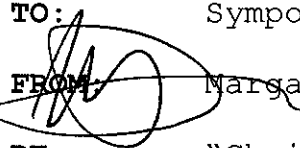


MEMORANDUM

TO: Symposium Attendees
FROM:  Margaret Dore, Esq.©
RE: "Choice" is a Lie
DATE: May 26, 2009

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A. The Compassion & Choices' Playbook

In Washington state, the "Yes" campaign followed a playbook, which is now being used throughout the United States. A good summary of its main themes is found in the attached excerpt from a Compassion & Choices' brief, as follows:

This case presents the question of whether a mentally competent, terminally ill patient who is facing an exceptionally painful or difficult death has the right to obtain a prescription for medication from a cooperating doctor which the patient can self-administer to bring about a peaceful death.

The patient - and the patient alone - has the choice to use or not use the drugs: to advance, incrementally, the timing of a death which is about to occur from the underlying disease in any event, in order to avoid prolonged suffering that has become unbearable to the individual; or to take comfort from the right to choose, but allow the medication to go unused. (Spacing Changed).

Compassion & Choices' brief, July 1, 2008. (Attached at A-2).

These themes are false and misleading for the following reasons:

1. Death is not necessarily imminent

As set forth above, the brief refers to "a death which is about to occur from the underlying disease in any event." It is, however, not true that death would necessarily be imminent. This is the point of a *Seattle Weekly* article published after the Washington election: Even patients with cancer can live years

beyond expectations.¹

Compassion & Choices is also now pushing for broader definitions of "terminal." For example, in Montana, Compassion & Choices defines "terminal," as follows:

The term "terminally ill adult patient", as used in the complaint, means a person 18 years of age or older who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time. (Emphasis added).²

With this definition, an 18 year old with diabetes who is insulin dependent, could have years, if not decades, to live. But, "without the administration of life-sustaining treatment," such person could be facing death "within a relatively short time." He or she would be "terminal" under the above definition.

Compassion & Choices has also proposed an expanded definition in New Hampshire, which includes people with disabilities who are not "dying." See: Not Dead Yet blog at A-13

¹ The article states:

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

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

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. (Attached at A-5).

² Plaintiffs' Interrogatory Answer # 4, attached to Plaintiffs' Brief in Support of Motion for Summary Judgment. (Attached at A-12).

(discussing the definition).

Once someone is labeled "terminal," the door is open to allowing comfort care only, not "treatment." However and regardless, the deaths at issue are not necessarily imminent; the people at issue are not necessarily "dying."

2. I-1000 allows a patient to be killed without consent

The Compassion & Choices' brief also includes the affirmative claim: "The patient - and the patient alone - has the choice to use or not use the drugs."

A similar claim was featured in the Washington election:

Only the patient - and no one else - may administer the medication [lethal dose].

Color Pamphlet, Paid for by Yes! on 1000. (A-15).

These claims are untrue. I-1000 and the other death with dignity acts don't say anything like this - anywhere.³ They instead allow a patient to be killed via the drugs without his consent. See below.

3. "Self-administer"

The brief fails to disclose that the term "self-administer" doesn't necessarily mean that administration will be by the patient. I-1000, now codified as RCW 70.245.010(12), defines self-administer as the "act of ingesting." (A-19). With this definition, someone else putting the lethal dose in the patient's

³ See: I-1000/Chapter 70.245 RCW, in its entirety.

mouth (or feeding tube or IV nutrition bag) qualifies as "self-administration."⁴

4. Patient consent is not required at death

The brief also fails to disclose that the patient's consent is not required when the lethal dose is administered.⁵ Without a right to consent at the time of administration, there is no right to choose.⁶ "Choice" is a lie.

5. Patient competency is not required at death

The brief also fails to disclose that the patient is not required to be competent, capable or even aware when the lethal dose is administered.⁷ Once again, the patient would not necessarily be doing the choosing.

6. Killing without consent is permissible if done according to I-1000

Intentionally killing an incompetent person or intentionally killing some other person without his consent, is homicide.⁸ I-1000 and other death with dignity acts, however, allow this

⁴ For more detail regarding this point, see: Margaret Dore, "'Death with Dignity': What do we tell our clients,?" May 2009. (Attached at A-25).

⁵ See Entire Text of I-1000, now codified at Chapter 70.245 RCW.

⁶ This is especially true for persons who plan, in the words of the brief, to "take comfort from the right to choose, but allow the medication to go unused." Without a right to consent when the lethal dose is administered, such persons could be in for a big surprise. Also, the "right to rescind" does not change this result. See: "The Right to Rescind is not a Substitute for Requiring Consent" at A-20.

⁷ See: I-1000/Chapter 70.245 RCW, in its entirety.

⁸ Cf. RCW 9A.32.010 (defining "homicide"); RCW 9A.32.020 (regarding premeditation); and RCW 9A.32.030 (defining "murder").

result as long as the actions taken are according to such acts.

I-1000 states:

Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. (Emphasis added).

I-1000, §18(1)/RCW 70.245.180(1).⁹

7. No witnesses

If for the purpose of argument, I-1000 does not "allow" killing without consent, patients are still vulnerable to the actions of other people. This is because there are no required witnesses at the death.¹⁰

Without disinterested witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi, as would regulations that require prosecutors and others to treat the death as "natural." (A-27). The patient's death without his consent would be the perfect crime. So much for "choice."

8. Motive

The above scenario would seem especially significant for patients with money. A California case, People v. Stuart, 67 Cal

⁹ For more detail regarding this point, see: Margaret Dore, "'Death with Dignity': What do we tell our clients,?" May 2009. (Attached at A-17 through A-26).

¹⁰ See: I-1000/Chapter 70.245 RCW, in its entirety.

Rptr. 3rd 129, 143 (2007), states:

Financial reasons [are] an all too common motivation for killing someone . . .¹¹

9. Other reasons

Other reasons that "choice" is a lie, include: that an heir, who will benefit from the patient's death, is allowed to help him sign up for the lethal dose, which invites coercion of the patient, not the patient's free and voluntary "choice" (A-18); purported liability for undue influence under I-1000, is illusory (A-21); individuals don't have the right to opt out of I-1000 (A-32); the "right" to legal assisted suicide will, over time, likely evolve into a "duty" to die (A-30 & 34); your healthcare may be compromised, thus reducing your "choice" for healthcare options (A-31); and/or the "Barbara Wagner" scenario. (A-32 & A-33)

Proof that "choice" is a lie can also be found in an article by Compassion & Choices' president, Barbara Coombs Lee. See: her article at A-36 through A-38; and Commentary at A-33 (describing Coombs Lee's argument against choice).

