

➤ Hearing Records ... HR

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WISCONSIN STATE  
LEGISLATURE ...  
PUBLIC HEARING  
COMMITTEE RECORDS

**2007-08**

(session year)

**Senate**

(Assembly, Senate or Joint)

Committee on  
Public Health, Senior  
Issues, Long Term  
Care and Privacy

(SC-PHSILTCP)

(FORM UPDATED: 07/02/2010)

**COMMITTEE NOTICES ...**

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**INFORMATION COLLECTED BY  
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Date?

**Statement of James L. Greenwald to the Senate Public Health Committee on Senate Bill 151, the Death with Dignity Act.**

My name is James L. Greenwald. I'm 77 years old and I live in Madison. I am a retired attorney. I spent the larger part of my career as an attorney in Wisconsin state government. I am a member of Compassion & Choices and was a member of the Hemlock Society before the merger.

Many supporters of physician aid in dying have seen their parents, spouses, relatives and friends die difficult and protracted deaths. They don't want to die that way themselves and they don't want others to have to die that way. I support the Bill for those reasons too.

I also support Senate Bill 151, the Death with Dignity Act, because it is in the best tradition of the constitutional principle of personal liberty. It is about that principle that I speak today.

This principle is not new and has been fought over the years by opponents who believe that their own moral precepts should be mandated for everybody.

The Fourteenth Amendment to the U.S. Constitution provides that no person shall be deprived of liberty without due process of law. The U.S. Supreme Court struck down a Connecticut statute prohibiting the sale of contraceptives holding that couples had the personal liberty to have sexual intercourse for purposes other than procreation. Griswold, 381 U.S. (1965). It struck down a Virginia law prohibiting a person from marrying a person of a different race. Loving, 388 U.S. (1967). It recognized the right of a woman to be free from government interference in deciding matters as personal as whether to continue an unwanted pregnancy to term. Roe v. Wade, 410 U.S. (1973). It recognized that a person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment. Cruzan v. Missouri Dept. of Health, 497 U.S. (1990).

Nancy Cruzan suffered severe injuries in an automobile accident. For six years, she was in a persistent vegetative state and her doctors said she has no hope of improvement in her condition. Her parents requested that artificial nutrition and hydration be terminated, but the state hospital refused.

Justice Brennan said in his separate opinion,

“There are ... affirmative reasons why someone like Nancy might choose to forgo artificial nutrition and hydration under these circumstances. Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence. ‘In certain, thankfully rare, circumstances the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve.’ (Case reference omitted) [The Court found] the subject of the proceeding ‘in a condition which he has indicated he would

consider degrading and without human dignity' and holding that 'the duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity.'

Brennan continued, "Another court, hearing a similar case, noted:

'It is apparent from the testimony that what was on the patient's mind was not only the invasiveness of life-sustaining systems, such as the nasogastric tube, upon the integrity of his body. It was also the utter helplessness of the permanently comatose person, the wasting of a once strong body, and the submission of the most private bodily functions to the attention of others.' (citation omitted)

"Such conditions are, for many, humiliating to contemplate, as is visiting a prolonged and anguished vigil on one's parents, spouse and children. A long, drawn-out death can have a debilitating effect on family members. (citations omitted) For some the idea of being remembered in their persistent vegetative states rather than as they were before their illness or accident may be very disturbing"

Those quotations from Justice Brennan's opinion are on pages 310 – 312 of the Court's decision in the Cruzan Case.

Brennan shows a great deal of empathy for someone in Nancy Cruzan's situation. He would undoubtedly have the same empathy for someone who was just told by his doctor that his illness was terminal and that he had less than 6 months to live. Such a terminally ill person would be rightly apprehensive as to what lie ahead for him and what his options were. He might wish he had the option of physician aid in dying and a hastened death if the dying process became unbearable for him.

Brennan addressed the state's claimed interest in keeping Nancy Cruzan alive. He said:

"The only state interest asserted here is a general interest in the preservation of life. But the State has no legitimate general interest in someone's life, completely abstract from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment. 'The regulation of constitutionally protected decisions ... must be predicated on legitimate state concerns other than disagreement with the choice the individual has made ... Otherwise, the interest in liberty protected by the Due Process Clause would be a nullity.' (citation omitted)" At page 313.

Why shouldn't a terminally person be entitled to the same right to death with dignity that a person who can not live without life support? The U.S. Supreme Court in Glucksberg, 65 LW (1997) said that such a constitutional right does not exist. Whether you are 6 month away from death in one case or only being kept alive by

medical intervention in another case, an individual should have the freedom to choose his own time to end his life. The Court said it was up to the states to create a statutory right to physician aid in dying. The bill being considered by the Committee, the Wisconsin Death with Dignity Bill, creates such a right for the terminally ill.

. Opponents of the Wisconsin bill will use the terms "suicide" and "killing". The term "suicide" hardly seems appropriate to apply to a person who is already dying. A terminally person does not want to die, he wants to live. Unfortunately, this disease is responsible to his dying. What he wants to do is to relieve his suffering. The term "killing" is totally inappropriate since under the bill a doctor does not kill his patient. The patient is not required to use the doctor's medicine. The purpose of the bill is not to kill people but to give patients, who are terminally ill, the option of ending their suffering, if they choose to do so. In addition, opponents claim that minorities, the disabled and women will be put at risk by a new statutory right, even though it contains all of the safeguards contained in the Oregon Law. The experience under Oregon Death with Dignity Law over the last 10 years proves that such claim is unfounded.

In my view, Wisconsin must give meaning to the concepts of personal freedom and personal liberty. The bill is a permissible bill. It does not mandate that a person facing death must act in a particular way. It does not mandate that a person, who believes for religious reasons that it is wrong for a dying patient to hasten his death, use the provisions of the law. Such a person can simply wait to succumb to his disease however long that takes and whatever suffering he endures. The bill allows the dying a choice.

The bill gives all of us when our time comes the right to choose when to drop the curtain. The bill gives dying patients the right to choose to hasten their deaths so as to try to preserve the last vestiges of their dignity and humanity.



SB 151?  
Date?

Physician assisted suicide does a variety of things which are wholly undesirable:

- 1) At the level of the society, physician assisted suicide is a threat to both the doctor and the patient. Illness renders a patient very vulnerable. Physically, mentally, and emotionally, they are at their weakest. Likewise, the physician, by virtue of his knowledge and skill, is in a relative position of strength. The patient must necessarily leave his or herself open bodily and often disclose the most intimate details of their life. The physician is given this privilege for the sole purpose of helping the patient wrestle with disease. There is an inherent imbalance of power in a therapeutic relationship between a doctor and patient than can never be eliminated. It is intrinsic to the nature of illness and treatment. Western medical ethics long ago recognized this vulnerability and imbalance and created safeguards to deal with it. Physicians are prohibited from exploiting patients financially or sexually. They are required to keep all that is told to them in absolute confidence. Above all else, the physician is prohibited from ever intentionally harming the patient. These safeguards serve to protect the patient, create the trust necessary to form a therapeutic alliance, and lastly assure that the physician will serve only the patient's interest. Legislation promoting physician assisted suicide destroys this most important safeguard. By creating a right to assistance in self destruction, the doctor is now obligated to act in a manner contrary to the basic principle of medicine "*primum no nocere...first, do no harm.*" Worse still, he or she now has a duty required by law to participate in an enterprise which is morally bankrupt regardless of any invitation, namely assisting in the deliberate taking of an innocent human life.
  
