IN THE SELECT COMMITTEE OF THE NATIONAL ASSEMBLY OF QUEBEC, DYING WITH DIGNITY

BRIEF OF MARGARET DORE OPPOSING EUTHANASIA AND ASSISTED SUICIDE BASED ON ELDER ABUSE

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TABLE OF CONTENTS

APPENDICES

I. THE AUTHOR

I am an elder law attorney in Washington State, where assisted suicide is legal. My publications include "'Death with Dignity': A Recipe for Elder Abuse and Homicide (Albeit Not by Name)," *Marquette Elder's Advisor*, Spring 2010.[1]

In 2009, I submitted a legal memorandum to the Canadian Parliament regarding Bill C-384, which sought to legalize assisted suicide and euthanasia in Canada.[2] I was also an amicus curie in the Montana assisted suicide case, Baxter v. Montana.[3]

II. SUMMARY

In Canada, like the US, elder abuse is a significant problem.[4] Preventing elder abuse is also a government priority. Canada's official government website states: "[E]lder abuse cannot and will not be tolerated."[5]

Legalising assisted suicide and euthanasia will create new paths of abuse. For this reason alone, assisted suicide and euthanasia should not be legalized in Quebec.

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1 A copy is attached to the Appendix, at A-1 through A-8.

2 Bill C-384 was defeated in April 2010, by a vote of 228 to 59. See National Post article regarding same, attached hereto at A-9.

3 354 Mont. 234, 224 P.3d 1211 (2009).

4 See Canadian Government website at A-10 through A-14.

5 Message from Minister of State (Seniors) Marjory LeBreton, Canadian government website, at A-10.

III. FACTUAL AND LEGAL CONTEXT

A. Elder Abuse

Elder abuse includes psychological abuse, financial abuse and physical abuse.[6] The perpetrators are often family members.[7] Financial abuse is the most commonly reported type.[8]

Elder abuse is, however, largely unreported and "can be very difficult to detect."[9] This is due in part to the reluctance of victims to report. Canada's official government website states:

> Older adults may feel ashamed or embarrassed to tell anyone that they are being abused by someone they trust.

Attached at A-12.

Elders' vulnerabilities and relative wealth can even lead to murder. In Canada, one of the most well known perpetrators is Melissa Friedrich, the "Internet Black Widow."[10] She was convicted of manslaughter for the death of her first husband and is accused of poisoning her second husband and another elderly

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[6] Canadian government web site, at A-11.

[7] See: CBC News staff, "Abusers of elderly are often family," *CBC News*, November 19, 2008, at A-15; and Government website, at A-12.

[8] Canadian government website at A-11.

[9] *Id.* at A-12.

[10] See: "Timeline: The Life of Melissa Friedrich," *The Fifth Estate*, at http://www.cbc.ca/fifth/2008-2009/black_widow/timeline.html; and John Leyden, "Internet black widow stalked pensioners on the net," *The Register*, 13th January 2005, attached at A-17 See also R.L. McNeely and Philip W. Cook, "Notes on Newspaper Accounts of Male Elder Abuse," *Journal of Elder Abuse and Neglect*, 2007, attached at A-19 through A-24 (Friedrich discussed at A-21).

man in order to get their money.[11]

B. "Death with Dignity" is a Recipe for Elder Abuse

Assisted suicide is legal in just two states, Washington and Oregon.[12] In both states, "Death with Dignity Acts" were passed via ballot initiatives in which voters were promised that their "choice" would be assured.[13] Both acts, however, contain potentially coercive provisions.[14] For example, an heir, who will benefit from a patient's death, is allowed to help the patient sign up for the lethal dose.[15]

There are also no witnesses required when the lethal dose is administered.[16] Without witnesses, the opportunity is created for someone to administer the lethal dose to the patient without his consent.[17] Even if he struggled, who would know?[18] The

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11 *Id.*

12 In Montana, Baxter v. State decriminalizes assisted suicide for doctors under certain narrow circumstances. Baxter does not generally "legalize" assisted suicide. See: http://www.montanafamily.org/portfolio/pdfs/Baxter_Decision_Analysis_v2.pdf. Montana State Senator Greg Hinkle has also proposed a bill, "The Montana Patient Protection Act," which would overrule the Baxter decision.

13 Margaret K. Dore, "'Death with Dignity': A Recipe for Elder Abuse and Homicide (Albeit Not by Name)," *Marquette Elder's Advisor*, Spring 2010, at page 387, attached at A-1.

14 *Id. at 388-395.*

15 *Id. at 388*

16 *Id. at 394.*

17 *Id.*

18 *Id.*

lethal dose request, voluntary or not, would provide the alibi.[19]

C. There is No Assisted-Suicide Bill You Can Write to Prevent Abuse

This year in New Hampshire, a proposed Death with Dignity Act was defeated due to its potential for abuse. New Hampshire Representative Nancy Elliott states:

> These acts empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money. There is no assisted-suicide bill that you can write to correct this huge problem. (Emphasis added).[20]

D. Killing Without Consent

In Holland, where both assisted suicide and euthanasia are legal, official government reports concede that some patients are killed without their consent.[21] In Oregon and Washington, the official reports avoid this problem by NOT ASKING whether the patient consented when the lethal dose was administered.[22] Moreover, on close reading, these Acts do not require such

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19 *Id.*

20 Nancy Elliott, "Right to Die is Prescription for Abuse," *Hartford Courant*, May 28, 2010. (Attached hereto at A-25).

21 In 2005, the last year for which there is an official Dutch government report, there are an admitted 550 patients whose lives were ended "without an explicit request of the patient." (Attached at A-26).

22 To view all official forms and reports to date, go to the state websites for Washington and Oregon, at http://www.doh.wa.gov/dwda/ and http://www.oregon.gov/DHS/ph/pas/index.shtml/shtml.

consent.[23]

E. Doctors are not Good at Policing Themselves

Doctors, as a profession, have a dismal track record of policing themselves. Consider, for example, Dr. Michael Swango, a serial killer.[24] His superiors saw that he was probably killing his patients.[25] Rather than call the authorities, they got rid of him by passing him on to the next hospital.[26] Dorothy Packer-Fletcher, M.F.A. and Kenneth E. Fletcher, PhD, state:

> [I]t is tragically common for doctors to be unwilling to report incompetent physicians to the national data bank, let alone to try to remove them from the medical profession.[27]

If doctors can't protect patients against a serial killer, when killing is clearly illegal, then how will doctors be able to protect patients when killing is sometimes legal? A Dr. Swango will simply say: "I did what the patient wanted, sorry about the lack of paperwork, will do better next time."

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[23] Margaret K. Dore, "'Death with Dignity': A Recipe for Elder Abuse and Homicide (Albeit Not by Name)," *Marquette Elder's Advisor*, Spring 2010, at page 390, attached at A-3 ("There is . . . no language requiring the patient's consent at the time of administration").

[24] James B. Stewart, Blind Eye: How the Medical Establishment Let a Doctor get Away with Murder, 1999.

[25] *Id.*

[26] *Id.*

[27] Dorothy Packer-Fletcher, M.F.A. and Kenneth E. Fletcher, PhD, Book Review of Blind Eye, Psychiatric Services, 51:1578, December 2000. (Attached hereto at A-27).

F. Patients are not Necessarily "Dying"

"Dying with dignity" implies that the patients at issue are in fact dying. But even with a statute like those in Oregon and Washington, which limit eligibility to patients with less than six months to live, this is not necessarily the case. Doctor prognoses can be wrong with patients living years beyond expectations.[28]

IV. ARGUMENT

A. Legalization will Result in Expanded Elder Abuse

Older people in Canada are already victims of abuse, including murder, due to their funds and vulnerabilities. With legalization of assisted suicide and/or euthanasia, there will be created new paths for abuse. This is counter to Canadian public policy, to prevent elder abuse.

IV. CONCLUSION

With preventing elder abuse a government priority, assisted suicide and euthanasia should be rejected. Don't make Washington's mistake.

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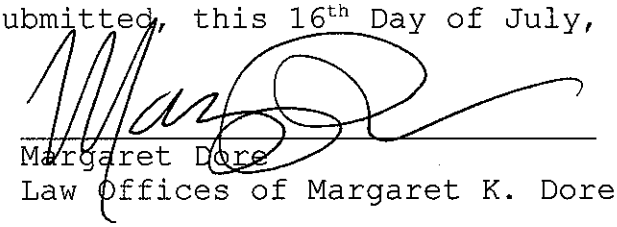
[28] Shapiro, Nina, "Terminal Uncertainty — Washington's new 'Death with Dignity' law allows doctors to help people commit suicide — once they've determined that the patient has only six months to live. But what if they're wrong?" Seattle Weekly, January 14, 2009, www.seattleweekly.com/2009-01-14/news/terminal-uncertainty

Respectfully submitted, this 16th Day of July, 2010



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MARQUETTE ELDER'S ADVISOR

Volume 11 Spring 2010 Number 2

A-1

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

Margaret K. Dore*

INTRODUCTION

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

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

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

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

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

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

HOW THE ACTS WORK

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

A COMPARISON TO PROBATE LAW

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

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

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

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

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

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

9. *Id.*

10. *Id.*

undue influence."[11]

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

A RELAXED STANDARD OF COMPETENCY

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

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

Regardless, without a requirement of strict competency,

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

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

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

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

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

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

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

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

NO MENTAL STANDARD OF CONSENT REQUIRED AT THE TIME OF ADMINISTRATION

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

"DOCTOR SHOPPING"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BOTH ACTS ALLOW INVOLUNTARY KILLING

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

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

(last visited Jan. 23, 2010).

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

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

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

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

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

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

34. *Id.*

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

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

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

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

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

COUNTER ARGUMENTS

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

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

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

38. *Id.*

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

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

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

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

NO WITNESS AT THE DEATH

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

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

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

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

43. *Id.*

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

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

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

OFFICIAL COVER

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

ILLUSORY LIABILITY FOR UNDUE INFLUENCE

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

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

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

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

47. *Id.*

48. OR. REV. STAT. §§ 127.800-995.

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

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

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

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

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

THE ANNUAL REPORTS ARE CONSISTENT WITH ELDER ABUSE

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

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

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

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

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

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

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

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

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

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

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

THE BARBARA WAGNER SCENARIO

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

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

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

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

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

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

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

CITIZENS ARE "BURDENS"

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

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

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

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

65. *Id.*

66. *Id.*

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

68. *Id.*

69. *Id.*

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

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

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

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

INDIVIDUAL "OPT OUTS" ARE NOT ALLOWED

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

PEOPLE COMMIT SUICIDE ANYWAY

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

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

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

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

THE BIG PICTURE

SIGNING THE FORM WILL LEAD TO A LOSS OF CONTROL

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

PROGNOSES CAN BE WRONG

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

CONCLUSION

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

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

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

77. *Id.*

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

POSTSCRIPT

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

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

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

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

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

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

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

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

The Week In Letters Readers give a big thumbs down tc with dignity'

National Post · Monday, Apr. 26, 2010

Every week, the Post receives hundreds of letters to the editor, providing a snapshot of our readers' collective state of mind. In the column below, our letters editor highlights some of the more passionately argued letters we received last week that did not make it into the paper.

Aprivate member's bill to amend the Criminal Code to allow people to "die with dignity" died an undignified death itself last Wednesday, going down to defeat by a vote of 228-59. But in that court of public opinion known as the National Post's Letters page, the verdict on the bill was even more one-sided.

The debate on our pages started on Monday, when we ran a letter from the bill's sponsor, Bloc MP Francine Lalonde, urging her fellow parliamentarians to allow a chronically ill patient to "put an end to his or her suffering ... the very expression of the greatest compassion."

Of the approximately 70 letters that came in after that -- from doctors, social workers, people suffering from chronic illnesses, relatives of the dearly departed and from dozens of regular Canadians -- only a handful sided with the idea that the laws around assisted suicide should be liberalized.

"Dying with dignity? That's what Ms. Lalonde would call it?" wrote Jim Altman. "There is nothing dignified, or heroic, or courageous or laudable about doing yourself in. Rather, it is a sign of greatest weakness and humiliating cowardice. Ms. Lalonde's words disgrace her."

"Killing someone is killing someone," agreed Rozalia Kennedy. "Euthanasia is the slippery slope, and doctors are not God. God has a plan for each of our lives -- a time to be born and a time to die. It is not for

doctors or the government to decide when someone should die."

"Medicine is supposed to be preventative; the fact that medicine is now developing a treatment to kill is yet another indication of how completely lost our society has become," added Sarah Volpatti. "Somewhere along the way freedom has become tainted by a false illusion of individualism. Freedom is not being able to choose life and death; this choice is not liberating, it is dehumanizing. It makes our existence less fated, less consequential, less providential, less inexplicable and less mysterious."

Not all readers, however, were convinced that the suffering that comes with death is something to be celebrated.

"Speaking personally, I have to say that I do not find pain to be uplifting or have any redemptive qualities," wrote Jim Peat. "But since my cramps usually last only minutes, I suppose that I have much to learn yet. I sincerely hope that no one will ever have the opportunity to say how much my sufferings have shown them how to live and die with dignity (nor would I believe them). Perhaps a few minutes with a thumb-screw on a regular basis would teach some correspondents about life with pain."