B. Further Information

For more detail about many of the above points, see Margaret Dore, "'Death with Dignity': What do we tell our clients,?" May 2009. (Attached at A-17 to A-26).

¹¹ An excerpt from Stuart is attached at A-28.

* * *

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18 GEORGE RISI, JR., M.D. and
19 COMPASSION & CHOICES,

20 Plaintiffs,

21 v.

22 STATE OF MONTANA and MIKE
23 MCGRATH, ATTORNEY GENERAL,

24 Defendants.

Judge: Dorothy McCarter
Cause No. DV 2007-787

PLAINTIFFS' BRIEF IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT

Thames

INTRODUCTION

This is a case of first impression in Montana, involving the most important issues a number of its citizens will face at any time in their lives: how and under what circumstances they will die; how much pain they will endure before their lives end; and who will control how these decisions are made. The issues revolve around several of the most precious rights guaranteed by the Montana Constitution, some of which have established parameters, and others which are just

Compassion & Choices' brief.

*Good Summary
of major themes*



1 beginning to receive judicial attention.

2 This case presents the question of whether a mentally competent, terminally ill patient
3 who is facing an exceptionally painful or otherwise difficult death has the right to obtain a
4 prescription for medication from a cooperating doctor which the patient can self-administer to
5 bring about a peaceful death. The patient – and the patient alone – has the choice to use or not
6 use the drugs: to advance, incrementally, the timing of a death which is about to occur from the
7 underlying disease in any event, in order to avoid prolonged suffering that has become
8 unbearable to the individual; or to take comfort from the right to choose but allow the medication
9 to go unused. See answer to Interrogatory No. 1, Plaintiffs' Responses to State of Montana's

10 First Discovery Requests. ~~XXXXXXXXXX~~

11 This case is being brought by two terminally ill Montanans, and four physicians who treat
12 terminally ill patients in the state, to establish their respective constitutional rights to receive and
13 provide aid in dying. It is based on the Montana Constitution's fundamental guarantees of
14 privacy, individual dignity, due process, equal protection of the law, and the right to seek safety,
15 health and happiness in all lawful ways.

16 The plaintiffs seek declaratory judgment and injunctive relief to prevent the application of
17 Montana's criminal homicide statutes against physicians who wish to help their patients achieve
18 a peaceful and humane death by providing aid in dying assistance. *implies death's necessity imminent.* The defendants have denied
19 the plaintiffs' entitlement to any of the relief requested. Plaintiffs have now moved for summary
20 judgment, asserting their right to prevail under the provisions of the Montana Constitution they
21 have cited.

22 **STANDARDS FOR DECIDING SUMMARY JUDGMENT**

23 Rule 56(c), M.R.Civ.P. describes the circumstances under which summary judgment may
24 be awarded: "The judgment shall be rendered forthwith if the pleadings, depositions, answers to

1 *Of Agriculture*, 2007 MT 293, ¶ 19, 339 Mont. 519, ¶ 19, 171 P.3d 715, ¶ 19.

2 Under the Montana Rights of the Terminally Ill Act, it is legal and does not constitute a
3 suicide or homicide for any purpose for medical care providers to withhold life-sustaining
4 treatment and procedures, as well as withdraw them once they are in place, under certain
5 specified circumstances. Sections 50-9-205 and 50-10-104, MCA. A terminally ill Montanan
6 who is suffering extreme pain and discomfort at the end of life and whose medical treatment
7 involves life-sustaining mechanical or other forms of intervention, therefore, can direct his
8 physician to remove the interventions so he can precipitate death and avoid continued suffering.
9 The physician is immune from prosecution for providing that assistance. Section 50-9-204,
10 MCA. A terminally ill Montanan whose condition is equally severe but does not happen to
11 involve these types of interventions, however, and who may be experiencing the same degree of
12 pain and discomfort and have the same desire to hasten death, is not allowed to obtain assistance
13 for that purpose from his physician without exposing the physician to potential criminal
14 prosecution. The result is that the first patient receives help in ending his suffering and achieving
15 a peaceful death, but the second is unable to do so because his physician is deterred from helping
16 him by the force of the law. The different treatment accorded by the law to patients in these two
17 situations constitutes a violation of equal protection.

18
19 Theme: Pain

20 CONCLUSION

21 A number of dying Montanans, even with excellent pain and symptom management, will
22 confront a prolonged dying process marked by extreme suffering and deterioration. Some of
23 these patients, based on their values and beliefs, will determine that hastening their impending
24 death is their best course. Two of these patients, and the doctors for many others, are now before
25 this Court to ask that the choice of aid in dying be made available to them. Recognizing their

PLAINTIFF'S BRIEF IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

Page 28

Theme: Choice

Theme: death will occur very soon anyway

1 right to do so is consistent with tradition, precedent, and the letter and spirit of the Montana
2 Constitution.

3 The explicit guarantees of privacy, individual dignity and equal protection in the Montana
4 Constitution, which have been assiduously guarded by the state's courts, have provided broad
5 protection for life-shaping decisions by Montanans. The choice of aid in dying falls well within
6 the sphere of individual decision-making protected by the Montana Supreme Court. This Court
7 should recognize the right of mentally competent, terminally ill Montanans to choose aid in dying
8 and grant summary judgment for plaintiffs on their claims.

9 DATED this 1st day of July, 2008.

10 CONNELL LAW FIRM

11
12 By: 
13 Mark S. Connell

14 Kathryn Tucker, Esq.
15 Compassion & Choices
16 Attorneys for Plaintiffs
17
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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.](#)

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

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— JAMA study examining the accuracy of prognosis.

UPDATE: "It Felt Like the Big One"

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

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

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

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

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

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

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

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

Sadly, Christakis' research has shown that his mother was an exception. In 2000, Christakis published a study in the *British Medical Journal* that followed 500 patients admitted to hospice programs in Chicago. He found that only 20 percent of the patients died approximately when their doctors had

predicted. Unfortunately, most died *sooner*. "By and large, the physicians were overly optimistic," says Christakis.

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

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

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

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

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

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

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

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

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

frequently."