- 2) Physician assisted suicide at the clinical level undermines the very essence of good medicine. Medicine always involves two distinct and equally important goals. The first of these is to maximize the health and well being of the patient. The second is to reduce or alleviate suffering caused by disease, and to provide comfort and human connection to those dealing with illness. The chronically ill or dying patient is often overwhelmed by fear, loss, and isolation. They suffer not only physical pain, but emotional anguish over their loss of independence and ability. Often family members, in the process of dealing with their own grief, withdraw from the patient. It is not surprising, therefore, that these patients frequently become depressed and suicidal. Good palliative care remedies this situation by this by maximizing pain control and improving day to day functioning, treating depression, and offering physical, spiritual and emotional support. It helps the patient work through the end of life process. Physician assisted suicide circumvents this dynamic. It affirms the patient's worst fears and offers no good solution to the problems facing the patient. Physician assisted suicide is not treatment; it is abandonment.

What are good goals for public policy regarding the care of those facing chronic or terminal illness?

The single greatest pressure on healthcare today is financial. As we seek to grapple with the staggering costs of healthcare, we need to avoid undermining the very ethical principles that promote good patient care. If we allow physician assisted suicide, we may find out that we have effectively limited our approach to the palliation of chronic illness. Unfortunately, it is cheaper to help a patient to die than to provide good end of life care. Physician assisted suicide could encourage a patient to die as a “duty” to his or her family, in the face of financial pressure. Likewise doctors could find their end of life care options curtailed by third party payers, or offered economic incentive to allow a suicide. As society ages, this could become a national tragedy. We need to fund good palliative care treatment practices. We need to insist as a society that our physicians are adequately trained in managing pain, and that palliative care be an ongoing part of medical education and research. Mechanisms to communicate desired treatment options (e.g., desire for or against life prolonging technology, cardiac resuscitation, etc.) continue to need refinement. Orders and instructions that can be updated as the patient’s condition changes need to be available in every setting, including home, nursing facility, or hospital. Lastly, we should affirm the traditional protections offered patients in western medical ethics. As the face of healthcare continues to change in Wisconsin and across the nation, no patient should fear that their physician would attempt to harm them under any circumstance, even if asked during a crisis of pain or fear.

What does good end of life care look like clinically?

The best practices in end of life care work to maximize the life of the patient. Instead of trying to determine if the patient’s life is so poor that it should be ended, good palliative care looks to understand how the patient’s life goals, comfort, and function can be improved. It always focuses on the whole person and the family. Early in a terminal illness, this may involve identifying things the patient wishes to accomplish before dying and facilitating those desires. Later as illness advances, the focus may increasingly shift to pain and symptom control, comfort measures, and emotional and spiritual support. Good end of life treatment plans do not necessarily attempt to prolong the dying process, but support the patient and their loved ones through the illness. While it is not uncommon for chronically ill patients to express fear, a sense of deep loss, loneliness, isolation, and a desire to die, good supportive care often alleviates these problems. Once the needs are addressed, the desire to end life prematurely usually subsides. A plea to die is really a cry for help. What is needed is support.

*On a personal note*

*In addition to being a physician and ethicist, I was also a son. My father died of chronic congestive heart failure, which claimed his life after 10 years with the disease. In his last months he spent much of his time in bed, on oxygen, and was able to walk only short distances. He experienced near miss events twice, including at least one full arrest requiring CPR. As I walked with him through that time, I saw how he faced his disease with strength and fortitude. His last act as my father was to receive downstairs to say goodbye and walk me to the front door, which required great effort. I learned from him that dying requires enormous courage, not only for yourself but those around you.*

*My mother faithfully cared for my dad through this time, and his death left her struggling with depression for her remaining 5 years. She experienced excruciating spinal fractures from brittle bones, and multiple surgeries for hip replacements. She was dependent on narcotics to get through each day. If her symptoms were bad, or her depression flared, she would become despondent. However, the family would rally behind her and once she received the support she needed, her sadness faded.*

*In 1993, she developed an acute bowel obstruction, and underwent surgery. Unfortunately, the stress of the illness and surgery proved too much. She developed multi-system organ failure a few days following her operation, which caused her lungs to fill with fluid, her kidneys to shut down, and her coagulation system to consume itself. I had been asked by her some years before to serve as her power of attorney should she become incapacitated, and I found myself faced with the terrible predicament of making decisions on her behalf.*

*She had always been clear that, in the event her chances of recovery were poor, life support on a ventilator was not an option. She had long experienced chronic pain, and hated the prospect of extended nursing care. If there was a strong likelihood that a survival could be obtained only with an extended disability, she wanted no part of it. After looking over her medical chart and talking with her physicians, we agreed to a care plan that did not include further ICU treatment. She died three days later.*

*While I respected my mother's decisions to avoid ICU treatment at the end of life, at no time would I have offered to harm my mother. While she often wished for suffering in this life to end, she never attempted to harm herself or asked for our assistance to do so. In part, I think because she got the help she needed it never came to that (at least not for long, anyway). I believe also that she loved us enough to never ask us to do such a thing.*

*Suffering, illness, and death are hard things. I believe you make them better by standing with people through them. If you don't give up on them, they won't give up. I think that's what death with dignity really means.*



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WISCONSINRIGHTTOLIFE

Date?

Testimony of Susan Armacost  
Legislative Director  
~~Wisconsin Right to Life~~

~~in opposition to SB 151~~

before the Senate Committee on Public Health,  
Long Term Care and Privacy



WISCONSINRIGHTTOLIFE

Wisconsin Right to Life urges you to oppose SB 151. This extremely onerous legislation would legalize the killing of vulnerable patients by allowing their physicians to prescribe lethal doses of drugs so the patients can kill themselves.

Wisconsin Right to Life is in the forefront on both the state and national levels in opposing measures that would legalize physician assisted suicide and euthanasia and in assisting other states facing such legislation.

Wisconsin Right to Life and Christian Life Resources founded the Nightingale Alliance and maintain a website devoted entirely to the issues of assisted suicide and euthanasia. The Nightingale Alliance is a worldwide information resource on these topics and can be accessed at [NightingaleAlliance.org](http://NightingaleAlliance.org). We urge you to visit this excellent website.

We must guard against those 'choices' which victimize the vulnerable, ourselves, and society as a whole. We must minister compassionately to those who suffer from pain and those who fear death. Doctors should heal, not kill. We must maintain the healing tradition of medicine.

Supporters of assisted suicide and euthanasia argue that the right of a competent patient to make medical treatment decisions should include the right to request and receive euthanasia or to be assisted with suicide. There are dangers, however, even when patients are allowed to "freely" request assisted suicide or euthanasia.

