵⁰ Alex Schadenberg, chair for the Euthanasia Prevention Coalition, International, elaborates:

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

⁴⁹ Id.

⁵⁰ The drugs used for assisted suicide in Oregon and Washington, Secobarbital and Pentobarbital (Nembutal), are water and alcohol soluble, such that they can be injected without consent, for example, to a sleeping or restrained person. See "Secobarbital Sodium Capsules, Drugs.Com, at <http://www.drugs.com/pr/seconal-sodium.html> and <http://www.drugs.com/pro/nembutal.html> See also Oregon's government report, page 5, attached at A-52 (listing these drugs).

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

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H. Individual "Opt Outs" Are Not Allowed.

The bills do not allow an individual to opt out of their provisions. Consider, for example, an older woman with a house and a bank account, concerned that her unemployed son will push her to assisted-suicide or euthanasia. A possible deterrent is a will provision stating that he will be disinherited if she dies under the proposed bills. Under the proposed bills, any such provision is invalid. The bills state:

A provision in a contract, will or other agreement, whether written or oral, that would affect whether a qualified individual may make or rescind a request for aid-in-dying pursuant to this article, is invalid.
(Emphasis added).⁵²

In other words, if you are a person who gets talked into things and you don't want to get talked into assisted suicide or euthanasia, you are not allowed to make legal arrangements to try and prevent it. So much for your personal choice and control.

I. The Death Certificate Is Required to List a Terminal Illness as the Cause of Death.

The bills state that when an individual dies after using the lethal dose, a terminal illness "shall" be listed as the cause of death on the death certificate. The bills state:

If a qualified individual dies after using aid-in-dying medication, the qualified individual's terminal illness shall be listed as the cause of death on his or her death

⁵² SB 16-025 and HB 16-1054, § 25-48-113, at A-13 and A-31, lines 11 to 15.
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certificate."⁵³

The significance is a legal inability to prosecute criminal behavior, for example, in the case of an outright murder for the money. The cause of death, as a matter of law, will be a terminal illness.

J. If Colorado Follows Washington State, the Death Certificate Will Not Disclose the True Cause of Death.

As noted above, the bills require a terminal illness to be listed on the death certificate as the cause of death.⁵⁴ The bills also state:

Actions taken in accordance with this article do not, for any purpose, constitute suicide, assisted suicide, mercy killing, homicide, or elder abuse under the "Colorado Criminal Code", Title 18, C.R.S.⁵⁵

In Washington State, similar language is interpreted by the Washington State Department of Health to require the death certificate to list a natural death - without even a hint that the true cause of death was assisted suicide or euthanasia. The Department's "Death Certificate Instructions for Medical Examiners, Coroners and Prosecuting Attorneys" (attached at A-68), states:

Washington's [law] states that "...the

⁵³ SB 16-025 and HB 16-1054, § 25-48-109(2). (Attached at A-10 and A-28).

⁵⁴ § 25-48-109(2). (Attached hereto at A-10 and A-28, lines 21-23).

⁵⁵ § 25-48-120. (Attached hereto at A-19 and A-35, lines 9 to 12).

patient's death certificate ... shall list the underlying terminal disease as the cause of death." The [law] also states that, "Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide under the law."

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

1. The underlying terminal disease must be listed as the cause of death.
2. The manner of death must be marked as "Natural."
3. The cause of death section may not contain any language that indicates that [Washington's law] was used, such as:
 - a. Suicide
 - b. Assisted suicide
 - c. Physician-assisted suicide
 - d. Death with Dignity
 - e. I-1000 [Washington's law was passed by I-1000]
 - f. Mercy killing
 - g. Euthanasia
 - h. Secobarbital or Seconal
 - i. Pentobarbital or Nembutal (Emphasis added).⁵⁶

If Colorado enacts the proposed bills and follows Washington's example, death certificates will not even hint that the true cause of death was assisted suicide or euthanasia.

⁵⁶ A copy of the Washington State Department of Health death certificate instruction is attached hereto at A-68.
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IV. OTHER CONSIDERATIONS

A. Any Study Claiming that Oregon's Law is Safe, is Invalid.

In 2011, the lack of oversight over administration of the lethal dose in Oregon prompted Montana State Senator Jeff Essmann to observe that any studies claiming that Oregon's assisted suicide law is safe are invalid. He stated:

[All] the protections end after the prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is [taken on a voluntary basis].

So frankly, any of the studies that come out of the state of Oregon's experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.⁵⁷

B. The Oregon Health Plan Steers Patients to Suicide.

It is well documented that Oregon's Health Plan (Medicaid) steers patients to suicide via coverage incentives. See Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (attached at A-82); KATU TV Web Staff, "Letter noting assisted suicide raises questions," July 30, 2008 (attached at A-85); and Affidavit of Kenneth Stevens, MD

⁵⁷ Hearing Transcript for the Montana Senate Judiciary Committee on SB 167, February 10, 2011, at http://www.margaretdore.com/pdf/senator_essmann_sb_167_001.pdf

(attached at A-56, ¶8 through A-61).

Under the proposed bills, private insurance companies and providers will have this same ability. Do you want this to happen to you or your family?

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

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

Oregon's assisted suicide act went into effect "in late 1997."⁵⁸

By 2000, Oregon's conventional suicide rate was "increasing significantly."⁵⁹

By 2007, Oregon's conventional suicide rate was 35% above the national average.⁶⁰

By 2010, Oregon's conventional suicide rate was 41% above the national average.⁶¹

⁵⁸ Oregon's assisted suicide report for 2014, first line, at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

⁵⁹ See Oregon Health Authority News Release, 09/09/10, at <http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf> ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached at A-72)

⁶⁰ *Id.*

⁶¹ Oregon Health Authority Report, *Suicides in Oregon, Trends and Risk Factors* (2012 Report), at A-77.

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

[T]he estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.⁶²

If Colorado, with its larger population, legalizes assisted suicide and has the same experience as Oregon, the financial cost could be larger.⁶³

D. Legal Physician-Assisted Suicide Can Be Traumatic for Family Members.

In 2012, a formal research study was released addressing trauma suffered by persons who witnessed a legal assisted suicide in Switzerland.⁶⁴ The study found that one out of five family members or friends present at an assisted suicide was traumatized. These people:

[E]xperienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.⁶⁵

⁶² See report at A-78.

⁶³ Colorado's estimated population for 2015 is 5,456,574; Oregon's estimated population is 4,028,977. United States Census Bureau at <http://www.census.gov/quickfacts/table/PST045215/00>.

⁶⁴ "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," B. Wagner, J. Muller, A. Maercker; *European Psychiatry* 27 (2012) 542-546, available at <http://choiceisanillusion.files.wordpress.com/2012/10/family-members-traumatized-eur-psych-2012.pdf>

⁶⁵ Id.

E. My Clients and Their Patient-Fathers in Washington State and Oregon.

In Washington State and Oregon, I had two cases where my clients suffered trauma due to legal assisted suicide. In the first case, one side of the family wanted the father to take the lethal dose, while the other side did not. The father spent the last months of his life caught in the middle and torn over whether or not he should kill himself. My client, his adult daughter, was severely traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it is not clear that administration of the lethal dose was voluntary. A man who was present told my client that my client's father refused to take the lethal dose when it was delivered, stating, "You're not killing me. I'm going to bed," but then took it the next night when he was intoxicated on alcohol. My client, although he was not present, was traumatized over the incident, and also by the sudden loss of his father.

V. CONCLUSION

If enacted, the proposed bills will create new paths of elder abuse, which will be legally sanctioned and hidden from view; healthcare care systems will be empowered to steer patients to suicide via coverage incentives; patients and their families, maybe you or your family, will be traumatized.

Even if you are for the concept of assisted suicide and euthanasia, the proposed bills are not what they appear to be. Don't make Oregon and Washington's mistake. I urge you to reject these bills.

Respectfully Submitted,



Margaret Dore, Esq., MBA
Law Offices of Margaret K. Dore, P.S.
Choice is an Illusion, a nonprofit corporation
www.margaretdore.com
www.choiceillusion.org
1001 4th Avenue, Suite 4400r
Seattle, WA 98154
206 389 1754 main reception
206 389 1562 direct line
206 697 1217 cell

Attachments

Margaret Dore Memo

Vote “No” on Colorado Bills

Submitted to the

Colorado Legislature

February 2016

1 COMMUNICATE AN INFORMED DECISION TO HEALTH CARE PROVIDERS,
2 INCLUDING COMMUNICATION THROUGH A PERSON FAMILIAR WITH THE
3 INDIVIDUAL'S MANNER OF COMMUNICATING IF THAT PERSON IS AVAILABLE.

4 (6) "CONSULTING PHYSICIAN" MEANS A COLORADO-LICENSED
5 PHYSICIAN WHO IS QUALIFIED BY SPECIALTY OR EXPERIENCE TO MAKE A
6 PROFESSIONAL DIAGNOSIS AND PROGNOSIS REGARDING A TERMINALLY ILL
7 INDIVIDUAL'S ILLNESS.

8 (7) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A PERSON
9 WHO IS LICENSED, CERTIFIED, REGISTERED, OR OTHERWISE AUTHORIZED OR
10 PERMITTED BY LAW TO ADMINISTER HEALTH CARE OR DISPENSE
11 MEDICATION IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A
12 PROFESSION. THE TERM INCLUDES A HEALTH CARE FACILITY, INCLUDING
13 A LONG-TERM CARE FACILITY AS DEFINED IN SECTION 25-3-103.7 (1) (f.3).

14 (8) "INFORMED DECISION" MEANS A DECISION THAT IS:

15 (a) MADE BY A QUALIFIED INDIVIDUAL TO REQUEST AND OBTAIN
16 A PRESCRIPTION FOR MEDICATION THAT THE QUALIFIED INDIVIDUAL MAY
17 SELF-ADMINISTER TO END HIS OR HER LIFE IN A PEACEFUL MANNER;

18 (b) BASED ON AN UNDERSTANDING AND ACKNOWLEDGMENT OF
19 THE RELEVANT FACTS; AND

20 (c) MADE AFTER THE ATTENDING PHYSICIAN FULLY INFORMS THE
21 QUALIFIED INDIVIDUAL OF:

22 (I) HIS OR HER MEDICAL DIAGNOSIS AND PROGNOSIS;

23 (II) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE
24 MEDICATION TO BE PRESCRIBED;

25 (III) THE PROBABLE RESULT OF TAKING THE MEDICATION TO BE
26 PRESCRIBED;

27 (IV) THE CHOICES AVAILABLE TO AN INDIVIDUAL THAT

1 DEMONSTRATE HIS OR HER SELF-DETERMINATION AND INTENT TO END HIS
2 OR HER LIFE IN A PEACEFUL MANNER, INCLUDING THE ABILITY TO CHOOSE
3 WHETHER TO:

4 (A) REQUEST AID IN DYING;
5 (B) OBTAIN A PRESCRIPTION FOR MEDICATION TO END HIS OR HER
6 LIFE;

7 (C) FILL AND POSSESS A PRESCRIPTION FOR MEDICATION TO END
8 HIS OR HER LIFE; AND

9 (D) ULTIMATELY SELF-ADMINISTER THE MEDICATION TO BRING
10 ABOUT A PEACEFUL DEATH; AND

11 (V) FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT
12 OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE
13 CARE, AND PAIN CONTROL.

14 (9) "LICENSED MENTAL HEALTH PROFESSIONAL" MEANS A
15 PSYCHIATRIST LICENSED UNDER ARTICLE 36 OF TITLE 12, C.R.S., OR A
16 PERSON LICENSED UNDER ARTICLE 43 OF TITLE 12, C.R.S., TO PRACTICE A
17 PARTICULAR MENTAL HEALTH PROFESSION.

18 (10) "MEDICALLY CONFIRMED" MEANS THAT A CONSULTING
19 PHYSICIAN WHO HAS EXAMINED THE TERMINALLY ILL INDIVIDUAL AND THE
20 INDIVIDUAL'S RELEVANT MEDICAL RECORDS HAS CONFIRMED THE MEDICAL
21 OPINION OF THE ATTENDING PHYSICIAN.

22 ~~X~~ (11) "QUALIFIED INDIVIDUAL" MEANS A TERMINALLY ILL ADULT
23 WHO IS CAPABLE, IS A RESIDENT, AND HAS SATISFIED THE REQUIREMENTS
24 OF THIS ARTICLE IN ORDER TO OBTAIN A PRESCRIPTION FOR AID-IN-DYING
25 MEDICATION TO END HIS OR HER LIFE.

26 (12) "RESIDENT" MEANS AN INDIVIDUAL WHO IS ABLE TO
27 DEMONSTRATE RESIDENCY IN COLORADO BY PROVIDING ANY OF THE

- 1 FOLLOWING DOCUMENTATION TO HIS OR HER ATTENDING PHYSICIAN:
- 2 (a) A COLORADO DRIVER'S LICENSE OR IDENTIFICATION CARD
- 3 ISSUED PURSUANT TO ARTICLE 2 OF TITLE 42, C.R.S.;
- 4 (b) A COLORADO VOTER REGISTRATION CARD OR OTHER
- 5 DOCUMENTATION SHOWING THE INDIVIDUAL IS REGISTERED TO VOTE IN
- 6 COLORADO;
- 7 (c) EVIDENCE THAT THE INDIVIDUAL OWNS OR LEASES PROPERTY
- 8 IN COLORADO; OR
- 9 (d) A COLORADO INCOME TAX RETURN FOR THE MOST RECENT TAX
- 10 YEAR.

11 (13) "SELF-ADMINISTRATION" MEANS, IF A QUALIFIED INDIVIDUAL,

12 TO ENGAGE IN AN AFFIRMATIVE AND VOLUNTARY ACT TO USE PRESCRIBED

13 MEDICATION TO BRING ABOUT HIS OR HER OWN PEACEFUL AND HUMANE

14 DEATH.

15 ~~X~~ (14) "TERMINAL ILLNESS" MEANS AN INCURABLE AND

16 IRREVERSIBLE ILLNESS THAT HAS BEEN MEDICALLY CONFIRMED AND WILL,

17 WITHIN REASONABLE MEDICAL JUDGMENT, RESULT IN DEATH WITHIN SIX

18 MONTHS.

19 **25-48-103. Right to request aid-in-dying medication.** (1) A

20 CAPABLE, ADULT RESIDENT OF COLORADO MAY MAKE A REQUEST, IN

21 ACCORDANCE WITH SECTIONS 25-48-104 AND 25-48-111, TO RECEIVE A

22 PRESCRIPTION FOR AID-IN-DYING MEDICATION IF:

23 (a) THE INDIVIDUAL'S ATTENDING PHYSICIAN HAS DIAGNOSED THE

24 INDIVIDUAL WITH A TERMINAL ILLNESS; AND

25 (b) THE INDIVIDUAL HAS VOLUNTARILY EXPRESSED THE WISH TO

26 RECEIVE A PRESCRIPTION FOR AID-IN-DYING MEDICATION.

27 (2) A PERSON DOES NOT QUALIFY TO RECEIVE A PRESCRIPTION FOR

1 AID-IN-DYING MEDICATION SOLELY BECAUSE OF AGE OR DISABILITY.

2 **25-48-104. Request process - witness requirements.** (1) IN
3 ORDER TO RECEIVE A PRESCRIPTION FOR AID-IN-DYING MEDICATION
4 PURSUANT TO THIS ARTICLE, AN INDIVIDUAL WHO SATISFIES THE
5 REQUIREMENTS IN SECTION 25-48-103 MUST MAKE TWO ORAL REQUESTS,
6 SEPARATED BY AT LEAST FIFTEEN DAYS, AND A VALID WRITTEN REQUEST
7 TO HIS OR HER ATTENDING PHYSICIAN.