The extensive input from letter-writers on this issue won praise from some readers, with a few asking why the story did not merit mention in our news section.

"I was surprised that the National Post did not write an article regarding the very important government decision not to legalize euthanasia," wrote Irene Freundorfer. "Major applause to all the MPs who voted against the bill. So many of us are indebted to your recognition of our dignity and the value of our lives."

- It's interesting to see what content of the paper raises readers' ire. While news stories about hot-button issues such as abortion, gay rights and euthanasia are the main culprits, something as innocuous as a crossword can also draw an angry reaction.

"I have been a daily, enthusiastic user of the Canadian Crisscross for several years," wrote R. Katz. "Although I rarely complete it, I continue to enjoy it because I am challenged to think as well as to remember new words. But never, until the April 17 issue, have I been so offended.

Government of Canada / Gouvernement du Canada

Canada

Seniors Canada

Message from Minister of State (Seniors) Marjory LeBreton

ELDER ABUSE

IT'S TIME TO FACE THE REALITY

I am proud of our government's commitment combat elder abuse. We want everyone to know that elder abuse cannot and will not be tolerated and that help is available.

I am pleased to announce that the Government of Canada has launched a nation-wide advertising campaign called Elder Abuse - It's Time To Face The Reality. The campaign launch on June 15, 2009 coincided with World Elder Abuse Awareness Day as well as with the launch of the Federal Elder Abuse Initiative Call for Proposals under the New Horizons for Seniors Program.

This campaign aims to increase awareness and understanding of the different types of elder abuse. Elder abuse takes many ugly forms: physical, financial, psychological and sexual. In whatever form, abuse is unacceptable. Seniors from all walks of life are vulnerable to abuse; it happens in communities across Canada. Many seniors do not report abuse because they feel isolated and are afraid to speak out. As a result, the problem of elder abuse remains largely hidden. This campaign strives to ensure that Canadians recognize the signs and symptoms of elder abuse and informs them that help is available.

Federal Elder Abuse Initiative Call for Proposals launched under the New Horizons for Seniors Program

Complementing the elder abuse awareness advertising campaign are ongoing federal government New Horizons for Seniors Program initiatives that help ensure seniors can benefit from and contribute to the quality of life in their communities through social participation and active living. Accordingly, the Government of Canada has launched a Federal Elder Abuse Initiative Call for Proposals under the New Horizons for Seniors Program.

Feel free to check back here regularly for updates on elder abuse and to find the latest information on our efforts to deal with this very serious issue. I also invite you to watch our television advertisement.

Elder Abuse
It's Time To Face The Reality

CA-542-05-09

A printable version is available in PDF format (296 kb, 7 pages). To download and print PDF files, you will need the free Adobe Acrobat Reader.

Elder Abuse: What it is and who can help

One in five Canadians believes they know of a senior who might be experiencing some form of abuse. Seniors from all walks of life are vulnerable to elder abuse and it is happening in communities across Canada.

Outlined here is basic information on how seniors and Canadians can spot elder abuse as well as information on how to help stop it.

What is elder abuse?

Elder abuse is any action by someone in a relationship of trust that results in harm or distress to an older person. Neglect is a lack of action by that person in a relationship of trust with the same result. Commonly recognized types of elder abuse include physical, psychological and financial. Often, more than one type of abuse occurs at the same time. Abuse can be a single incident or a repeated pattern of behaviour.

Financial abuse is the most commonly reported type of elder abuse.

Why does elder abuse happen?

Elder abuse often occurs because of the abuser's power and control over an older person. In some situations, the abuse may also result from addiction issues (drugs, alcohol or gambling), mental health problems, a cycle of family violence or ageism. Abuse can happen when the aggressor wants to intimidate, isolate, dominate or control another person.

Who abuses seniors?

Older adults affected by abuse often know and trust the person mistreating them. Elder abuse can be caused by a family member, a friend, someone who provides assistance with basic needs or services, or health care providers in institutional settings. In many situations of elder abuse, the abuser is dependent on the older adult for money, food or shelter.

Who is affected by elder abuse?

Most older people who experience abuse are able to make decisions for themselves.

Abuse can happen to anyone, in any family or relationship. It can happen to people of all backgrounds, ages, religions, races, cultures and ethnic origins.

Why are some older adults reluctant to talk about elder abuse?

Older adults may feel ashamed or embarrassed to tell anyone they are being abused by someone they trust. They may fear retaliation or punishment, or they may have concerns about having to move from their home or community. They may also feel a sense of family loyalty. Often, older adults may not be aware of people and resources that can help.

Who can help?

It is important that the older person have access to information to make informed decisions and be aware of available help. This may include support and assistance from family members or friends, health care providers, social services, police, legal professionals and/or members of faith communities. No one ever deserves to be abused or neglected.

What are indicators of elder abuse and neglect?

Elder abuse and neglect can be very difficult to detect. The following signs and symptoms may indicate that an older adult is being victimized or neglected:

- fear, anxiety, depression or passiveness in relation to a family member, friend or care provider;
- unexplained physical injuries;
- dehydration, poor nutrition or poor hygiene;
- improper use of medication;
- confusion about new legal documents, such as a new will or a new mortgage;
- sudden drop in cash flow or financial holdings; and
- reluctance to speak about the situation.

Raising awareness among seniors about their right to live safely and securely is seen as the most important issue for governments when it comes to elder abuse, with 9 in 10 Canadians (90.5 percent) rating it as a high priority.*

* Results of a survey of 3,001 Canadians, including 718 seniors aged 65 and older, conducted between May 21 and June 6, 2008; *Environics.*

Physical abuse of seniors

Physical abuse of seniors includes actions that injure or risk injuring an older person or cause them physical pain and may include:

- striking;
- hitting;
- pushing;
- shaking;
- burning;
- shoving;
- inappropriate physical and chemical restraints; or
- harm created by over or under medicating.

Psychological abuse of seniors

Psychological abuse of seniors includes actions that decrease their sense of self-worth and dignity, and may include:

- insults;
- threats;
- intimidation;
- humiliation;
- harassment;
- treating them like a child; or
- isolating them from family, friends or regular activities.

Financial abuse of seniors

Financial abuse includes actions that decrease the financial worth of an older person without benefit to that person and may include:

- misusing or stealing a senior's assets, property or money;
- cashing an elderly person's cheques without authorization;
- forging an elderly person's signature;
- unduly pressuring seniors to make or change a will, or to sign legal documents that they do not fully understand; and
- sharing an older person's home without paying a fair share of the expenses when requested.

Neglect of seniors

Neglect includes inactions that may result in harm to an older person and may include a caregiver or family member not providing appropriate:

- water or food;
- shelter;
- clothing;
- medication or medical attention; and
- assistance with basic necessities.

Seniors most vulnerable to neglect include those who are socially isolated, and those with serious health conditions.

Abuse happens when one person hurts or mistreats another. Remember:

- Seniors are entitled to respect.
- Seniors have every right to live in safety and security.
- There is no excuse for abuse.

96 percent of Canadians think most of the abuse experienced by older adults is hidden or goes undetected.*

*Results of a survey of 3,001 Canadians, including 718 seniors aged 65 and older, conducted between May 21 and June 6, 2008; *Environics*.

Federal activities on elder abuse

Federal initiatives on elder abuse complement and build upon efforts by the provinces and territories as well as by national, regional and local organizations to address the abuse of older adults.

The New Horizons for Seniors Program is designed to help ensure that seniors benefit from, and contribute to, the quality of life in their communities through social participation and active living. The program was expanded in 2007 to include elder abuse awareness activities. The Elder Abuse Awareness component of the New Horizons for Seniors Program helps non-profit organizations develop national or regional education and awareness activities to reduce the incidence of abuse of seniors.

The Family Violence Initiative (FVI), a partnership of 15 federal departments, agencies and Crown corporations, is coordinated by the Public Health Agency of Canada. The FVI promotes public awareness of the risk factors of family violence and the need for public involvement in responding to it. It also strengthens criminal justice, health and housing systems responses, as well as supporting data collection, research and evaluation efforts to identify effective interventions.

Elder Abuse
It's Time To Face The Reality

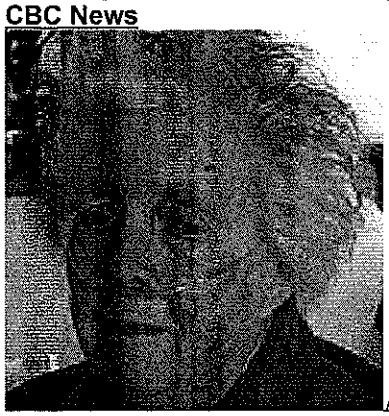
To find out more on what the Government of Canada is doing for seniors visit www.seniors.gc.ca or call:

- 1 800-O-Canada ()
- TTY:

Abusers of elderly are often family: police

Last Updated: Wednesday, November 19, 2008 | 4:01 PM ET **Comments2Recommend17**

CBC News



Maggie Garrick, 87, learned that one of her grandchildren had stolen money from her bank account. (Simon Gardner/CBC)

Relatives often worry about elderly parents or grandparents suffering abuse at the hands of strangers, but more than half of all elder abuse is committed by the victim's children, grandchildren or other relatives, Ottawa police say.

About 75 to 80 per cent of elder abuse involve a financial crime, and that crime is most often perpetrated by a member of the victim's family, said Det. Brenda McGillivray of the Ottawa police.

Overall, family members have been the suspect in 256 of 468 cases — 55 per cent — investigated by the Ottawa police elder abuse unit since it was established in January 2005.

Maggie Garrick, 87, is one Ottawa resident who fell victim to such a crime. A little over a year ago, most of the money she received from the sale of her condo went missing from her bank account. It turned out that someone had taken her debit card out of her wallet while she was working out, along with the paper where she had written her PIN, due to her failing memory.

Elder abuse in Ottawa

The Ottawa Police Service elder abuse unit has investigated 468 cases since January 2005 including:

- **81** at private retirement homes.
- **98** at regulated long-term care homes.
- **33** involving personal support workers in the client's own home.
- **256** cases where the suspect was a family member.

The investigations have led to 57 arrests and 623 charges.

Source: Ottawa Police Service elder abuse unit

"They were used to go the rounds of the bank machines and clean me out," she said. "And because I'm blind I had no idea they were gone, and put back, gone and put back until the bank called me one day and warned me." The crime was traced back to her granddaughter.

"It was devastating," Garrick recalled.

But she said she and her family got through it, police worked with the courts so her granddaughter didn't have to be charged, and although the money has yet to be repaid, she and her granddaughter have put the incident behind them.

However, she advises other seniors to be alert and not leave their wallet or cards lying around.

Power-of-attorney abuse common: police

McGillivray said many other cases of financial crime involve family members who abuse their power of attorney.

The fact that the suspect in the abuse is often a family member makes it hard for victims to come forward and may lead them to tolerate quite a lot of abuse.

"They don't really want to talk about, or really acknowledge out loud that their son or daughter, grand-daughter, grandson, might actually do this to them, might treat them this way," she said.

McGillivray said seniors can minimize their risk by having a lawyer draft documents designating power of attorney rather than drafting the documents themselves. In addition, she advises making sure conditions specify when power of attorney comes into effect so it can't be exploited immediately.

- Post a comment
  2Comments have been posted
- Recommend this story
  17People have recommended this story

Story comments (2)

Sort: Most recent | First to last | Agreed
MMMKAYE **wrote:**Posted 2008/11/21
at 4:32 PM ETI think sentencing or punishment should be extra-harsh for anyone convicted of preying on or abusing seniors in any way. (if they aren't already??) They didn't work their entire lives giving us younger folks a better life, only to be abused for it in the golden years. What ever happened to respect. It's sickening.

- 5
- 0

5Agree 0DisagreePolicy Report abuse
AaronABaker **wrote:**Posted 2008/11/19
at 9:35 PM ETWell, it's about time.

I've been in the medical sector for over 18 years and I've seen my share of elder abuse in facilities and in private homes. Where did it go when I reported it to the powers that be in the facilities?? Nowhere.
I was labeled the trouble maker.
Not long ago, I read an article in the Ottawa Sun re; this same situation, however, the police were involved. They have a very small group who work with this kind of situation and I congratulate them. I know they are bombarded with calls and need help. I for one am retired now and would be happy to volunteer some of my time helping them with calls and office work. So, to the group at the Ottawa Police Dept. I am at your disposal.
Great work by the way.

JJ

Original URL: http://www.theregister.co.uk/2005/01/13/internet_black_widow/

Internet black widow 'stalked pensioners on the net'

Grandma Death on poisoning charges

By **John Leyden**

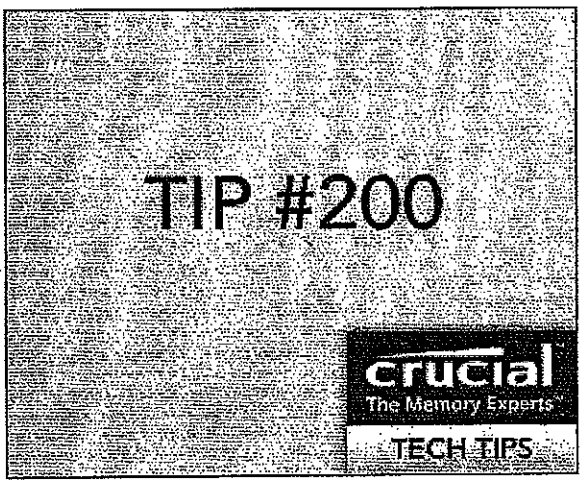
Posted in Music and Media, 13th January 2005 21:44 GMT

US police are investigating if a 69 year-old Canadian woman already convicted of killing her first husband murdered her second spouse. Melissa Friedrich is also accused of drugging a 73-year-old man she met an online dating service in order to systematically fleece him of $20,000, CBC News reports (http://www.cbc.ca/story/world/national/2005/01/13/black-widow-050113.html).