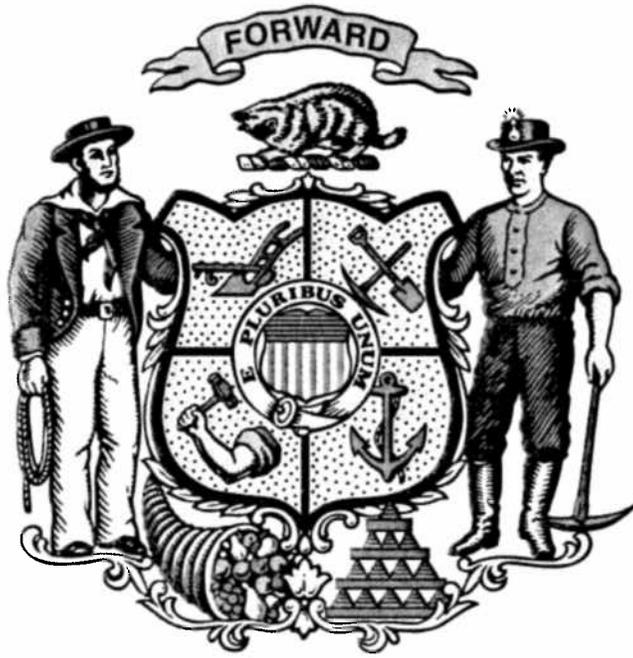


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Some of these dangers are:

- Patients are misdiagnosed and could make an irreversible decision to die based on the wrong information.
- A government-ordered study in the Netherlands found that 65% of family physicians are of the opinion that a doctor may offer the choice of euthanasia to a patient who has not asked for it.
- Because patients are strongly influenced by doctors, a vulnerable patient may feel there is no other alternative if his or her doctor recommends death.
- Who can confirm that the euthanasia or suicide choice was freely made when the only witness is dead?
- Patients with terminal or serious illnesses change their minds. When they don't feel well, they may want to die. When feeling better, they want to live.
- Patients suffering from depression may request death, not knowing that their quality of life can be improved with proper treatment.
- If society endorses assisted suicide and euthanasia, it will "teach" the weak and frail that they have a "duty" to die.
- The collapse of support systems will lead patients to believe they have no other choice but death.
- Although some believe assisted suicide and euthanasia are needed to relieve pain, modern pain control techniques eliminate this reason.

Wisconsin Right to Life urges you to oppose SB 151. Thank you.



SB 151?  
Date?

Dear Committee Members,

Frankly, I was a bit surprised to see this issue alive and well in Wisconsin. While I am not a medical professional, I do have some strong feelings about this issue. I will touch on my personal feelings as Ms. Coleman is more comprehensive in her paper on this issue.

I am not as familiar with this issue as I once was, when Dr. Kevorkian was running rampant; but the issue is still much the same. The bill has the potential to open some doors that are best left closed. Once the idea of assisting someone to kill themselves becomes "OK" it becomes much easier to broaden it out. Why were his victims predominately people with disabilities?

"Death with dignity" Looking at that phrase by itself is a bit scary; it can mean a lot of different things to a lot of people.

Assisted suicide is supposedly about terminal illness, as I believe this bill is supposed to address. However, who defines dignity? Is it the ability to die quietly - surrounded by your loved ones in the comfort of your own home?

It would seem that this is what dignity means for purposes of this legislation - what about life with dignity? The person with a disability who has struggled to stay in their own home, and then became sick because of inadequate resources and supports is now checked into a nursing home and sitting in a hallway with 30 other half dressed people who are facing the same "dignified" life style.

But, now that this person has become terminally ill, suddenly they are allowed to be dignified again? But only in their death, not their life. I mentioned this because I believe that this bill calls for 3 witnesses to the death request. However, in a facility, there need be only 1 witness. Is that because we find it so much easier to believe that a person doomed to a facility would request death as a preferable alternative to life in that situation? So much so we need only one witness to believe it? If we believe this, which many of us do- is it such a leap in logic to realization that we will be able to eliminate half the population in our nursing facilities? After all, that is what we hear now "People in nursing facilities are no longer a capable of living in the community" Although personally, I don't believe it.

I realize that everyone says that there are safe guards in place, and this will not happen here, Doctor's know what they are doing, etc. It is the last one that scares me. After my injury my mother was told that I was terminal and for a while there if I had a chance to take your magic little pill, I may very well have. I am here today and can readily say that I am glad I did not have that chance. Some would say I do more with my "so called" limitation than many people with out disabilities are able to accomplish.

The legislation says that those requesting death must be informed of other options such as hospice, adequate pain relief etc. Adequate pain relief is an issue our culture has yet to come to terms with. Each of the legislators here should check in to see what the availability of hospice is in their respective districts. Lastly, as the managed care freight train comes directly towards the people with disabilities and seniors in this state I encourage you to make sure that not only are people informed of other options, but they are actually able to receive these options. As with everything in life, there is no magic bullet, nor is there a magic pill.

Steve Vanden



Good morning! I am appearing here today in support of Senate Bill 151. While I agree with the arguments that have been made in support of this bill, I won't bore you by repeating them. The reason that I have asked to speak at this hearing is to address one of the arguments that I have heard people make who are opposed to any legislation that would allow individuals to request medication for the purpose of hastening their death. Some people make the argument that: There would be no need for patients to hasten their deaths if patients are given adequate pain medication and if the delivery of other palliative care measures is improved. These people argue that state government should be focusing on improving palliative care for terminally ill patients instead of enacting death with dignity legislation, like Senate Bill 151. Although I agree that palliative care for terminally ill patients is important and needs to be continually improved, I know from sad personal experience that the best that palliative care has to offer is sometimes not good enough.

My husband died of esophageal cancer nearly two years ago. Shortly after he was first diagnosed, he underwent chemotherapy, radiation therapy and surgery to shrink and remove the tumor on his esophagus. As he was recovering from his surgery, his doctors and I soon realized that he was hypersensitive to the side effects of narcotic pain medications. He had terrifying hallucinations, extreme restlessness and anxiety attacks. He pulled out a drainage tube and IVs that had been inserted following the surgery. His doctors tried several different opiate pain killers, but they were never able to find one that worked well for him. His doctors finally used a spinal block to relieve his pain while he recovered from the surgery. Within a few years, however, the cancer reappeared in my husband's neck and lungs. In the last 7 months of his life, the tumor in his neck caused him ever increasing pain. The tumor in my husband's neck was too high on his spine for a spinal block to be used. His doctors tried to relieve his pain by once again prescribing various opiate pain medications and other medications to try to counteract the opiate's side effects, but the opiates never gave him much pain relief and as the doctors increased the dosage of the opiates in an unsuccessful attempt to relieve his pain, the side effects became horrible. The frightening hallucinations, the restlessness and the anxiety attacks returned and continued for months. In spite of his doctors' best efforts, my husband suffered a great deal in the last few months of his life. I believe strongly that he should have had the option to legally hasten his death. Simply seeking to improve palliative care is not the solution for all terminally ill patients. Medical science has its limits and I believe that patients should be allowed to make the decision to hasten their death if they find that their suffering can not be relieved by other means as death approaches.

Thank you for giving me the opportunity to present my views to your committee.



Date ?

As I was reading the analysis of SB-151 from the Legislative Reference Bureau and the bill itself, I was struck by several thoughts. Thank you for allowing me to share these thoughts.

I was struck by the extent at which legislators need to go to change the status of suicide: to legitimize it and make it legal. The bill declares about the terminally ill, "I will accept full moral responsibility," thus recognizing the moral (that is to say the right or wrongness of something) implications of this change. Any normal individual, in their right mind, understands the discussion of this act as suicide. Without this bill, it would still be suicide, a criminal and morally reprehensible act.

