Submission on:

Rights of the Terminally Ill

(Euthanasia Laws Repeal)

Bill 2008

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Senator Bob Brown (Greens) is making an attempt to reinstate the Northern Territory's Rights of the Terminally Ill Act 1995, by sponsoring the **Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008** in the Senate.

When the N.T. Legislative Assembly passed the Northern Territory euthanasia legislation in 1995 it was to be the Trojan horse of the euthanasia or "right to die" movement in Australia.

That was the case then and it is clearly the case again.

I say this because the Northern Territory, being so far from mainstream Australia, with a small far flung population one quarter of whom are indigenous peoples, and which is lacking in oncology and palliative care services, was the perfect place to start.

It is ironic that legislation, which would give to medical practitioners the power to end life - even if it were at the request of the patient often in no fit state to decide to embrace such a "final solution" - should be thought to be of benefit to the people of the Northern Territory.

Of all Australia's states and territories, the Northern Territory, is the most disadvantaged in terms of provision of good medical care for all.

Those who are lacking most in this regard are indigenous peoples whose paucity of basic health care is constantly being held up to extensive public scrutiny in the daily press of major cities.

Why then, does Senator Brown and those who support his legislation believe it would be a social good for Territorians?

Surely it is nothing short of adding insult to injury by attempting to legalise patient killing in a place which is crying out for major improvements in provision of good healthcare.

Having been involved in the debate over the N.T. Rights of the Terminally Ill Act 1995 at the time, I well recall that Aboriginal people were fearful of it and opposed to it. But how many of them were equipped with the educational skills to effectively protest against it?

I haven't forgotten sitting in the N.T. Legislative Assembly watching the bill pass in the small hours of the morning by one vote from an indigenous M.L.A. who was pressured to leave the Darwin Casino for that purpose. I recall Marshall Perron First Minister and the bill's sponsor crossing the chamber and going to the Labor party room to rouse the gentleman in question from slumber to come in and provide that final vote.

Reliable sources revealed that another MLA had to be recalled from a restaurant and revived under the shower so as he could vote for the bill.

And so legalised patient killing was allowed in the Northern Territory, until the passage of the Euthanasia Laws Act in 1997, which succeeded in overturning the N.T. euthanasia law.

Should Senator Brown's bill pass the Australian parliament the current A.C.T. government has, as part of its stated policy, the legalisation of euthanasia, which it would act upon. One can easily imagine how quickly the nation's capital would attract euthanasia-seeking tourists.

It is interesting to note that no Australian state has legislated to allow physician assisted suicide or euthanasia. There have been several attempts in the South Australian parliament to legalise euthanasia but all have failed, namely the Quirke bill, the Levy bill, the Kanck bill and the Such bill.

I believe my description of the Brown bill as a Trojan horse is very apt. It is much easier to pass euthanasia legislation in these tiny legislatures, only 17 members in the A.C.T. Assembly and 25 members in the N.T. Assembly. Having achieved that, as the practice slowly but surely escalates, as in Holland and the state of Oregon (in the U.S.), in these territories especially in the A.C.T. passage of similar legislation would be more likely to follow in the states.

There would be no way of stopping the A.C.T. from becoming the mecca of those seeking euthanasia, especially as the A.C.T. is in essence part of the state of New South Wales.

No doubt the proponents of legalised euthanasia would say – well – if this would cause a flow on effect of euthanasia legislation in the states – that is a good thing.

It is hard to understand why there is demand for the right of a sick person to have his/her life ended by a medical practitioner when we live in an age of greatly improved provision of palliative care and effective pain relief.

Pain relief specialists tell us most pain can be effectively relieved and good pain relief helps a terminally ill patient to live longer than they would without it. This is simply because they are not distressed by their pain. In October 1994 there was published in the British Medical Journal the results of a survey of 2000 relatives of deceased patients in the UK. The survey was conducted by a sociologist and an epidemiologist. The bereaved were asked – Did the deceased request euthanasia? Less than 4% did so. What was their reason? The main reason for doing so was fear of being a burden to their families.

That was 14 years ago.