Investigators suspect Friedrich forged relationships with elderly men in order to rip off their life savings, leading her to be dubbed the "internet black widow" by the son of her latest alleged victim.

Canada's wrinkly femme fatale

Friedrich served two years in prison for manslaughter after she fed her first husband, Gordon Stewart, a lethal dose of prescription drugs prior to running him over with a car in 1991. She claimed rape by Stewart prompted her lethal assault. At the time, Stewart had 30 convictions for fraud, false pretences and impersonation dating back 15 years, The Daily News in Halifax, via AP reports (http://www.miami.com/mld/miamiherald/email/news/breaking_news/10624201.htm?1c).



Following her release two years into a six-year sentence, Friedrich left Nova Scotia and eventually settled in Florida. She married second husband, Robert Friedrich, in 2001. The couple met through an

online matchmaking service. His death a year later at 83 initially caused no concern. But Florida police have now reopened the case after uncovering evidence that Friedrich drugged and defrauded her latest partner. Friedrich moved in with Alexander Strategos in Pinellas Park, near Tampa, Florida last year after meeting him through an online Christian dating service.

Trace of guilt

Soon afterwards, Strategos's son, Dean, became concerned when his father's health suddenly deteriorated. When a blood test by Dean on his father revealed traces of unprescribed sedatives he called in the police. A suitcase filled with pills was subsequently discovered at his father's condominium. Investigators say Friedrich drugged Strategos and persuaded him to hand her a power-of-attorney via which she withdrew $18,000 from his bank accounts over three months.

Friedrich has been charged being held on a charge of "exploitation of the elderly" with bail set at $10,000. She's not allowed to leaving the US. Friedrich is also in trouble for allegedly lying to the US Department of Homeland Security about her Canadian manslaughter conviction. No charges have been made in the death of Robert Friedrich. ®

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NOTES ON NEWSPAPER ACCOUNTS OF MALE ELDER ABUSE *

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R.L. McNeely is a professor of social welfare, at the University of Wisconsin-Milwaukee, and a practicing attorney. He has published books as well as articles appearing in professional journals focusing upon work and family issues, aging issues, racial issues, and on numerous aspects of domestic violence. He is a Research Fellow of the Gerontological Society of America, he has testified before Congress on the issue of domestic violence, he serves as a domestic violence consultant for the U.S. Army and, as an attorney, he has successfully represented individuals falsely accused of domestic violence.

Philip W. Cook, author of the volume, *Abused Men: The Hidden Side of Domestic Violence* (Praeger, 1997), is a former broadcast journalist who has won awards for his reporting from the Associated Press and from The Professional Journalism Society. His book, *Abused Men,* has received widespread praise from, among others, the West Coast Review of Books, The London Observer, the University of New Hampshire Family Research Laboratory, *The Detroit News*, and from "Dear Abby" (Abigail Van Buren). He also is president of Arrowdot Productions, a recently incorporated publishing company that has been established to produce broadcast media documentaries, and educational materials for the print media, focusing upon selected human rights issues, including domestic violence.

Keywords/Running Heads: Aging; domestic violence; caregiver abuse; elder abuse; economic exploitation; male elder abuse; male domestic violence victims.

*** Published in: *Journal of Elder Abuse and Neglect*, Vol. 19, (1/2), 2007: 99-108.**
Published simultaneously in hard copy: Jordan I. Kosberg, (Ed), Abuse of Older Men, Binghamton, N.Y: The Haworth Press, 2007: 99-108.

NOTES ON NEWSPAPER ACCOUNTS OF MALE ELDER ABUSE

A review of recent newspaper accounts detailing the abuse of elderly men yielded five categories of violence. These categories include cases involving: (a) economic abuse; (b) false allegations of prior abuse by the perpetrator; (c) non-relative caregiver abuse; (d) institutional caregiver abuse; and (e) abuse of male elders by family members. The categories are not mutually exclusive. Many of the reported cases involve murder. This brief note provides vivid accounts, within the five categories, which are offered to detail the actual experiences of the victims, rather than subsuming these victimization experiences within broad and comparatively sterile categorical classifications such as "elder abuse" or "elder neglect." The "grittiness" of these cases yields insight not only with respect to the terror experienced by some of these men, but also of their utter vulnerability, defenselessness, and susceptibility to their own victimization. Especially, it appears, in post-industrial countries where extended family ties often are not robust, social isolation and/or loneliness can be salient contributing aspects to the victimization, particularly in cases involving late-life intimate relationships.

Economic Exploitation

In Portland, Oregon, forty-three year-old Roxanna Thomas was charged with criminal treatment and theft involving an eighty-two year-old man after an investigation was launched following reports being made of the man's sudden change in attitude toward family members.[1] Thomas, who worked at a grocery store in which the elderly man shopped, "befriended" him, following which $530,000 worth of the victim's assets either were conveyed outright to Thomas, or her relatives, or the perpetrators were made joint owners of the victim's assets. Officials noted that elder abuse is epidemic in their Washington County community and that economic abuse of elderly men by strangers appears more common than either physical abuse or neglect. The victim ultimately benefited from intervention when he was the subject of an emergency guardianship and his financial accounts were frozen. Other men, ostensibly with little or no contact with relatives, or whose relatives were less vigilant, have not been as fortunate.

Two homeless elderly men, for example, fifty-year-old Kenneth McDavid, and seventy-three year-old Paul Vados, both of whom resided in Los Angeles, were found dead after being defrauded out of two million dollars by seventy-two year-old Olga Rutterschmidt and seventy-five year-old Helen Golay.[2] The women paid for apartments for the men over a period of two years in exchange for the men naming the women as beneficiaries of insurance policies procured by the women. Both men, subsequently, died when involved in separate hit-and-run automobile incidents. The women were arrested when surveillance revealed them talking to several other elderly men who also were observed signing documents provided by the women.

False Allegations: Victimization by Intimates

In another murder case, twenty-seven year-old Tatjana Edwards, married to seventy-two year-old Gwyn Edwards, was convicted of having murdered her elderly spouse, despite Edwards' false allegations, at trial, of having been physically abused by her husband. The two

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[1] Sandy James, "Woman Arrested After Trying to Bilk Elderly Man Out of More Than a Quarter Million Dollars," Media Information, Washington County, Portland, Oregon, Sheriff's Office, April 5, 2004.

[2] Peter Y. Hong, "Two Women Accused of Killing Transients Plead Not Guilty," Los Angeles Times, September 14, 2006; John Spano, "Police Still Seeking Three Men Linked to Women in Homeless Murder Case," Los Angeles Times, August 29, 2006; Paul Pringle, "Elderly Women Face Murder Charges," Los Angeles Times, August 1, 2006.

had met at the London, England massage parlor where Mrs. Edwards worked as a "massage therapist" prior to the marriage. In pronouncing sentence, Judge Geoffrey Rivlin, noting that she had falsely accused her husband of domestic violence and had shown no remorse or contrition, also commented:

> "You lived with him rather less than two years, during which time you took every penny off him you could, and when you could get no more you took his life away."

Edwards used a kitchen knife to stab her husband to death. She was sentenced to a life term, meaning she will have to serve a minimum of twelve years in prison.[3]

In a similar case, celebrated Canadian, Melissa Friedrich, was a cause célèbre for battered women until she pled guilty to felony charges arising from the victimization of a second elderly male. Friedrich, known as Melissa Stewart at the time she was celebrated, first made headlines in Nova Scotia as an abused woman who had struck back at her allegedly abusive husband, Gordon Stewart. In killing her husband, she gave him a lethal dose of pills, liquor, and rubbing alcohol, and then ran over him with her automobile on a deserted road near Halifax International Airport. Despite the crime's grisliness, Friedrich was featured in Canada's National Film Board documentary, *Why Women Kill*, as an exponent of battered women's syndrome, and she was given a governmental grant to fund an Ontario hotline for battered women. But she made news, again, following her marriage to eighty-four year-old Robert Friedrich, a man she had met on an Internet dating site, after his children successfully litigated a civil suit alleging that Friedrich had killed their father by administering a lethal overdose of drugs. But Friedrich's story didn't end there. Two years later, amid allegations that she was poisoning hospitalized seventy-three year-old Floridian, Alex Strategos, she was charged with several offenses, including defrauding Canada's social insurance system, after witnesses observed Friedrich forcing Strategos, on his hospital bed, to sign several documents.[4]

Non-relative Caregivers

Non-hospital and other non-institutionalized settings provide fertile opportunities for abuse because, unlike settings such as retirement homes, assisted living arrangements, and the like, privately arranged care-giving is not regulated. Absent state regulation and inspection, cases like that of fifty-nine year-old boarding home operator, Dorothea Puente, of Sacramento, California, can go on for years without detection.[5] It may also be that older care-giver women

[3] Paul Cheston, "Life for Gold-Digging Prostitute Who Murdered Husband of Seventy-Two," Evening Standard, March 24, 2006: P.2; Vickram Dodd, "Former Prostitute Found Guilty of Murdering The Husband She Thought Was A Millionaire," The Guardian, March 24, 2006: P.7; "Greedy Wife Gets Life for Murder," BBC News, March 24, 2006; "Tragic End to Unlikely Marriage," BBC News, March 23, 2006; "Estonian Prostitute Accused of Murdering Elderly Husband," UK News, March 7, 2006.

[4] Chris Tisch, "Scamming Woman Gets Five-Year Term," St. Petersburg Times, March 15, 2006; "Melissa Friedrich: Internet Black Widow," CBC News, March 14, 2005; John Leyden, "Internet Black Widow Stalked Pensioners on the Net," The Register, January 13, 2005; Jamie Thompson, "Police Say Woman Victimized Companion," St. Petersburg Times, January 12, 2005.

[5] Doug Nelson, "Valley of Death," Sacramento News and Review, May 2, 2006; Wayne Wilson, "Puente's Conviction Reaffirmed But Misconduct Charge Will be Probed," The Sacramento Bee, September 10, 1997, p. B1.

are assumed to be both less inclined and less capable than others of bringing about harm to men, thereby causing them to be more likely to escape suspicion and subsequent detection by law enforcement authorities. In Puente's case, nine bodies of elderly victims, one of whom had been dismembered with his head cut off, were found buried either in Puente's garden or within her boarding home's surrounding premises. Autopsies revealed that all of those murdered had been killed by drug overdoses. Puente's crimes eventually were discovered, but only after she continued to cash the governmental assistance checks of her victims. Puente, however, was convicted only of three murders, not nine, when a male juror refused to believe that she could have been responsible for all of the murders, pointing to an unsophisticated but pervasive belief that women just cannot be as dangerous, or as lethal, as males.

Another California case receiving media attention involved an elderly man brutalized by a burly male home health aide employed by the victim's wife.[6] The brutalized man, as he laid on a gurney in a Santa Ana hospital emergency room, repeatedly told the same story of the home health aide's beatings, while the aide, and the victim's wife, insisted that the elderly man had fallen. But the bruises on the man's chest were determined to be the result of having been punched, he had purple bruises *all over* his body with some of the bruises beginning to fade to yellow, and the man had the bloody outline of a shoe on his leg. Perhaps, in part because the perpetrator was male, a prosecutor was sufficiently convinced to charge the aide with a felony, despite the victim having manifested signs of dementia when interviewed.

Institutional Caregivers

While fertile ground exists for abuse to occur in unlicensed and non-regulated care-giving settings, deterrents imposed by state authority by no means eliminate abuse in licensed institutional settings, as the case of military veteran, Thomas Joyner, illustrates. Fifty-two year-old wheelchair-bound Joyner, a resident of a state run home for veterans located in Barstow, California, had just lit a cigarette when he was accosted by the home's acting administrator, and two employees, who promptly broke Joyner's finger in forcing the cigarette from his hand. Barstow, who had lighted the cigarette in an area of the home referred to as the "olive garden," unknowingly had violated a very recently enacted rule limiting smoking to certain hours and prohibiting smoking in certain areas, such as the olive garden. As noted by Joyner, the three women approached him from behind, held him down, forcibly took the cigarette, breaking the fourth finger on his right hand, and then searched his pockets for more cigarettes. Joyner reported that he said: "Help, you are hurting me...Please don't take my cigarettes." Joyner is partially paralyzed, has impaired speech, limited vision and hearing, and he requires assistance in eating, bathing, and taking his medications. Less than two months after his incident, the facility was fined $95,000 in the death of a World War II infantryman and, prior to the infantryman's case, the facility had been ordered to pay fines for the death of a veteran involved in an eating incident, and for the death of another veteran whose diabetes had not been monitored properly. The California Highway Patrol, which investigates crimes occurring on state property, urged prosecutors to file elder abuse charges, in Joyner's case, against the three women.[7]

[6] Jane Gross, "Forensic Skills Seek to Uncover Hidden Patterns of Elder Abuse," The New York Times, September 27, 2006.