8 (2) (a) TO BE VALID, A WRITTEN REQUEST FOR AID-IN-DYING
9 MEDICATION MUST BE:

10 (I) SUBSTANTIALLY IN THE SAME FORM AS SET FORTH IN SECTION
11 25-48-111;

12 (II) SIGNED AND DATED BY THE INDIVIDUAL SEEKING THE
13 MEDICATION; AND

14 (III) WITNESSED BY AT LEAST TWO INDIVIDUALS WHO, IN THE
15 PRESENCE OF THE INDIVIDUAL, ATTEST TO THE BEST OF THEIR KNOWLEDGE
16 AND BELIEF THAT THE INDIVIDUAL IS:

17 (A) CAPABLE;

18 (B) ACTING VOLUNTARILY; AND

19 (C) NOT BEING COERCED TO SIGN THE REQUEST.

20 (b) OF THE TWO WITNESSES TO THE WRITTEN REQUEST, AT LEAST
21 ONE MUST NOT BE:

22 (I) RELATED TO THE INDIVIDUAL BY BLOOD, MARRIAGE, CIVIL
23 UNION, OR ADOPTION;

24 (II) AN INDIVIDUAL WHO, AT THE TIME THE REQUEST IS SIGNED, IS
25 ENTITLED, UNDER A WILL OR BY OPERATION OF LAW, TO ANY PORTION OF
26 THE INDIVIDUAL'S ESTATE UPON HIS OR HER DEATH; OR

27 (III) AN OWNER, OPERATOR, OR EMPLOYEE OF A HEALTH CARE

1 FACILITY WHERE THE INDIVIDUAL IS RECEIVING MEDICAL TREATMENT OR
2 IS A RESIDENT.

3 (c) THE INDIVIDUAL'S ATTENDING PHYSICIAN SHALL NOT SERVE AS
4 A WITNESS TO THE WRITTEN REQUEST.

5 **25-48-105. Right to rescind request - requirement to offer**
6 **opportunity to rescind.** (1) AT ANY TIME, AN INDIVIDUAL MAY RESCIND
7 HIS OR HER REQUEST FOR AID-IN-DYING MEDICATION WITHOUT REGARD TO
8 THE INDIVIDUAL'S MENTAL STATE.

9 (2) AN ATTENDING PHYSICIAN SHALL NOT WRITE A PRESCRIPTION
10 FOR AID-IN-DYING MEDICATION UNDER THIS ARTICLE UNLESS THE
11 ATTENDING PHYSICIAN OFFERS THE QUALIFIED INDIVIDUAL AN
12 OPPORTUNITY TO RESCIND THE REQUEST FOR THE MEDICATION.

13 **25-48-106. Attending physician responsibilities.** (1) THE
14 ATTENDING PHYSICIAN SHALL:

15 (a) MAKE THE INITIAL DETERMINATION OF WHETHER AN
16 INDIVIDUAL REQUESTING AID-IN-DYING MEDICATION HAS A TERMINAL
17 ILLNESS, IS CAPABLE OF MAKING AN INFORMED DECISION, AND HAS MADE
18 THE REQUEST VOLUNTARILY;

19 (b) REQUEST THAT THE INDIVIDUAL DEMONSTRATE COLORADO
20 RESIDENCY BY PROVIDING DOCUMENTATION AS DESCRIBED IN SECTION
21 25-48-102 (12);

22 (c) PROVIDE A STANDARD OF CARE UNDER ACCEPTED MEDICAL
23 GUIDELINES;

24 (d) REFER THE INDIVIDUAL TO A CONSULTING PHYSICIAN OF THE
25 INDIVIDUAL'S CHOOSING FOR MEDICAL CONFIRMATION OF THE DIAGNOSIS
26 AND PROGNOSIS AND FOR A DETERMINATION OF WHETHER THE INDIVIDUAL
27 IS CAPABLE AND ACTING VOLUNTARILY;

- 1 (e) PROVIDE FULL, INDIVIDUAL-CENTERED DISCLOSURES TO
2 ENSURE THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION BY
3 DISCUSSING WITH THE INDIVIDUAL:
- 4 (I) HIS OR HER MEDICAL DIAGNOSIS AND PROGNOSIS;
- 5 (II) THE FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT
6 OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE
7 CARE, AND PAIN CONTROL;
- 8 (III) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE
9 AID-IN-DYING MEDICATION TO BE PRESCRIBED;
- 10 (IV) THE PROBABLE RESULT OF TAKING THE AID-IN-DYING
11 MEDICATION TO BE PRESCRIBED; AND
- 12 (V) THE POSSIBILITY THAT THE INDIVIDUAL CAN OBTAIN THE
13 MEDICATION BUT CHOOSE NOT TO USE IT;
- 14 (f) REFER THE INDIVIDUAL TO A LICENSED MENTAL HEALTH
15 PROFESSIONAL PURSUANT TO SECTION 25-48-108 IF, IN THE ATTENDING
16 PHYSICIAN'S OPINION, THE INDIVIDUAL'S ABILITY TO MAKE AN INFORMED
17 DECISION IS COMPROMISED FOR ANY REASON;
- 18 (g) CONFIRM THAT THE INDIVIDUAL'S REQUEST DOES NOT ARISE
19 FROM COERCION OR UNDUE INFLUENCE BY ANOTHER PERSON BY
20 DISCUSSING WITH THE INDIVIDUAL, WITHOUT THE PRESENCE OF OTHER
21 PERSONS, WHETHER THE INDIVIDUAL IS FEELING COERCED OR UNDULY
22 INFLUENCED BY ANOTHER PERSON;
- 23 (h) COUNSEL THE INDIVIDUAL ABOUT THE IMPORTANCE OF:
- 24 (I) HAVING ANOTHER PERSON PRESENT WHEN THE INDIVIDUAL
25 SELF-ADMINISTERS THE AID-IN-DYING MEDICATION PRESCRIBED PURSUANT
26 TO THIS ARTICLE;
- 27 (II) NOT TAKING THE AID-IN-DYING MEDICATION IN A PUBLIC

1 PLACE;

2 (III) SAFE-KEEPING AND PROPER DISPOSAL OF UNUSED
3 MEDICATION IN ACCORDANCE WITH SECTION 25-48-119; AND

4 (IV) NOTIFYING HIS OR HER NEXT OF KIN OF THE REQUEST FOR
5 AID-IN-DYING MEDICATION;

6 (i) INFORM THE INDIVIDUAL THAT HE OR SHE MAY RESCIND THE
7 REQUEST FOR AID-IN-DYING MEDICATION AT ANY TIME AND IN ANY
8 MANNER;

9 (j) VERIFY, IMMEDIATELY PRIOR TO WRITING THE PRESCRIPTION
10 FOR AID-IN-DYING MEDICATION, THAT THE INDIVIDUAL IS MAKING AN
11 INFORMED DECISION;

12 (k) ENSURE THAT ALL APPROPRIATE STEPS ARE CARRIED OUT IN
13 ACCORDANCE WITH THIS ARTICLE BEFORE WRITING A PRESCRIPTION FOR
14 AID-IN-DYING MEDICATION; AND

15 (I) (I) DISPENSE AID-IN-DYING MEDICATIONS DIRECTLY TO THE
16 QUALIFIED INDIVIDUAL, INCLUDING ANCILLARY MEDICATIONS INTENDED
17 TO MINIMIZE THE INDIVIDUAL'S DISCOMFORT, IF THE ATTENDING
18 PHYSICIAN HAS A CURRENT DRUG ENFORCEMENT ADMINISTRATION
19 CERTIFICATE AND COMPLIES WITH ANY APPLICABLE ADMINISTRATIVE
20 RULE; OR

21 (II) WITH THE QUALIFIED INDIVIDUAL'S WRITTEN CONSENT:

22 (A) CONTACT A LICENSED PHARMACIST AND INFORM THE
23 PHARMACIST OF THE PRESCRIPTION; AND

24 (B) DELIVER THE WRITTEN PRESCRIPTION PERSONALLY, BY MAIL,
25 OR THROUGH AUTHORIZED ELECTRONIC TRANSMISSION IN THE MANNER
26 PERMITTED UNDER ARTICLE 42.5 OF TITLE 12, C.R.S., TO THE PHARMACIST,
27 WHO SHALL DISPENSE THE MEDICATION TO THE QUALIFIED INDIVIDUAL,

1 THE ATTENDING PHYSICIAN, OR AN INDIVIDUAL EXPRESSLY DESIGNATED
2 BY THE QUALIFIED INDIVIDUAL.

3 **25-48-107. Consulting physician responsibilities.** (1) BEFORE
4 AN INDIVIDUAL WHO IS REQUESTING AID-IN-DYING MEDICATION CAN
5 RECEIVE A PRESCRIPTION FOR THE MEDICATION, A CONSULTING PHYSICIAN
6 OF THE INDIVIDUAL'S CHOOSING MUST:

7 (a) EXAMINE THE INDIVIDUAL AND HIS OR HER RELEVANT MEDICAL
8 RECORDS;

9 (b) CONFIRM, IN WRITING, TO THE ATTENDING PHYSICIAN:

10 (I) THAT THE INDIVIDUAL IS SUFFERING FROM A TERMINAL
11 ILLNESS;

12 (II) THE INDIVIDUAL'S PROGNOSIS; AND

13 (III) THAT THE INDIVIDUAL IS CAPABLE OF MAKING AN INFORMED
14 DECISION, OR PROVIDE DOCUMENTATION THAT THE CONSULTING
15 PHYSICIAN HAS REFERRED THE INDIVIDUAL FOR FURTHER EVALUATION IN
16 ACCORDANCE WITH SECTION 25-48-108.

17 **25-48-108. Confirmation that individual is capable - referral**
18 **to mental health professional.** (1) AN ATTENDING PHYSICIAN SHALL NOT
19 PRESCRIBE AID-IN-DYING MEDICATION UNDER THIS ARTICLE FOR AN
20 INDIVIDUAL WITH A TERMINAL ILLNESS UNTIL THE INDIVIDUAL IS
21 DETERMINED TO BE CAPABLE OF MAKING AN INFORMED DECISION AND
22 THAT DETERMINATION IS CONFIRMED IN ACCORDANCE WITH THIS SECTION.

23 (2) THE DETERMINATION OF WHETHER AN INDIVIDUAL WITH A
24 TERMINAL ILLNESS WHO IS REQUESTING AID-IN-DYING MEDICATION IS
25 CAPABLE OF MAKING AN INFORMED DECISION AND CONFIRMATION OF THAT
26 DETERMINATION MUST BE MADE BY TWO OF THE FOLLOWING:

27 (a) THE ATTENDING PHYSICIAN;

1 (b) THE CONSULTING PHYSICIAN; OR

2 (c) A LICENSED MENTAL HEALTH PROFESSIONAL.

3 (3) IF, IN THE OPINION OF THE ATTENDING PHYSICIAN OR THE
4 CONSULTING PHYSICIAN, THE INDIVIDUAL'S ABILITY TO MAKE AN
5 INFORMED DECISION IS COMPROMISED, THE ATTENDING PHYSICIAN OR
6 CONSULTING PHYSICIAN SHALL REFER THE INDIVIDUAL TO A LICENSED
7 MENTAL HEALTH PROFESSIONAL FOR A DETERMINATION OF WHETHER THE
8 INDIVIDUAL IS CAPABLE OF MAKING AN INFORMED DECISION.

9 (4) A LICENSED MENTAL HEALTH PROFESSIONAL WHO EVALUATES
10 AN INDIVIDUAL UNDER THIS SECTION SHALL COMMUNICATE, IN WRITING,
11 TO THE ATTENDING OR CONSULTING PHYSICIAN WHO REQUESTED THE
12 EVALUATION, HIS OR HER CONCLUSIONS ABOUT WHETHER THE INDIVIDUAL
13 IS CAPABLE OF MAKING AN INFORMED DECISION. IF THE LICENSED MENTAL
14 HEALTH PROFESSIONAL DETERMINES THAT THE INDIVIDUAL IS NOT
15 CAPABLE OF MAKING AN INFORMED DECISION, THE ATTENDING PHYSICIAN
16 SHALL NOT PRESCRIBE AID-IN-DYING MEDICATION TO THE INDIVIDUAL.

17 ~~X~~ **25-48-109. Death certificate.** (1) UNLESS OTHERWISE
18 PROHIBITED BY LAW, THE ATTENDING PHYSICIAN MAY SIGN THE DEATH
19 CERTIFICATE OF A QUALIFIED INDIVIDUAL WHO OBTAINS AND
20 SELF-ADMINISTERS AID-IN-DYING MEDICATION.

21 ~~X~~ (2) IF A QUALIFIED INDIVIDUAL DIES AFTER USING AID-IN-DYING
22 MEDICATION, THE QUALIFIED INDIVIDUAL'S TERMINAL ILLNESS SHALL BE
23 LISTED AS THE CAUSE OF DEATH ON HIS OR HER DEATH CERTIFICATE.
24 WHEN AN ATTENDING PHYSICIAN CERTIFIES THAT A DEATH OCCURRED IN
25 ACCORDANCE WITH THIS ARTICLE, THE DEATH IS NOT REPORTABLE AND
26 DOES NOT CONSTITUTE GROUNDS FOR POSTMORTEM INQUIRY UNDER
27 SECTION 30-10-606 (1), C.R.S.

1 **25-48-110. Informed decision required.** (1) AN INDIVIDUAL
2 WITH A TERMINAL ILLNESS IS NOT A QUALIFIED INDIVIDUAL AND MAY NOT
3 RECEIVE A PRESCRIPTION FOR AID-IN-DYING MEDICATION UNLESS HE OR
4 SHE HAS MADE AN INFORMED DECISION.

5 (2) IMMEDIATELY BEFORE WRITING A PRESCRIPTION FOR
6 AID-IN-DYING MEDICATION UNDER THIS ARTICLE, THE ATTENDING
7 PHYSICIAN SHALL VERIFY THAT THE INDIVIDUAL WITH A TERMINAL
8 ILLNESS IS A QUALIFIED INDIVIDUAL AND IS MAKING AN INFORMED
9 DECISION.

10 **25-48-111. Form of written request.** A REQUEST FOR
11 AID-IN-DYING MEDICATION AUTHORIZED BY THIS ARTICLE MUST BE IN
12 SUBSTANTIALLY THE FOLLOWING FORM:

13 REQUEST FOR MEDICATION TO END MY LIFE
14 IN A HUMANE AND DIGNIFIED MANNER

15 I, _____, AM AN ADULT OF SOUND MIND. I AM SUFFERING
16 FROM _____, WHICH MY ATTENDING PHYSICIAN HAS DETERMINED IS A
17 TERMINAL ILLNESS AND WHICH HAS BEEN MEDICALLY CONFIRMED. I HAVE
18 BEEN FULLY INFORMED OF MY DIAGNOSIS AND PROGNOSIS, THE NATURE OF
19 THE AID-IN-DYING MEDICATION TO BE PRESCRIBED AND POTENTIAL
20 ASSOCIATED RISKS, THE EXPECTED RESULT, AND THE FEASIBLE
21 ALTERNATIVES OR ADDITIONAL TREATMENT OPPORTUNITIES, INCLUDING
22 COMFORT CARE, PALLIATIVE CARE, HOSPICE CARE, AND PAIN CONTROL.
23 I REQUEST THAT MY ATTENDING PHYSICIAN PRESCRIBE AID-IN-DYING
24 MEDICATION THAT WILL END MY LIFE IN A HUMANE AND DIGNIFIED
25 MANNER IF I CHOOSE TO TAKE IT, AND I AUTHORIZE MY ATTENDING
26 PHYSICIAN TO CONTACT ANY PHARMACIST ABOUT MY REQUEST.
27 I UNDERSTAND THAT I HAVE THE RIGHT TO RESCIND THIS REQUEST AT ANY

1 TIME.
2 I UNDERSTAND THE SERIOUSNESS OF THIS REQUEST, AND I EXPECT TO DIE
3 IF I TAKE THE AID-IN-DYING MEDICATION PRESCRIBED. I FURTHER
4 UNDERSTAND THAT ALTHOUGH MOST DEATHS OCCUR WITHIN THREE
5 HOURS, MY DEATH MAY TAKE LONGER, AND MY ATTENDING PHYSICIAN
6 HAS COUNSELED ME ABOUT THIS POSSIBILITY.