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

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

It's been like this for years. A decade ago, after clearing a jungle of blackberries off a lot he had bought adjacent to his secluded ranch house south of Tacoma, Bud came down with a case of pneumonia. "Well, no wonder he's so sick," Heidi recalls the chief of medicine saying at the hospital where he was brought. "He's in congestive heart failure."

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

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

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

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

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

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

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

Given these two studies, it's no surprise that in Oregon some people who got a prescription for lethal medication on the basis of a six-month prognosis have lived longer. Of the 341 people who put themselves to death as of 2007 (the latest statistics available), 17 did so between six months and two years after getting their prescription, according to state epidemiologist Katrina Hedberg. Of course, there's no telling how long any of the 341 would have lived had they not killed themselves. The Department of Health does not record how long people have lived after getting prescriptions they do not use, so there's no telling, either, whether those 200 people outlived their prognosis. Compassion & Choices of Oregon, which independently keeps data on the people whom it helps navigate the law, says some have lived as long as eight years after first inquiring about the process (although it doesn't track whether they ever received the medication and a six-month prognosis).

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

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

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

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

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

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

Randy Niedzielski reached that point in the summer of 2006, according to his wife Nancy. Diagnosed with brain cancer in 2000, the onetime Lynnwood property manager had been through several rounds

of chemotherapy and had lived years longer than the norm. But the cancer cells had come back in an even more virulent form and had spread to his muscle system. "He would have these bizarre muscle contractions," Nancy recalls. "His feet would go into a cone shape. His arms would twist in weird angles." Or his chest would of its own volition go into what Nancy calls a "tent position," rising up from his arms. "He'd just be screaming in pain."

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

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

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

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

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

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

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

Maryanne Clayton says she has never reached that point. Still, she voted for the Death With Dignity Act. "Why force me to suffer?" she asks, adding that if she were today in as much pain as she was when first diagnosed with lung cancer, she might consider taking advantage of the new law. But for now, she still

enjoys life. Her 35-year-old son Eric shares a duplex with her in the Tri-Cities. They like different food. But every night he cooks dinner on his side, she cooks dinner on her side, and they eat together. And one more day passes that proves her prognosis wrong.

nshapiro@seattleweekly.com

1 person understands what he or she is doing and the probable consequences of his or her acts.
2 Mental competence will be determined by the person's attending physician based upon the
3 physician's professional judgment and assessment of the relevant medical evidence.
4

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

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

17 *New Broader version of "terminal"*

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

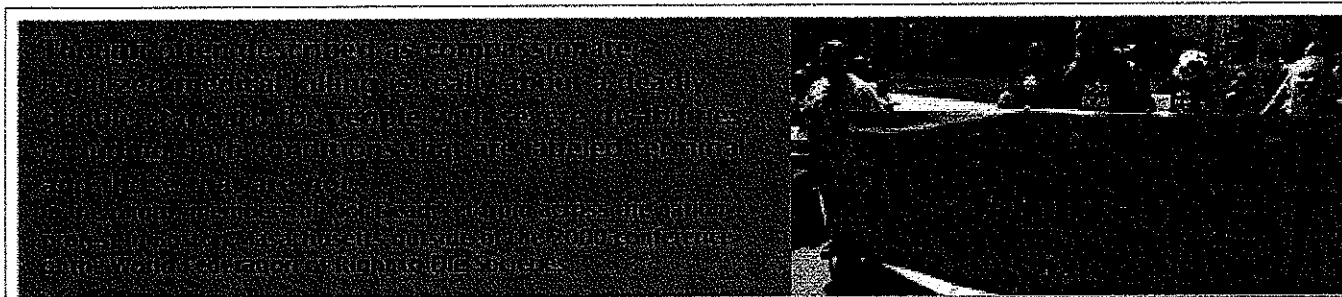
20 **ANSWER:** This is a subjective determination made by the individual patient based upon
21 his or her medical condition and circumstances, symptoms, and personal values and beliefs.
22

23 **INTERROGATORY NO. 6:** Define how a patient seeking "aid in dying" "requests such
24 assistance" as it is described in the Complaint.
25

↑
Compassion of Choices et al

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FRIDAY, JANUARY 30, 2009

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New Hampshire Poised to Redefine "Terminally Ill" - to PWDs and others for Assisted Suicide Eligibility

Well, advocates for assisted suicide in New Hampshire can say - with a straight face - that the bill they've introduced is limited to people with "terminal conditions."

The trick, of course, is that they've come up with a new and expansive definition of "terminal condition."

How expansive?

Here's a link to HB 304 - AN ACT relative to death with dignity for certain persons suffering from a terminal condition.

Definition of "terminal condition":

XIII. "Terminal condition" means an incurable and irreversible condition, for the end stage of which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death.

Read that definition carefully, terminality is defined as having a condition that is irreversible and will result in a premature death. My partner would fit that definition. Many people I work with also fit the definition.

None of them are dying.

Keep in mind that this definition is to be used *only* in terms of eligibility for assisted suicide. It doesn't, for example, apply to hospice services which are limited by federal rules to those who are deemed as having six months or less to live.

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ABOUT NOT DEAD YET

Since 1983, many people with disabilities have opposed the assisted suicide and euthanasia movement. Though often described as compassionate, legalized medical killing is really about a deadly double standard for people with severe disabilities, including both conditions that are labeled terminal and those that are not.

Not Dead Yet was founded on April 27, 1996, shortly after Jack Kevorkian was acquitted in the assisted suicides of two women with non-terminal disabilities. In a 1997 Supreme Court rally, the outcry of 500 people with disabilities chanting "Not Dead Yet" was heard

So, no guarantee of palliative care for people with significant disabilities or conditions, unless they're thought to be close to death. That would be expensive.

OTOH, this bill would offer help with easy and successful suicide for anyone with a serious, significant, potentially life-shortening condition/disability at any time at all.

So, no guarantee of medical support to make life easier, but a "hand out" to those who want to die, even if they're not dying.

I don't think this can be written off as just sloppy wording. The sponsors involved are legislators, and if we assume competence on their parts, then we can also assume that they are fully aware of the importance of the specific definitions used in a bill when it comes to applying it in the real world as law.

Make no mistake. This bill, if passed, will guarantee an easy suicide to just about any person with diagnoses of quadriplegia, spinal muscular atrophy, HIV/AIDS, and many other conditions disabilities. Nothing to help people who could have many happy years with the right supports - just an easy and *cheap* out. -- Stephen Drake

We've heard that the judiciary committee is holding a hearing on the bill on February 4th. No sign of the hearing on the NH legislature website and no mention in the press. That indicates that the people who got the early notice and probably already signed up to testify are *supporters* of assisted suicide and euthanasia.