[7] Carl Ingram, "CHP Alleges Elder Abuse at Veterans Home: Three Employees of a Barstow Facility Are Accused of Breaking Resident's Finger While Taking a Cigarette from Him," The Los Angeles Times, February 26, 2003: p. B.8.

Nursing home resident, seventy-eight year-old Alzheimer's patient, Marshall Rhodes, was beaten at the hands of his institutional caretaker over an eight-month period following which he subsequently died. He had been taken to a hospital after nurses discovered him in his room clothed in a torn and blood-stained sleeping gown. Six months prior to his death, two nursing assistants reported to two supervisors their suspicions that aide Karl Willard was beating Rhodes, but their protestations were rebuffed. Subsequently, Charles B. Kaiser, III, president of the company which operated the home, American Healthcare Management, received the maximum penalty of one year in jail with a fine of $1,000 for having failed to report elder abuse to the state. Additionally, American Healthcare Management, and the home, St. Louis's St. Charles Claywest, also were convicted for failing to report the abuse and each were given maximum fines under Missouri law of $5,000. Karl Willard was found guilty of elder abuse and is serving fifteen years in prison. Prior to the Rhodes' case, American Healthcare Management and Claywest had settled several wrongful death cases out of court. Reportedly, this was the first instance in the State of Missouri in which a nursing home executive was sentenced to jail in a case involving patient abuse.[8]

Family Caregivers

Sixty-eight year-old retiree, plumber, Robert Heitzman, who had suffered debilitating strokes for nearly twenty years, was found dead in the home he shared with his family. He died, lying in excrement, of septic poisoning resulting from infected bedsores due to his being bedridden on the exposed springs of a mattress that was rotting away from his own bodily secretions. At trial, the presiding judge noted that Heitzman's sons could have made a simple phone call to relieve their father of severe suffering. It also was asserted by the prosecutor that the sons failed to do so because the victim was receiving monthly payments of nearly eight hundred dollars in combined Veterans Administration and Social Security payments. Both sons, Jerry and Richard, were convicted of involuntary manslaughter, and sentenced to four-year terms.[9]

Ralph Dills, formerly lauded as a venerable judge and lawmaker who had served longer than any other politician in California, died on his fifty acre ranch, unable to take a shower when often left alone because feces from his wife's rottweilers littered his bathroom. His wife, fifty-seven year-old Wendi Lewellen, who also was Dills' former non-adopted stepdaughter, had married the ninety-one year-old former lawmaker, less than a year prior to his death, while he already was suffering from Alzheimer's. As reported by family members and confirmed by court and medical records, Lewellen deceived her stepfather by impersonating her deceased mother, thereafter plundering Dills' estate to such an extent that Dills thought he was going broke despite receiving nearly $14,000, monthly, in pensions and Social Security. Allegedly, and prior to the marriage, Lewellen, wielding undue influence, also was the cause of her brother, Leighton Dills, being omitted from the will of Ralph and Elizabeth Dills. Elizabeth Dills, who died in 2000, was Lewellen's natural mother.[10]

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[8] Valerie Schremp, "Nursing Home Chief Gets One-Year Sentence; He Failed to Report Elderly Abuse," St. Louis Post-Dispatch, February 7, 2003: p. A.1.

[9] Mark I. Pinsky, "Sons Get Prison for Fatal Neglect of Their Father, Courts: Judge Cites 'Cruelty and Depravity' of Huntington Beach Brothers Who are Sentenced to Four Years for Letting Parent Die of Septic Poisoning on His Rotting Mattress," Los Angeles Times, March 26, 1993: p. 1.

[10] "Elder Abuse Suspected in Dills' Marriage," Daily Breeze (Torrance CA), August 19, 2002: p. A9.

Comments

One theme emerging from the accounts is that many of the victimized men appear isolated, infirm, lonely, and bereft of vigilant family members concerned about their care. One impaired individual who subsequently became a ward had manifested a "sudden change" in attitude toward his family following meeting a younger woman, two individuals were homeless, another married a much younger woman who was a prostitute, and yet another married a woman he met on an Internet dating site. Other victims resided in non-regulated boarding home settings but some victims were domiciled in institutional settings employing staff reminiscent of those portrayed in the movie, *One Flew Over the Cuckoo's Nest.* On the other hand, several cases involved the complicity of relatives, ostensibly motivated primarily by exploitative economic gain, but one older man was saved from further economic victimization by vigilant family members, whereas another was saved from possible death by witnesses who were vigilant in their observation of his hospital care. Economic motivations were at the heart of many of the cases. Poisoning appeared to be the method of choice in cases involving murder.

In the majority of cases, the victim was infirm prior to being victimized. One individual was sufficiently impaired as to require a court-ordered guardianship over his person and estate, one was partially paralyzed with other infirmities, two were victims of Alzheimer's, and one had suffered debilitating strokes prior to his exploitation. These elderly men were particularly vulnerable, virtually defenseless, and exceedingly susceptible to becoming prey of the unscrupulous.

Many of the unscrupulous perpetrators were women, and some of the women had gone undetected for years despite leaving numerous corpses or individuals victimized by other means in their wake. Given the grisliness of their crimes, one is forced to wonder about a prevailing view held by many that women involved in domestic violence simply are not capable of being as lethal as men. Late-life marriages appeared especially implicated in the victimizations.

One theme, not particularly explicated in the accounts, is that perpetrators, institutional and otherwise, tend to receive comparatively meager punishment for their crimes. One individual perpetrator, for example, was even celebrated as a victim of domestic violence, one murderer received a "stiff" sentence of life imprisonment that required a minimum incarceration of only twelve years, another whose vulnerable victim subsequently died will be incarcerated only for fifteen years, and two others received respective terms only of four years.. As noted in the accounts, institutional perpetrators are just beginning to be prosecuted.

Another theme not explicitly addressed by the accounts is the role of agency and conservatorships in economic exploitation. An unscrupulous person designated by an infirm older individual as the elder's attorney-in-fact, or agent, via a power-of-attorney document, is granted license virtually to loot the elderly person's estate. The only recourse is for a person, or persons, with "standing" recognized by a court, to file suit, following which they must prove that the agent did not act in the best interests of the elder. By then, most often, it is too late. Indeed, in some states, conservators can be appointed without notice to the elder, whereas other states allow a decedent's creditor to become executor of the decedent's estate.[11] These scenarios leave the door wide open for financial abuse, during life, and afterwards.

[11] "State Needs Better Oversight of Professional Conservators; Unwanted Takeover of O.C. Senior's Affairs Raises Concern," Los Angeles Times (Orange County Edition), December 7, 1997: p. 8; Wisconsin Statutes, § 856.07(2).

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Opinion

Right To Die Is Prescription For Abuse

Updated: 7:55 PM 5/28/2010

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

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

Do not be deceived.

Nancy Elliott, Merrimack, N.H.

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Top of page

Opinion

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Box 2: Estimated frequencies of medical end-of-life decisions and continuous deep sedation in the Netherlands in 2005 and 2001 (death certificate study)

	2005		2001	
	Abs.	%*	Abs.	%*
Medical decisions on end of life:				
Euthanasia	2,325	1.7	3,500	2.6
Physician-assisted suicide	100	0.1	300	0.2
Ending of life without an explicit request of the patient	550	0.4	950	0.7
Intensified alleviation of pain or symptoms with hastening of death as a possible side effect	33,700	25	29,000	21
Abandoning potentially life-prolonging treatment	21,300	16	28,000	20
Continuous deep sedation:				
With medical end-of-life decisions†	9,700	7.1	8,500	6.0
Without medical end-of-life decisions	1,500	1.1	‡	

* Percentage of all deaths

† Cases of continuous deep sedation in which a medical decision was taken with the shortening of the patient's life as a possible or intended consequence were, depending on the answers given by the physician, classified as abandoning life-prolonging treatment, intensifying the alleviation of pain or symptoms, or (rarely) as ending of life. These cases should therefore not be added to the total number of medical end-of-life decisions.

‡ Unknown for 2001

Medical decision-making at the end of life (chapters 5, 6, 7, §12.2)

Box 2 gives the major frequency estimations of medical end-of-life decisions in 2005 and 2001. Cases were classified as euthanasia when the physician had indicated that decease was caused by a medicine administered at the explicit request of the patient with the explicit intention of hastening the end of the patient's life. One of the most remarkable findings in the practical investigation is the decrease in euthanasia and assistance in suicide in 2005 compared to 2001 and 1995. The number of requests for euthanasia 'in due course' (from 34,700 in 2001 to 28,600 in 2005) and 'within the foreseeable future' (from 9,700 in 2001 to 8,400 in 2005) also have decreased. This decline is linked to

This excerpt from the most recent official report on Euthanasia from the Dutch government, can be viewed here: http://english.minvws.nl/en/ (then go to "themes," then "euthanasia" and then scroll down the page for the "evaluation").

PSYCHIATRIC SERVICES

Psychiatr Serv 51:1578, December 2000

Book Review

Blind Eye: How the Medical Establishment Let a Doctor Get Away With Murder

by James B. Stewart; New York City, Simon & Schuster, 1999, 334 pages, $25 hardcover, $14 softcover

Dorothy Packer-Fletcher, M.F.A. and Kenneth E. Fletcher, Ph.D.

This biography of Michael Swango, M.D., by Pulitzer Prize winner James B. Stewart, is not only the chilling story of a psychopathic serial poisoner. It is also a cautionary tale about how the medical profession can at times misguidedly protect its own.

Michael Swango, the favorite son of a doting mother and an often absent, alcoholic, military father, showed great promise at an early age. He excelled in schoolwork, in music, and in athletics. However, from his early days in medical school, it was obvious to some of Swango's classmates that something was wrong. His work was sloppy. Among other things, he mangled his cadaver, and he failed to recognize an X-ray of the heart. At the same time, he regularly commuted 100 miles to work as an emergency medical technician, which was against school regulations.

When students finally raised charges against him because they felt he was not competent to become a physician, Swango managed to win over school administrators with his clean-cut good looks, his boundless energy, and his willingness to work hard to prove himself. When the faculty chose to allow him to graduate despite his poor performance, this first opportunity to remove him from the medical profession was missed.

Swango then became a resident at Ohio State. While he was there, serious questions were raised about whether he had attempted to poison one of his patients by injecting something into her IV line. However, since the main complaints had been raised by a nurse and the patient's elderly roommate, the doctors and administrators minimized the complaints and chose to protect a fellow physician. Once again, the serial killer slipped through the net.

Fascinated by poisons, violent death, and serial killers—which were often compulsive topics of his conversations with others—Dr. Swango managed to continue practicing medicine and killing patients. The law finally caught up with him in 1985 for attempting to poison several coworkers. Incredibly, after serving time for this felony, he went on to continue to practice medicine, both in the United States and in Africa.

Throughout his travels, questionable deaths and charges of poisoning patients dogged him. It was not until he had to stop in the United States to pick up a visa on his way to Saudi Arabia, where he was slated to take up yet another position as a practicing physician, that he was arrested and convicted of falsifying statements and documents related to a previous application for a position at a Veterans Administration hospital in New York.

Although it is rare, thankfully, to find a psychopathic serial killer among the ranks of the medical profession, it is tragically common for doctors to be unwilling to report incompetent physicians to the national data bank, let alone to try to remove them from the medical profession. If the first oath of all physicians is to do no harm, allowing incompetent physicians to practice raises serious moral questions. It also raises malpractice

premiums. Patients and doctors alike would be well advised to read *Blind Eye* and to reconsider the options for protecting medicine from bad practitioners.

Footnotes

Ms. Packer-Fletcher is a freelance writer, and Dr. Fletcher is assistant professor of psychiatry and director of the behavioral sciences research core at the University of Massachusetts Medical Center in Worcester.

IN THE SELECT COMMITTEE OF THE NATIONAL ASSEMBLY OF QUEBEC, DYING WITH DIGNITY

SECOND BRIEF OF MARGARET DORE OPPOSING EUTHANASIA/ASSISTED SUICIDE BASED ON ELDER ABUSE, THE "BARBARA WAGNER" SCENARIO AND SUICIDE PREVENTION

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TABLE OF CONTENTS

I. THE AUTHOR

I am an elder law attorney in Washington State, USA, where assisted suicide is legal.[1] In July 2010, I submitted a brief to this Committee titled: "Brief of Margaret Dore Opposing Euthanasia and Assisted Suicide Based on Elder Abuse."

II. SUMMARY

The Committee's consultation document suggests that euthanasia and/or assisted suicide should be legalised.[2] The document, however, overlooks elder abuse.[3] The document also relies on erroneous information about the Oregon and Washington assisted suicide laws, to the effect that these laws assure patient choice, which is not the case. These laws are, instead, a recipe for abuse. Euthanasia/assisted suicide should also be rejected due to the "Barbara Wagner" scenario and public policies such as suicide prevention.

---

[1] I am an attorney licensed to practice in Washington State since 1986. I am a former Law Clerk to the Washington State Supreme Court for then Chief Justice Vernon Pearson. I am a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. For more information, see www.margaretdore.com.