Looking at a country that has taken this very dangerous step such as the Netherlands, we have seen that the categories of killable people have extended in the Netherlands in particular so that now a severely depressed person can request termination of his/her life and even babies born with disabilities can be euthanised. Under the terms of the "Gronnigen Protocol", a baby can be lethally injected if he/she has no chance of survival (which can be misdiagnosed) if they may survive after a period of intensive treatment but expectation for their future is very grim, or if they have an extremely poor prognosis.

Initially, euthanasia in the Netherlands was confined to those who requested it but gradually it began to be applied to those who were unable to request it. Once the principle of the life not worthy to be lived has been embraced in practice why would it not then be applied to those whom we think would be better off dead? It would be claimed that to deny it to those who can't request it would be discriminatory.

Interestingly the Dutch are now about to have access to a suicide guide. A scientific D.I.Y. suicide guide is to go on sale to help people end their lives by a variety of means.

There are about 4,400 suicides a year in the Netherlands (excluding the thousands of euthanasia deaths). This is similar to

the numbers of suicides annually in the U.K. which has approximately four times the population!

In the United States, one state only, Oregon, has legalised physician assisted suicide. For the benefit of the Senate Committee, I am including in the appendix a copy of an article from the International Task Force on Euthanasia and Assisted Suicide in Oregon.

Suffice it to say that the Oregon death law has done more harm that good it would seem.

Once the practice of deliberate ending of lives of the sick and disabled is entrenched it is much easier for patients who are old and lonely to feel they have a duty to get out of the way and not place a burden on their families.

Passage of euthanasia legislation would be a very dangerous public policy especially in this day and age where we have an increasingly ageing population and not enough younger people whose taxes are needed to provide adequate healthcare. Pressure on bed space in our public hospitals is a major problem.

The late Dr Karel Gunning of Rotterdam, in the Netherlands whom I knew really well, told me of a case of a woman terminally ill with lung cancer, being treated by his friend a senior consultant. He wanted the patient to be admitted to hospital telling her that she would be more appropriately treated in hospital and therefore more comfortable.

The patient replied that she was scared to go to hospital because she might be given euthanasia. Her doctor reassured her that he would be looking after her and that would not happen. Reluctantly she agreed and was feeling much more comfortable. The doctor was off duty for the weekend and came back to find his patient no longer in the bed. On enquiring into the reason for this another doctor told him – “Oh we gave her euthanasia. After all she was going to die in three weeks and we needed the bed.”

Appendix

By the International Task Force on Euthanasia and Assisted Suicide

Ten Years of Assisted Suicide in Oregon

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. (1) *Since the law, called the "Death with Dignity Act," went into effect in 1997, ten 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. (2)

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.(3) The public and press were not present during the closed- door hearings. However, the proceedings, which included the exact wording of questions and answers, were published in three volumes by the House of Lords.

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

THE STATISTICS

<u>Assisted-suicide deaths reported during the first ten years</u>

Official Reports: 341
Actual number: Unknown

The latest annual report indicates that reported assisted-suicide deaths have increased by more than 306% since the first year of legal assisted suicide in Oregon.(4) The number of deaths, 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." (5)

The DHS has to rely on the word of doctors who prescribe the lethal drugs.(6) 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."(7)

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

<u>Complications occurring during assisted suicide</u>

Official Reports: 20 (19 instances of vomiting & 1 patient who did not die)
Actual Number: Unknown

Prescribing doctors may not know about all complications since, over the course of ten years, physicians who prescribe the lethal drugs for assisted suicide were present at only 21.7% of reported deaths.(8) Information they provide might come from secondhand accounts of those present at the death (9) 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."(10) She acknowledged that, "after they write the prescription, the physician may not keep track of the patient."(11) 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."(12)

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." (13)

  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..."(14) 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…" (15)

  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. (16) But Barrett wouldn't say exactly which symptoms had taken place in this instance. She has refused any further discussion of the case. Annual reports do not reflect this 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.(17) DHS issued a release saying it "has no authority to investigate individual Death with Dignity cases."(18)

- 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."(19)
- 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."(20)

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.(21)

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.(22)

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.****"(23)*

<u>Assisted-suicide deaths of patients with dementia</u>

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. (24)

- 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 certain that all the steps happened *up to the point the prescription was written,*"(25) 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*."(26)

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) became involved. Dr. Peter Goodwin, medical director of CID,(27) 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."(28)
- 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."(29)