POSTED BY NOT DEAD YET AT 1:45 PM

FILED IN: ASSISTED SUICIDE, LEGISLATION, NEW HAMPSHIRE, POLICY, REALITY CHECK

3 COMMENTS:

Sophia said...

The lack of hospice eligibility does prove that this is all about the "right"=duty to die for so many disabled people. Blech.

JANUARY 30, 2009 7:06 PM

hymes said...

Every single person on dialysis would fit that definition. Even though some have lived 35 years or more on dialysis.

around the world. Since then, eleven other national disability rights groups have joined NDY in opposing legalized assisted suicide, chapters have taken action in over 30 states, and we helped put Jack Kevorkian behind bars in 1999. In the 2003-2005 fight to save Terri Schiavo, twenty-five national disability groups joined Not Dead Yet in opposing her guardian's right to starve and dehydrate her to death.

ISSUES

"end of life" (10)
"mercy killings" (7)
"special" (1)
abuse (4)
access to health care (3)
action alert (5)
activism (19)
ADAPT (13)
adaptive technology (1)
advance directives (3)
advocacy (22)
als (6)
AMA (2)
Americans with Disabilities Act (1)
amicus brief (1)
announcement (2)
ari ne'eman (1)
Art Caplan (3)
articles (1)
ASAN (1)
aspergers (5)
assisted suicide (61)
Australia (1)
autism (2)
barbara coombs lee (1)

Yes on I-1000: It's My Decision

I-1000 allows mentally competent, terminally ill adults with six months or less to live to receive - under strict safeguards - a prescription for life-ending medication.

This choice belongs exclusively to the terminally ill individual. Government, politicians, religious groups and others should not dictate these personal decisions.

Ten Years of Dignity in Oregon

The Washington law mirrors the law in Oregon, which has been in place for more than 10 years. The Oregon law was upheld by the U.S. Supreme Court and approved twice by voters.

Independent studies of Oregon's Death with Dignity law prove that the safeguards protect patients, prevent misuse and coercion, and allow terminally ill patients the option of a peaceful, dignified death.

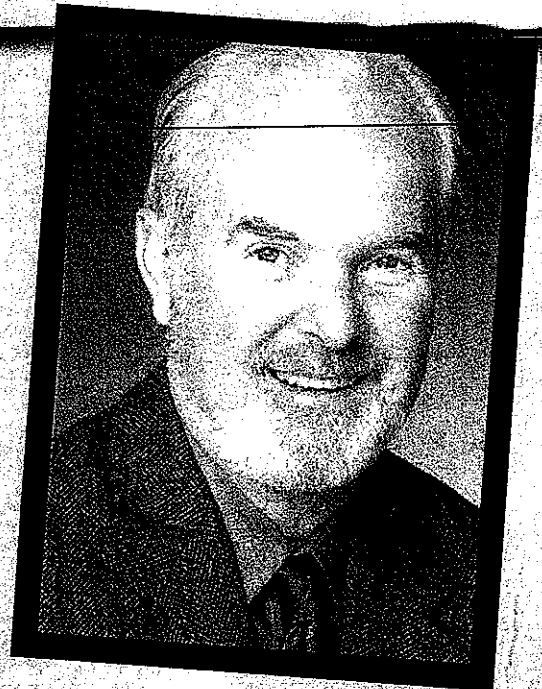
Safeguards Work

There are multiple safeguards in Washington's death with dignity law, including oral and written requests, waiting periods, and mental competency diagnosis by two physicians. Only the patient - and no one else - may administer the medication.

The Oregonian

January 13, 2008

Opponents, including us, warned that the law could steamroller vulnerable patients into suicide, target the disabled and become a destination for terminally ill people seeking to die with doctor-prescribed drugs. In a decade of experience with the law, though, no such abuses have shown up.



"Initiative 1000 is my final campaign. It's a legacy I can leave for all Washington citizens—the freedom to make their own final decisions in life. I urge you to vote yes on I-1000."

—former Governor Booth Gardner

Please Vote Yes On I-1000

The Seattle Times



Jan 10, 2008

As Oregon has demonstrated, can be administered in a civilized way... Gardner's law will not affect many people. But those it does affect, and their families, will be thankful for its passage.

Herald

Jan 25, 2008

Dignity should still be in reach at life's end.

Dignity is a fundamental human right. Being on death's doorstep shouldn't change that.

That's why we support an initiative filed this month by former Gov. Booth Gardner that would have our state join Oregon in providing terminally ill, mentally competent adults access to life-ending medication.

YES! on I-1000
WASHINGTON
DEATH WITH DIGNITY

yeson1000.org

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**Death with Dignity:
What do we tell our Clients?**

by Margaret Dore, Esq.

[In April 2009, the Bar News ran an article by Pamela Hanlon praising Washington's new Death with Dignity Act. This article, by Margaret Dore, presents an opposing view.]

A client wants to know about the new Death with Dignity Act, which legalizes physician-assisted suicide in Washington State. Do you take the politically correct path and agree that it's the best thing since sliced bread? Or, do you do your job as a lawyer and tell him that the Act has problems and that he may want to take steps to protect himself? I would hope the latter.

Not What the Voters were Promised

The new act was passed by the voters as Initiative 1000 and has now been codified as Chapter 70.245 RCW.

During the election, proponents touted it as providing "choice" for end of life decisions. A glossy brochure declared:

Only the patient - and no one else - may
administer the [lethal dose].¹

The Act, however, doesn't say this - anywhere. The Act also contains coercive provisions. For example, it allows an heir who will benefit from the patient's death, to help the patient sign up for the lethal dose.

How the Act Works

The Act has an application process to obtain the lethal dose, which includes a written request form with two required witnesses.² The Act allows one of these witnesses to be the patient's heir.³

Once the lethal dose is issued by the pharmacy, there is no oversight.⁴ The death is not required to be witnessed by disinterested persons.⁵ Indeed, no one is required to be present.⁶

A Comparison to Probate Law

When signing a will, having an heir act as one of the witnesses, creates a presumption of undue influence. The probate statute states that when one of two required witnesses is a taker under the will, there is a rebuttable presumption that the taker/witness:

procured the gift by duress, menace, fraud,
or undue influence.

RCW 11.12.160(2).

The Act's lethal dose request process, which allows an heir to be a witness on the lethal dose request form, does not promote patient choice. It invites coercion.