[2] The consultation document invites all points of view. The document's focus is, nonetheless, on how legalization should occur as opposed to whether it should occur. *See e.g.* questions posed on pages 21-26.

[3] The consultation document does not mention elder abuse by family members and others seeking to benefit from the death, for example, due to an inheritance.

III. DISCUSSION

A. Canada and Most States Have Rejected Euthanasia/ Assisted Suicide

In 2010, the Canadian Parliament rejected a bill that would have legalized euthanasia and assisted suicide throughout Canada.[4] The vote was 228 to 59.[5] In the United States, the majority of states to consider legalizing euthanasia/assisted suicide have also rejected it.[6]

There are just two states where euthanasia/assisted suicide is legal: Oregon and Washington.[7] Oregon's "Death with Dignity Act" went into effect in 1997.[8] Washington's act, which is modeled on Oregon's act, was passed in 2008 and went into effect

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[4] *See* Canadian government website at http://bit.ly/Official_Report_C-384 (last visited October 22, 2010) and *How'd They Vote: Bill C-384,* available at http://howdtheyvote.ca/bill.php?id=2053 (last visited Nov. 14, 2010). (Attached at B-1).

[5] Id.

[6] Int'l Task Force, *Attempts to Attempts to Legalize Euthanasia/Assisted Suicide in the United States,* available at http://www.internationaltaskforce.org/pdf/200906_attempts_to_legalize_assisted_suicide.pdf (last visited October 22, 2010)("Between January 1994 and June 2009, there were 113 legislative proposals in 24 states. All were either defeated, tabled for the session, or languished with no action taken.")(Attached at B-2)

[7] In Montana, there is a court decision that gives doctors a potential defence to criminal prosecution for aiding a suicide. This decision does not legalize assisted suicide. *See* Margaret Dore & Senator Greg Hinkle, "Report to the 62nd Legislature for the State of Montana: The Montana Patient Protection Act, Nov. 5, 2010, available at http://www.margaretdore.com/pdf/HinkleReport.pdf.

[8] *See* the 2009 annual report for Oregon's Death with Dignity Act, available at http://www.oregon.gov/DHS/ph/pas/docs/year12.pdf (Act "enacted in late 1997").

in 2009.[9]

B. The Oregon and Washington Acts

1. "Choice" is not assured

As noted in my prior brief, the Oregon and Washington acts have significant gaps so that patient choice is not assured.[10] For example, neither act requires witnesses at the death.[11] If the patient struggled, who would know?

2. "Self-administer"

The consultation document states that under the Oregon act: "The patient must self-administer the medication (without assistance) . . ."[12] The document also states that Washington's act is similar to Oregon's act.[13] There is, however, nothing in either act that requires a patient to administer the lethal dose to himself.

The Washington act does state that patients "self-administer" the lethal dose.[14] "Self-administer" is, however, a

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[9] The Washington Death with Dignity Act was passed via a voter's initiative in November 2008. It went into effect in 2009. *See* WASH. REV.CODE ANN. § 70.245.903.

[10] Brief of Margaret Dore Opposing Euthanasia and Assisted Suicide Based on Elder Abuse, July 16, 2010, pages 3-4.

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

[12] Consultation document, at 33.

[13] Id. at 34.

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

defined term that means the "act of ingesting." The Washington act states: "'*Self-administer' means a qualified patient's act of ingesting* medication to end his or her life . . ." (Emphasis added).[15] In other words, someone else putting the lethal dose in the patient's mouth qualifies as proper administration because the patient will thereby "ingest" the dose.[16] Someone else putting the lethal dose in a feeding tube or IV nutrition bag will also qualify because the patient will thereby "absorb" the dose, i.e., "ingest" it.[17]

Oregon's act does not use the term "self-administer."[18] The act does, however, refer to administration as the "act of ingesting."[19] Official forms for both acts also refer to administration as "ingestion," "ingesting" and other forms of the word "ingest."[20] With administration defined as mere ingestion,

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15 WASH. REV. CODE ANN. § 70.245.010(12). (Attached at B-3).

16 Neither Act defines "ingest." *See* Washington and Oregon Acts at note 11. Dictionary definitions of "ingest" include "*to take* (food, drugs, etc.) *into the body, as by swallowing*, inhaling, *or absorbing*." (Emphasis added). Webster's New World College Dictionary, www.yourdictionary.com/ingest (last visited Nov. 14, 2010). (Attached at B-4).

17 *See* Webster's New World College Dictionary, defining "ingest" at note 16.

18 *See* Oregon's act in its entirety, at note 11.

19 *See* OR. REV. STAT. § 127.875 § 3.13 (stating "[n]either shall a qualified patient's *act of ingesting* medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy." (Emphasis added)). (Attached at B-5).

20 *See e.g.* Washington's "Attending Physician's After Death Reporting" form, http://www.doh.wa.gov/dwda/forms/AfterDeathReportingForm.pdf (referring to administration of the lethal dose as "ingestion," "ingesting" and other forms of the word "ingest")(last visited Nov. 14, 2010)(Attached at B-6 to B-10). *See also* "Oregon's Death With Dignity Act Attending Physician Interview"

someone else is allowed to administer the lethal dose to the patient.

3. Euthanasia

The consultation document lists the Oregon and Washington acts as only providing assisted suicide.[21] However, with someone else allowed to administer the lethal dose to the patient, these acts also allow euthanasia. The consultation document defines euthanasia as follows: "An act that consists of deliberately causing the death of another person . . ."[22]

A counter-argument would be that the Oregon and Washington acts prohibit "euthanasia," which is another name for mercy killing.[23] This prohibition is, however, defined away in the next sentence. For example, the Washington act states:

> Nothing in this chapter authorizes . . . mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute . . . mercy killing [also known as "euthanasia"] . . ."[24]

Similarly, the Oregon act states:

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form, http://www.Oregon.gov/DHS/ph/pas/docs/mdintdat.pdf (also referring to administration of the lethal dose as "ingestion," "ingesting" and other forms of the word "ingest"). (Last visited November 14, 2010) (Attached at B-11 to B-16).

[21] Consultation document, pp. 16-17 & 33-34.

[22] *See* consultation document, page 10.

[23] "Mercy killing" means "euthanasia." *See* http://medical-dictionary.thefreedictionary.com/mercy+killing (Attached at B-17).

[24] WASH. REV. CODE ANN. §§ 70.245.180(1). (Attached at B-18).

> Nothing in [this act] shall be construed to authorize . . . mercy killing or active euthanasia. Actions taken in accordance with [this act] shall not, for any purpose, constitute . . . mercy killing [also known as "euthanasia"] . . . .[25]

C. A Bipartisan Vote Defeats Assisted Suicide

In 2010, a bill modeled on Oregon's act was defeated in the New Hampshire House of Representatives.[26] New Hampshire Representative Nancy Elliott states:

> [M]any legislators who initially thought that they were for the act became uncomfortable when they studied it further.[27]

In New Hampshire, the vote to defeat assisted suicide was bipartisan.[28] The vote was also by a wide margin, 242 to 113.[29]

D. Oregon: A Positive Correlation Between Legalization of Assisted Suicide and Increasing Suicide Rates

According to a recent report from the Oregon Health Authority, Oregon's suicide rate, which excludes suicide under

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[25] OR. REV. STAT. § 127.880 § 3.14. (Attached at B-19).

[26] *See* New Hampshire House Record, No. 9, January 13, 2010 regarding HB 304, at http://www.gencourt.state.nh.us/house/caljourns/journals/2010/houjou2010_09.html (last visited Nov. 4 2010). (Attached at B-20). ("This bill is modeled on the Oregon death with dignity law").

[27] Nancy Elliott, Letter to the Editor, *Right to Die is Prescription for Abuse*, Hartford Courant, May 28, 2010, *available at* http://articles.courant.com/2010-05-28/news/hc-elliott-letter-suicide-0528-20100528_1_new-hampshire-abuse-prescription (last visited Nov. 14, 2010) (Attached at B-21).

[28] *See* E-mail from New Hampshire General Court Staff with vote breakdown by party; a "yea" vote is a vote to defeat the bill: 242 yeas (100 Democrats; 142 Republicans); 113 nays (93 Democrats; 20 Republicans). (Attached at B-22).

[29] Id.

Oregon's assisted suicide act, is 35% higher than the US national average.[30] This rate has been "increasing significantly since 2000."[31] Just three years prior, Oregon legalized physician-assisted suicide.[32] There is at least a statistical correlation between these two events.

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

E. Washington: Legalization Brought "Dr. Death"

Philip Nitschke is the founder of Exit International, a suicide/euthanasia promotion and retail company based in Australia.[33] After the passage of Washington's act in 2008, he told reporter Elenor Schoen that the act "is helpful to us."[34]

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[30] Oregon Health Authority, News Release, *Rising suicide rate in Oregon reaches higher than national average*, September 9, 2010, available at http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf (Last visited October 13, 2010). (Attached at B-23). An assisted suicide under Oregon's assisted suicide law is not tallied as a "suicide." *See* OR. REV. STAT. 127.880 § 3.14 ("Actions taken in accordance with ORS 127.800 to 127.897 [the Oregon Death With Dignity Act] shall not, for any purpose, constitute suicide . . . under the law"). (Attached at B-24).

[31] Oregon Health Authority, *Rising suicide rate*, at note 30.

[32] *See* 2009 Annual Report, Oregon's Death with Dignity Act, http://www.oregon.gov/DHS/ph/pas/docs/year11.pdf (Last visited October 14, 2010). (Attached at B-25). (Oregon's act "was enacted in late 1997").

[33] *See e.g.*, PHILLIP NITSCHKE & FIONA STEWART, THE PEACEFUL PILL HANDBOOK, Exit International USA, as of October 10, 2009, giving explicit instructions on: how to kill yourself (& others); how to purchase the necessary equipment; and/or how to evade the authorities. (Excerpts attached at B-26 to 37). *See also* Exit International's Retail order form. (Attached at B-38).

[34] Elenor Schoen, Letter to the Editor, *Legalization of assisted suicide brought "Dr. Death,"* Missoulan, July 8, 2010, available at http://missoulian.com/news/opinion/mailbag/article_2cd65f76-8912-11df-96e1-001cc4c002e0.html (Last visited October 22, 2010). (Attached at B-39).

He also moved part of Exit's retail operation to Washington.[35]

In Washington, Exit now sells equipment for the purpose of committing suicide via the "Exit Bag" method, which uses helium to cause a hypoxic death.[36]

Nitschke's target market is the "well elderly."[37] In June 2010, however, his ideas were linked to the suicide deaths of James Robertson, age 19, and Robert Miller, age 20.[38]

F. The "Barbara Wagner" Scenario

In Oregon, patients have been denied desired treatment and offered assisted suicide instead. The most well-known case involves Barbara Wagner.[39] The Oregon Health Plan refused to pay for a drug to possibly prolong her life and offered to pay for

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[35] *See* Washington State Secretary of State printout regarding Exit International (showing Exit's incorporation in Washington State on December 7, 2009 and listing Nitschke as one of three directors). (As of December 7, 2009). (Attached at B-40).

[36] PHILLIP NITSCHKE & FIONA STEWART, supra at note 33, at 74 to 83, explaining Exit Bag method. (Attached at B-27 to B-31) *See also* Exit Store Retail order form for Bellingham Washington, giving prices for: "exit gas flow controls," which retail for $74.00; and an "exit pressure gauge and tube," which retail for $55.00. (Attached at B-38).

[37] Elenor Schoen, supra at note 34.

[38] Id. *See also* Jane Simpson & Patricia Kane, *'Suicide by laptop' riddle of two brilliant students found dead in hotel room*, The Daily Mail, June 14, 2010, available at http://www.dailymail.co.uk/news/article-1286170/Laptop-suicide-riddle-brillian t-students-dead-hotel-room.html, stating that "the tragedy has raised fears that the pair were influenced by Australian doctor Philip Nitschke . . . ." (Last visited October 22, 2010). (Attached at B-41)

[39] video transcript of Barbara Wagner, http://www.katu.com/news/26119539.html?video=YHI&t=a (last visited Nov. 14, 2010) (attached at B-43 & B-44); Kenneth Stevens, MD, Letter to the Editor, Oregon mistake costs lives, *The Advocate*, the official publication of the Idaho Bar Association, September 2010 at http://www.isb.idaho.gov/pdf/advocate/issues/adv10sep.pdf. (Attached at B-46 to B-47).

her suicide instead.[40] In other words, she was steered to suicide. Wagner did not see this event as a celebration of her "choice." She said: "I'm not ready, I'm not ready to die."[41]

If euthanasia/assisted suicide is legalised in Quebec, will this scenario become part of your healthcare?

G. "Choice" Doesn't Mean One's Personal Choice

In the United States, the main proponent of assisted suicide is Compassion & Choices, a successor organization to the Hemlock Society.[42] Its constant theme is that "aid in dying" promotes choice.[43]

After Wagner's death, however, Compassion & Choices's president, Barbara Coombs Lee published an editorial arguing against Wagner's choice to try and beat her cancer.[44] Coombs Lee also defended the Oregon Health Plan and argued for a public policy change to discourage people from seeking cures.[45]

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[40] Video transcript, supra at note 39.