Logically, I found some difficulties with this proposal to change and legalizing suicide (And no matter how we try to cleanse and legitimize the term suicide, we must call it for what it is).

If a perfectly healthy individual were to request drugs, proceed to take them, in an attempt to end his or her life, what would we do as a society? They would be locked up in a mental ward of a hospital to discover what mental health condition they suffer. Certainly, an individual who is distressed because of their physical condition, (just mention the word cancer and notice one's reaction), is in no better mental health to request his or her death. How could a psychologist declare the one mentally ill and the other "in their right mind?"

Another question of logic about the change of the status of suicide revolves around the persons *desire* to take his or her own life. Just because I *desire* something, does not make it right! If a man *desires* more money than he has and robs a bank, should we change the laws about robbery to make legitimize it and make it legal? We are walking on a slippery slope. I believe that our society has been doing this for many years, especially since Roe vs. Wade realistically changed the killing of a baby, into the discarding of a little blob of flesh. Do we have a foundation upon which to base our walk down this path other than the desire and feelings of an individual?

Biblically, I am appalled by the attempt to change, thus legitimizing suicide. Man is created in the image of God, Genesis 1:27, "So God created man in his own image, in the image of God created he him; male and female created he them." The taking of a life is to be left in the hands of our Sovereign God. In Job 1:21 we read, "And said, Naked came I out of my mother's womb, and naked shall I return thither: the LORD gave, and the LORD hath taken away; blessed be the name of the LORD."

What is a terminal illness? Scripture and experience tell us that we all suffer a terminal illness. "Wherefore, as by one man sin entered into the world, and death by sin; and so death passed upon all men, for that all have sinned: (Romans 5:12)." You and I have never met anyone who has not or will not die. We are all terminal! When will the definition of terminal illness be redefined so that anyone might seek to end his or her life? In other states, this type of problem already exists within the medical marijuana debate. What illness is sufficient to receive the treatment? A headache?

Of course the Scriptures declare: "Thou shalt not kill" (Exodus 20:13). I will not spend any time here, since assisted suicide obviously makes the doctor an accessory to murder at the very least.

The bill also makes the proclamation that this decision to commit suicide must be and "informed decision." Only five items are mentioned as to what the person desiring suicide must be informed. That doesn't sound very informative for such a permanent decision. And as a pastor, I make just a few more suggestions. Does the person have an understanding of what happens at death? Except one raise from the dead and be a witness to the after life, they could not inform the person desiring suicide. Yes! Jesus did just that! He arose from the dead and in his very own words describes what happens to an individual after death. Please read Luke 16:19-31.

Should a clergy member be involved with these decisions, so that an informed decision can be made?

Practically, there are some difficulties regarding this change regarding assisted suicide. Doctors would be forced to disregard non maleficence (first do no harm) for their patient. Second, certainly the doctor is prohibited from further ministering for the beneficence of the patient. This bill would also drive doctors from our state in fear of prosecution for not obeying this mandate placed upon them.

"Putting out of their misery" is a term we use for animals (and I'm sure that PETA would not approve), not for man, who is created in the image of God. Hell (in the words of Jesus) is much more miserable than any pain and suffering on earth.

Let me end with a personal story. My father in law fought with MS for over 30 years of his life. I can't tell you how many people I have met that were encouraged by his struggle with this disease. Please don't allow someone to take away the value of a suffering individual by declaring their life would be better ended.

*Respectfully Submitted*  
*Mike Murphy*



Open letter to Wisconsin Right to Life Legislative Director

SB 151 ?  
Date ?

Dear Susan Armacost:

Your statements opposing Sen. Fred Risser's and Rep. Frank Boyle's "Death with Dignity" bill indicate you did not research how the law has been implemented in Oregon. As the executive director of the statewide organization that has stewarded more than 1000 qualified, terminally ill Oregonians through the safeguards and guidelines of our law please allow me to address your specific concerns.

Not one person who qualified to use the law requested to use it because they believed they had a "duty to die." All of them had a "will to live" as long as possible. The average length of time from when these individuals contact us to their death by the lethal medication is 116 days; this can hardly be considered rushing to die after having received a six month prognosis.

Of the more than 1000 Oregonians our organization has been honored to serve and who began the process to use our law, only 250 actually took the medication that ended their suffering. Not one of them consumed the medication out of depression or a duty to end their life.

More than 84% of those who took the medication were enrolled in hospice care at their death. This refutes your claim that they are not receiving the best care. More than 95% had secondary education or higher, in fact 70% had a college degree or higher. The top three reasons they gave for taking the medication was loss of autonomy, fear of loss of control and dependence on others for care. Everyone who has taken the 5-6 ounce lethal mixture has died peacefully, with family or friends present, and at peace with their decision. These facts alone refute your claim that these are weak and frail people. They are among the bravest, strongest willed, deeply spiritual people I have ever met.

Of the more than 1000 Oregonians we have worked with, more than 900 self identified as being religious or spiritual, 434 acknowledged as voting Republican and 439 as voting Democrat, 98% had health insurance, 538 were males, and the ages ranged from 20 to 109 with the average age of 69. These are fiercely independent people who do not choose this method because they do not wish to live, they choose it because they know their death is imminent and they wish to face it on their terms with dignity and grace.

Today's accepted Hippocratic oath states a physician will *practice and prescribe to the best of my ability for the good of my patients, and to try to avoid harming them and never to do deliberate harm to anyone for anyone else's interest.* Those physicians who prescribe medication for their terminally ill and suffering patients are doing so "for the good of their patients" and if they allow them to continue to suffer they believe it would be doing harm to them.

A law that allows one to die with dignity brings hope to all. If one is terminally ill, has 2 physicians say they will likely die within six months from their illness and the person goes through the waiting period, makes the required 3 requests for assistance, is mentally competent and is able to self administer the medication, then they are given the strength to face death with the knowledge that there is a safety net for them if the suffering becomes unbearable. Please let others have this choice, even if you do not wish to exercise it.

Please check your facts before you speak for those of us who have the "will to live" life to its fullest, but want the right to die with dignity when our death is near.

Sincerely,

*George Eghmey*

Executive Director

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*Compassion*, through its network of professional volunteers, offers consultation about all end-of-life options to terminally ill, adult Oregonians and their families. We provide free consultation on pain and symptom management, hospice care, and for mentally competent adults who make an enduring and voluntary request, we provide information about hastening death to avoid further suffering.

SB 151 ?  
Date ?

## **Summary of Physician-Assisted Suicide Proposal Introduced by Rep. Frank Boyle & Senator Fred Risser**

### **Individual requesting physician-assisted aid in dying must be:**

- At least 18 years of age.
- Resident of Wisconsin.
- Suffering from a terminal disease (defined as an incurable and irreversible disease that will cause death within six months), confirmed by two doctors.
- Of sound mind & not incapacitated.

### **Procedure for request to physician:**

- First request must be made orally.
- Not fewer than 15 days later, the patient must again make the request in writing, signed in the presence of 3 qualified witnesses.
- If the patient is in a health care facility, at least one of the witnesses must be a patients' advocate designated by the Board on Aging and Long-Term Care.
- After request is filed, patient must make a second oral request.