Under the assisted suicide law, depressed or mentally ill patients can receive assisted suicide if they do not have "impaired judgment."(30) Concerning the decision to refer for a psychological evaluation, Dr. Kohn said, "According to the law, it's up to the docs' discretion."(31) According to the tenth annual report, *not one patient was referred for a psychological evaluation or counseling before receiving a prescription for assisted suicide 2007.* (32)

Assisted-suicide requests based on financial concerns

Official Reports: 9
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, 36.2% of patients whose deaths were reported were on Medicare (for senior citizens) or Medicaid (for the poor) and an additional 0.9% had no insurance.(33) 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 (34) 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 drooped by 17 percent. (35) 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 the cut-off line are not provided. As of January 2008, the state covers the first 503 of the current 680 listed treatments. (36) Wish assisted suicide remaining a covered service, it could be the only "treatment" some people can afford.

Patients who received lethal dose more than 6 months before death

Official Reports: 2 or 4 (After 2nd year, official reports deleted this category, however an overall time range is now included.)
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.(37)

- One patient was still alive 17 months after the lethal drugs were prescribed,(38) and, during the first two years of the law's implementation, at least one lethal dose was prescribed more than 8 months before the patient took it.(39) The DHS is not authorized to investigate how physicians determine their patients' diagnoses or life expectancies.(40)

- According to the tenth official report, the time between writing the assisted-suicide prescription and death ranged from 0 to 698 days. Thus, some patients (number unknown) lived for almost two years after receiving the lethal drugs - well beyond the required six months life expectancy.(41)

- Dr. Peter Rasmussen, an advisory board member of the Oregon chapter of C & C, (42) 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...."(43)

Shortest length of time reported for prescribing doctor-patient relationship

Official Reports: Less than 1 week
Actual length: Unknown

Oregon's assisted-suicide law requires that at least 15 days between the patient's first and last requests for lethal drugs.(44) Nonetheless, for the third through tenth years, the doctor-patient relationship in some reported assisted-suicide cases was under one week.(45) Thus, official reports indicate that either some physicians are not complying with the 15 day 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.(46)

First physician asked agreed to write prescription

Official Reports: 27 (41%) (After 3rd year, official reports deleted category.)
Actual number: Unknown

"Many patients who sought assistance with suicide had to ask more than one physician for a prescription for lethal medication."(47) 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.(48)

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-suicide 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...." (49)

  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."(50)

  Kaiser's Northwest Regional Medical Director Allan Weiland, MD, called Hamilton's comments "ludicrous and insulting." (51) 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.(52) During the 2003 calendar year, it was involved in 79% of such deaths.(53) According to Dr. Elizabeth Goy of Oregon Health Science University, the assisted-suicide advocacy organization sees "almost 90% of requesting Oregonians."(54)

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OTHER TROUBLING ASPECTS OF ASSISTED SUICIDE IN OREGON.

<u>No family notification required before a doctor helps a loved one commit suicide</u>

Family notification is only recommended, but not required, under Oregon's assisted-suicide law.(55) 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. Residency can be demonstrated by means that include, but are not limited to, a driver's license or a voter registration.(56) 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*..."(57)

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% 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.(58)

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As other jurisdictions 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:

(1) ORS 127.865 §3.11.
(2) See: "The Oregon Experience".
(3) On May 12, 2006, the British proposal was defeated in the House of Lords by a vote of 148-100.
(4) DHS, "Tenth Annual Report on Oregon's Death with Dignity Act," March 18, 2008, "Prescription History."
(5) Linda Prager, "Details emerge on Oregon's first assisted suicides, " *American Medical News,* Sept. 7, 1998.
(6) Joe Rojas-Burke, "Suicide critics say lack of problems in Oregon is odd," *Oregonian*, Feb. 24, 2000.
(7) Oregon Health Division, *CD Summary*, vol. 48, no. 6 (March 16, 1999), p. 2.
(8) DHS, "Tenth Annual Report on Oregon's Death with Dignity Act," March 18, 2008, Table I. The annual report states that the presence of the attending physician in the 63 out of 292 reported deaths is 29%, however the calculation is mathematically inaccurate. The correct calculation is 21.5%.
(9) DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, "Methods.";
(10) 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.) Note: The hearings were held in Portland, Oregon during December 2004, however they were published in April 2005.
(11) Ibid., p. 259, question 567.
(12) Testimony of Dr. Melvin Kohn, *HL*, p. 263, question 598.
(13) Erin Hoover, "Dilemma of assisted suicide: When?" *Oregonian*, Jan. 17,1999 and Erin Hoover, "Man with ALS makes up his mind to die," *Oregonian*, March 11, 1999.
(14) Testimony of Dr. Katrina Hedberg, *HL*, p. 267, question 621.