No Mental Standard or Consent is Required at the Time of Administration

Under the Act, an "attending physician" and a "consulting physician" are required to determine whether the patient is

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competent at the time of the lethal dose request.⁷ The Act does not, however, require that the patient be competent or even aware when the lethal dose is administered.⁸ There is also no language requiring the client's consent at the time of administration.⁹

Without a requirement of competency, consent or even awareness when the lethal dose is administered, the stage is set for undue influence and worse.

"Self-administer" Does Not Necessarily Mean that a Patient Administers the Lethal Dose to Himself

The Act does not state that "only" the patient may administer the lethal dose.¹⁰ The Act instead provides that the patient "self-administer" the dose.¹¹

In an Orwellian twist, the term "self-administer" does not mean that administration will necessarily be by the patient.

"Self-administer" is instead defined as the act of ingesting.

The Act states:

"Self-administer" means a qualified patient's act of ingesting medication to end his or her life . . . (Emphasis added).

RCW 70.245.010(12).

In other words, someone else putting the lethal dose in the patient's mouth qualifies as "self-administration."¹² Someone else putting the lethal dose in a feeding tube or IV nutrition bag would also qualify.¹³ "Self-administer" means that someone else can administer the lethal dose to the patient.

The Point

In summary, someone other than the patient is allowed to administer the lethal dose. The Act contains no requirement that the patient be competent or even aware when the lethal dose is administered. There is no requirement that the patient consent when the lethal dose is administered.

Intentionally killing an incompetent person or intentionally killing some other person without his consent, is homicide.¹⁴ The Act, however, allows this result as long as the action taken is according to the Act. The Act states:

Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. (Emphasis added).

RCW 70.245.180(1).

The Right to Rescind is not a Substitute for Requiring Consent

The Act's proponents may counter that consent is actually required because patients have a right to rescind a request for the lethal dose "at any time."¹⁵ A right to rescind is not the same thing as a right to consent when the lethal dose is administered. Consider for example, an incompetent or unaware patient who obtained the lethal dose on a "just in case basis" and has not consented to taking it. He would not have the ability to rescind because he is incompetent, sedated or simply sleeping. Without the right to consent, someone else would,

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nonetheless, be free to administer the lethal dose to him.

Without the right to consent, the client's control over the "time, place and manner" of his death is an illusion.

No Witnesses at the Death

If for the purpose of argument, the Act does not "allow" a patient's death without consent, patients are, nonetheless, unprotected from this result due to the lack of required witnesses at the death.

Without witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi.

This scenario would seem especially significant for patients with money. A California case, People v. Stuart, 67 Cal Rptr. 3rd 129, 143 (2007), states:

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

No Liability for Administration without Consent

Proponents may counter that the Act protects patients from wrongdoing due to provisions imposing civil and criminal liability in RCW 70.245.200. None of these provisions purport to prohibit administration of the lethal dose without the patient's consent. These provisions are instead concerned with the lethal dose request and general issues.¹⁶

Illusory Liability for Undue Influence

In connection with the lethal dose request, the Act purports to impose criminal liability for undue influence.¹⁷ This purported liability is illusory because the concept of undue influence is too vague to be criminally enforced. See: *City of Tacoma v. Luvene*, 118 Wn.2d 826, 844-5, 827 P.2d 1374 (1992) (citizens must be given clear notice of prohibited conduct); and *Mays v. State*, 116 Wn. App. 864, 876, 68 P.3d 1114 (2003) (statute unconstitutionally vague where "reasonably intelligent people must guess as to its meaning"). As noted above, the Act specifically allows conduct that would normally create a presumption of undue influence (allowing an heir to act as a witness on the lethal dose request form). In addition, the Act's prohibition against undue influence is not defined and has no elements of proof.¹⁸ Undue influence is also a traditionally equitable concept, which is "not susceptible of precise definition and must depend heavily on the facts of each case."¹⁹

What elements would a prosecutor be required to prove for the purported "crime" of undue influence? It's hard to say.

Official Cover

In the event anyone questions a patient's death, a meaningful response from law enforcement, generally, seems unlikely. This is because medical examiners, coroners and prosecuting attorneys are required to treat deaths under the Act

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as "natural."²⁰ The death certificate is required to list an underlying disease as the official cause of death.²¹

What to Tell Clients

1. Signing the form will lead to a loss of control

By signing the lethal dose request form, the client is taking an official position that if he dies suddenly, no questions should be asked. The client will be unprotected against others in the event he changes his mind after the lethal prescription is filled and decides that he wants to live. This would seem especially important for patients with money. There is, regardless, a loss of control.

2. Reality check

The Act applies to adults determined by an "attending physician" and a "consulting physician" to have a disease expected to produce death within six months.²² But what if the doctors are wrong? This is the point of a recent *Seattle Weekly* article: Even patients with cancer can live years beyond expectations.²³ The article states:

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

"We almost lost her because she was having too much fun, not from cancer" [her son chuckles].²⁴

Conclusion

As lawyers, we often advise our clients of worst case

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

* * *

Margaret Dore is an attorney admitted to practice in 1986. Her practice has included probate, guardianship and appeals. She is the immediate past chair of the Elder Law Committee of the ABA Family Law Section. She is a former chair of what is now the King County Bar Guardianship and Elder Law Section. She is also a former law clerk to both the Washington State Supreme Court and the Washington State Court of Appeals. For more information on Ms. Dore, see www.margaretdore.com.

1. I-1000 Color Pamphlet, ("Paid for by Yes! on 1000").
2. RCW §§ 70.245.030 and .220 state that one of two required witnesses to the lethal dose request form cannot be the patient's heir or other person who will benefit from the patient's death; the other witness may be an heir or other person who will benefit from the death.
3. Id.
4. See: Entire Act, Chapter 70.245 RCW.
5. Id.
6. Id.
7. RCW 70.245.040(1)(a) and RCW 70.245.050.

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8. The following Act provisions address the issue of competency in conjunction with the lethal dose request, not later. See: RCW 70.245.010(3); RCW 70.245.010(5); RCW 70.245.010(11); RCW 70.245.020; RCW 70.245.030(1); RCW 70.245.040(1)(a); RCW 70.245.040(1)(d); RCW 70.245.050; RCW 70.245.120(3) & (4); and RCW 70.245.220 (regarding the patient's appearing to be of "sound mind"). There is no provision that requires the patient to be competent or even aware at the time of administration. See: Entire Act, Chapter 70.245 RCW.