### **Witnesses must be at least 18 years of age and cannot be any of the following:**

- Related to the patient by blood, marriage or adoption.
- An individual who has knowledge that he or she is entitled to or has a claim on any portion of the requester's estate.
- Directly financially responsible for the requester's health care.
- An individual who is a health care provider who is serving the patient at the time of the witnessing; an employee, other than a chaplain or a social worker, of a health care facility in which the requester is a patient.

### **The physician must:**

- Inform the patient of his or her diagnosis & prognosis.
- Inform the patient of the probable results of taking the prescribed medication and alternatives to doing so.
- Refer the patient to a consulting physician for review.
- Refer the patient to a psychiatrist or psychologist for review, if that person is suffering from a psychiatric or psychological disorder.
- Certify that the statutory requirements have been met.
- Ask the patient to inform his or her next of kin about the request.
- Offer the opportunity for the patient to revoke the request.



## NINE YEARS OF ASSISTED SUICIDE IN OREGON

SB151?

*Under Oregon's law permitting physician-assisted suicide, the Oregon Department of Human Services (DHS) – previously called the Oregon Health Division (OHD) – is required to collect information, review a sample of cases and publish a yearly statistical report.<sup>1</sup> Since the law, called the "Death with Dignity Act," went into effect in 1997, nine official reports have been published. However, due to major flaws in the law and the state's reporting system, there is no way to know for sure how many or under what circumstances patients have died from physician assisted suicide.*

*Statements made by individuals who have been involved in assisted suicide in Oregon – those who implement it, compile official reports about it, or prescribe the lethal drugs – clearly show that the law's "safeguards" are not protective and that effective monitoring is close to non-existent.<sup>2</sup>*

*Members of a British House of Lords Committee traveled to Oregon seeking information regarding Oregon's assisted-suicide law for use in their deliberations about a similar proposal that was under consideration in Parliament.<sup>3</sup> The public and press were not present during the closed-door hearings. However, the House of Lords published the committee's proceedings in three lengthy volumes, which included the exact wording of questions and answers.*

*Statements from portions of the 744-page second volume of those proceedings are included in this fact sheet. None of those included statements were made by opponents of Oregon's law.*

### Assisted-suicide deaths reported during the first nine years

Official Reports: 292

Actual number: Unknown

The latest annual report indicates that reported assisted-suicide deaths have increased by more than 287% since the first year of legal assisted suicide in Oregon.<sup>4</sup> The numbers, however, could be far greater. From the time the law went into effect, Oregon officials in charge of formulating annual reports have conceded "there's no way to know if additional deaths went unreported" because Oregon DHS "has no regulatory authority or resources to ensure compliance with the law."<sup>5</sup>

The DHS has to rely on the word of doctors who prescribe the lethal drugs.<sup>6</sup> Referring to physicians' reports, the reporting division admitted: "For that matter the entire account [received from a prescribing doctor] could have been a cock-and-bull story. We assume, however, that physicians were their usual careful and accurate selves."<sup>7</sup>

*The Death with Dignity law contains no penalties for doctors who do not report prescribing lethal doses for the purpose of suicide.*

### Complications occurring during assisted suicide

Official Reports: 17 (16 instances of vomiting & 1 patient who did not die from the lethal dose)

Actual number: Unknown

Prescribing doctors may not know about all complications since, over the course of nine years, physicians who prescribed the lethal drugs for assisted suicide were present at only 21.5% of reported deaths.<sup>8</sup> Information they provide might come from secondhand accounts of those present at the deaths<sup>9</sup> or may be based on guesswork.

When asked if there is any systematic way of finding out and recording complications, Dr. Katrina Hedberg who was a lead author of most of Oregon's official reports said, "Not other than asking physicians."<sup>10</sup> She acknowledged that, "after they write the prescription, the physician may not keep track of the patient."<sup>11</sup> Dr. Melvin Kohn, a lead author of the eighth annual report, noted that, in every case that they hear about, "it is the self-report, if you will, of the physician involved."<sup>12</sup>

### Complications contained in news reports are not included in official reports

- ◆ Patrick Matheny received his lethal prescription from Oregon Health Science University via Federal Express. He had difficulty when he tried to take the drugs four months later. His brother-in-law, Joe Hayes, said he had to "help" Matheny die. According to Hayes, "It doesn't go smoothly for everyone. For Pat it was a huge problem. It would have not worked without help."<sup>13</sup>

Referring to the Matheny case, Dr. Hedberg said that "we do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted..."<sup>14</sup> The annual report did not take note of this situation.

- ◆ Speaking at Portland Community College, pro-assisted-suicide attorney Cynthia Barrett described a botched assisted suicide. "The man was at home. There was no doctor there," she said. "After he took it [the lethal dose], he began to have some physical symptoms. The symptoms were hard for his wife to handle. Well, she called 911. The guy ended up being taken by 911 to a local Portland hospital. Revived. In the middle of it. And taken to a local nursing facility. I don't know if he went back home. He died shortly – some....period of time after that..."<sup>15</sup>

Overdoses of barbiturates are known to cause vomiting as a person begins to lose consciousness. The patient then inhales the vomit. In other cases, panic, feelings of terror and assaultive behavior can occur from the drug-induced confusion.<sup>16</sup> But Barrett would not say exactly which symptoms had taken place in this instance. She has refused any further discussion of the case.

### Complications are not investigated

- ◆ David Prueitt took the prescribed lethal dose in the presence of his family and members of Compassion & Choices. [Note: In early 2005, Compassion in Dying (CID) merged with the Hemlock Society. The combined organization is now called

Compassion & Choices (C & C).] After being unconscious for 65 hours, he awoke. It was only after his family told the media about the botched assisted suicide that C & C publicly acknowledged the case.<sup>17</sup> DHS issued a release saying it "has no authority to investigate individual Death with Dignity cases."<sup>18</sup>

- ♦ Referring to DHS's ability to look into complications, Dr. Hedberg explained that "we are not given the resources to investigate" and "not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."<sup>19</sup>
- ♦ David Hopkins, Data Analyst for the Eighth Annual Report said, "We do not report to the Board of Medical Examiners if complications occur; no, it is not required by law and it is not part of our duty."<sup>20</sup>

*In the Netherlands, assisted-suicide complications and problems are not uncommon. One Dutch study found that, because of problems or complications, doctors in the Netherlands felt compelled to intervene (by giving a lethal injection) in 18% of cases.<sup>21</sup> This led Dr. Sherwin Nuland of Yale University of Medicine to question the credibility of Oregon's lack of reported complications. Nuland, who favors physician-assisted suicide, noted that the Dutch have had years of practice to learn ways to overcome complications, yet complications are still reported. "The Dutch findings seem more credible [than the Oregon reports]," he wrote.<sup>22</sup>*

*Similarly, a member of the British Parliament questioned the lack of reported complications associated with assisted suicide in Oregon. After hearing witnesses from Oregon claim that there had been no complications (other than "regurgitation") associated with more than 200 assisted-suicide deaths, Lord McColl of Dulwich, a surgeon, questioned that assertion. He said that, in his practice as a physician, "If any surgeon or physician had told me that he did 200 procedures without any complications, I knew he possibly needed counseling and had no insight. **We come here and I am told there are no complications. There is something strange going on.**"<sup>23</sup>*

### **Assisted-suicide deaths of patients with dementia**

Official Reports: 0 (Official reports do not contain this category.)