(15) Audio tape on file with author. Also see: 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.
(16) 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.
(17) Associated Press, "Assisted suicide attempt fails," March 4, 2005.
(18) DHS news release, "No authority to investigate Death with Dignity case, DHS says," March 4, 2005.
(19) Testimony of Dr. Katrina Hedberg, *HL*, p. 266, question 615.
(20) Testimony of David Hopkins, *HL*, p. 259-260, question 568.
(21) *Supra* note 16.
(22) Sherwin Nuland, "Physician-Assisted Suicide and Euthanasia in Practice," 342 *New England Journal of Medicine* (Feb. 24, 2000), pp. 583-584.
(23) 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.)
(24) Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.
(25) Testimony of Dr. Katrina Hedberg, *HL*, p. 259, question 566. (Emphasis added.)
(26) Ibid., p. 259, question 567. (Emphasis added.)
(27) 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.
(28) 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 1st 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*, Apr. 13, 1998.
(29) 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.
(30) ORS 127.825 §3.03.
(31) Andis Robeznieks, "Assisted-suicide numbers in Oregon," *American Medical News*, Apr. 5, 2004.
(32) *Supra* note 8.
(33) Ibid.
(34) Oregon Health Services Commission, "Current Prioritized List of Health Services," Jan. 1, 2008, p. 30 of 114 and p. 87 of 114.
(35) Jonathon Oberlander, "Health Reform Interrupted: The Unraveling of the Oregon Health Plan," *Health Affairs*, Dec. 19, 2006.
(36) Oregon Health Services Commission, "Current Prioritized List," January 1, 2008.
(37) ORS 127.800 §1.01 (12), ORS 127.815 §3.01 (a), and ORS 127.820 §3.02.
(38) *Supra* note 29.
(39) Department of Human Services (DHS), Oregon Health Division (OHD), "Oregon's Death with Dignity Act: The Second Year's Experience," Feb. 23, 2000, Table 2. (http://www.ohd.hr.state.or.us/chs/pas /year2/ar-index.cfm)
(40) Katrina Hedberg *et al*, Letter to the Editor in response to "The Oregon Report: Neutrality at OHD?," *Hastings Center Report*, Jan.-Feb. 2000, p. 4.

(41) *Supra, note 8.*
(42) Compassion and Choices of Oregon listing of board members and advisory board. (43) Testimony of Dr. Peter Rasmussen, *HL*, pl 312, question 842. (Emphasis added.)
(44) ORS 127.840 §3.06 and ORS 127.850 §3.08.
(45) *Supra* note 8.
(46) Testimony of Dr. Katrina Hedberg, *HL*, p. 257, question 555.
(47) Amy Sullivan, Katrina Hedberg, David Fleming, "Legalized Physician-Assisted Suicide in Oregon – The Second Year," 342 *New England Journal of Medicine* (Feb. 24, 2000), p. 603.
(48) *Supra* note 8.
(49) Andis Robeznieks, "HMO query reignites assisted-suicide controversy," *American Medical News*, Sept. 9, 2002.
(50) Ibid.
(51) Ibid.
(52) Transcript of tape of Peter Goodwin, "Oregon," Jan. 11, 2003, presented at 13th National Hemlock Biennial Conference, "Charting a New Course, Building on a Solid Foundation, Imagining a Brighter Future for America's Terminally Ill," Jan. 9-12, 2003, Bahia Resort Hotel, San Diego California.
(53) "Compassion in Dying of Oregon Summary of Hastened Deaths," Data attached to Compassion in Dying of Oregon's IRS Form 990 for 2003.
(54) 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.)
(55) ORS 127.835 §3.05.
(56) ORS 127.860 §3.10.
(57) Testimony of Dr. Katrina Hedberg, *HL*, p. 267, question 620. (Emphasis added.)
(58) Testimony of Sue Davidson, *HL*, p. 357-358, question 1098.