7 I MAKE THIS REQUEST VOLUNTARILY, WITHOUT RESERVATION, AND
8 WITHOUT BEING COERCED, AND I ACCEPT FULL RESPONSIBILITY FOR MY
9 ACTIONS.

10 SIGNED: _____

11 DATED: _____

12 DECLARATION OF WITNESSES

13 WE DECLARE THAT THE INDIVIDUAL SIGNING THIS REQUEST:

14 (a) IS PERSONALLY KNOWN TO US OR HAS PROVIDED PROOF OF
15 IDENTITY;

16 (b) SIGNED THIS REQUEST IN OUR PRESENCE;

17 (c) APPEARS TO BE OF SOUND MIND AND NOT UNDER DURESS,
18 FRAUD, OR UNDUE INFLUENCE; AND

19 (d) IS NOT AN INDIVIDUAL FOR WHOM EITHER OF US IS THE
20 ATTENDING PHYSICIAN.

21 _____ WITNESS 1/DATE

22 _____ WITNESS 2/DATE

23 NOTE: ONLY ONE OF THE TWO WITNESSES MAY: BE A RELATIVE (BY
24 BLOOD, MARRIAGE, CIVIL UNION, OR ADOPTION) OF THE INDIVIDUAL
25 SIGNING THIS REQUEST; BE ENTITLED TO ANY PORTION OF THE
26 INDIVIDUAL'S ESTATE UPON DEATH; OR OWN, OPERATE, OR BE EMPLOYED
27 AT A HEALTH CARE FACILITY WHERE THE INDIVIDUAL IS A PATIENT OR

1 RESIDENT.

2 **25-48-112. Standard of care.** (1) PHYSICIANS AND HEALTH CARE
3 PROVIDERS SHALL PROVIDE MEDICAL SERVICES UNDER THIS ARTICLE THAT
4 MEET OR EXCEED THE STANDARD OF CARE FOR END-OF-LIFE MEDICAL
5 CARE.

6 (2) WHEN A HEALTH CARE PROVIDER MAKES A DIAGNOSIS THAT AN
7 INDIVIDUAL HAS A TERMINAL ILLNESS, THE HEALTH CARE PROVIDER, UPON
8 THE INDIVIDUAL'S REQUEST, SHALL PROVIDE THE INDIVIDUAL WITH
9 COMPREHENSIVE INFORMATION AND COUNSELING, IN ACCORDANCE WITH
10 THIS SECTION, REGARDING LEGAL END-OF-LIFE MEDICAL CARE OPTIONS.

11 ~~X~~ **25-48-113. Effect on wills, contracts, and statutes.** (1) A
12 PROVISION IN A CONTRACT, WILL, OR OTHER AGREEMENT, WHETHER
13 WRITTEN OR ORAL, THAT WOULD AFFECT WHETHER A QUALIFIED
14 INDIVIDUAL MAY MAKE OR RESCIND A REQUEST FOR AID IN DYING
15 PURSUANT TO THIS ARTICLE IS INVALID.

16 (2) AN OBLIGATION OWING UNDER ANY CURRENTLY EXISTING
17 CONTRACT MUST NOT BE CONDITIONED UPON, OR AFFECTED BY, A
18 QUALIFIED INDIVIDUAL'S ACT OF MAKING OR RESCINDING A REQUEST FOR
19 AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE.

20 **25-48-114. Insurance or annuity policies.** (1) THE SALE,
21 PROCUREMENT, OR ISSUANCE OF, OR THE RATE CHARGED FOR, ANY LIFE,
22 HEALTH, OR ACCIDENT INSURANCE OR ANNUITY POLICY MUST NOT BE
23 CONDITIONED UPON, OR AFFECTED BY, A QUALIFIED INDIVIDUAL'S ACT OF
24 MAKING OR RESCINDING A REQUEST FOR AID-IN-DYING MEDICATION IN
25 ACCORDANCE WITH THIS ARTICLE.

26 (2) A QUALIFIED INDIVIDUAL'S ACT OF SELF-ADMINISTERING
27 AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE DOES NOT AFFECT

1 A LIFE, HEALTH, OR ACCIDENT INSURANCE OR ANNUITY POLICY, OTHER
2 THAN THAT THE DEATH IS A NATURAL DEATH RESULTING FROM THE
3 QUALIFIED INDIVIDUAL'S TERMINAL ILLNESS.

4 ~~25-48-115. Immunity for good-faith participation - prohibition~~
5 ~~against reprisals.~~ (1) A PERSON IS NOT SUBJECT TO CIVIL OR CRIMINAL
6 LIABILITY OR PROFESSIONAL DISCIPLINARY ACTION FOR PARTICIPATING IN
7 GOOD FAITH UNDER THIS ARTICLE, WHICH INCLUDES BEING PRESENT WHEN
8 A QUALIFIED INDIVIDUAL SELF-ADMINISTERS THE PRESCRIBED
9 AID-IN-DYING MEDICATION.

10 (2) A HEALTH CARE PROVIDER OR PROFESSIONAL ORGANIZATION
11 OR ASSOCIATION SHALL NOT SUBJECT AN INDIVIDUAL TO ANY OF THE
12 FOLLOWING FOR PARTICIPATING OR REFUSING TO PARTICIPATE IN
13 GOOD-FAITH COMPLIANCE UNDER THIS ARTICLE:

- 14 (a) CENSURE;
- 15 (b) DISCIPLINE;
- 16 (c) SUSPENSION;
- 17 (d) LOSS OF LICENSE, PRIVILEGES, OR MEMBERSHIP; OR
- 18 (e) ANY OTHER PENALTY.

19 (3) A REQUEST BY A QUALIFIED INDIVIDUAL FOR, OR THE
20 PROVISION BY AN ATTENDING PHYSICIAN OF, AID-IN-DYING MEDICATION
21 IN GOOD-FAITH COMPLIANCE WITH THIS ARTICLE DOES NOT:

- 22 (a) CONSTITUTE NEGLIGENCE OR ELDER ABUSE FOR ANY PURPOSE OF
23 LAW; OR
- 24 (b) PROVIDE THE SOLE BASIS FOR THE APPOINTMENT OF A
25 GUARDIAN OR CONSERVATOR.

26 **25-48-116. No duty to prescribe or dispense.** (1) A HEALTH
27 CARE PROVIDER MAY CHOOSE WHETHER TO PARTICIPATE IN PROVIDING

1 AID-IN-DYING MEDICATION TO A QUALIFIED INDIVIDUAL IN ACCORDANCE
2 WITH THIS ARTICLE.

3 (2) IF A HEALTH CARE PROVIDER IS UNABLE OR UNWILLING TO
4 CARRY OUT A QUALIFIED INDIVIDUAL'S REQUEST FOR AID-IN-DYING
5 MEDICATION MADE IN ACCORDANCE WITH THIS ARTICLE, AND THE
6 QUALIFIED INDIVIDUAL TRANSFERS HIS OR HER CARE TO A NEW HEALTH
7 CARE PROVIDER, THE PRIOR HEALTH CARE PROVIDER SHALL TRANSFER,
8 UPON REQUEST, A COPY OF THE QUALIFIED INDIVIDUAL'S RELEVANT
9 MEDICAL RECORDS TO THE NEW HEALTH CARE PROVIDER.

10 **25-48-117. Health care facility may prohibit participation -**
11 **sanctions if provider violates policy.** (1) A HEALTH CARE FACILITY MAY
12 PROHIBIT A PHYSICIAN FROM WRITING A PRESCRIPTION FOR AID-IN-DYING
13 MEDICATION FOR A QUALIFIED INDIVIDUAL WHO IS A RESIDENT IN THE
14 FACILITY AND WHO INTENDS TO USE THE AID-IN-DYING MEDICATION ON
15 THE FACILITY'S PREMISES. THE HEALTH CARE FACILITY MUST NOTIFY THE
16 PHYSICIAN IN WRITING OF ITS POLICY WITH REGARD TO PRESCRIPTIONS FOR
17 AID-IN-DYING MEDICATION.

18 (2) A HEALTH CARE FACILITY OR HEALTH CARE PROVIDER SHALL
19 NOT SUBJECT A PHYSICIAN, NURSE, PHARMACIST, OR OTHER PERSON TO
20 DISCIPLINE, SUSPENSION, LOSS OF LICENSE OR PRIVILEGES, OR ANY OTHER
21 PENALTY OR SANCTION FOR ACTIONS TAKEN IN GOOD-FAITH RELIANCE ON
22 THIS ARTICLE OR FOR REFUSING TO ACT UNDER THIS ARTICLE.

23 (3) NOTHING IN THIS SECTION OR IN SECTION 25-48-115 OR
24 25-48-116 PREVENTS A HEALTH CARE PROVIDER FROM PROVIDING TO AN
25 INDIVIDUAL HEALTH CARE SERVICES THAT DO NOT CONSTITUTE
26 PARTICIPATION UNDER THIS ARTICLE.

27 **25-48-118. Liabilities.** (1) A PERSON COMMITS A CLASS 2 FELONY

1 AND IS SUBJECT TO PUNISHMENT IN ACCORDANCE WITH SECTION
2 18-1.3-401, C.R.S., IF THE PERSON, WITH INTENT OR THE EFFECT OF
3 CAUSING AN INDIVIDUAL'S DEATH, PURPOSELY OR KNOWINGLY:

4 (a) ALTERS OR FORGES A REQUEST FOR AID-IN-DYING MEDICATION
5 TO END AN INDIVIDUAL'S LIFE WITHOUT THE INDIVIDUAL'S
6 AUTHORIZATION; OR.

7 (b) CONCEALS OR DESTROYS A RESCISSION OF A REQUEST FOR
8 AID-IN-DYING MEDICATION.

9 (2) A PERSON COMMITS A CLASS 2 FELONY AND IS SUBJECT TO
10 PUNISHMENT IN ACCORDANCE WITH SECTION 18-1.3-401, C.R.S., IF THE
11 PERSON PURPOSELY OR KNOWINGLY COERCES OR EXERTS UNDUE
12 INFLUENCE ON AN INDIVIDUAL WITH A TERMINAL ILLNESS TO:

13 (a) REQUEST AID-IN-DYING MEDICATION FOR THE PURPOSE OF
14 ENDING THE TERMINALLY ILL INDIVIDUAL'S LIFE; OR

15 (b) DESTROY A RESCISSION OF A REQUEST FOR AID-IN-DYING
16 MEDICATION.

17 (3) NOTHING IN THIS ARTICLE LIMITS FURTHER LIABILITY FOR CIVIL
18 DAMAGES RESULTING FROM OTHER NEGLIGENT CONDUCT OR INTENTIONAL
19 MISCONDUCT BY ANY PERSON.

20 (4) THE PENALTIES SPECIFIED IN THIS ARTICLE DO NOT PRECLUDE
21 CRIMINAL PENALTIES APPLICABLE UNDER OTHER LAW FOR CONDUCT THAT
22 IS INCONSISTENT WITH THIS ARTICLE.

23 **25-48-119. Safe disposal of unused medications.** A PERSON WHO
24 HAS CUSTODY OR CONTROL OF AID-IN-DYING MEDICATION DISPENSED
25 UNDER THIS ARTICLE THAT THE TERMINALLY ILL INDIVIDUAL DECIDES NOT
26 TO USE OR THAT REMAINS UNUSED AFTER THE TERMINALLY ILL
27 INDIVIDUAL'S DEATH SHALL DISPOSE OF THE UNUSED AID-IN-DYING

1 MEDICATION BY LAWFUL MEANS IN ACCORDANCE WITH SECTION 25-15-328
2 OR ANY OTHER STATE OR FEDERALLY APPROVED MEDICATION TAKE-BACK
3 PROGRAM AUTHORIZED UNDER THE FEDERAL "SECURE AND RESPONSIBLE
4 DRUG DISPOSAL ACT OF 2010", PUB.L. 111-273, AS AMENDED, AND
5 REGULATIONS ADOPTED PURSUANT TO THE FEDERAL ACT.

6 ~~X~~ **25-48-120. Actions complying with article not a crime.**
7 NOTHING IN THIS ARTICLE AUTHORIZES A PHYSICIAN OR ANY OTHER
8 PERSON TO END AN INDIVIDUAL'S LIFE BY LETHAL INJECTION, MERCY
9 KILLING, OR EUTHANASIA. ACTIONS TAKEN IN ACCORDANCE WITH THIS
10 ARTICLE DO NOT, FOR ANY PURPOSE, CONSTITUTE SUICIDE, ASSISTED
11 SUICIDE, MERCY KILLING, HOMICIDE, OR ELDER ABUSE UNDER THE
12 "COLORADO CRIMINAL CODE", TITLE 18, C.R.S.

13 **25-48-121. Claims by government entity for costs.** A
14 GOVERNMENT ENTITY THAT INCURS COSTS RESULTING FROM AN
15 INDIVIDUAL TERMINATING HIS OR HER LIFE PURSUANT TO THIS ARTICLE IN
16 A PUBLIC PLACE HAS A CLAIM AGAINST THE ESTATE OF THE INDIVIDUAL TO
17 RECOVER THE COSTS AND REASONABLE ATTORNEY FEES RELATED TO
18 ENFORCING THE CLAIM.

19 **25-48-122. No effect on advance medical directives.**

20 (1) NOTHING IN THIS ARTICLE AFFECTS OR NEGATES:

21 (a) A DECLARATION MADE UNDER ARTICLE 18 OF TITLE 15, C.R.S.,
22 DIRECTING THAT LIFE-SUSTAINING PROCEDURES BE WITHHELD OR
23 WITHDRAWN;

24 (b) A CPR DIRECTIVE EXECUTED UNDER ARTICLE 18.6 OF TITLE 15,
25 C.R.S.; OR

26 (c) AN ADVANCE MEDICAL DIRECTIVE EXECUTED UNDER ARTICLE
27 18.7 OF TITLE 15, C.R.S.

1 **SECTION 2. Applicability.** This act applies to conduct occurring
2 on or after the effective date of this act.

3 **SECTION 3. Safety clause.** The general assembly hereby finds,
4 determines, and declares that this act is necessary for the immediate
5 preservation of the public peace, health, and safety.

1 COMMUNICATE AN INFORMED DECISION TO HEALTH CARE PROVIDERS,
2 INCLUDING COMMUNICATION THROUGH A PERSON FAMILIAR WITH THE
3 INDIVIDUAL'S MANNER OF COMMUNICATING IF THAT PERSON IS AVAILABLE.