[41] Id.

[42] IAN DOWBIGGIN, A CONCISE HISTORY OF EUTHANASIA 146 (2007)(In 2003, Hemlock changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices). (Attached at B-48).

[43] *See e.g.* Kathryn Tucker, Director of Legal Affairs for Compassion & Choices, "Aid in Dying: Law, Geography and Standard of Care in Idaho, *The Advocate*, August 2010, pages 42-46, available at http://www.isb.idaho.gov/pdf/advocate/issues/adv10aug.pdf.

[44] Barbara Coombs Lee, *Sensationalizing a sad case cheats the public of sound debate*, The Oregonian, November 29, 2008, *available at* http://www.oregonlive.com/opinion/index.ssf/2008/11/sensationalizing_a_sad_case_ch.html (Last visited February 16, 2009). (Attached at B-49 to B-51).

[45] *Id.* She stated: "The burning health policy question is whether we inadvertently encourage patients to act against their own self interest, chase an unattainable dream of cure and foreclose the path of acceptance that

Compassion & Choices appears to be following a historical pattern. Canadian historian, Ian Dowbiggen, offers this description of Charles Potter, head of the Euthanasia Society of America during the 1930's:

> Despite his repeated invocations of individual freedom as a political goal, Potter, a supporter of involuntary eugenics and euthanasia, was no defender of laissez-faire personal choice. . . . If human beings were to be freed from long-standing moral and ethical beliefs, it was to enable them to make the right choices, not any choice whatsoever. Choice did not mean freedom to do what individuals pleased, but empowerment to do what a scientifically grounded humanism taught them to do.[46]

H. William Melchert-Dinkel

In March 2008, a depressed Canadian teen, Nadia Kajouji, killed herself after entering a suicide pact with another young woman she had met online. "Cami" was actually a middle-aged man, William Melchert-Dinkel, who has been linked to multiple suicide deaths.[47] He is alleged to have trolled the Internet impersonating young women so as to induce victims to hang themselves in front of a webcam so that he could watch.[48]

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curative care has been exhausted . . . Such encouragement serves neither the patients, families, nor the public." (Attached at B-50).

[46] IAN DOWBIGGEN, at note 42, at page 83 (Attached at B-52).

[47] Ian MacLeod, Minnesota man linked to death of Carleton student admits encouraging five suicides: affidavit, The Ottawa Citizen, May 11, 2009, attached at B-53 & B-54. *See also*: *Death Online Timeline*, The Fifth Estate, at http://www.cbc.ca/fifth/2009-2010/death_online/timeline.html (last visited October 24, 2010); *Death Online Synopsis*, The Fifth Estate, attached at B-55 & B-56.

[48] Id.

Instant messages from him to Nadia include the following:

> Get a yellow nylon rope about eight feet. . . . [L]ook around your apartment for somewhere to hang from. I can help you with the cam when you need to.[49]

On April 23, 2010, Melchert-Dinkel was charged in Minnesota with aiding Nadia's suicide.[50] He was also charged in connection with the suicide death of Mark Drybrough, age 32.[51] According to the charging document, Melchert-Dinkel's motivation was the "thrill of the chase."[52]

On November 8, 2010, the Minnesota court denied Melchert-Dinkel's motion to dismiss.[53] The court's holding included that Minnesota's statute criminalizing assisted suicide was not discriminatory. The court stated:

> The statute . . . does not limit or classify the types of offenders that can be prosecuted thereunder.[54]

If, however, Minnesota also had legal assisted suicide, this might not be the case: There would be one rule for doctors and

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[49] Harpers's Magazine, *Hope I'm being a help to you*, September 2009, quoting instant messages between Nadia and Melchert-Dinkel. (Excerpt attached at B-57).

[50] State v. Melchert-Dinkel, Criminal Complaint, filed April 23, 2010, available at http://www.cbc.ca/news/pdf/melchert-dinkel-complaint.pdf (Attached at B-58 to B-64).

[51] Id.

[52] Id. at B-61 ("[Melchert-Dinkel] estimated he most likely encouraged dozens of persons to commit suicide and characterized it as the thrill of the chase").

[53] Omnibus Order and Memorandum, 11/8/10 (Excerpts at B-66 to B-68).

[54] Id. at B-68.

others such as family members who advise and encourage suicide under the assisted suicide statute and another rule for everyone else.

If euthanasia/assisted suicide is legalised in Quebec, will legalization interfere with the protection of depressed people?

IV. CONCLUSION

Legalized euthanasia/assisted suicide is not about promoting personal choice. These laws are instead a recipe for abuse. This Committee should reject legalization of euthanasia and assisted suicide.

Respectfully submitted this 15th day of November 2010

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

Votes:

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

Related Bills:

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

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B-1

Attempts to Legalize Euthanasia/Assisted Suicide in the United States

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

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

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

.....

Ballot Initiatives that Passed

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

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

Ballot Initiatives that Were Defeated

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

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

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

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

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in the state of Washington.

(11) "Qualified patient" means a competent adult who is a resident of Washington state and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.

(12) "Self-administer" means a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner.

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

CREDIT(S)

[2009 c 1 § 1 (Initiative Measure No. 1000, approved November 4, 2008), eff. March 5, 2009.]

West's RCWA 70.245.010, WA ST 70.245.010

Current with all 2010 Legislation

END OF DOCUMENT

Washington Act

ingest definition

in·gest (in jest′)

transitive verb

to take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing

Origin: < L *ingestus*, pp. of *ingerere*, to carry, put into < *in-*, into + *gerere*, to carry

Related Forms:

- **ingestion in·ges′·tion** ***noun***
- **ingestive in·ges′·tive** ***adjective***

in·gest (ĭn-jĕst')

transitive verb **in·gest·ed, in·gest·ing, in·gests**

1. To take into the body by the mouth for digestion or absorption. See Synonyms at eat.
2. To take in and absorb as food: *"Marine ciliates ... can be observed ... ingesting other single-celled creatures and harvesting their chloroplasts" (Carol Kaesuk Yoon).*

Origin: Latin *ingerere, ingest-* : *in-*, *in*; see **in-** [2] + *gerere, to carry*.

Related Forms:

- **in·gest'i·ble** ***adjective***
- **ingestion in·ges'tion** ***noun***
- **ingestive in·ges'tive** ***adjective***

B-4

Westlaw.

O.R.S. § 127.875

C

West's Oregon Revised Statutes Annotated Currentness
Title 13. Protective Proceedings; Powers of Attorney; Trusts
Chapter 127. Powers of Attorney; Advance Directives for Health Care; Declarations for Mental Health Treatment; Death with Dignity
The Oregon Death with Dignity Act (Refs & Annos)
(Safeguards) (Section 3)

127.875. § 3.13. Insurance or annuity policies

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

CREDIT(S)

Laws 1995, c. 3, § 3.13.

O. R. S. § 127.875, OR ST § 127.875

Current through 2010 Special Session Laws. Revisions to Acts made by the Oregon Reviser were unavailable at the time of publication.

END OF DOCUMENT

Washington State Department of Health

ATTENDING PHYSICIAN'S AFTER DEATH REPORTING FORM

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

Dear Physician:

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

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

Physician's Name: _____

Date: ___/___/___

Patient Name: _____

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

County of Death: _____

Washington's After Death Reporting Form
- questions regarding "ingestion"
- no questions regarding patient consent when the lethal dose was administered.

1. What was the patient's underlying illness?

   _____

   _____

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

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

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

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

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

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

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

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

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

   A concern about:

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

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

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

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

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

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

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

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

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

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

   _____

   _____

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

X

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

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

"Took or Take" is a word like ingest – consent not necessarily occurring No question regarding consent.

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

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

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

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

_____

☐ 3 No
☐ 9 Unknown

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

☐ 1 Yes
☐ 2 No

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

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

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

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

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

☐ 1 Yes
☐ 2 No

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

_____

_____

_____

☐ 9 Unknown

B-8

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

☐ 1 Yes

Please Describe:

_____

_____

_____

☐ 2 No
☐ 9 Unknown

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

☐ 1 Yes

Please describe:

_____

_____

_____

☐ 2 No
☐ 9 Unknown

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

Minutes: _____ or Hours: _____ ☐ Unknown

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

Minutes: _____ or Hours: _____ ☐ Unknown

If the patient lived longer than six hours:

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

_____

_____

_____

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

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

B-9

20. Where did the patient ingest the medication?

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

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

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

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

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

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

Years: ____

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

_____

_____

_____

Original Signature of Physician: _____

FOR OFFICIAL USE ONLY

CASE ID NUMBER:

☐ DWDA ☐ ILLNESS ☐ OTHER

PHYSICIAN ID NUMBER:

B.10

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

Oregon Death with Dignity Act
Attending Physician Follow-up Form

Dear Physician:

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

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

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

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

Name of Attending (Prescribing) Physician: _____

_____

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

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

Attending (Prescribing) Physician Signature _____

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

Attending (Prescribing) Physician Signature _____

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

Please specify: _____
_____
_____

Attending (Prescribing) Physician Signature _____

Oregon Reporting Form
- questions regarding ingestion
- no questions regarding whether patient consented at the time of ingestion" or "taking the dose.

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

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

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

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

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

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

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

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

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

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

"Took" does not necessarily mean a voluntary act. See the definition of "ingest" at B-4: "To take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing"

- ☐ 1 Yes
- ☐ 2 No

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

X

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

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

- ☐1 Yes
- ☐ 2 No

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

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

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

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

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

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

X

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

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

X

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

Minutes: _____ or Hours: _____ ☐ Unknown

X

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

Minutes: _____ or Hours: _____ ☐ Unknown

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

_____

_____

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

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

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

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

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

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

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

_____

_____

_____

_____

_____

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

_____

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

_____

Signature of Licensed Health Care Provider

_____

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

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

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

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

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

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

A concern about...

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

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

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

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

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

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

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

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

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

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

_____

_____

_____

_____

_____

Signature of Attending (Prescribing) Physician:

_____

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

mercy killing

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

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

mercy killing.
See euthanasia, def 1.

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

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

Westlaw

West's RCWA 70.245.180

C
West's Revised Code of Washington Annotated Currentness
Title 70. Public Health and Safety (Refs & Annos)
Chapter 70.245. The Washington Death with Dignity Act (Refs & Annos)

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

(1) Nothing in this chapter authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as 'suicide' or 'assisted suicide.' Consistent with RCW 70.245.010(7), (11), and (12), 70.245.020(1), 70.245.040(1)(k), 70.245.060, 70.245.070, 70.245.090, 70.245.120(1) and (2), 70.245.160(1) and (2), 70.245.170, 70.245.190(1)(a) and (d), and 70.245.200(2), state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication.

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

CREDIT(S)

[2009 c 1 § 18 (Initiative Measure No. 1000, approved November 4, 2008), eff. March 5, 2009.]

West's RCWA 70.245.180, WA ST 70.245.180

Current with all 2010 Legislation

END OF DOCUMENT

Westlaw

O.R.S. § 127.880

C

West's Oregon Revised Statutes Annotated Currentness
Title 13. Protective Proceedings; Powers of Attorney; Trusts
Chapter 127. Powers of Attorney; Advance Directives for Health Care; Declarations for Mental Health Treatment; Death with Dignity
The Oregon Death with Dignity Act (Refs & Annos)
(Safeguards) (Section 3)

→127.880. § 3.14. Construction of Act

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

CREDIT(S)

Laws 1995, c. 3, § 3.14.

O. R. S. § 127.880, OR ST § 127.880

Current through 2010 Special Session Laws. Revisions to Acts made by the Oregon Reviser were unavailable at the time of publication.

END OF DOCUMENT

N. H. House Journal

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

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

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

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

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

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

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

AMENDED ANALYSIS

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

Majority committee amendment adopted.

Majority committee report adopted and ordered to third reading.

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

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

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

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

Reps. Watrous, Weed and Winters spoke against.

Reps. Nancy Elliott and Lucy Weber spoke in favor.

Rep. Rowe spoke in favor and yielded to questions.

Rep. DiFruscia spoke against and yielded to questions.

Rep. Vaillancourt requested a roll call; sufficiently seconded.

YEAS 242 NAYS 113 Bill died.

YEAS 242

BELKNAP

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

CARROLL

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

Right To Die Is Prescription For Abuse

May 28, 2010

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

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

Do not be deceived.

Nancy Elliott, Merrimack, N.H.

Find more stories about

- New Hampshire

FEATURED ARTICLES

Town News Briefing
June 27, 2006

Seniors' Main Issue: War
October 25, 2004

A Crisis Worsening With Age
December 25, 2000

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

Hi Margaret!
Here is the information you requested:

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

YEA
DEMOCRATS 100
REPUBLICANS 142
242

} votes to defeat the bill

NAY
DEMOCRATS 93
REPUBLICANS 20
113

} votes in favour of the bill

TOTAL VOTING:
DEMOCRATS 193
REPUBLICANS 162
355

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

VACANT SEATS 1

TOTAL 400

Bipartisan Vote to defeat Oregon-style bill

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

B-22

NEWS RELEASE

Date: Sept. 9, 2010

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

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

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

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

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

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

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

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

The report also included the following findings:

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

B-23

-

Westlaw.