Actual number: **Unknown**

- ♦ Kate Cheney, 85, died of assisted suicide under Oregon's law even though she reportedly was suffering from early dementia. Her own physician declined to provide the lethal prescription. When counseling to determine her capacity was sought, a psychiatrist determined that she was not eligible for assisted suicide since she was not explicitly seeking it, and her daughter seemed to be coaching her to do so. She was then taken to a psychologist who determined that she was competent but possibly under the influence of her daughter who was "somewhat coercive." Finally, a managed care ethicist who was overseeing her case determined that she was qualified for assisted suicide and the drugs were prescribed.<sup>24</sup>
- ♦ Even if a patient is competent when the prescription is written, that may not be the case when the lethal drugs are taken. Dr. Hedberg acknowledged that there is no assessment of patients after the prescribing is completed. "Our job is to make sure

that all the steps happened *up to the point the prescription was written.*"<sup>25</sup> she said. "In fact, after they write the prescription, the physician may not keep track of that patient....[T]he law itself only provides for writing the prescription, *not what happens afterwards.*"<sup>26</sup>

### **Assisted-suicide deaths of depressed patients**

Official Reports: 0 (Official reports do not contain this category.)

**Actual number: Unknown**

- ♦ The first known assisted-suicide death under the Oregon law was that of a woman in her mid-eighties who had been battling breast cancer for twenty-two years. Two doctors, including her own physician who believed that her request was due to depression, refused to prescribe the lethal drugs. Then Compassion in Dying (CID), now called Compassion and Choices, became involved. Dr. Peter Goodwin, medical director of CID,<sup>27</sup> determined that she was an "appropriate candidate" for death and referred her to a doctor who provided the lethal prescription. In an audiotape, made two days before her death and played at a CID press conference, the woman said, "I will be relieved of all the stress I have."<sup>28</sup>
- ♦ In 2001, Dr. Peter Reagan, an assisted-suicide advocate affiliated with CID, gave Michael Freeland a prescription for lethal drugs under Oregon's law. Freeland, 64, had a 43-year history of acute depression and suicide attempts. However, when Freeland and his daughter went to see Dr. Reagan about arranging a legal assisted suicide, Reagan said he didn't think that a psychiatric consultation was "necessary."<sup>29</sup>

Under the assisted-suicide law, depressed or mentally ill patients can receive assisted suicide if they do not have "impaired judgment."<sup>30</sup> Concerning the decision to refer for a psychological evaluation, Dr. Kohn said, "According to the law, it's up to the docs' discretion."<sup>31</sup> During the last year for which reports are available, only 4% of patients were referred for a psychological evaluation or counseling before receiving a prescription for assisted suicide.<sup>32</sup>

### **Assisted-suicide requests based on financial concerns**

Official Reports: 7

**Actual number: Unknown**

Data about reasons for requests is based on prescribing doctors' understanding of patients' motivations. It is possible that financial concerns were much greater than reported. According to official reports, 36% of patients whose deaths have been reported since the law went into effect were on Medicare (for senior citizens) or Medicaid (for the poor) and an additional 1% had no insurance.<sup>33</sup> However, after the second annual report, the reports have not differentiated between Medicare and Medicaid patients dying from assisted suicide. Oregon's Medicaid program pays for assisted suicide<sup>34</sup> but not for many other medical interventions that patients need and want.

According to a December 2006 report, Oregon's Medicaid program has eliminated much of its available treatments. Fewer people are covered and enrollment has dropped by 17

percent.<sup>35</sup> When the program began, 745 possible treatments were listed in order of priority. Based on budgetary constraints, the state makes a determination of a cut-off line on the priority list. Treatments below the cut-off line are not provided. However, physician-assisted suicide is high on the priority list. (It is ranked 262 and falls under the category of "comfort care."<sup>36</sup>) It could become the only "treatment" some people can afford.

### **Patients who received lethal dose more than 6 months before death**

Official Reports: 2 or 4 (After the 2<sup>nd</sup> year, official reports stopped including this category.)

**Actual number: Unknown**

Lethal prescriptions under the Oregon law are supposed to be limited to patients who have a life expectancy of six months or less.<sup>37</sup>

- ◆ However, one patient was still alive 17 months after the lethal drugs were prescribed,<sup>38</sup> and, during the first two years of the law's implementation, at least one lethal dose was prescribed more than eight months before the patient took it.<sup>39</sup> The DHS is not authorized to investigate how physicians determine their patients' diagnoses or life expectancies.<sup>40</sup>
- ◆ According to the Oregon Medical Association's Chief Operating Officer, Jim Kronenberg, most physicians have told him that trying to predict that a patient has less than six months to live "is a stretch." "Two hours, a day, yes, but six months is difficult to do," he explained.<sup>41</sup>
- ◆ Dr. Peter Rasmussen, an advisory board member of the Oregon chapter of C & C,<sup>42</sup> has been involved in Oregon assisted-suicide deaths numbering into double digits. He said life expectancy predictions for a person entering the final phase of life are inaccurate. He dismissed this as unimportant, saying, "Admittedly, we are inaccurate in prognosticating the time of death under those circumstances, *we can easily be 100 percent off, but I do not think that is a problem.* If we say a patient has six months to live and we are off by 100 percent and it is really three months or even twelve months, I do not think the patient is harmed in any way...."<sup>43</sup>

### **Shortest length of time reported for prescribing doctor-patient relationship**

Official Reports: Less than one week

**Actual number: Unknown**

Oregon's assisted-suicide law requires that at least two weeks elapse between the patient's first and last requests for lethal drugs.<sup>44</sup> Nonetheless, for the third through the ninth years, the doctor-patient relationship in some reported assisted-suicide cases was under one week.<sup>45</sup> Thus, official reports indicate that either some physicians are not complying with the two-week requirement or they step in to write an assisted-suicide prescription after other physicians refused.

Dr. Hedberg stated that there have been a number of cases over the years in which guidelines were not followed, including cases where doctors prescribed the lethal drugs without waiting for fifteen days as the law requires.<sup>46</sup>

### **First physician asked agreed to write prescription**

Official Reports: 27 (41%) in the first three years (After the 3rd year, official reports stopped including this category.)

**Actual number: Unknown**

"Many patients who sought assistance with suicide had to ask more than one physician for a prescription for lethal medication."<sup>47</sup> Patients or their families can "doctor shop" until a willing physician is found. There is no way to know, however, why the previous physicians refused to lethally prescribe (i.e., the patient was not terminally ill, had impaired judgment, etc.) since non-prescribing physicians are not interviewed for the official state reports. The only physicians interviewed for official reports are those who actually wrote lethal drug prescriptions for patients.<sup>48</sup>

*The unwillingness of many physicians to write lethal prescriptions led one HMO to issue a plea for physicians to facilitate assisted suicide and has also resulted in an assisted-suicide advocacy organization's involvement in most assisted-suicides cases.*

### **HMO's efforts to facilitate assisted suicide**

On August 6, 2002, Administrator Robert Richardson, MD, of Oregon's Kaiser Permanente sent an e-mail to doctors affiliated with Kaiser, asking doctors to contact him if they were willing to act as the "attending physician" for patients requesting assisted suicide. According to the message, the HMO needed more willing physicians because, "Recently our ethics service had a situation where no attending MD could be found to assist an eligible member in implementing the law for three weeks...."<sup>49</sup>

Gregory Hamilton, MD, a Portland psychiatrist pointed out that the Kaiser message caused concern for several reasons. "This is what we've been worried about: Assisted suicide would be administered through HMOs and by organizations with a financial stake in providing the cheapest care possible," he said. Furthermore, despite promoters' claims that assisted suicide would be strictly between patients and their long time, trusted doctors, the overt recruitment of physicians to prescribe the lethal drugs indicated that those claims were not accurate. Instead, "if someone wants assisted suicide, they go to an assisted-suicide doctor – not their regular doctor."<sup>50</sup>

Kaiser's Northwest Regional Medical Director Allan Weiland, MD, called Hamilton's comments "ludicrous and insulting."<sup>51</sup> However, it appears that Hamilton was correct, as the involvement of an assisted-suicide advocacy group indicates.