4 (6) "CONSULTING PHYSICIAN" MEANS A COLORADO-LICENSED
5 PHYSICIAN WHO IS QUALIFIED BY SPECIALTY OR EXPERIENCE TO MAKE A
6 PROFESSIONAL DIAGNOSIS AND PROGNOSIS REGARDING A TERMINALLY ILL
7 INDIVIDUAL'S ILLNESS.

8 (7) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A PERSON
9 WHO IS LICENSED, CERTIFIED, REGISTERED, OR OTHERWISE AUTHORIZED OR
10 PERMITTED BY LAW TO ADMINISTER HEALTH CARE OR DISPENSE
11 MEDICATION IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A
12 PROFESSION. THE TERM INCLUDES A HEALTH CARE FACILITY, INCLUDING
13 A LONG-TERM CARE FACILITY AS DEFINED IN SECTION 25-3-103.7(1)(f.3).

14 (8) "INFORMED DECISION" MEANS A DECISION THAT IS:

15 (a) MADE BY A QUALIFIED INDIVIDUAL TO REQUEST AND OBTAIN
16 A PRESCRIPTION FOR MEDICATION THAT THE QUALIFIED INDIVIDUAL MAY
17 SELF-ADMINISTER TO END HIS OR HER LIFE IN A PEACEFUL MANNER;

18 (b) BASED ON AN UNDERSTANDING AND ACKNOWLEDGMENT OF
19 THE RELEVANT FACTS; AND

20 (c) MADE AFTER THE ATTENDING PHYSICIAN FULLY INFORMS THE
21 QUALIFIED INDIVIDUAL OF:

22 (I) HIS OR HER MEDICAL DIAGNOSIS AND PROGNOSIS;

23 (II) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE
24 MEDICATION TO BE PRESCRIBED;

25 (III) THE PROBABLE RESULT OF TAKING THE MEDICATION TO BE
26 PRESCRIBED;

27 (IV) THE CHOICES AVAILABLE TO AN INDIVIDUAL THAT

1 DEMONSTRATE HIS OR HER SELF-DETERMINATION AND INTENT TO END HIS
2 OR HER LIFE IN A PEACEFUL MANNER, INCLUDING THE ABILITY TO CHOOSE
3 WHETHER TO:

4 (A) REQUEST AID IN DYING;

5 (B) OBTAIN A PRESCRIPTION FOR MEDICATION TO END HIS OR HER
6 LIFE;

7 (C) FILL AND POSSESS A PRESCRIPTION FOR MEDICATION TO END
8 HIS OR HER LIFE; AND

9 (D) ULTIMATELY SELF-ADMINISTER THE MEDICATION TO BRING
10 ABOUT A PEACEFUL DEATH; AND

11 (V) FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT
12 OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE
13 CARE, AND PAIN CONTROL.

14 (9) "LICENSED MENTAL HEALTH PROFESSIONAL" MEANS A
15 PSYCHIATRIST LICENSED UNDER ARTICLE 36 OF TITLE 12, C.R.S., OR A
16 PERSON LICENSED UNDER ARTICLE 43 OF TITLE 12, C.R.S., TO PRACTICE A
17 PARTICULAR MENTAL HEALTH PROFESSION.

18 (10) "MEDICALLY CONFIRMED" MEANS THAT A CONSULTING
19 PHYSICIAN WHO HAS EXAMINED THE TERMINALLY ILL INDIVIDUAL AND THE
20 INDIVIDUAL'S RELEVANT MEDICAL RECORDS HAS CONFIRMED THE MEDICAL
21 OPINION OF THE ATTENDING PHYSICIAN.

22 X (11) "QUALIFIED INDIVIDUAL" MEANS A TERMINALLY ILL ADULT
23 WHO IS CAPABLE, IS A RESIDENT, AND HAS SATISFIED THE REQUIREMENTS
24 OF THIS ARTICLE IN ORDER TO OBTAIN A PRESCRIPTION FOR AID-IN-DYING
25 MEDICATION TO END HIS OR HER LIFE.

26 (12) "RESIDENT" MEANS AN INDIVIDUAL WHO IS ABLE TO
27 DEMONSTRATE RESIDENCY IN COLORADO BY PROVIDING ANY OF THE

1 FOLLOWING DOCUMENTATION TO HIS OR HER ATTENDING PHYSICIAN:

2 (a) A COLORADO DRIVER'S LICENSE OR IDENTIFICATION CARD
3 ISSUED PURSUANT TO ARTICLE 2 OF TITLE 42, C.R.S.;

4 (b) A COLORADO VOTER REGISTRATION CARD OR OTHER
5 DOCUMENTATION SHOWING THE INDIVIDUAL IS REGISTERED TO VOTE IN
6 COLORADO;

7 (c) EVIDENCE THAT THE INDIVIDUAL OWNS OR LEASES PROPERTY
8 IN COLORADO; OR

9 (d) A COLORADO INCOME TAX RETURN FOR THE MOST RECENT TAX
10 YEAR.

11 (13) "SELF-ADMINISTRATION" MEANS, IF A QUALIFIED INDIVIDUAL,
12 TO ENGAGE IN AN AFFIRMATIVE AND VOLUNTARY ACT TO USE PRESCRIBED
13 MEDICATION TO BRING ABOUT HIS OR HER OWN PEACEFUL AND HUMANE
14 DEATH.

15 X (14) "TERMINAL ILLNESS" MEANS AN INCURABLE AND
16 IRREVERSIBLE ILLNESS THAT HAS BEEN MEDICALLY CONFIRMED AND WILL,
17 WITHIN REASONABLE MEDICAL JUDGMENT, RESULT IN DEATH WITHIN SIX
18 MONTHS.

19 **25-48-103. Right to request aid-in-dying medication.** (1) A
20 CAPABLE, ADULT RESIDENT OF COLORADO MAY MAKE A REQUEST, IN
21 ACCORDANCE WITH SECTIONS 25-48-104 AND 25-48-111, TO RECEIVE A
22 PRESCRIPTION FOR AID-IN-DYING MEDICATION IF:

23 (a) THE INDIVIDUAL'S ATTENDING PHYSICIAN HAS DIAGNOSED THE
24 INDIVIDUAL WITH A TERMINAL ILLNESS; AND

25 (b) THE INDIVIDUAL HAS VOLUNTARILY EXPRESSED THE WISH TO
26 RECEIVE A PRESCRIPTION FOR AID-IN-DYING MEDICATION.

27 (2) A PERSON DOES NOT QUALIFY TO RECEIVE A PRESCRIPTION FOR

1 AID-IN-DYING MEDICATION SOLELY BECAUSE OF AGE OR DISABILITY.

2 **25-48-104. Request process - witness requirements.** (1) IN
3 ORDER TO RECEIVE A PRESCRIPTION FOR AID-IN-DYING MEDICATION
4 PURSUANT TO THIS ARTICLE, AN INDIVIDUAL WHO SATISFIES THE
5 REQUIREMENTS IN SECTION 25-48-103 MUST MAKE TWO ORAL REQUESTS,
6 SEPARATED BY AT LEAST FIFTEEN DAYS, AND A VALID WRITTEN REQUEST
7 TO HIS OR HER ATTENDING PHYSICIAN.

8 (2) (a) TO BE VALID, A WRITTEN REQUEST FOR AID-IN-DYING
9 MEDICATION MUST BE:

10 (I) SUBSTANTIALLY IN THE SAME FORM AS SET FORTH IN SECTION
11 25-48-111;

12 (II) SIGNED AND DATED BY THE INDIVIDUAL SEEKING THE
13 MEDICATION; AND

14 (III) WITNESSED BY AT LEAST TWO INDIVIDUALS WHO, IN THE
15 PRESENCE OF THE INDIVIDUAL, ATTEST TO THE BEST OF THEIR KNOWLEDGE
16 AND BELIEF THAT THE INDIVIDUAL IS:

17 (A) CAPABLE;

18 (B) ACTING VOLUNTARILY; AND

19 (C) NOT BEING COERCED TO SIGN THE REQUEST.

20 (b) OF THE TWO WITNESSES TO THE WRITTEN REQUEST, AT LEAST
21 ONE MUST NOT BE:

22 (I) RELATED TO THE INDIVIDUAL BY BLOOD, MARRIAGE, CIVIL
23 UNION, OR ADOPTION;

24 (II) AN INDIVIDUAL WHO, AT THE TIME THE REQUEST IS SIGNED, IS
25 ENTITLED, UNDER A WILL OR BY OPERATION OF LAW, TO ANY PORTION OF
26 THE INDIVIDUAL'S ESTATE UPON HIS OR HER DEATH; OR

27 (III) AN OWNER, OPERATOR, OR EMPLOYEE OF A HEALTH CARE

1 FACILITY WHERE THE INDIVIDUAL IS RECEIVING MEDICAL TREATMENT OR
2 IS A RESIDENT.

3 (c) THE INDIVIDUAL'S ATTENDING PHYSICIAN SHALL NOT SERVE AS
4 A WITNESS TO THE WRITTEN REQUEST.

5 **25-48-105. Right to rescind request - requirement to offer**
6 **opportunity to rescind.** (1) AT ANY TIME, AN INDIVIDUAL MAY RESCIND
7 HIS OR HER REQUEST FOR AID-IN-DYING MEDICATION WITHOUT REGARD TO
8 THE INDIVIDUAL'S MENTAL STATE.

9 (2) AN ATTENDING PHYSICIAN SHALL NOT WRITE A PRESCRIPTION
10 FOR AID-IN-DYING MEDICATION UNDER THIS ARTICLE UNLESS THE
11 ATTENDING PHYSICIAN OFFERS THE QUALIFIED INDIVIDUAL AN
12 OPPORTUNITY TO RESCIND THE REQUEST FOR THE MEDICATION.

13 **25-48-106. Attending physician responsibilities.** (1) THE
14 ATTENDING PHYSICIAN SHALL:

15 (a) MAKE THE INITIAL DETERMINATION OF WHETHER AN
16 INDIVIDUAL REQUESTING AID-IN-DYING MEDICATION HAS A TERMINAL
17 ILLNESS, IS CAPABLE OF MAKING AN INFORMED DECISION, AND HAS MADE
18 THE REQUEST VOLUNTARILY;

19 (b) REQUEST THAT THE INDIVIDUAL DEMONSTRATE COLORADO
20 RESIDENCY BY PROVIDING DOCUMENTATION AS DESCRIBED IN SECTION
21 25-48-102 (12);

22 (c) PROVIDE A STANDARD OF CARE UNDER ACCEPTED MEDICAL
23 GUIDELINES;

24 (d) REFER THE INDIVIDUAL TO A CONSULTING PHYSICIAN OF THE
25 INDIVIDUAL'S CHOOSING FOR MEDICAL CONFIRMATION OF THE DIAGNOSIS
26 AND PROGNOSIS AND FOR A DETERMINATION OF WHETHER THE INDIVIDUAL
27 IS CAPABLE AND ACTING VOLUNTARILY;

1 (e) PROVIDE FULL, INDIVIDUAL-CENTERED DISCLOSURES TO
2 ENSURE THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION BY
3 DISCUSSING WITH THE INDIVIDUAL:

4 (I) HIS OR HER MEDICAL DIAGNOSIS AND PROGNOSIS;

5 (II) THE FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT
6 OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE
7 CARE, AND PAIN CONTROL;

8 (III) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE
9 AID-IN-DYING MEDICATION TO BE PRESCRIBED;

10 (IV) THE PROBABLE RESULT OF TAKING THE AID-IN-DYING
11 MEDICATION TO BE PRESCRIBED; AND

12 (V) THE POSSIBILITY THAT THE INDIVIDUAL CAN OBTAIN THE
13 MEDICATION BUT CHOOSE NOT TO USE IT;

14 (f) REFER THE INDIVIDUAL TO A LICENSED MENTAL HEALTH
15 PROFESSIONAL PURSUANT TO SECTION 25-48-108 IF, IN THE ATTENDING
16 PHYSICIAN'S OPINION, THE INDIVIDUAL'S ABILITY TO MAKE AN INFORMED
17 DECISION IS COMPROMISED FOR ANY REASON;

18 (g) CONFIRM THAT THE INDIVIDUAL'S REQUEST DOES NOT ARISE
19 FROM COERCION OR UNDUE INFLUENCE BY ANOTHER PERSON BY
20 DISCUSSING WITH THE INDIVIDUAL, WITHOUT THE PRESENCE OF OTHER
21 PERSONS, WHETHER THE INDIVIDUAL IS FEELING COERCED OR UNDULY
22 INFLUENCED BY ANOTHER PERSON;

23 (h) COUNSEL THE INDIVIDUAL ABOUT THE IMPORTANCE OF:

24 (I) HAVING ANOTHER PERSON PRESENT WHEN THE INDIVIDUAL
25 SELF-ADMINISTERS THE AID-IN-DYING MEDICATION PRESCRIBED PURSUANT
26 TO THIS ARTICLE;

27 (II) NOT TAKING THE AID-IN-DYING MEDICATION IN A PUBLIC

1 PLACE;

2 (III) SAFE-KEEPING AND PROPER DISPOSAL OF UNUSED
3 MEDICATION IN ACCORDANCE WITH SECTION 25-48-119; AND

4 (IV) NOTIFYING HIS OR HER NEXT OF KIN OF THE REQUEST FOR
5 AID-IN-DYING MEDICATION;

6 (i) INFORM THE INDIVIDUAL THAT HE OR SHE MAY RESCIND THE
7 REQUEST FOR AID-IN-DYING MEDICATION AT ANY TIME AND IN ANY
8 MANNER;

9 (j) VERIFY, IMMEDIATELY PRIOR TO WRITING THE PRESCRIPTION
10 FOR AID-IN-DYING MEDICATION, THAT THE INDIVIDUAL IS MAKING AN
11 INFORMED DECISION;

12 (k) ENSURE THAT ALL APPROPRIATE STEPS ARE CARRIED OUT IN
13 ACCORDANCE WITH THIS ARTICLE BEFORE WRITING A PRESCRIPTION FOR
14 AID-IN-DYING MEDICATION; AND

15 (l) (I) DISPENSE AID-IN-DYING MEDICATIONS DIRECTLY TO THE
16 QUALIFIED INDIVIDUAL, INCLUDING ANCILLARY MEDICATIONS INTENDED
17 TO MINIMIZE THE INDIVIDUAL'S DISCOMFORT, IF THE ATTENDING
18 PHYSICIAN HAS A CURRENT DRUG ENFORCEMENT ADMINISTRATION
19 CERTIFICATE AND COMPLIES WITH ANY APPLICABLE ADMINISTRATIVE
20 RULE; OR

21 (II) WITH THE QUALIFIED INDIVIDUAL'S WRITTEN CONSENT:

22 (A) CONTACT A LICENSED PHARMACIST AND INFORM THE
23 PHARMACIST OF THE PRESCRIPTION; AND

24 (B) DELIVER THE WRITTEN PRESCRIPTION PERSONALLY, BY MAIL,
25 OR THROUGH AUTHORIZED ELECTRONIC TRANSMISSION IN THE MANNER
26 PERMITTED UNDER ARTICLE 42.5 OF TITLE 12, C.R.S., TO THE PHARMACIST,
27 WHO SHALL DISPENSE THE MEDICATION TO THE QUALIFIED INDIVIDUAL,

1 THE ATTENDING PHYSICIAN, OR AN INDIVIDUAL EXPRESSLY DESIGNATED
2 BY THE QUALIFIED INDIVIDUAL.

3 **25-48-107. Consulting physician responsibilities.** (1) BEFORE
4 AN INDIVIDUAL WHO IS REQUESTING AID-IN-DYING MEDICATION CAN
5 RECEIVE A PRESCRIPTION FOR THE MEDICATION, A CONSULTING PHYSICIAN
6 OF THE INDIVIDUAL'S CHOOSING MUST:

7 (a) EXAMINE THE INDIVIDUAL AND HIS OR HER RELEVANT MEDICAL
8 RECORDS;

9 (b) CONFIRM, IN WRITING, TO THE ATTENDING PHYSICIAN:

10 (I) THAT THE INDIVIDUAL IS SUFFERING FROM A TERMINAL
11 ILLNESS;

12 (II) THE INDIVIDUAL'S PROGNOSIS; AND

13 (III) THAT THE INDIVIDUAL IS CAPABLE OF MAKING AN INFORMED
14 DECISION, OR PROVIDE DOCUMENTATION THAT THE CONSULTING
15 PHYSICIAN HAS REFERRED THE INDIVIDUAL FOR FURTHER EVALUATION IN
16 ACCORDANCE WITH SECTION 25-48-108.