O.R.S. § 127.880

C
West's Oregon Revised Statutes Annotated Currentness
Title 13. Protective Proceedings; Powers of Attorney; Trusts
Chapter 127. Powers of Attorney; Advance Directives for Health Care; Declarations for Mental Health Treatment; Death with Dignity
The Oregon Death with Dignity Act (Refs & Annos)
(Safeguards) (Section 3)

127.880. § 3.14. Construction of Act

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

CREDIT(S)

Laws 1995, c. 3, § 3.14.

O. R. S. § 127.880, OR ST § 127.880

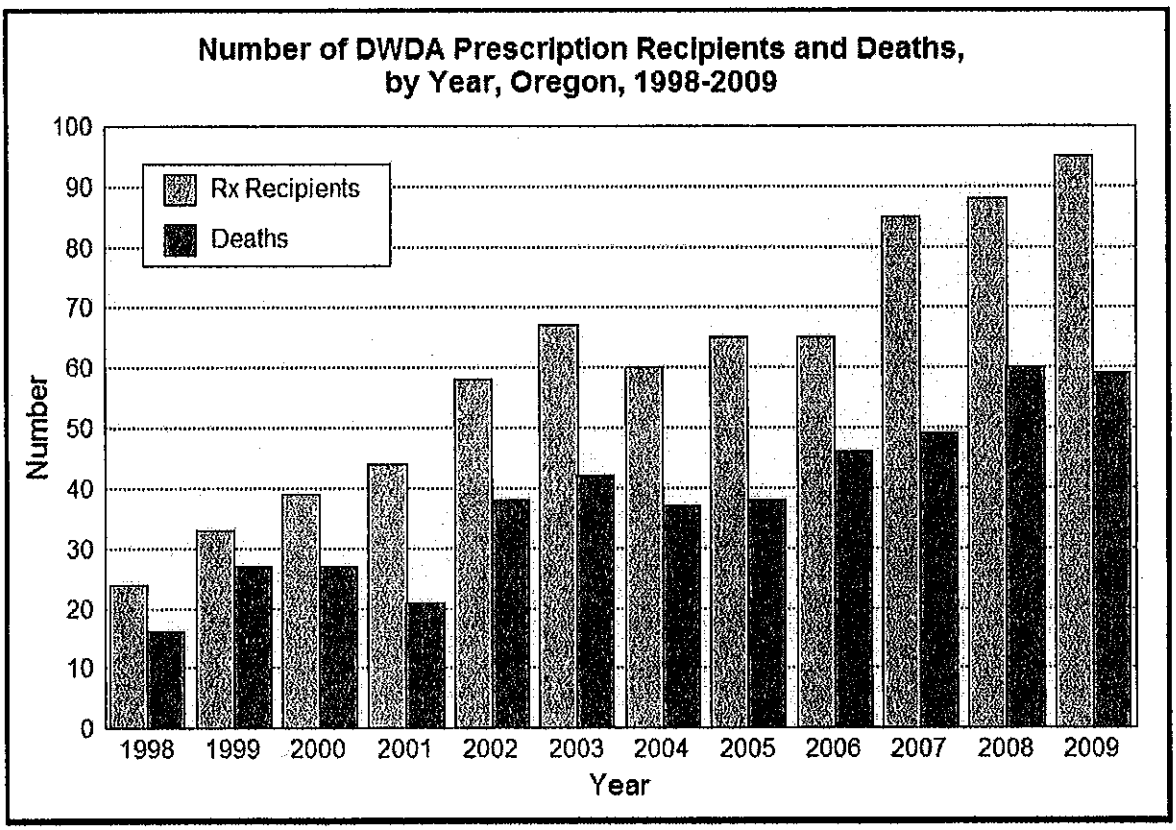
Current through 2010 Special Session Laws. Revisions to Acts made by the Oregon Reviser were unavailable at the time of publication.

END OF DOCUMENT

Oregon Act

2009 Summary of Oregon's Death with Dignity Act

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



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

B-25

This is not to say that the motor car cannot be used as a source of carbon monoxide to effect a reliable death, but there are many problems associated with the method. One concern is the mechanical connection of the exhaust to the hose carrying gas to the car. Many modern vehicles have elliptical exhaust outlets. Coupling the exhaust to a round hose, often using plastic tape, can cause problems because of the heat of exhaust gas. If the tape or tube melts or is destroyed by the heat, failure is likely. Fig 6.1 shows a carefully engineered system using metal connections and clamps and heat resistant tubing.

The approach demands meticulous attention to detail and testing is strongly recommended. Testing is readily achieved using a carbon monoxide meter. By placing the meter on the front seat, and running the car using the planned setup, the meter can be watched safely from outside the car. The reading on the meter will rapidly reveal if the system will work. If the meter moves quickly off-scale (most meters full scale at 500ppm), the method is unlikely to fail. If the meter struggles to rise, even when the motor is started cold and allowed to idle, the system should be avoided.

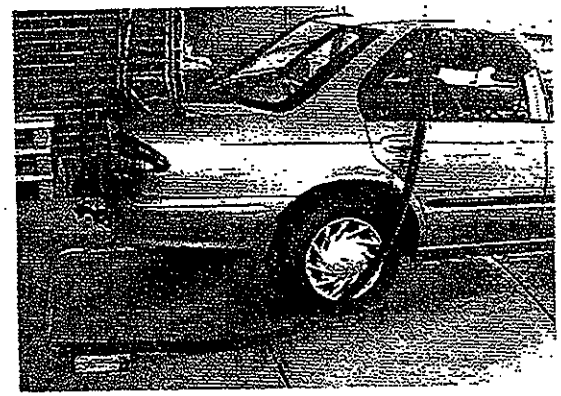


Fig 6.1
The car as a carbon monoxide source

How to commit suicide with vehicle.

In addition, careful planning is required to avoid the possibility of intervention. A car running with a hose fed into the back window will almost certainly attract attention. And, even if effective, sitting in an environment of hot, foul smelling, burnt engine waste, just to make use of the tiny percentage of monoxide present, is surely an unpleasant way to die. In Exit's survey of our elderly members, only a small percentage showed any interest in carbon monoxide poisoning.

History of the COGen (carbon monoxide generator)

The idea of a seriously ill person having to sit in a car full of unpleasant fumes has little appeal, so attempts have been made to produce pure carbon monoxide that is much easier to inhale. In the 1990s, Dr Jack Kevorkian helped more than 100 seriously ill people to end their lives peacefully, nearly half of whom used carbon monoxide. Dr Kevorkian used a cylinder of compressed carbon monoxide (30% CO in air). The person wanting to die switched on the gas at the cylinder and breathed through a loose-fitting face mask. A few deep breaths of the carbon monoxide-air mixture and the person lost consciousness and died shortly afterwards. Dr Kevorkian would then switch off the gas and remove the cylinder and face mask. Those present at these deaths described the effectiveness and peacefulness of the approach.

In late 2002, Exit International decided to take Dr Kevorkian's use of carbon monoxide one step further. Since compressed carbon monoxide is difficult to source, Exit set out to develop a generator that would produce the carbon monoxide gas when and as it was required. The first carbon monoxide generator (the COGen) made use of the simple chemical reaction that takes place when formic and sulphuric acids are mixed. This generates pure carbon monoxide gas.

The Exit Bag

This is the plastic bag which is filled with inert gas. It is designed to enable simple filling with no contamination with any oxygen, and the ease with which one can suddenly immerse oneself in the inert gas.

1. Making an Exit Bag

While different people make slightly different bags, the standard Exit Bag involves a plastic bag of:

- a reasonable size
- a suitable soft plastic
- a neck band of elastic that allows the bag to make a snug fit around a person's neck

In the past, Exit Bags have been able to be purchased from organizations such as Right to Die Canada. As the original inventors of the Bag, Right to Die Canada were active for many years in their manufacture and sale and for a while provided a mail-order service for their members.

For a short period in 2001, Exit International also made bags available to supporters of the organization. However, with the experience of Canadian VE activist, Evelyn Martyns, fresh in our minds, (see *Killing Me Softly: VE and the Road to the Peaceful Pill*), Exit was forced to revise its position.

Recent changes to the Australian Customs Act have increased the risks associated with distribution so Exit now concentrates on providing information that enable people to construct their own bags and associated equipment.

B-27

B-27

To make an Exit Bag, several items are needed (see Fig 5.7)

- Plastic bag - polyester 'oven bag' available in supermarkets is a good size (Large 35cm x 48cm) 'A & B'
- 1 metre of 10 mm wide elastic, 'D'
- 1 toggle to adjust elastic length
- 1 roll of 20mm sticky tape 'C' (Micropore or equivalent)
- 1 small roll of ~ 35 mm plastic duct tape
- Pair of sharp scissors

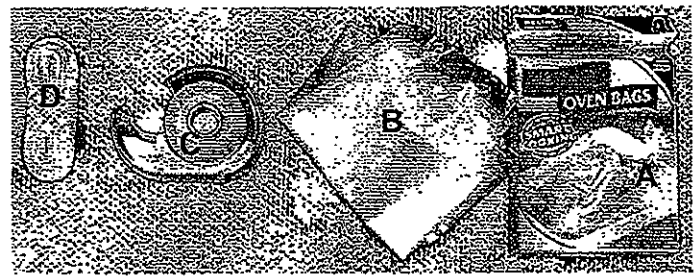
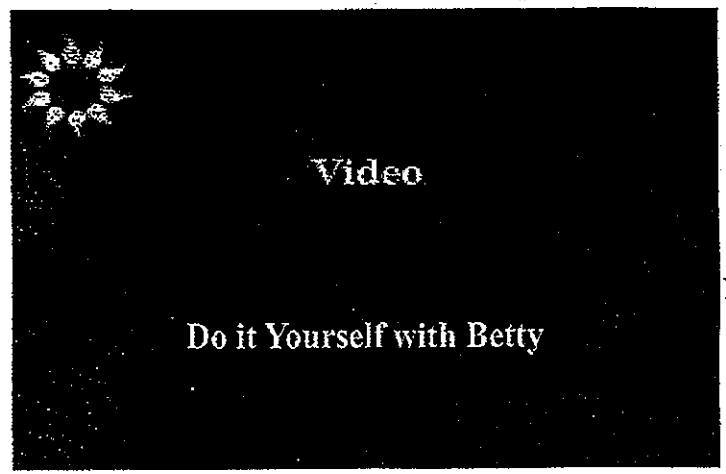


Fig 5.7 Items used to construct an Exit Bag



Construction (See Fig 5.8 & *Do it yourself with Betty* video)

1. Lay the bag out on a flat surface and folded back ~ 25mm (1") around the open end (A-B)
2. Make a 25mm cut in the folded polyester
3. Lay the elastic (C) inside the fold and had the two ends exit through this cut
4. Tape completely along the folded edge of the plastic with the sticky tape
5. Place a cut in a ~ 60mm piece of duct tape and fold this over the exiting elastic to strengthen this part of the bag
6. Thread a small wire tie through two cuts in another piece (~50mm) of duct tape and stick this to the inside of the bag ~ 15cm up from the elastic (E). This can be used to secure the plastic helium hose inside the bag.
7. The toggle (D) is then threaded onto the two ends of the elastic to complete the bag (Fig 5.9)

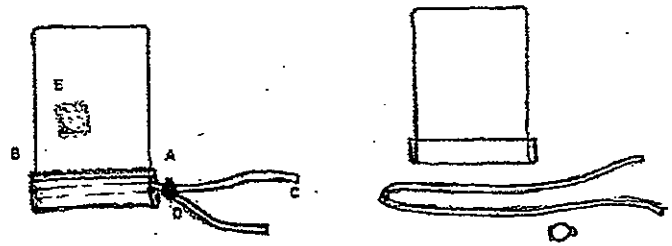


Fig 5.8: Exit Bag Manufacture

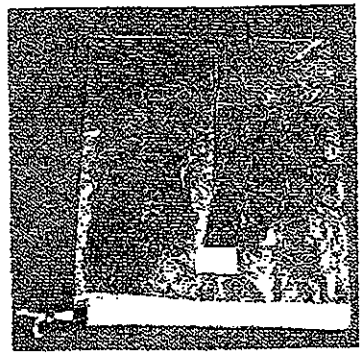


Fig 5.9: The completed Exit Bag

B-28

The Gas Flow Control Unit

Exit International has investigated several methods of controlling the gas flow from helium cylinders. The simplest way of achieving this is to restrict the flow of gas with an appropriate jet that fits inside the hose tail coupling.

Once the jet is clipped into position and the tap on the cylinder switched fully on, this jet provides an initial gas flow of 15 l/min at full cylinder pressure. And, the flow decreases as the pressure falls, which is exactly what is required. At the start of the process, as the bag is filling and prior to the first breath, the flow rates are highest.

One can assembly such a flow fitting oneself (instructions for manufacture follow) or the complete unit can be purchased from the website - *www.peacefulpill.com*

The original fitting that comes with a Balloon Time Helium cylinder on purchase, the modified fitting and the control jet to provide the initial 15 l/min flow are shown in Fig 5.10.