### **Assisted-suicide advocacy group involved in majority of assisted-suicide deaths**

If a physician opposes assisted suicide or believes the patient does not qualify under the law, C & C or its predecessor organizations has often arranged the death. According to Dr. Peter Goodwin, the group's former medical director, about 75% of those who died using Oregon's assisted-suicide law through the end of 2002 did so with the organization's assistance.<sup>52</sup> During the 2003 calendar year, it was involved in 79% of such deaths.<sup>53</sup> According to Dr. Elizabeth Goy of Oregon Health Science University, the assisted-suicide advocacy organization sees "almost 90% of requesting Oregonians."<sup>54</sup>

.....

## **OTHER TROUBLING ASPECTS OF ASSISTED SUICIDE IN OREGON**

### **No family notification required before a doctor helps a loved one commit suicide**

Family notification is only recommended, but not required, under Oregon's assisted-suicide law.<sup>55</sup> The first time that a family learns that a loved one was considering suicide could be after the death has occurred.

### **Prescribing doctors decide what "residency" means**

Under Oregon's law, a patient must be a resident of Oregon. Residence can be demonstrated by means that include, but are not limited to, a driver's license or a voter registration.<sup>56</sup> According to Dr. Hedberg, "It is up to the doctor to decide" whether the person is a resident. There is no time element during which one must have lived in Oregon. "If somebody really wanted to participate, they could move from their home state," she said. "I do not think it happens *very much*..."<sup>57</sup>

### **Pain control has become increasingly inadequate in Oregon**

As of 2004, nurses reported that the inadequacy of meeting patients' pain needs had increased "up to 50 percent even though the emphasis on pain management has remained the same or is slightly more vigorous...Most of the small hospitals in the state do not have pain consultation teams at all," said Sue Davidson of the Oregon Nurses Association.<sup>58</sup>

.....

*As other states and countries consider Oregon-type laws, it remains to be seen whether decision-makers will rely on the deceptively rosy picture painted by assisted-suicide supporters -- or on the reality of the Oregon experience.*

Endnotes:

- <sup>1</sup> ORS 127.865 §3.11.
- <sup>2</sup> See: "The Oregon Experience" at: <http://www.internationaltaskforce.org/orexp.htm>.
- <sup>3</sup> On May 12, 2006, the British proposal was defeated in the House of Lords by a vote of 148-100.
- <sup>4</sup> DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, "Prescription History." (<http://www.oregon.gov/DHS/ph/pas/docs/prescriptionhistory.pdf>)
- <sup>5</sup> Linda Prager, "Details emerge on Oregon's first assisted suicides," *American Medical News*, Sept. 7, 1998.
- <sup>6</sup> Joe Rojas-Burke, "Suicide critics say lack of problems in Oregon is odd," *Oregonian*, Feb. 24, 2000.
- <sup>7</sup> Oregon Health Division, *CD Summary*, vol. 48, no. 6 (March 16, 1999), p. 2. (<http://www.ohd.hr.state.or.us/chs/pas/pascdsm2.htm>)
- <sup>8</sup> DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, Table I. (<http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf>) The annual report states that the presence of the attending physician in 63 out of 292 reported deaths is 29%, however the calculation is mathematically inaccurate. The correct calculation is 21.5%.
- <sup>9</sup> DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, "Methods." (<http://www.oregon.gov/DHS/ph/pas/docs/Methods.pdf>)
- <sup>10</sup> Testimony of Dr. Katrina Hedberg before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence*, Apr. 4, 2005, p. 263, question 597. (Hereafter referred to as *HL*.) Available at: <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf>. (Last accessed Apr. 23, 2007.)
- <sup>11</sup> *Ibid.*, p. 259, question 567.
- <sup>12</sup> Testimony of Dr. Melvin Kohn, *HL*, p. 263, question 598.
- <sup>13</sup> Erin Hoover, "Dilemma of assisted suicide: When?" *Oregonian*, January 17, 1999 and Erin Hoover, "Man with ALS makes up his mind to die," *Oregonian*, March 11, 1999.
- <sup>14</sup> Testimony of Dr. Katrina Hedberg, *HL*, p. 267, question 621.
- <sup>15</sup> Audio tape on file with author. Also see Catherine Hamilton, "The Oregon Report: What's Hiding behind the Numbers?" *Brainstorm*, March 2000 (<http://www.brainstormnw.com>); David Reinhard, "The pills don't kill: The case, First of two parts," *Oregonian*, March 23, 2000 and David Reinhard, "The pills don't kill: The cover-up, Second of two parts," *Oregonian*, March 26, 2000.
- <sup>16</sup> Johanna H. Groenewoud *et al*, "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands," *342 New England Journal of Medicine* (Feb. 24, 2000), pp. 553-555.
- <sup>17</sup> Associated Press, "Assisted suicide attempt fails," March 4, 2005.
- <sup>18</sup> DHS news release, "No authority to investigate Death with Dignity case, DHS says," March 4, 2005.
- <sup>19</sup> Testimony of Dr. Katrina Hedberg, *HL*, p. 266, question 615.
- <sup>20</sup> Testimony of David Hopkins, *HL*, p. 259-260, question 568.
- <sup>21</sup> *Supra* note 16.
- <sup>22</sup> Sherwin Nuland, "Physician-Assisted Suicide and Euthanasia in Practice," *342 New England Journal of Medicine* (February 24, 2000), pp. 583-584.
- <sup>23</sup> Remarks by Lord McColl of Dulwich, a member of the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *HL*, p. 334, question 956. (Emphasis added)
- <sup>24</sup> Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.
- <sup>25</sup> Testimony of Dr. Katrina Hedberg, *HL*, p. 259, question 566. (Emphasis added.)
- <sup>26</sup> *Ibid.*, p. 259, question 567. (Emphasis added.)
- <sup>27</sup> Dr. Peter Goodwin was an Associate Professor (now professor emeritus) in the Department of Family Medicine at the Oregon Health Science University in Portland, Oregon and was Chair of Oregon Right to Die during the campaign to pass Oregon's assisted-suicide law. He had been active in the Hemlock Society. Speaking at a 1993 Hemlock conference in Orlando, Florida, he explained that he favored both the lethal injection and assisted suicide, but he realized that most people were not yet ready to accept the former so incremental steps would need to be taken.