17 **25-48-108. Confirmation that individual is capable - referral**
18 **to mental health professional.** (1) AN ATTENDING PHYSICIAN SHALL NOT
19 PRESCRIBE AID-IN-DYING MEDICATION UNDER THIS ARTICLE FOR AN
20 INDIVIDUAL WITH A TERMINAL ILLNESS UNTIL THE INDIVIDUAL IS
21 DETERMINED TO BE CAPABLE OF MAKING AN INFORMED DECISION AND
22 THAT DETERMINATION IS CONFIRMED IN ACCORDANCE WITH THIS SECTION.

23 (2) THE DETERMINATION OF WHETHER AN INDIVIDUAL WITH A
24 TERMINAL ILLNESS WHO IS REQUESTING AID-IN-DYING MEDICATION IS
25 CAPABLE OF MAKING AN INFORMED DECISION AND CONFIRMATION OF THAT
26 DETERMINATION MUST BE MADE BY TWO OF THE FOLLOWING:

27 (a) THE ATTENDING PHYSICIAN;

1 (b) THE CONSULTING PHYSICIAN; OR

2 (c) A LICENSED MENTAL HEALTH PROFESSIONAL.

3 (3) IF, IN THE OPINION OF THE ATTENDING PHYSICIAN OR THE
4 CONSULTING PHYSICIAN, THE INDIVIDUAL'S ABILITY TO MAKE AN
5 INFORMED DECISION IS COMPROMISED, THE ATTENDING PHYSICIAN OR
6 CONSULTING PHYSICIAN SHALL REFER THE INDIVIDUAL TO A LICENSED
7 MENTAL HEALTH PROFESSIONAL FOR A DETERMINATION OF WHETHER THE
8 INDIVIDUAL IS CAPABLE OF MAKING AN INFORMED DECISION.

9 (4) A LICENSED MENTAL HEALTH PROFESSIONAL WHO EVALUATES
10 AN INDIVIDUAL UNDER THIS SECTION SHALL COMMUNICATE, IN WRITING,
11 TO THE ATTENDING OR CONSULTING PHYSICIAN WHO REQUESTED THE
12 EVALUATION, HIS OR HER CONCLUSIONS ABOUT WHETHER THE INDIVIDUAL
13 IS CAPABLE OF MAKING AN INFORMED DECISION. IF THE LICENSED MENTAL
14 HEALTH PROFESSIONAL DETERMINES THAT THE INDIVIDUAL IS NOT
15 CAPABLE OF MAKING AN INFORMED DECISION, THE ATTENDING PHYSICIAN
16 SHALL NOT PRESCRIBE AID-IN-DYING MEDICATION TO THE INDIVIDUAL.

17 ~~25-48-109. Death certificate. (1) UNLESS OTHERWISE~~
18 ~~PROHIBITED BY LAW, THE ATTENDING PHYSICIAN MAY SIGN THE DEATH~~
19 ~~CERTIFICATE OF A QUALIFIED INDIVIDUAL WHO OBTAINS AND~~
20 ~~SELF-ADMINISTERS AID-IN-DYING MEDICATION.~~

21 ~~(2) IF A QUALIFIED INDIVIDUAL DIES AFTER USING AID-IN-DYING~~
22 ~~MEDICATION, THE QUALIFIED INDIVIDUAL'S TERMINAL ILLNESS SHALL BE~~
23 ~~LISTED AS THE CAUSE OF DEATH ON HIS OR HER DEATH CERTIFICATE.~~
24 ~~WHEN AN ATTENDING PHYSICIAN CERTIFIES THAT A DEATH OCCURRED IN~~
25 ~~ACCORDANCE WITH THIS ARTICLE, THE DEATH IS NOT REPORTABLE AND~~
26 ~~DOES NOT CONSTITUTE GROUNDS FOR POST-MORTEM INQUIRY UNDER~~
27 ~~SECTION 30-10-606 (1), C.R.S.~~

1 **25-48-110. Informed decision required.** (1) AN INDIVIDUAL
2 WITH A TERMINAL ILLNESS IS NOT A QUALIFIED INDIVIDUAL AND MAY NOT
3 RECEIVE A PRESCRIPTION FOR AID-IN-DYING MEDICATION UNLESS HE OR
4 SHE HAS MADE AN INFORMED DECISION.

5 (2) IMMEDIATELY BEFORE WRITING A PRESCRIPTION FOR
6 AID-IN-DYING MEDICATION UNDER THIS ARTICLE, THE ATTENDING
7 PHYSICIAN SHALL VERIFY THAT THE INDIVIDUAL WITH A TERMINAL
8 ILLNESS IS A QUALIFIED INDIVIDUAL AND IS MAKING AN INFORMED
9 DECISION.

10 **25-48-111. Form of written request.** (1) A REQUEST FOR
11 AID-IN-DYING MEDICATION AUTHORIZED BY THIS ARTICLE MUST BE IN
12 SUBSTANTIALLY THE FOLLOWING FORM:

13 REQUEST FOR MEDICATION TO END MY LIFE

14 IN A HUMANE AND DIGNIFIED MANNER

15 I, _____, AM AN ADULT OF SOUND MIND. I AM SUFFERING
16 FROM _____, WHICH MY ATTENDING PHYSICIAN HAS DETERMINED IS A
17 TERMINAL ILLNESS AND WHICH HAS BEEN MEDICALLY CONFIRMED. I HAVE
18 BEEN FULLY INFORMED OF MY DIAGNOSIS AND PROGNOSIS, THE NATURE OF
19 THE AID-IN-DYING MEDICATION TO BE PRESCRIBED AND POTENTIAL
20 ASSOCIATED RISKS, THE EXPECTED RESULT, AND THE FEASIBLE
21 ALTERNATIVES OR ADDITIONAL TREATMENT OPPORTUNITIES, INCLUDING
22 COMFORT CARE, PALLIATIVE CARE, HOSPICE CARE, AND PAIN CONTROL.

23 I REQUEST THAT MY ATTENDING PHYSICIAN PRESCRIBE AID-IN-DYING
24 MEDICATION THAT WILL END MY LIFE IN A HUMANE AND DIGNIFIED
25 MANNER IF I CHOOSE TO TAKE IT, AND I AUTHORIZE MY ATTENDING
26 PHYSICIAN TO CONTACT ANY PHARMACIST ABOUT MY REQUEST.

27 I UNDERSTAND THAT I HAVE THE RIGHT TO RESCIND THIS REQUEST AT ANY

1 TIME.
2 I UNDERSTAND THE SERIOUSNESS OF THIS REQUEST, AND I EXPECT TO DIE
3 IF I TAKE THE AID-IN-DYING MEDICATION PRESCRIBED. I FURTHER
4 UNDERSTAND THAT ALTHOUGH MOST DEATHS OCCUR WITHIN THREE
5 HOURS, MY DEATH MAY TAKE LONGER, AND MY ATTENDING PHYSICIAN
6 HAS COUNSELED ME ABOUT THIS POSSIBILITY.
7 I MAKE THIS REQUEST VOLUNTARILY, WITHOUT RESERVATION, AND
8 WITHOUT BEING COERCED, AND I ACCEPT FULL RESPONSIBILITY FOR MY
9 ACTIONS.

10 SIGNED: _____

11 DATED: _____

12 DECLARATION OF WITNESSES

13 WE DECLARE THAT THE INDIVIDUAL SIGNING THIS REQUEST:

14 (a) IS PERSONALLY KNOWN TO US OR HAS PROVIDED PROOF OF
15 IDENTITY;

16 (b) SIGNED THIS REQUEST IN OUR PRESENCE;

17 (c) APPEARS TO BE OF SOUND MIND AND NOT UNDER DURESS,
18 FRAUD, OR UNDUE INFLUENCE; AND

19 (d) IS NOT AN INDIVIDUAL FOR WHOM EITHER OF US IS THE
20 ATTENDING PHYSICIAN.

21 _____ WITNESS 1/DATE

22 _____ WITNESS 2/DATE

23 NOTE: ONLY ONE OF THE TWO WITNESSES MAY: BE A RELATIVE (BY
24 BLOOD, MARRIAGE, CIVIL UNION, OR ADOPTION) OF THE INDIVIDUAL
25 SIGNING THIS REQUEST; BE ENTITLED TO ANY PORTION OF THE
26 INDIVIDUAL'S ESTATE UPON DEATH; OR OWN, OPERATE, OR BE EMPLOYED
27 AT A HEALTH CARE FACILITY WHERE THE INDIVIDUAL IS A PATIENT OR

1 RESIDENT.

2 **25-48-112. Standard of care.** (1) PHYSICIANS AND HEALTH CARE
3 PROVIDERS SHALL PROVIDE MEDICAL SERVICES UNDER THIS ACT THAT
4 MEET OR EXCEED THE STANDARD OF CARE FOR END-OF-LIFE MEDICAL
5 CARE.

6 (2) WHEN A HEALTH CARE PROVIDER MAKES A DIAGNOSIS THAT AN
7 INDIVIDUAL HAS A TERMINAL ILLNESS, THE HEALTH CARE PROVIDER, UPON
8 THE INDIVIDUAL'S REQUEST, SHALL PROVIDE THE INDIVIDUAL WITH
9 COMPREHENSIVE INFORMATION AND COUNSELING, IN ACCORDANCE WITH
10 THIS SECTION, REGARDING LEGAL END-OF-LIFE MEDICAL CARE OPTIONS.

11 ~~X~~ **25-48-113. Effect on wills, contracts, and statutes.** (1) A
12 PROVISION IN A CONTRACT, WILL, OR OTHER AGREEMENT, WHETHER
13 WRITTEN OR ORAL, THAT WOULD AFFECT WHETHER A QUALIFIED
14 INDIVIDUAL MAY MAKE OR RESCIND A REQUEST FOR AID IN DYING
15 PURSUANT TO THIS ARTICLE IS INVALID.

16 (2) AN OBLIGATION OWING UNDER ANY CURRENTLY EXISTING
17 CONTRACT MUST NOT BE CONDITIONED UPON, OR AFFECTED BY, A
18 QUALIFIED INDIVIDUAL'S ACT OF MAKING OR RESCINDING A REQUEST FOR
19 AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE.

20 **25-48-114. Insurance or annuity policies.** (1) THE SALE,
21 PROCUREMENT, OR ISSUANCE OF, OR THE RATE CHARGED FOR, ANY LIFE,
22 HEALTH, OR ACCIDENT INSURANCE OR ANNUITY POLICY MUST NOT BE
23 CONDITIONED UPON, OR AFFECTED BY, A QUALIFIED INDIVIDUAL'S ACT OF
24 MAKING OR RESCINDING A REQUEST FOR AID-IN-DYING MEDICATION IN
25 ACCORDANCE WITH THIS ARTICLE.

26 (2) A QUALIFIED INDIVIDUAL'S ACT OF SELF-ADMINISTERING
27 AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE DOES NOT AFFECT

1 A LIFE, HEALTH, OR ACCIDENT INSURANCE OR ANNUITY POLICY, OTHER
2 THAN THAT THE DEATH IS A NATURAL DEATH RESULTING FROM THE
3 QUALIFIED INDIVIDUAL'S TERMINAL ILLNESS.

4 ~~X~~ **25-48-115. Immunity for good-faith participation - prohibition**
5 **against reprisals.** (1) A PERSON IS NOT SUBJECT TO CIVIL OR CRIMINAL
6 LIABILITY OR PROFESSIONAL DISCIPLINARY ACTION FOR PARTICIPATING IN
7 GOOD FAITH UNDER THIS ARTICLE, WHICH INCLUDES BEING PRESENT WHEN
8 A QUALIFIED INDIVIDUAL SELF-ADMINISTERS THE PRESCRIBED
9 AID-IN-DYING MEDICATION.

10 (2) A HEALTH CARE PROVIDER OR PROFESSIONAL ORGANIZATION
11 OR ASSOCIATION SHALL NOT SUBJECT AN INDIVIDUAL TO ANY OF THE
12 FOLLOWING FOR PARTICIPATING OR REFUSING TO PARTICIPATE IN
13 GOOD-FAITH COMPLIANCE UNDER THIS ARTICLE:

- 14 (a) CENSURE;
- 15 (b) DISCIPLINE;
- 16 (c) SUSPENSION;
- 17 (d) LOSS OF LICENSE, PRIVILEGES, OR MEMBERSHIP; OR
- 18 (e) ANY OTHER PENALTY.

19 (3) A REQUEST BY A QUALIFIED INDIVIDUAL FOR, OR THE
20 PROVISION BY AN ATTENDING PHYSICIAN OF, AID-IN-DYING MEDICATION
21 IN GOOD-FAITH COMPLIANCE WITH THIS ARTICLE DOES NOT:

- 22 (a) CONSTITUTE NEGLIGENCE OR ELDER ABUSE FOR ANY PURPOSE OF
23 LAW; OR
- 24 (b) PROVIDE THE SOLE BASIS FOR THE APPOINTMENT OF A
25 GUARDIAN OR CONSERVATOR.

26 **25-48-116. No duty to prescribe or dispense.** (1) A HEALTH
27 CARE PROVIDER MAY CHOOSE WHETHER TO PARTICIPATE IN PROVIDING

1 AID-IN-DYING MEDICATION TO A QUALIFIED INDIVIDUAL IN ACCORDANCE
2 WITH THIS ARTICLE.

3 (2) IF A HEALTH CARE PROVIDER IS UNABLE OR UNWILLING TO
4 CARRY OUT A QUALIFIED INDIVIDUAL'S REQUEST FOR AID-IN-DYING
5 MEDICATION MADE IN ACCORDANCE WITH THIS ARTICLE, AND THE
6 QUALIFIED INDIVIDUAL TRANSFERS HIS OR HER CARE TO A NEW HEALTH
7 CARE PROVIDER, THE PRIOR HEALTH CARE PROVIDER SHALL TRANSFER,
8 UPON REQUEST, A COPY OF THE QUALIFIED INDIVIDUAL'S RELEVANT
9 MEDICAL RECORDS TO THE NEW HEALTH CARE PROVIDER.

10 **25-48-117. Health care facility may prohibit participation -**
11 **sanctions if provider violates policy.** (1) A HEALTH CARE FACILITY MAY
12 PROHIBIT A PHYSICIAN FROM WRITING A PRESCRIPTION FOR AID-IN-DYING
13 MEDICATION FOR A QUALIFIED INDIVIDUAL WHO IS A RESIDENT IN THE
14 FACILITY AND WHO INTENDS TO USE THE AID-IN-DYING MEDICATION ON
15 THE FACILITY'S PREMISES. THE HEALTH CARE FACILITY MUST NOTIFY THE
16 PHYSICIAN IN WRITING OF ITS POLICY WITH REGARD TO PRESCRIPTIONS FOR
17 AID-IN-DYING MEDICATION.