9. The following provisions require that a determination of whether a patient is acting "voluntarily" be made in conjunction with the lethal dose request, not later. See: RCW 70.245.020(1); RCW 70.245.030(1); RCW 70.245.040(1)(a); RCW 70.245.040(1)(d); RCW 70.245.050; RCW 70.245.120(3) & (4); and RCW 70.245.220. There is no provision that requires the patient to be acting voluntarily and/or give consent at the time of administration. See: Entire Act, Chapter 70.245 RCW ("consent" not mentioned).

10. See: Entire Act, Chapter 70.245 RCW.

11. See: RCW 70.245.010(7); RCW 70.245.010(12); RCW 70.245.020(1); RCW 70.245.090; RCW 70.245.140; RCW 70.245.170; RCW 70.245.180(1); and RCW 70.245.220.

12. Webster's New World College Dictionary at www.yourdictionary.com/ingest defines "ingest" as: "to take (food, drugs, etc.) into the body, as by swallowing, inhaling or absorbing." Someone putting the lethal dose in the patient's mouth qualifies as "self-administration" because the patient will thereby "ingest" the dose.

13. Someone putting the lethal dose in a feeding tube or IV nutrition bag qualifies as "self-administration" because the patient will thereby "ingest" the dose.

14. Cf. RCW 9A.32.010 (defining "homicide"); RCW 9A.32.020 (regarding premeditation); and RCW 9A.32.030 (defining "murder").

15. RCW 70.245.100.

16. RCW 70.245.200 states:

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death is guilty of a class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication to end the patient's life, or to destroy a rescission of a request, is guilty of a class A felony.

(3) This chapter does not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct that is inconsistent with this chapter. (Emphasis added).

17. The Act states:

A person who coerces or exerts undue influence on a patient to request medication to end the patient's life, or to destroy a rescission of a request, is guilty of a class A felony.

RCW 70.245.200(2).

18. See: 70.245.200(2) and Entire Act, Chapter 70.245 RCW.

19. Mark Reutlinger, Washington Law of Wills and Intestate Succession, Washington State Bar Association, 2006, p.88.

20. Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with the Death with Dignity Act, Washington State Department of Health, Revised April 8, 2009, at <http://www.doh.wa.gov/dwda/forms/MEsAndCoroners.pdf>.

21. Id., RCW 70.245.040(2) and RCW 70.245.180(1).

22. RCW 70.245.040(1)(a); RCW 70.245.050; and RCW 70.245.010(13).

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

24. Id.



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.

the court gave at least some credence to the contentions which conflicted with defendant's account. The court did not abuse its discretion in doing so. A reasonable person could conclude from the record that defendant, whether or not she believed Isabel wanted to die, smothered her mother to death as Isabel slept on the evening of January 11, 2004, without Isabel's knowledge or consent, doing so after a day of thinking about it and at least in part for her own financial gain.^{FN6}

FN6. Even if Isabel had in some fashion consented to defendant's acts, we are satisfied from our independent research that defendant's actions should not be treated in effect as assisting a suicide. Our Supreme Court rejected an "assisted suicide" argument in *People v. Matlock* (1959) 51 Cal.2d 682, 336 P.2d 505 (*Matlock*), stating "where a person actually performs, or actively assists in performing, the overt act resulting in death, such as shooting or stabbing the victim, administering the poison, or holding one under water until death takes place by drowning, his act constitutes murder, and it is wholly immaterial whether this act is committed pursuant to an agreement with the victim...." (*Id.* at p. 694, 336 P.2d 505, followed in *People v. Cleaves* (1991) 229 Cal.App.3d 367, 376-377, 280 Cal.Rptr. 146; but see *In re Joseph G.* (1983) 34 Cal.3d 429, 194 Cal.Rptr. 163, 667 P.2d 1176 [making an exception to *Matlock's* murder rule when one of two people engaged in a simultaneous suicide effort actively employs the single instrumentality involved].)

B. Defendant's "Unusual Case" Argument

[10] Defendant argues that she plainly overcame the presumption against probation because "this was extremely unusual in the most basic, fundamental way central to the statutory bar: Ms. Stuart inflicted great bodily injury or death upon her

mother out of a felt love for and duty to her. However misdirected those laudable impulses were, she acted 'from a heartfelt place,' which can rarely if ever be said about the willful infliction of death or great bodily injury." Defendant also asserts that "[t]he homicide of one's beloved parent prompted by care and concern for that aged parent and filial obedience to and honor of that parent's apparent wishes is a most peculiar manslaughter indeed, and one that is at the lowest end of the spectrum**143 of moral opprobrium when examining the motives of those who willfully inflict great bodily injury or death." We disagree.

As we have already discussed, a reasonable person could conclude that defendant acted at least in part out of financial considerations, an all too common motivation for killing someone, and without Isabel's knowledge or consent. This undermines defendant's argument that she acted with a reduced moral culpability.

Furthermore, a killer's subjective belief about the reason for a crime, including that he or she acted out of the "compassion and empathy" that *183 defendant contends she acted upon here, does not necessarily mean the case is "unusual." It is not particularly unusual for a killer to believe his or her action was justified; it is, for example, the root of any vigilantism. Moreover, that defendant believes she acted out of good intentions has little, if any, bearing on an objective view of her legal and moral culpability under the circumstances. It is reasonable to conclude an adult child who takes it upon herself to commit the "mercy killing" of a very elderly parent based only on that parent's "apparent wishes" has abused a position of trust and committed a very serious crime. A court is not required to conclude such an act rests on a higher moral plane than any other killing. Indeed, to do so would potentially expose some of the most vulnerable in our society to the grave danger of being killed by loved ones, however compassionate they may be, who are unable to resist a temptation which dovetails with their financial self-interest, as the record suggests

People v. Stuart



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If doctors who won't kill are 'wicked,' the world is sick

Licia Corbella

Calgary Herald

Saturday, January 10, 2009

Talk about Orwellian. A woman described as a "leading expert in ethics" has declared that doctors who refuse to kill their patients are "genuinely wicked." I'm not making this up.

Mary Warnock, a British baroness told the Northern Ireland Forum for Ethics in Medicine and Healthcare this past Monday, that doctors who refuse to break their Hippocratic oath are evil.

It seems that virtually every day, I read another story that proves the world--and what is accepted as good and true --is being turned on its head.