- <sup>28</sup> Erin Hoover and Gail Hill, "Two die using suicide law; Woman on tape says she looks forward to relief," *Oregonian*, March 26, 1998; Kim Murphy, "Death Called 1<sup>st</sup> under Oregon's New Suicide Law," *Los Angeles Times*, March 26, 1998; and Diane Gianelli, "Praise, criticism follow Oregon's first reported assisted suicides," *American Medical News*, April 13, 1998.
- <sup>29</sup> N. Gregory Hamilton, M.D. and Catherine Hamilton, M.A., "Competing Paradigms of Responding to Assisted-Suicide Requests in Oregon: Case Report," presented at the American Psychiatric Association Annual Meeting, New York, New York, May 6, 2004. (<http://www.pccef.oorg/articles/art28.htm>)
- <sup>30</sup> ORS 127.825 §3.03.
- <sup>31</sup> Andis Robeznieks, "Assisted-suicide numbers in Oregon," *American Medical News*, April 5, 2004.
- <sup>32</sup> *Supra* note 8.
- <sup>33</sup> *Ibid*.
- <sup>34</sup> Oregon Health Services Commission, "Current Prioritized List of Health Services," Jan. 1, 2007, p. 30 of 114 and p. 87 of 114. (<http://www.oregon.gov/DAS/OHPPR/HSC/docs/Jan07Plist.pdf>)
- <sup>35</sup> Jonathon Oberlander, "Health Reform Interrupted: The Unraveling of the Oregon Health Plan," *Health Affairs*, Dec. 19, 2006.
- <sup>36</sup> *Supra* note 34.
- <sup>37</sup> ORS 127.800 §1.01(12), ORS 127.815 §3.01 (a), and ORS 127.820 §3.02.
- <sup>38</sup> *Supra* note 29.
- <sup>39</sup> Department of Human Services (DHS), Oregon Health Division (OHD), "Oregon's Death with Dignity Act: The Second Year's Experience," February 23, 2000, Table 2. (<http://www.ohd.hr.state.or.us/chs/pas/year2/ar-index.cfm>)
- <sup>40</sup> Katrina Hedberg *et al*, Letter to the editor in response to "The Oregon Report: Neutrality at OHD?" *Hastings Center Report*, January-February 2000, p. 4.
- <sup>41</sup> Testimony of Jim Kronenberg, *HL*, p. 312, question 842.
- <sup>42</sup> Compassion and Choices of Oregon web site (<http://www.compassionoforegon.org>) last accessed Apr. 23, 2007.
- <sup>43</sup> Testimony of Peter Rasmussen, *HL*, p. 312, question 842. (Emphasis added.)
- <sup>44</sup> ORS 127.840 §3.06 and ORS 127.850 §3.08.
- <sup>45</sup> *Supra* note 8.
- <sup>46</sup> Testimony of Dr. Katrina Hedberg, *HL*, p. 257, question 555.
- <sup>47</sup> Amy Sullivan, Katrina Hedberg, David Fleming, "Legalized Physician-Assisted Suicide in Oregon – The Second Year," 342 *New England Journal of Medicine* (February 24, 2000), p. 603.
- <sup>48</sup> *Supra* note 9.
- <sup>49</sup> Andis Robeznieks, "HMO query reignites assisted-suicide controversy," *American Medical News*, September 9, 2002.
- <sup>50</sup> *Ibid*.
- <sup>51</sup> *Ibid*.
- <sup>52</sup> Transcript of tape of Peter Goodwin, "Oregon" January 11, 2003, presented at 13<sup>th</sup> National Hemlock Biennial Conference, "Charting a New Course, Building on a Solid Foundation, Imagining a Brighter Future for America's Terminally Ill," January 9-12, 2003, Bahia Resort Hotel, San Diego California.
- <sup>53</sup> "Compassion in Dying of Oregon Summary of Hastened Deaths," Data attached to Compassion in Dying of Oregon's IRS Form 990 for 2003.
- <sup>54</sup> Testimony of Dr. Elizabeth Goy, *HL*, p. 291, question 768. (Goy is an assistant professor, Dept. of Psychiatry, School of Medicine, OHSU, and has worked with Dr. Linda Ganzini in formulating results of surveys dealing with Oregon's law.)
- <sup>55</sup> ORS 127.835 §3.05.
- <sup>56</sup> ORS 127.860 §3.10.
- <sup>57</sup> Testimony of Dr. Katrina Hedberg, *HL*, p. 267, question 620. (Emphasis added.)
- <sup>58</sup> Testimony of Sue Davidson, *HL*, p. 357-358, question 1098.



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SB 151 ?

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Marker is the author of the critically acclaimed book, *Deadly Compassion*. (Wm. Morrow & Co., 1993; Harper/Collins, 1994; Avon Books, 1995). Reviewers in the United States, Great Britain, Australia and New Zealand all agreed that *Deadly Compassion* is a compelling, persuasive, well-written and revealing discussion of both the personal and public sides of the euthanasia debate.

She is a contributor to *Contemporary Perspectives on Rational Suicide* (Taylor & Francis, 1999) and the author of articles that have appeared in numerous publications including:

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- Chicago Sun-Times
- Detroit News
- Duquesne Law Review
- Journal of Pharmacy Technology
- Maryland Journal of Contemporary Legal Issues
- Michigan Hospitals
- Saint John's Journal of Legal Commentary
- Senior Patient
- State Government News
- USA Today

**INTERNATIONAL TASK FORCE EXECUTIVE DIRECTOR**

Marker has been the executive director of the International Task Force on *Euthanasia and Assisted Suicide* since it began in 1987. She was among the first to be profiled in the American Medical Association's *American Medical News* in its series on "people making news in an era of dramatic change in medicine."

**ATTORNEY**

Marker is a practicing attorney.

**EDUCATOR AND SPEAKER**

Marker is a former adjunct professor of Political Science & Ethics at the University of Steubenville, Ohio. She has made presentations and debated in Hong Kong, Ireland, Italy, France, Belgium, England, Australia, Canada, Colombia, Switzerland, Slovenia and the United States including:

- American Bar Association
- Case Western Law School
- Commonwealth Club of San Francisco
- Florida State University
- Italian Society of Bioethics
- Kentucky Legislature
- League of United Latin American Citizens

(over)

Marquette University  
Michigan Governor's Conference on Aging  
Michigan Legislature  
NAACP  
National Council of Slovenia  
Nebraska Legislature  
New Jersey Gerontology Institute  
Ohio Legislature  
St. John's University School of Law  
Seattle Pacific University  
Seton Hall Law School  
University of Iowa Law School  
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University of Pittsburgh at Bradford  
University of Pittsburgh Law School  
University of San Francisco  
University of Tennessee  
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University of Trieste  
University of Wisconsin Law School

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ABC News  
ABC Prime Time Live  
CBS This Morning  
CNBC  
CNN News  
Crossfire  
C-Span  
Geraldo Show  
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Larry King Show  
MSNBC  
National Public Television  
NBC News  
RAI TV (Italian National Television)  
Sixty Minutes (Australia)  
Gerry Spence Show  
The Fifth Estate (Canada)  
Tom Snyder Show

**ADMITTED TO PRACTICE**

California  
District of Columbia  
United States Court of Appeals for the Ninth Circuit  
United States District Court, Northern District of California  
United States Supreme Court