18 (2) A HEALTH CARE FACILITY OR HEALTH CARE PROVIDER SHALL
19 NOT SUBJECT A PHYSICIAN, NURSE, PHARMACIST, OR OTHER PERSON TO
20 DISCIPLINE, SUSPENSION, LOSS OF LICENSE OR PRIVILEGES, OR ANY OTHER
21 PENALTY OR SANCTION FOR ACTIONS TAKEN IN GOOD-FAITH RELIANCE ON
22 THIS ARTICLE OR FOR REFUSING TO ACT UNDER THIS ARTICLE.

23 (3) NOTHING IN THIS SECTION OR IN SECTION 25-48-115 OR
24 25-48-116 PREVENTS A HEALTH CARE PROVIDER FROM PROVIDING TO AN
25 INDIVIDUAL HEALTH CARE SERVICES THAT DO NOT CONSTITUTE
26 PARTICIPATION UNDER THIS ARTICLE.

27 **25-48-118. Liabilities.** (1) A PERSON COMMITS A CLASS 2 FELONY

1 AND IS SUBJECT TO PUNISHMENT IN ACCORDANCE WITH SECTION
2 18-1.3-401, C.R.S., IF THE PERSON, WITH INTENT OR THE EFFECT OF
3 CAUSING AN INDIVIDUAL'S DEATH, PURPOSELY OR KNOWINGLY:

4 (a) ALTERS OR FORGES A REQUEST FOR AID-IN-DYING MEDICATION
5 TO END AN INDIVIDUAL'S LIFE WITHOUT THE INDIVIDUAL'S
6 AUTHORIZATION; OR

7 (b) CONCEALS OR DESTROYS A RESCISSION OF A REQUEST FOR
8 AID-IN-DYING MEDICATION.

9 (2) A PERSON COMMITS A CLASS 2 FELONY AND IS SUBJECT TO
10 PUNISHMENT IN ACCORDANCE WITH SECTION 18-1.3-401, C.R.S., IF THE
11 PERSON PURPOSELY OR KNOWINGLY COERCES OR EXERTS UNDUE
12 INFLUENCE ON AN INDIVIDUAL WITH A TERMINAL ILLNESS TO:

13 (a) REQUEST AID-IN-DYING MEDICATION FOR THE PURPOSE OF
14 ENDING THE TERMINALLY ILL INDIVIDUAL'S LIFE; OR

15 (b) DESTROY A RESCISSION OF A REQUEST FOR AID-IN-DYING
16 MEDICATION.

17 (3) NOTHING IN THIS ARTICLE LIMITS FURTHER LIABILITY FOR CIVIL
18 DAMAGES RESULTING FROM OTHER NEGLIGENT CONDUCT OR INTENTIONAL
19 MISCONDUCT BY ANY PERSON.

20 (4) THE PENALTIES SPECIFIED IN THIS ARTICLE DO NOT PRECLUDE
21 CRIMINAL PENALTIES APPLICABLE UNDER OTHER LAW FOR CONDUCT THAT
22 IS INCONSISTENT WITH THIS ARTICLE.

23 **25-48-119. Safe disposal of unused medications.** A PERSON WHO
24 HAS CUSTODY OR CONTROL OF AID-IN-DYING MEDICATION DISPENSED
25 UNDER THIS ARTICLE THAT THE TERMINALLY ILL INDIVIDUAL DECIDES NOT
26 TO USE OR THAT REMAINS UNUSED AFTER THE TERMINALLY ILL
27 INDIVIDUAL'S DEATH SHALL DISPOSE OF THE UNUSED AID-IN-DYING

1 MEDICATION BY LAWFUL MEANS IN ACCORDANCE WITH SECTION 25-15-328
2 OR ANY OTHER STATE OR FEDERALLY APPROVED MEDICATION TAKE-BACK
3 PROGRAM AUTHORIZED UNDER THE FEDERAL "SECURE AND RESPONSIBLE
4 DRUG DISPOSAL ACT OF 2010", PUB.L. 111-273, AND REGULATIONS
5 ADOPTED PURSUANT TO THE FEDERAL ACT.

6 ~~25-48-120. Actions complying with article not a crime.~~
7 NOTHING IN THIS ARTICLE AUTHORIZES A PHYSICIAN OR ANY OTHER
8 PERSON TO END AN INDIVIDUAL'S LIFE BY LETHAL INJECTION, MERCY
9 KILLING, OR EUTHANASIA. ACTIONS TAKEN IN ACCORDANCE WITH THIS
10 ARTICLE DO NOT, FOR ANY PURPOSE, CONSTITUTE SUICIDE, ASSISTED
11 SUICIDE, MERCY KILLING, HOMICIDE, OR ELDER ABUSE UNDER THE
12 "COLORADO CRIMINAL CODE", TITLE 18, C.R.S.

13 **25-48-121. Claims by government entity for costs.** A
14 GOVERNMENT ENTITY THAT INCURS COSTS RESULTING FROM AN
15 INDIVIDUAL TERMINATING HIS OR HER LIFE PURSUANT TO THIS ARTICLE IN
16 A PUBLIC PLACE HAS A CLAIM AGAINST THE ESTATE OF THE INDIVIDUAL TO
17 RECOVER THE COSTS AND REASONABLE ATTORNEY FEES RELATED TO
18 ENFORCING THE CLAIM.

19 **25-48-122. No effect on advance medical directives.**

20 (1) NOTHING IN THIS ARTICLE AFFECTS OR NEGATES:

21 (a) A DECLARATION MADE UNDER ARTICLE 18 OF TITLE 15, C.R.S.,
22 DIRECTING THAT LIFE-SUSTAINING PROCEDURES BE WITHHELD OR
23 WITHDRAWN;

24 (b) A CPR DIRECTIVE EXECUTED UNDER ARTICLE 18.6 OF TITLE 15,
25 C.R.S.; OR

26 (c) AN ADVANCE MEDICAL DIRECTIVE EXECUTED UNDER ARTICLE
27 18.7 OF TITLE 15, C.R.S.

1 **SECTION 2. Applicability.** This act applies to conduct occurring
2 on or after the effective date of this act.

3 **SECTION 3. Safety clause.** The general assembly hereby finds,
4 determines, and declares that this act is necessary for the immediate
5 preservation of the public peace, health, and safety.

Opinion 2.211 - Physician-Assisted Suicide

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

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

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

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

Opinion 2.21 - Euthanasia

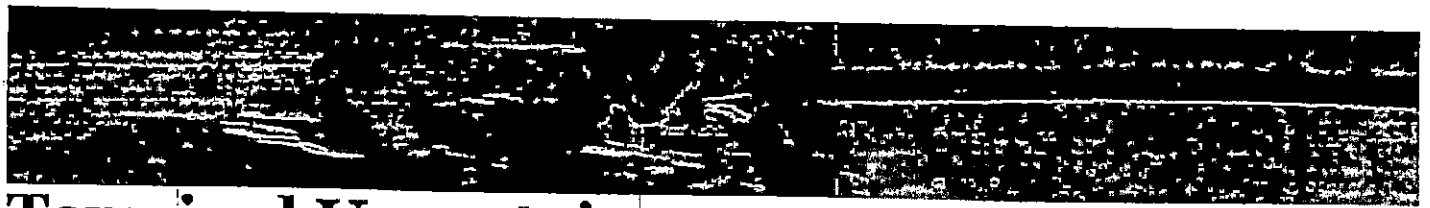
X Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

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

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.

Instead of engaging in euthanasia, 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. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

Issued June 1994 based on the report "Decisions Near the End of Life," adopted June 1991 (JAMA. 1992; 267: 2229-2233); Updated June 1996



Terminal Uncertainty

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

By Nina Shapiro

published: January 14, 2009

Nina Shapiro



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

Details:

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

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

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

That was almost four years ago.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Breaking the Silence on Elder Abuse

From Washington Lawyer, February 2015

By Kathryn Alfisi



The issue of elder abuse made front-page news in 2009 when famed philanthropist Brooke Astor's son, Anthony Marshall, was convicted on 14 of 16 counts for financially exploiting his mother, stealing millions of dollars from her.

A few years earlier in the District of Columbia, a similar case played out on a much smaller scale and away from the media glare.

D.C. resident Hattie Mae Goode was a housekeeper who, along with her husband, had scrimped and saved, bought a house (in which she took great pride), and wanted to be independent in her elder years. Several years after her husband died, Goode was introduced to Reginald Rogers by a mutual friend. Rogers, a lawyer, soon became indispensable to Goode, taking her to doctor appointments, to the bank, and eventually obtaining power of attorney over her.

"She trusted him to take care of her and her financial affairs, which turned out to be a very bad idea. He just cleaned her out," says Goode's niece Alma Robinson, who is executive director of the California Lawyers for the Arts.

"It was such a horrible story. This widow by herself with nobody looking after her, and then he convinces her that her family is trying to take advantage of her," Robinson says. Cases such as Goode's and Astor's are all too common, say experts, yet the issue of elder abuse often goes unnoticed.

Vulnerable and Exploited

While statistics are hard to come by, a recent report by the U.S. Department of Justice and U.S. Department of Health and Human Services states that elder abuse—which includes physical, sexual, and psychological abuse, as well as neglect, abandonment, and financial exploitation—affects about five million Americans each year. According to the report, just one in 24 cases of elder abuse is reported to authorities. [\[1\] \(/bar-resources/publications/washington-lawyer/articles/february-2015-elder-abuse.cfm#ftnref1\)](#)

While elder abuse may not be garnering a lot of public attention, there appears to be growing sensitivity to the issue among lawyers, says David English, a professor at the University of Missouri School of Law and chair of the American Bar Association's (ABA) Commission on Law and Aging. English recalls leading an ABA program on elder abuse in 1995 that only about 10 people attended; now such programs are sold out.

Lawyers are likely seeing an increasing number of elder abuse cases for several reasons: There are now more individuals who are considered elderly; people are living longer than ever before, but are not necessarily in a state of good health; and the power of attorney is more widely used and, therefore, more likely to be abused.

In a 2003 report, the National Research Council defined elder mistreatment (both abuse and neglect) as "(a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm." [\[2\] \(/bar-resources/publications/washington-lawyer/articles/february-2015-elder-abuse.cfm#ftnref2\)](#)

The Web site of the U.S. Administration on Aging's National Center on Elder Abuse (NCEA) provides statistics and data that help to paint a picture of the problem. Citing figures from the U.S. Census Bureau, the NCEA states that people age 65 or older are expected to account for 20 percent of the country's total population by 2050. Currently, seniors 85 years old and up comprise the fastest growing segment of the U.S. population: 5.8 million as of 2010, a number that is projected to increase to 19 million people by 2050.

The NCEA also offers various findings that reveal the prevalence of elder abuse. One such finding, from the 2003 report by the National Research Council, showed that only 1 in 14 cases of elder abuse ever come to the attention of authorities.

Another finding, from a 2011 report on New York State elder abuse prevalence, revealed that major financial exploitation was self-reported at a rate of 41 per 1,000 older residents surveyed, higher than other forms of abuse. [\[3\] \(/bar-resources/publications/washington-lawyer/articles/february-2015-elder-abuse.cfm#ftnref3\)](#)

Misplaced Trust

Traci Tait often deals with elder abuse cases at her job as assistant Bar counsel with the D.C. Office of Bar Counsel. Tait handled the Goode case, which in many ways was not that different from the many cases concerning the elderly that are taken by Bar Counsel. However, the U.S. Attorney's Office also became involved with the Goode case, and Tait ended up

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working collaboratively with the FBI.

The investigation into Goode's attorney started as a cold call by Robinson, Goode's niece, to the Office of Bar Counsel. Not wanting to jump to conclusions, Tait first suggested that Robinson take certain steps, such as taping a conversation with Rogers (with his permission) with a witness present, before filing a complaint against him. Tait also advised Robinson to file a complaint with the U.S. Attorney's Office, which agreed to take the case.

Robinson, along with Goode's sister, decided to fly from California to the District of Columbia when they heard that Goode was in the hospital. Once in the District, they soon became aware of how much control Rogers had over Goode's financial affairs.

Following Tait's advice, Robinson set up a meeting with Rogers in which he told her that the books were open and he had nothing to hide. But when Robinson and her aunt went to the bank, they discovered that Rogers had withdrawn all the remaining cash (close to \$6,000) from Goode's accounts. Meanwhile, Goode's phone had been disconnected because the bills weren't being paid, according to Robinson.

With Tait's assistance, Robinson was able to terminate Rogers' power of attorney over Goode and bring charges against him, including intentional misappropriation, within six months of Robinson's initial call.

"The things that will get you disbarment are misappropriation, theft, and dishonesty, depending on how big the dishonesty is," says Tait.

Goode lost more than \$260,000 in savings and was able to only recover \$75,000, the most money allowed from the D.C. Bar's Clients' Security Fund.

Despite the successful outcome of the case, the whole situation was very upsetting to Robinson.

"It was just horrible to think that someone would take advantage of her like this when she was so vulnerable," she says.

The Silent Crime

As upsetting as the case was, at least Goode was able to see the situation resolved. Many elder abuse cases are never reported or investigated because there's no family member or loved one involved. And the elderly often make unreliable witnesses due to dementia, making it difficult to bring a case without a third-party witness. But this is why the elderly make such easy targets.

"The elderly are an at-risk group for a lot of reasons, including, but not limited to, diminished capacity, isolation from family or other caregivers, lack of sophistication when it comes to purchasing property, financing, or using computers," says Amy Mix of the AARP Legal Counsel for the Elderly (LCE).

Mix heads up the Consumer Fraud and Financial Abuse Unit at LCE, which works closely with the D.C. Department of Human Services' Adult Protective Services and the Metropolitan Police Department. She has seen cases where, like with Goode, someone has convinced an elderly person to assign them the power of attorney, and then used that authority to either take the senior's home—often a target of predatory lenders or con artists—or strip their bank accounts of all their money.

Which is what happened to an 86-year-old client of Mix whose case she had been litigating for four years. A family friend of the client had convinced her that she was in financial distress and had her sign some paperwork that ended up being a deed transferring the title to her home. The "friend" then took a mortgage out on the property and walked away with \$320,000 in cash.

"A lot of defendants are family members, lots are friends, often people who befriend a senior through church or some other community group. We had a senior victim who had given her life savings away to some scammer who told her she'd won the lottery and would have to pay the taxes ahead of time," says Mix. The scammer found the victim using information in her husband's obituary.

There are also repeat offenders, according to Mix. "There are people who make a living off of this," she adds.

Mary Ann Parker also works for LCE, but as an attorney for the Office of the D.C. Long Term-Care Ombudsman Program, which monitors individuals in long-term care facilities in the District, including nursing homes, group homes, and assisted living facilities, as well as people who are getting a high level of service at home through the Medicaid waiver.

Parker says the program received about 50 complaints within the last year or two concerning elder physical or sexual abuse or neglect. The complaints take a lot of investigation and, similar to financial exploitation, it can be difficult to prove that abuse or neglect had taken place.

"When you talk about a vulnerable population that might have cognitive impairment, it's very difficult to find out if there was abuse. When you look at [elderly persons] with a big bruise on their cheek you might think that someone hit them, but it could be because their medication makes them bruise easily. They may be able to tell you or they may not," she says.

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Adult Abuse Defined

Adult abuse generally refers to mistreatment of an older person by someone who has a special relationship with the elder such as a spouse, sibling, child, friend, or caregiver. Abuse may take the form of one or all of the following: physical, financial or emotional abuse, neglect or abandonment. Abuse includes the willful infliction of serious pain or injury, unreasonable confinement, intimidation or forced sexual contact.