Referring to terminally ill patients who make a written request to be killed when they reach a certain point in their illness, Warnock said: "There are doctors, we know, who don't pay any attention (to those written wishes to be killed).

"But that seems to me a genuinely wicked thing to do--to disregard what somebody had quite explicitly said, that he wants to die . . . "

This is the same old bird (she's 84) who argued that people who have dementia or Alzheimer's disease have a "duty to die" because they are a burden to society and their families.

"If you're demented, you're wasting people's lives--your family's lives--and you're wasting the resources of the National Health Service," she said a few months ago.

There was a time when such statements would be described as wicked and the orator as well.

But in Warnock's twisted world of "ethics," doctors who kill are righteous and doctors who refuse to kill are villainous.

Black is white, white is black and wrong is right. Murder is merciful and compassionate care, cruel. Somewhere out there, George Orwell is saying, "I told you so."

In her Jan. 5 speech, Warnock dismisses the idea that murdering the elderly and "demented" will not lead to a slippery slope of killing infants, depressed teens and others.

But that is precisely what is happening in Holland, where euthanasia has been practised since 1980 and has been fully legal since 2002.

Currently, infants born with defects are often killed by their doctor, with or without the parents' permission, not that permission makes it any more acceptable.

That's not just a slippery slope, it's Mount Everest in a blizzard.

The language surrounding euthanasia is necessarily softened by its proponents, calling the

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active killing of another human being, mercy killing, dying with dignity and choice. But what actually has been shown to happen in places that embrace legalized euthanasia is the antithesis of choice.

In a government study in the Netherlands, called Medical Decisions about the End of Life, it was found that in 1990 alone 1,031 patients were actively killed by their doctor without their request and of those people, 14 per cent were fully competent, 72 per cent had never expressed that they wanted their lives ended and in eight per cent of the cases, doctors performed "involuntary euthanasia" even though they believed other options were available.

Similar subsequent studies found similar outcomes.

So, this form of "choice" actually leads to thousands of people never being able to make a choice--ever again.

Even some staunch proponents of euthanasia say Holland is an extreme example. Much better to look to Oregon, where physician assisted suicide (PAS) has been legal since 1997.

But in the reports published annually by the state, it's evident that choice is compromised in Oregon too.

In 1998, 12 per cent of PAS patients in Oregon said they chose this irreversible course of action because they didn't want to burden their family. That rose to 26 per cent in 1999, 42 per cent in 2005 and 45 per cent in 2007, the last year figures are available. If that were a company's bottom line, champagne corks would be popping!

In other words, for the infirm and disabled, the right to die quickly becomes the duty to die. Wanting to live despite being frail or ill increasingly is viewed as selfish in places where euthanasia is the law.

That's not empowerment, it's coercion, guilt for living, pressure to die.

According to Belfast's daily paper, The News Letter, after Warnock spoke in the debate -- which was ironically held in a local church, one of the members of the audience, Avril Robb, a lawyer and a member of the Medical Legal Society, said she had cared for her parents through their terminal illnesses and stated: "I do know that the last months were very precious."

That is what many who spend time caring for a dying parent, child or spouse says about a loved one's last days and months. Their vulnerability causes all emotional walls to tumble down and petty problems to vanish.

A nurse friend of mine who works in palliative care but had also spent years helping to bring babies into the world says: "I'm convinced that dying can be a more blessed a time than birth."

That may sound counterintuitive, but compared to saying that refusing to kill is wicked, it's much easier to believe.

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Hawaii Reporter

Freedom to Report Real News

Don't Follow Oregon's Lead: Say No to Assisted Suicide

By Charles Bentz, MD, 2/13/2009 10:08:04 AM

I am an internal medicine doctor, practicing in Oregon where assisted suicide is legal. I would like to share a story about one of my patients.

I was caring for a 76 year-old man who came in with a sore on his arm. The sore was ultimately diagnosed as a malignant melanoma, and I referred him to two cancer specialists for evaluation and therapy. I had known this patient and his wife for over a decade. He was an avid hiker, a popular hobby here in Oregon. As he went through his therapy, he became less able to do this activity, becoming depressed, which was documented in his chart.

During this time, my patient expressed a wish for doctor-assisted suicide to one of the cancer specialists. Rather than taking the time and effort to address the question of depression, or ask me to talk with him as his primary care physician and as someone who knew him, the specialist called me and asked me to be the "second opinion" for his suicide. She told me that barbiturate overdoses "work very well" for patients like this, and that she had done this many times before.

I told her that assisted-suicide was not appropriate for this patient and that I did NOT concur. I was very concerned about my patient's mental state, and I told her that addressing his underlying issues would be better than simply giving him a lethal prescription. Unfortunately, my concerns were ignored, and approximately two weeks later my patient was dead from an overdose prescribed by this doctor. His death certificate, filled out by this doctor, listed the cause of death as melanoma.

The public record is not accurate. My patient did not die from his cancer, but at the hands of a once-trusted colleague. This experience has affected me, my practice, and my understanding of what it means to be a physician. What happened to this patient, who was weak and vulnerable, raises several important questions that I have had to answer, and that Hawaiian citizens should also consider:

- If assisted suicide is made legal in Hawaii, will you be able to trust your doctors, insurers and HMOs to give you and your family members the best care? I referred my patient to specialty care, to a doctor I trusted, and the outcome turned out to be fatal.
- How will financial issues affect your choices? In Oregon, patients under the Oregon Health Plan have been denied coverage for treatment and offered coverage for suicide instead, which says the plan money. See e.g. KATU TV story and video at <http://www.katu.com/home/video/26119539.html> (about Barbara Wagner). Do you want this to be your choice?
- If your doctor and/or HMO favors assisted suicide, will they let you know about all possible options or will they simply encourage you to kill yourself?

In most states, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient received was a lethal prescription, intended to kill him.

To the citizens of Hawaii, is this where you want to go? Please learn the real lesson from Oregon. Despite all of the so-called safeguards in our assisted suicide law, numerous instances of coercion, inappropriate selection, botched attempts, and active euthanasia have been documented in the public record.

Protect your health care. Don't let legalized assisted suicide come to Hawaii.

Charles J. Bentz MD, FACP is a Clinical Associate Professor of Medicine, Division of General Medicine and Geriatrics, at the Oregon Health & Sciences University in Portland, Oregon. Reach him at

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This is Pennsylvania

4. Individual "Opt Outs" Are Not Allowed

SB 404 does not allow patients to opt out of its provisions. SB 404 says that no provision that affects whether a patient may make or rescind a lethal dose request "shall be valid."¹⁴

So, if you are a person who gets talked into things, and you don't want to get talked into suicide, you are not allowed to make legal arrangement to try and prevent it.