Abusers

Typically, the abuser is a relative, frequently an adult child of the victim. The abusers may suffer from alcohol or drug abuse. Sometimes the abusers were abused as children. The abuser may be emotionally unstable. Sometimes, the caregiver can no longer cope with a stressful situation and does not know where to turn for help.

Reporting Abuse

Many who suffer from abuse may feel ashamed and embarrassed and suffer from low self esteem. Some don't want to report their own child as an abuser. Often the abused simply fears more abuse if they report it. Others are too feeble to think clearly, or they may not realize that help is available.

You Can Help

It's up to you to break the silence. Certain people are required by law to report abusers. They are conservators and guardians, court-appointed mental retardation advocates, police officers, licensed health professionals, health care administrators and social workers. Others such as neighbors, church members, relatives, and friends may report voluntarily. Persons reporting voluntarily need not identify themselves.

Who to Call

Call the hotline at **(202) 541-3950**. More victims are helped by callers outside the family than in it. When you call the hotline, a social worker will assist you. The social worker will take information about your concerns and will conduct an investigation to determine if abuse, neglect, or exploitation is occurring. Sometimes medical or psychiatric care helps resolve the problem. In other cases, services can be provided to victims in their homes or they can be removed from danger.

If the investigation indicates that a person is in need of protection, a variety of services may be made available to them. Social workers may arrange for counseling, legal services, emergency placement, and/or medical services.

Remember, the person you are worried about can refuse intervention. The merely eccentric will be left in peace. And your identity will be protected, because reports are confidential.



Home / News

Monday, January 25, 2016 | 5:37 am

Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

News sources

POSTED: 11:35 PM PDT September 7, 2011
 UPDATED: 4:38 AM PDT July 14, 2011



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

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

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

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

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

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

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

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

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

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

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

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

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

Sawyer and her husband, a former Bend police captain, face trial scheduled for December in Eugene

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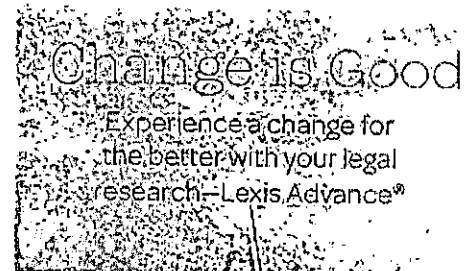
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Oregon Revised Statute

Chapter 127

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

Contact Us

dwda.info@state.or.us

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

127.800 s.1.01. Definitions.

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

- (1) "Adult" means an individual who is 18 years of age or older.
- (2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- (3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
- (4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- (5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- (6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.
- (7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
 - (a) His or her medical diagnosis;
 - (b) His or her prognosis;
 - (c) The potential risks associated with taking the medication to be prescribed;
 - (d) The probable result of taking the medication to be prescribed; and
 - (e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.
- (8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.
- (9) "Patient" means a person who is under the care of a physician.
- (10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.
- (11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.
- (12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

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

(Section 2)

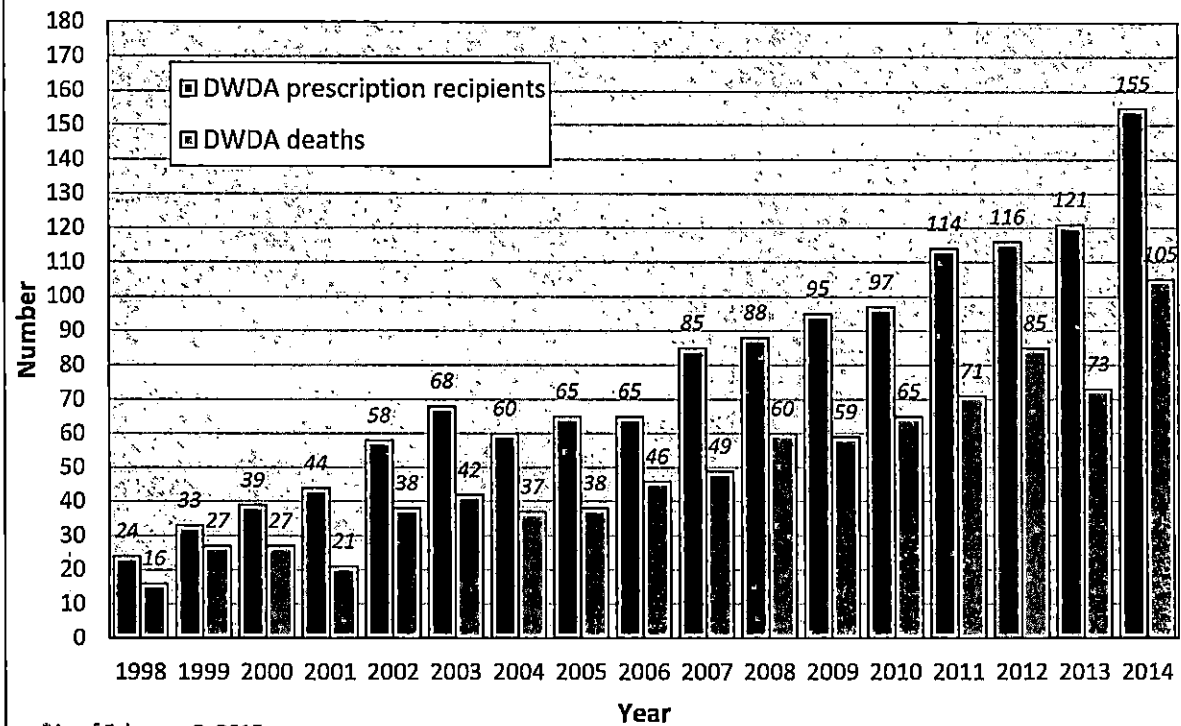
127.805 s.2.01. Who may initiate a written request for medication.

- (1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and

Oregon's Death with Dignity Act--2014

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. The key findings from 2014 are presented below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of February 2, 2015. For more detail, please view the figures and tables on our web site: <http://www.healthoregon.org/dwd>.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2014



*As of February 2, 2015

- As of February 2, 2015, prescriptions for lethal medications were written for 155 people during 2014 under the provisions of the DWDA, compared to 121 during 2013 (Figure 1). At the time of this report, 105 people had died from ingesting the medications prescribed during 2014 under DWDA. This corresponds to 31.0 DWDA deaths per 10,000 total deaths.¹

¹ Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2013 (33,931), the most recent year for which final death data are available.

Oregon Public Health Division

- Since the law was passed in 1997, a total of 1,327 people have had DWDA prescriptions written and 859 patients have died from ingesting medications prescribed under the DWDA.
- Of the 155 patients for whom DWDA prescriptions were written during 2014, 94 (60.6%) ingested the medication; all 94 patients died from ingesting the medication. No patients that ingested the medication regained consciousness.
- Eleven patients with prescriptions written during the previous years (2012 and 2013) died after ingesting the medication during 2014.
- Thirty-seven of the 155 patients who received DWDA prescriptions during 2014 did not take the medications and subsequently died of other causes.
- Ingestion status is unknown for 24 patients who were prescribed DWDA medications in 2014. For all of the 24 patients, both death and ingestion status are pending (Figure 2).
- Of the 105 DWDA deaths during 2014, most (67.6%) were aged 65 years or older. The median age at death was 72 years. As in previous years, decedents were commonly white (95.2%) and well-educated (47.6% had a least a baccalaureate degree).
- While most patients had cancer, the percent of patients with cancer in 2014 (68.6%) was lower than in previous years (79.4%), and the percent with amyotrophic lateral sclerosis (ALS) was higher (16.2% in 2014, compared to 7.2% in previous years).
- While similar to previous years that most patients had cancer (68.6%), this percent was lower than the average for previous years (79.4%); in contrast, the percent of patients with ALS was higher in 2014 (16.2%) than in previous years (7.2%).
- Most (89.5%) patients died at home, and most (93.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, all (100.0%) had some form of health care insurance, although the number of patients who had private insurance (39.8%) was lower in 2014 than in previous years (62.9%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (60.2% compared to 35.5%).
- As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (86.7%), and loss of dignity (71.4%).
- Three of the 105 DWDA patients who died during 2014 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for 14 patients (13.9%) during 2014 compared to 15.9% in previous years.

- A procedure revision was made in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 20 of the 105 DWDA deaths during 2014. Among those 20 patients, time from ingestion until death ranged from eleven minutes to one hour.
- Eighty-three physicians wrote 155 prescriptions during 2014 (1-12 prescriptions per physician).
- During 2014, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2014, as of February 2, 2015

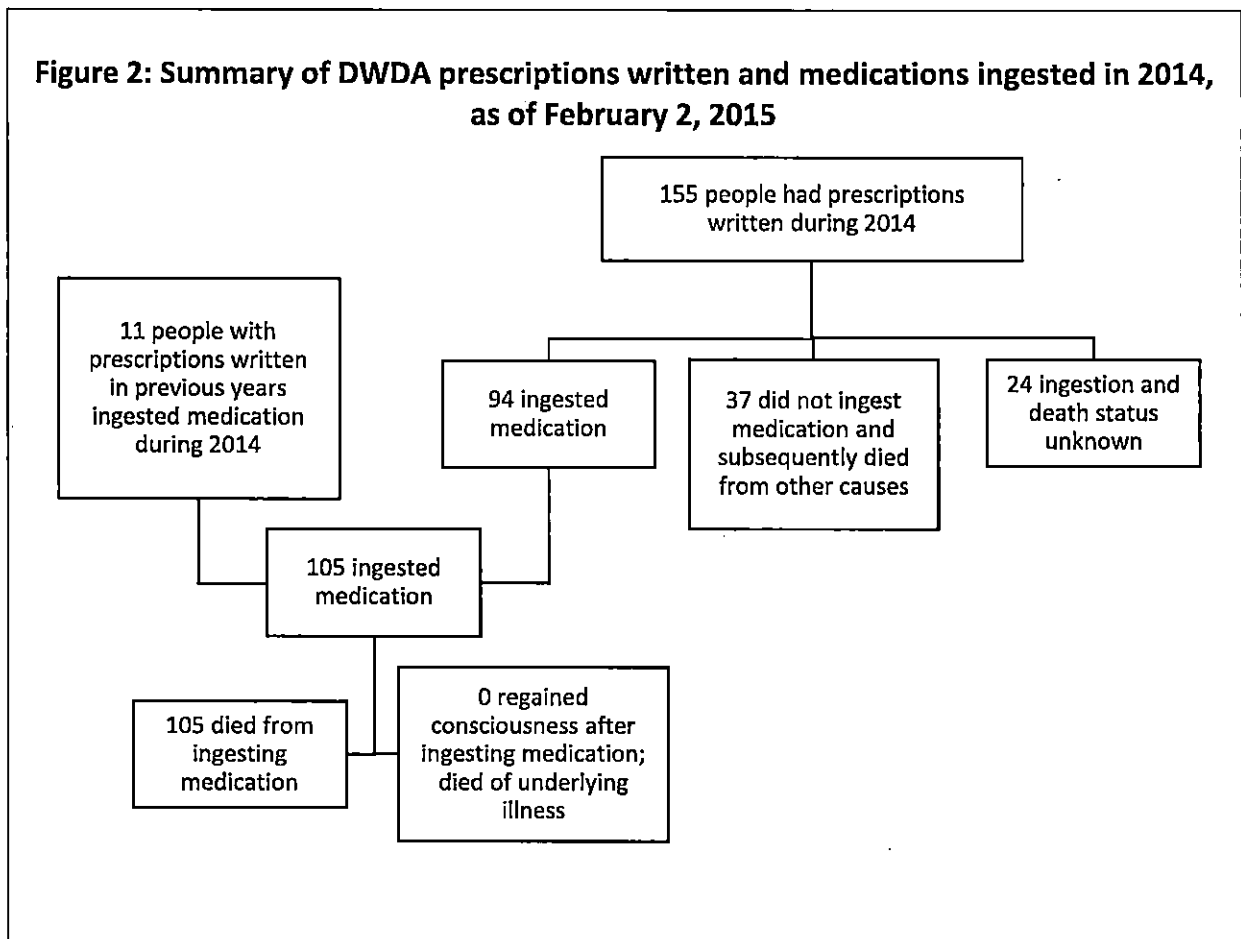


Table 1. Characteristics and end-of-life care of 857 DWDA patients who have died from ingesting a lethal dose of medication as of February 2, 2015, by year, Oregon, 1998-2014

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Sex			
Male (%)	56 (53.3)	397 (52.7)	453 (52.7)
Female (%)	49 (46.7)	357 (47.3)	406 (47.3)
Age at death (years)			
18-34 (%)	1 (1.0)	6 (0.8)	7 (0.8)
35-44 (%)	2 (1.9)	16 (2.1)	18 (2.1)
45-54 (%)	3 (2.9)	58 (7.7)	61 (7.1)
55-64 (%)	28 (26.7)	156 (20.7)	184 (21.4)
65-74 (%)	29 (27.6)	218 (28.9)	247 (28.8)
75-84 (%)	23 (21.9)	206 (27.3)	229 (26.7)
85+ (%)	19 (18.1)	94 (12.5)	113 (13.2)
Median years (range)	72 (29-96)	71 (25-96)	71 (25-96)
Race			
White (%)	100 (95.2)	731 (97.3)	831 (97.1)
African American (%)	0 (0.0)	1 (0.1)	1 (0.1)
American Indian (%)	0 (0.0)	2 (0.3)	2 (0.2)
Asian (%)	1 (1.0)	8 (1.1)	9 (1.1)
Pacific Islander (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	2 (1.9)	1 (0.1)	3 (0.4)
Two or more races (%)	1 (1.0)	2 (0.3)	3 (0.4)
Hispanic (%)	1 (1.0)	5 (0.7)	6 (0.7)
Unknown	0	3	3
Marital Status			
Married (%) ²	48 (45.7)	347 (46.2)	395 (46.1)
Widowed (%)	26 (24.8)	172 (22.9)	198 (23.1)
Never married (%)	6 (5.7)	63 (8.4)	69 (8.1)
Divorced (%)	25 (23.8)	169 (22.5)	194 (22.7)
Unknown	0	3	3
Education			
Less than high school (%)	6 (5.7)	45 (6.0)	51 (6.0)
High school graduate (%)	23 (21.9)	164 (21.9)	187 (21.9)
Some college (%)	26 (24.8)	198 (26.4)	224 (26.2)
Baccalaureate or higher (%)	50 (47.6)	342 (45.7)	392 (45.9)
Unknown	0	5	5
Residence			
Metro counties (%) ³	46 (44.7)	315 (41.9)	361 (42.3)
Coastal counties (%)	6 (5.8)	57 (7.6)	63 (7.4)
Other western counties (%)	40 (38.8)	325 (43.3)	365 (42.7)
East of the Cascades (%)	11 (10.7)	54 (7.2)	65 (7.6)
Unknown	2	3	5
End of life care			
Hospice			
Enrolled (%) ⁴	93 (93.0)	654 (90.0)	747 (90.3)
Not enrolled (%)	7 (7.0)	73 (10.0)	80 (9.7)
Unknown	5	27	32
Insurance			
Private (%) ⁵	37 (39.8)	452 (62.9)	489 (60.2)
Medicare, Medicaid or Other Governmental (%)	56 (60.2)	255 (35.5)	311 (38.3)
None (%)	0 (0.0)	12 (1.7)	12 (1.5)
Unknown	12	35	47

Underlying Illness

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Underlying illness			
Malignant neoplasms (%)	72 (68.6)	596 (79.4)	668 (78.0)
Lung and bronchus (%)	16 (15.2)	139 (18.5)	155 (18.1)
Breast (%)	7 (6.7)	57 (7.6)	64 (7.5)
Colon (%)	5 (4.8)	49 (6.5)	54 (6.3)
Pancreas (%)	9 (8.6)	47 (6.3)	56 (6.5)
Prostate (%)	2 (1.9)	33 (4.4)	35 (4.1)
Ovary (%)	5 (4.8)	28 (3.7)	33 (3.9)
Other (%)	28 (26.7)	243 (32.4)	271 (31.7)
Amyotrophic lateral sclerosis (%)	17 (16.2)	54 (7.2)	71 (8.3)
Chronic lower respiratory disease (%)	4 (3.8)	34 (4.5)	38 (4.4)
Heart Disease (%)	3 (2.9)	14 (1.9)	17 (2.0)
HIV/AIDS (%)	0 (0.0)	9 (1.2)	9 (1.1)
Other illnesses (%) ⁶ <i>See this footnote at p. A-53</i>	9 (8.6)	44 (5.9)	53 (6.2)
<i>Unknown ("diabetes mellitus")</i>	0	3	3
DWDA process			
Referred for psychiatric evaluation (%)	3 (2.9)	44 (5.9)	47 (5.5)
Patient informed family of decision (%) ⁷	95 (90.5)	634 (93.6)	729 (93.2)
Patient died at			
Home (patient, family or friend) (%)	94 (89.5)	716 (95.3)	810 (94.6)
Long term care, assisted living or foster care facility (%)	8 (7.6)	29 (3.9)	37 (4.3)
Hospital (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	3 (2.9)	5 (0.7)	8 (0.9)
Unknown	0	3	3
Lethal medication			
Secobarbital (%)	63 (60.0)	403 (53.4)	466 (54.2)
Pentobarbital (%)	41 (39.0)	344 (45.6)	385 (44.8)
Other (%) ⁸	1 (1.0)	7 (0.9)	8 (0.9)
End of life concerns ⁹	(N=105)	(N=754)	(N=859)
Losing autonomy (%)	96 (91.4)	686 (91.5)	782 (91.5)
Less able to engage in activities making life enjoyable (%)	91 (86.7)	667 (88.9)	758 (88.7)
Loss of dignity (%) ¹⁰	75 (71.4)	504 (80.6)	579 (79.3)
Losing control of bodily functions (%)	52 (49.5)	376 (50.1)	428 (50.1)
Burden on family, friends/caregivers (%)	42 (40.0)	300 (40.0)	342 (40.0)
Inadequate pain control or concern about it (%)	33 (31.4)	178 (23.7)	211 (24.7)
Financial implications of treatment (%)	5 (4.8)	22 (2.9)	27 (3.2)
Health-care provider present ¹¹	(N=105)	(N=684)	(N=789)
When medication was ingested ¹²			
Prescribing physician	14	119	133
Other provider, prescribing physician not present	6	238	244
No provider	4	76	80
Unknown	81	251	332
At time of death			
Prescribing physician (%)	14 (13.9)	107 (15.9)	121 (15.7)
Other provider, prescribing physician not present (%)	6 (5.9)	263 (39.2)	269 (34.8)
No provider (%)	81 (80.2)	301 (44.9)	382 (49.5)
Unknown	4	13	17
Complications ¹²	(N=105)	(N=754)	(N=859)
Regurgitated	0	22	22
Seizures	0	0	0
Other	0	1	1
None	20	487	507
Unknown	85	244	329
Other outcomes			
Regained consciousness after ingesting DWDA medications ¹³	0	6	6

drugs used for patient deaths.

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Timing of DWDA event			
Duration (weeks) of patient-physician relationship ¹⁴			
Median	19	12	13
Range	1-1312	0-1905	0-1905
Number of patients with information available	105	752	857
Number of patients with information unknown	0	2	2
Duration (days) between 1st request and death			
Median	43	48	47
Range	15-439	15-1009	15-1009
Number of patients with information available	105	754	859
Number of patients with information unknown	0	0	0
Minutes between ingestion and unconsciousness ^{11,12}			
Median	5	5	5
Range	2-15	1-38	1-38
Number of patients with information available	20	487	507
Number of patients with information unknown	85	267	352
Minutes between ingestion and death ^{11,12}			
Median	27	25	25
Range (minutes - hours)	11mins-1hr	1min-104hrs	1min-104hrs
Number of patients with information available	20	492	512
Number of patients with information unknown	85	262	347

1 Unknowns are excluded when calculating percentages.

2 Includes Oregon Registered Domestic Partnerships.

3 Clackamas, Multnomah, and Washington counties.

4 Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.

5 Private insurance category includes those with private insurance alone or in combination with other insurance.

6 Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.

7 First recorded beginning in 2001. Since then, 37 patients (4.7%) have chosen not to inform their families, and 16 patients (2.0%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.

8 Other includes combinations of secobarbital, pentobarbital, phenobarbital, and/or morphine.

9 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

10 First asked in 2003. Data available for all 105 patients in 2014, 625 patients between 1998-2013, and 730 patients for all years.

11 The data shown are for 2001-2014 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.

12 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

13 There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (<http://www.healthoregon.org/dwd>) for more detail on these deaths.

14 Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.



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

12 million Americans misdiagnosed each year

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

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

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

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

→ More from Morning Rounds with Dr. LaPook

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

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



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GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

1. I am a doctor in Oregon USA where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have treated thousands of patients with cancer.
2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify for the court that this does not necessarily mean that patients are dying.
3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for cancer. I understand that he had referred her to me.

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

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

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

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

8. Today, for patients under the Oregon Health Plan (Medicaid), there is also a financial incentive to commit suicide: The Plan covers the cost. The Plan's "Statements of Intent for the April 1, 2012 Prioritized List of Health Services," states:

It is the intent of the [Oregon Health Services] Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services.

Attached hereto at page SI-1.

9. Under the Oregon Health Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient's treatment. For example, patients with cancer are denied treatment if they have a "less than 24 months median survival with treatment" and fit other criteria. This is the Plan's "Guideline Note 12." (Attached hereto at page GN-4).

10. The term, "less than 24 months median survival with treatment," means that statistically half the patients receiving treatment will live less than 24 months (two years) and the other half will live longer than two years.

11. Some of the patients living longer than two years will likely live far longer than two years, as much as five, ten or twenty years depending on the type of cancer. This is because there are always some people who beat the odds.

12. All such persons who fit within "Guideline Note 12" will nonetheless be denied treatment. Their suicides under Oregon's assisted suicide act will be covered.

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

14. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Canada, your government health plan could follow a similar pattern. If so, the plan will pay for a patient to die, but not to live.

SWORN BEFORE ME at *Sherwood*
Oregon, USA
on *September 18,* 2012

NAME: *Jessica Borgo*

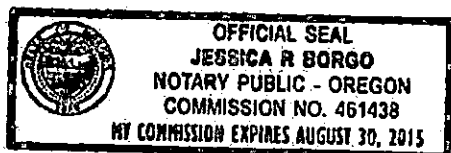
A notary in and for the
State of Oregon

ADDRESS: *16100 Sw Tualatin - Sherwood Rd*

EXPIRY OF COMMISSION: *Aug, 30, 2015*

PLACE SEAL HERE: *Jessica Borgo*

Ken Stevens MD
Ken Stevens, MD



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

STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

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

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

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

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

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

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

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

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

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

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

Ventricular assist devices are not covered for destination therapy.

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

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

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

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

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

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

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

CANADA

C O U R S U P É R I E U R E

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

C.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur
et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

**AFFIDAVIT OF JEANETTE HALL
OPPOSING ASSISTED SUICIDE**

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

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

Affidavit of Jeanette Hall - Page 1

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

Dated this 17th day of August 2012

Jeanette Hall
Jeanette Hall

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

NAME: Sheena Marie Leslie

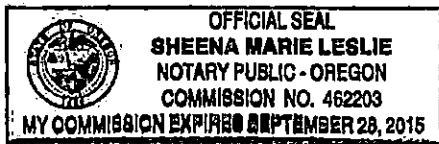
JEANETTE HALL

A notary in and for the
State of Oregon

ADDRESS: 15905 SW 116th Ave
Tigard, OR 97224

EXPIRY OF COMMISSION:
September 28, 2015

PLACE SEAL HERE:



BEFORE THE LEGISLATURE OF THE
STATE OF NEW YORK

IN RE NEW YORK BILLS

DECLARATION OF KENNETH
STEVENS, MD

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

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

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

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

Declaration

~~Affidavit~~ of Kenneth Stevens, Jr., MD - page 1

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

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

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

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

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

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

Declaration

Affidavit of Kenneth Stevens, Jr., MD - page 2

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

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

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

Kenneth Stevens, Jr., MD
Kenneth Stevens, Jr., MD
Sherwood, Oregon

Declaration

Affidavit of Kenneth Stevens, Jr., MD - page 3

\\MSK\SERVERS\KASE 2516 - 4142\1-6-16\Kenneth Stevens MD Declaration.vpd

mercy killing

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

mercy killing

n.

Euthanasia.

American Heritage® Dictionary of the English Language, Fifth Edition. Copyright © 2011 by Houghton Mifflin Harcourt Publishing Company.
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mercy killing

n.

(Medicine) another term for euthanasia

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

eu•tha•na•sia (,yu θəˈneɪ ʒə, -zi ə, -zi ə)

n.

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

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

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Thesaurus

Legend: = Synonyms ↔ Related Words ≠ Antonyms

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

= euthanasia

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



Based on WordNet 3.0, Farlex clipart collection. © 2003-2012 Princeton University, Farlex Inc.



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

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

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

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

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

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

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

Letter to editor, New Haven Register

1 message

William Toffler <toffler@ohsu.edu>
To: "letters@nhregister.com" <letters@nhregister.com>

Sun, Feb 23, 2014 at 7:23 PM

Dear Editor,

I am a professor of Family Medicine and a practicing physician in Oregon for over 30 years. I write to provide some insight on the issue of assisted suicide, which is legal in Oregon, and which has been proposed for legalization in Connecticut. (Raised Bill No. 5326)

Our law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions such as "chronic lower respiratory disease" and "diabetes". Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live. They are unlikely die in less than six months unless they don't receive their medications. Such persons, with treatment, could otherwise have years or even decades to live.

This illustrates a great problem with our law—it encourages people with years to live, to throw away their lives. I am also concerned, that by starting to label people with chronic conditions "terminal," there will be an excuse to deny such persons appropriate medical treatment to allow them to continue to live healthy and productive lives.

These factors are something for your legislators to consider. Do you want this to happen to you or your family?

Furthermore, in my practice I have had many patients ask about assisted-suicide. In each case, I have offered care and treatment but declined to provide assisted suicide. In one case, the man's response was "Thank you."

To read a commentary on the most recent Oregon government assisted-suicide report, which lists chronic conditions as the "underlying illness" justifying assisted suicide, please go here: <http://www.noassistedsuicideconnecticut.org/2014/02/oregons-new-assisted-suicide-report.html>

To read about some of my cases in Oregon, please go here: http://www.choiceillusion.org/p/what-people-mean_25.html

I hope that Connecticut does not repeat Oregon's mistake.

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
503-494-5322
503-494-8573 (patient care)
503-494-4496 (fax)
toffler@ohsu.edu

NEWS RELEASE



Date: Sept. 9, 2010

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

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

Oregon's suicide rate is 35 percent higher than the national average. The rate is 15.2 suicides per 100,000 people compared to the national rate of 11.3 per 100,000. (for 2007)

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

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

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

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

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

The report also included the following findings:

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



OREGON

Public Health Division

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

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



*Excerpt
Printed
2/9/14*

Executive Summary

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

Key Findings

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

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

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

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

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

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

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

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

Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year^{1,2}. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts^{3,4}. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon³. The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars^{3,4,5}. The loss to families and communities broadens the impact of each death.

The
cost
is

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors"⁶. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

¹ Oregon Healthy Teens 2009 -11th Grade Results. <http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2009/11/Documents/mental11.pdf>

² Crosby A.E., Han B., Ortega L.A.G., Park S.E., et al, Suicidal Thoughts and Behaviors Among Adults aged >= 18 Years - United States, 2008-2009. MMWR. 2011;60:13.

³ Oregon Vital Statistics Annual Report, Vol. 2, 2010. Oregon Health Authority.

⁴ Wright D., Millet L., et al, Oregon Injury and Violence Prevention Program Report for 2011 Data year, Oregon Health Authority.

⁵ Corso P.S., Mercy J.A., Simon T.R., et al, Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States. Am J Prev Med. 2007;32(6):474-482.

⁶ Maris R.W., Berman A.L., Silverman A.M. (2000). Comprehensive Textbook of suicidology. New York: The Guilford Press. (p378)

CANADA

C O U R S U P É R I E U R E

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

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

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

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

AFFIDAVIT OF JOHN NORTON- Page 1

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A-79

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

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

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

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on, August 16th, 2012

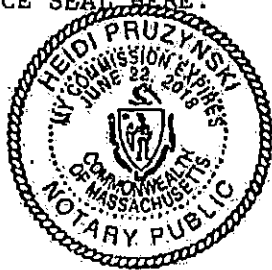
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Death Drugs Cause Uproar in Oregon

By SUSAN DONALDSON JAMES • Aug. 6, 2008

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



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



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

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

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

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

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

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

Letter's Impact 'Devastating'

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

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

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

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

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

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

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

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

"It's been tough," said her daughter, Susie May, who burst into tears

while talking to ABCNews.com.

"I was the first person my mom called when she got the letter," said May, 42. "While I was telling her, 'Mom, it will be ok,' I was crying, but trying to stay brave for her."

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

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

Playing With 'My Life'

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

The Oregon Health Plan was established in 1994 and the physician-
... recently hailed



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

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

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

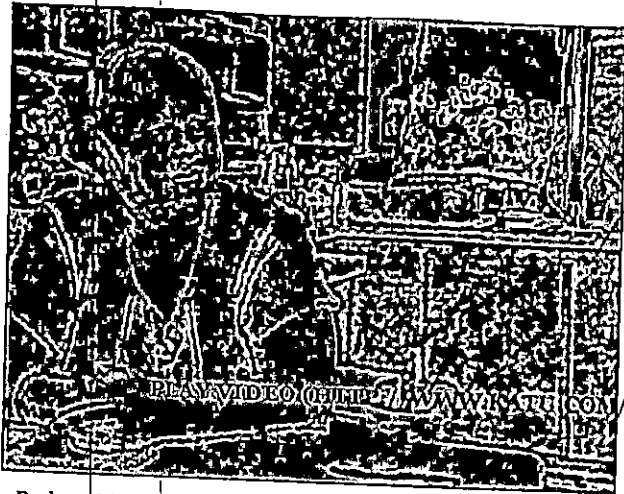
The state also regularly evaluates and updates approvals for cancer treatments. "We look as exhaustively as we can with good peer review evidence," she said.

More ABCNews

Cities Cities The health plan takes "no position" on the physician-assisted suicide
New York City New York City law, according to spokesman Jim Sellers.
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Letter noting assisted suicide raises questions

By Susan Harding and KATU Web Staff | Published: Jul 30, 2008 at 6:30 PM PDT (2008-07-31T1:30:0Z) | Last Updated: Oct 30, 2013 at 7:35 AM PDT (2013-10-30T14:35:0Z)



Barbara Wagner

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

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

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

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

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

An unfortunate interpretation?

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

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

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

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