So much for your personal "control."

C. Assisted Suicide Allows Insurers to Steer Patients to Suicide

If SB 404 is passed, health care insurers in Pennsylvania will be able to follow Oregon's lead to steer patients to "choose" voluntary suicide. Consider the case of Oregon resident, Barbara Wagner.¹⁵ The Oregon Health Plan refused to pay for a cancer drug to prolong her life and offered to pay for her assisted suicide instead. Unable to afford the drug, she was

Similar provision
I-1000
§16/
RCW
70.245,
160

¹⁴ SB 404 states:

No provision in a contract, will, or other agreement, whether written or oral, shall be valid which affects whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner. (Emphasis added).

54B15 (Attached, *infra* at A-11, lines 23-27).

¹⁵ For articles discussing Barbara Wagner, see: Margaret Datile, "A Price on Your Head," *Washington Times*, November 2, 2008 (*infra* at A-39); Rita Marker, "Oregon's Suicidal Approach to Health Care," *American Thinker*, September 14, 2008 (*infra* at A-42); Asher Meir, "Ethics@Work: Death as a Function of Finances," *Jerusalem Post*, October 30, 2008 (*infra* at A-45); Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008, <http://www.abcnews.go.com/Health/Story?id=5517492&page=2> (*infra* at A-47); and video transcript of Barbara Wagner, and also link to video at <http://www.katu.com/news/26119539.html?video=YHI&t=a>. (*Infra* at A-51).

steered toward suicide.

For every patient who "chooses" the suicide option, the plan saves money because it does not even have to pay for comfort care; the patient is dead.

D. **"Compassion & Choices" Argues Against "Choice" and Cures**

The suicide group, Compassion and Choices, has sought to neutralize the Barbara Wagner story. Consider, for example, "Sensationalizing a sad case cheats the public of sound debate," by Compassion & Choices' President, Barbara Coombs Lee.¹⁶

Therein, Coombs Lee argues against Wagner's choice to try and beat her cancer.¹⁷ Coombs Lee also argues for a public policy change to discourage people from seeking cures.¹⁸

If Coombs Lee had been in charge during the AIDS epidemic of the 1980's, would we now have people living with HIV/AIDS? Or with a public policy to discourage people from seeking cures, would we have a different result?

In a recent blog post, Coombs Lee referred to kidney dialysis as "extraordinary treatment." (*Infra* at A-56). Will

¹⁶ *The Oregonian*, November 29, 2008, beginning *infra* at A-53.

¹⁷ *Id* at A-53 & A-54.

¹⁸ Coombs Lee states:

The burning public policy question is whether we inadvertently encourage patients to act against their own self interest, chase an unattainable dream of cure and foreclose the path of acceptance that curative care has been exhausted . . . Such encouragement serves neither the patients, families, nor the public. (Attached, *infra* at A-54).

the next target be insulin for diabetics?

E. Oregon Promotes the Idea that its Citizens are "Burdens," Which is an Acceptable Reason for Them to Kill Themselves

The official doctor reporting form for deaths under Oregon's law, includes a check-the-box question with seven possible concerns that contributed to the lethal dose request. (*Infra* at A-60). These concerns include the patient's feeling that he is a "burden" on family, friends or care givers. (*Id.*). The prescribing doctor is instructed:

Please check "yes," "no," or "Don't know" depending on whether or not you believe that a concern contributed to the request.

Infra at A-60.

The data collected is then summarized in annual statistical reports. According to the report for 2008, doctors have checked the "burden" box for 38.3% of all patients who have died under Oregon's law to date. (*Infra* at A-65).

In other states, someone describing a vulnerable person as a "burden" is a warning sign of abuse, neglect and exploitation. The website for the Idaho Commission on Aging, for example, lists the following "warning sign":

Suspect Behavior by the caregiver: . . .

* Describes the vulnerable adult as a burden or nuisance. (Emphasis added).

Infra at A-32.

The Idaho Commission on Aging recommends that when

sufficient "warning signs" exist, a report should be made to law enforcement or Adult Protective Services.¹⁹

The State of Oregon, by contrast, instructs its doctors to check a "burden" box. Oregon promotes the idea that its citizens are burdens, which justifies having its doctors prescribe lethal drugs to them. Oregon's law does not promote patient "control," but officially sanctioned abuse of vulnerable adults.

F. The Oregon Statistical Reports

Oregon's annual statistical reports are otherwise consistent with elder abuse. They support that the majority of persons dying via Oregon's law have been those with money.²⁰ This is consistent with the coercive provisions described above, which are also present in Oregon's law (allowing an heir to be a witness on the lethal dose request form, allowing an heir to talk for the patient, etc.).²¹

¹⁹ The Commission's website states:

These "warning signs" should . . . serve as indicators that a problem may exist and a report should be made to law enforcement or to the local Adult Protection service provider. (*Infra* at A-31).

²⁰ The Oregon statistics do not specifically track patient income or net worth. The statistics, however, do show that the majority of people who used Oregon's law in 2008 were: white (98%); well educated (60% had at least a BA); and with private insurance (88%). *See*: Oregon Eleven Year Report *infra* at A-63. Typically, people with these attributes would be those with money. The minority, approximately 8% (36% in years prior), had Medicare or Medicaid, some of whom would be the poor. *Id.*

²¹ ORS 127.810 §2.02 & 127.897 §6.01 state that one of the two required witnesses to the lethal dose request form cannot be the patient's heir; the other witness is allowed to be an heir. (*Infra* at A-68 & A-69). ORS 127.800 §1.01(3) defines "capable" in a manner that allows someone else to talk for such patient, e.g., an heir. (*Infra* at A-67). There is no stated

Sensationalizing a sad case cheats the public of sound debate

Posted by rattig November 29, 2008 19:30PM

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



*Barbara Coombs
Lee argues
against
Barbara Wagner's
choice to try
of life*

Barbara Coombs Lee

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

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

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

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

← focus: not personal autonomy

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

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

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

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

Argues against Wagner's "choice" to try

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

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

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

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

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

Coombs Lee is president of the group Compassion & Choices.

Categories:

Comments

LetDocDecide says...

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

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

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

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

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

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

Respectfully
Bob

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