The Construction of the Jet Flow Control Fitting

The flow control kit is a simple device for regulating the gas flow from the gas cylinder. The Kit consists of two parts:

- A brass fitting made from a brass coupling (HELDON ¼ F-SAE X ¼ F-BSP Part No: 227-0404 or equivalent) and a Male Coupling (¼" RYCO BSPT – ¼ 201 or equivalent)

- A control jet ('HM' camping stove jet or equivalent) threaded into a 1/4" hose tail (RYCO Hose Tail Male – ¼ 205) or equivalent

1. Using a 4.5mm metric fine taper tap cut an internal thread into the 1/4" hose tail (D, the non-hose tail end). Thread the jet (C) into the threaded end of the hose tail and tighten with the spanner (T). See fig 5.10.
2. Test to see that the hose tail clips neatly into the brass cylinder fitting. Now when the cylinder is turned on the hiss of gas leaking through the jet at ~ 15 l/min will be heard.

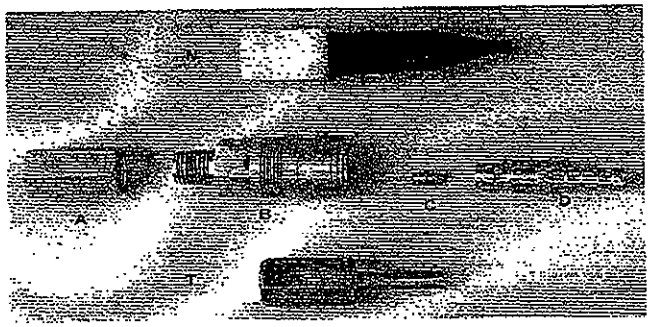


Fig 5.10: The Helium Flow Control Assembly

N: Nylon & Rubber fitting to be replaced
A: 'Heldon' Brass connector
B: 1/4" BSP Male compressed air connector
D: 1/4" Hose Tail
C: 'HM' Camping Stove gas jet
T: Spanner for inserting jet

The availability of Flow Fitting parts in other countries

There are some equivalent gas fittings from manufacturers in the UK and USA for the HELDON Coupling (A), the RYCO connector (B), the RYCO Hose Tail (D), the Pressure Gauge and Coupling Tail (Fig 5.12 A&B).
For details contact: *exit@euthanasia.net*

To purchase the complete Flow Control Fitting or Pressure Gauge (Fig 5.12)

Visit: *www.peacefulpill.com*

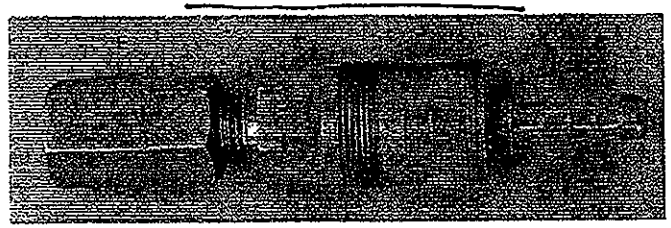
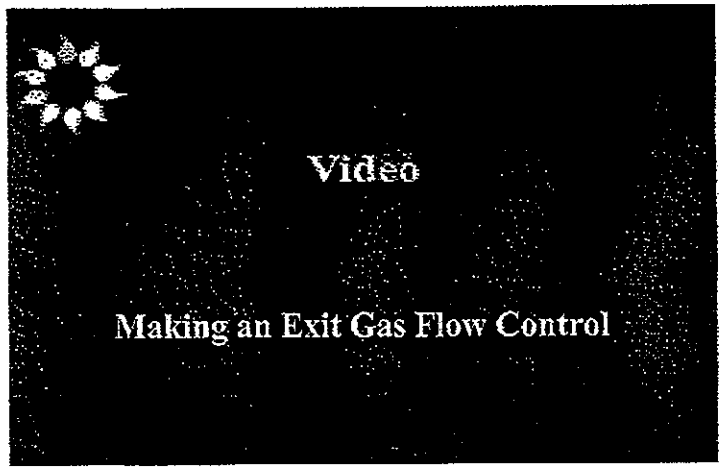


Fig 5.11: The complete flow control assembly

Exit sells control fittings



B-129

Testing the Pressure of the gas in the Cylinder

Pressure should ALWAYS be checked prior to use to ensure the cylinder is full. The easiest way to ensure that a cylinder is full is to check the pressure using a gauge with range up to 2500 kPa (350 psi).

A pressure gauge that fits the female 1/4" BSP Male compressed air connector (see Fig 5.7B & 5.9) is useful. A full cylinder should have a pressure of > 1700 kPa (250 psi). It is important to test the pressure of a disposable Helium cylinder before use because a small minority of newly purchased cylinders have been found to have leaks and not all contain the full 420 litres of helium. Cylinders occasionally have a faulty tap and when kept in storage for a long period, gas may have leaked from the cylinder.

To test the pressure, remove the jet assembly from the cylinder fitting. The gauge can be clipped in position and opening the cylinder tap will immediately provide the cylinder pressure. (Fig 5.13)

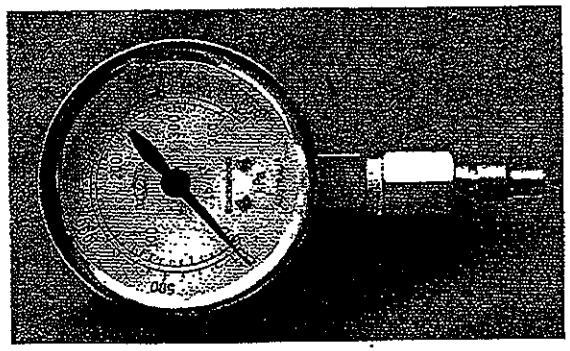


Fig 5.12: Pressure gauge used to check if gas cylinder is full

Fig 5.13:
Helium cylinder with pressure gauge attached to flow control assembly

Gas Purity

Exit has very occasionally received reports of failures by people using Exit Bags with Helium. Although this information has been sketchy, the descriptions suggest that there has been some unexpected contamination of the helium in the cylinder.

The reports have been of people breathing the gas inside the bag for some minutes but with no loss of consciousness. The only possible contamination that could produce this result would be the addition of a significant quantity of oxygen to the helium . This has long been postulated as a possible means of frustrating the use of disposable helium cylinders by those wanting a peaceful death. The introduction of 10% of oxygen would have no effect on the marketed use of the gas - balloons filled with this mixture would float - but the gas would be of no use in an Exit bag.

Every year, Exit tests new Helium cylinders. The results of these tests have been reassuring with no significant contamination found.

Typical Helium gas analysis:
O^2 ~0.4%, CO^2 <0.01%, CO <0.1ppm, Hydrocarbons ~ 40ppm.

The gas from cylinders used in the failed attempts was not tested. This needs to be carried out. Cylinder gas testing for contaminants is quick but one needs reliable test equipment. Exit offers this service.

Finally, our members have been in active email contact with the manufacturers who likewise assure us that no oxygen has been added to their Helium cylinders and if this were to be the case they assured us it would be noted prominently on the cylinder.

Connecting the Cylinder to the Exit Bag

To use the Exit Bag with an inert gas like Helium, one needs to connect the cylinder with gas flow fitting to the Exit bag. Plastic tubing (standard 2 metre oxygen tubing with soft connectors) is very suitable for this purpose. It can be fitted very tightly to the tail end on the flow control and then stuck to the inside of the Exit bag with Micropore tape. Test that the attachment of the tube to the flow fitting and to the Exit bag is secure and not easily dislodged.

Fig 5.14: Positioning, inflating & Using the Exit Bag with Helium

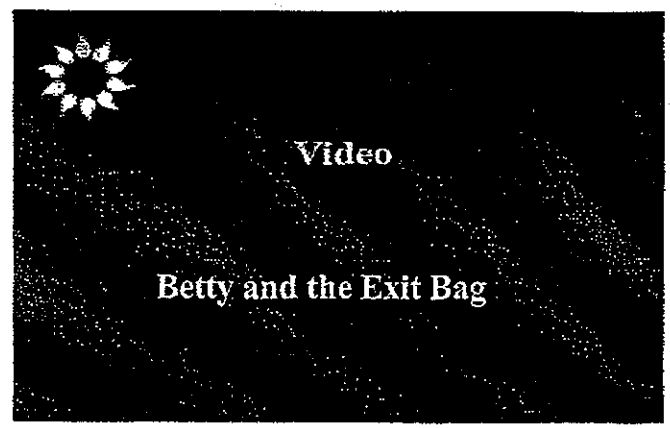
The Procedure

The goal is to produce a reliable, quick and peaceful death from hypoxia. There are 3 stages in this process and these are shown in the Video (Betty and the Exit Bag) and in fig 5.14.

- Adjust the elastic in the bag so that it is a firm fit around the neck. Then place the bag on the head across the forehead. Crush the bag down onto the head to exclude all air then open the tap on the Helium bottle. The flow of Helium at ~15 l/min fills the bag in about a minute.

- When the bag is filled with gas the Helium begins to leak around the elastic while keeping the bag fully inflated. Have a look in the mirror to ensure the bag is correctly positioned and full of Helium.

- To bring about a peaceful death, exhale totally (fully empty your lungs) and hold your breath while pulling the bag down over your head. When the bag is over your head and snugly around your neck, take the deepest breath possible. Loss of consciousness will occur almost immediately - within one or two breaths. Death occurs within a few minutes.



Cover stories, etc

15

After it's All Over

Introduction

For those left behind, the period immediately following the death of a loved one can be a sad and stressful time. A voluntary euthanasia death can present an additional and unique set of circumstances.

On the one hand, family and friends may be enormously relieved that their loved one was able to die peacefully and with dignity. On the other hand, there may be feelings of resentment, even anger that the person they loved has chosen to leave them. While it is one thing to know that a person you love is about to die by their own hand, it is another to be able to predict how this will make you feel.

There will also be a number of practical issues that those left behind have to confront. In a well planned death, some of these will have been discussed before the death. For example, will anyone be responsible for clearing away any used equipment from the scene of death? And what about a suicide note? Who will keep hold of it, should one be required?

3.3.2

Then there is the issue of having the death certificate signed, and whether or not an autopsy will be conducted. Will there will be a coronial investigation? Many of these issues can be anticipated and prepared for. In this Chapter we use the real life example of Australian former Qantas pilot Graeme Wylie to illustrate what can and does go wrong when someone decides to take their own life. We point the way to each of the factors which contribute towards a well planned death.

Background to Graeme Wylie

In March 2006 Graeme Wylie died drinking a lethal dose of veterinary Nembutal that his friend of over 30 years, Caren Jenning, had brought back for him from Mexico. While the plan and Caren's motive for helping her old friend were straight forward, Graeme Wylie's death was always going to be complicated. In June 2008, Graeme Wylie's partner of 18 years, Shirley Justins and his friend of over 30 years, Caren Jenning were found guilty of his manslaughter and accessory to manslaughter respectively.

Graeme Wylie was suffering dementia, anything from 'mild to moderate' to 'moderate to severe' depending on which doctor carried out the assessment. In the court case that followed his death, Graeme Wylie was deemed not to have had the capacity to know what he was doing in drinking the Nembutal. Mr Wylie did not, therefore, take his own life.

Rather he was killed by his partner, Shirley Justins, and his dear friend Caren Jenning. So, the first issue to determine in any decision for a loved one to take his/ her own life is 'do they have the capacity to make the decision?' This is an extreme example of why a suicide note is always a good idea. In Sydney there is now an excellent 'Capacity Toolkit' that can be downloaded to provide advice about how to tell who has an has not got 'medical capacity' and what one can do about it.

The Suicide Note

If Graeme Wylie had written, signed and dated a suicide note stating that his actions were entirely his own, that he understood the consequences of what he was about to do and gave the reasons for dying, his partner Shirley and good friend Caren would have been much less likely to have found themselves in front of a Supreme Court jury.

The law around suicide and assisted-suicide is murky. Those left behind by a death are almost always at risk of some form of inquisition. Writing a note and storing it in a safe place or with a trusted friend makes a good deal of sense. If, when the doctor is called to the death and an underlying disease is believed responsible, a natural death is confirmed and the death certificate signed. In such situations it is unlikely there will be any need for the suicide note to ever be 'found'.

If, however, like Graeme Wylie, the doctor refused to sign the death certificate, and the coroner contacted and an autopsy arranged, then this would be the time for the signed suicide note to be produced. If the unexpected does then occur, a suicide note will provide a very useful safeguard if loved ones find themselves implicated in the death. If on theother hand, the person taking their life does not care that their death be a known suicide, the note can be left alongside their body.

The Process of a Death

If a death takes place outside of a hospital, hospice or other medical institution (eg. at home), it is normal practice upon 'discovering' the death, that a doctor be called. Upon arriving at the house, the doctor will then have two options.

If the death looks to be natural, and the patient has been seen by the doctor in the past two months, the doctor will certify death and sign the death certificate citing the person's underlying disease as the cause of death. There will be no red tape. The body will be released, and funeral arrangements can be made.

If, on the other hand, the doctor suspects that the death is *not* natural (eg. if the death is possibly a suicide or if the cause of death is unclear) the doctor can certify death, but will not sign the death certificate. In this case the doctor will call the coroner's office and the police will be involved. Those close to the deceased may be required to be interviewed by the police about their relationship with the deceased, and about their possible role in the person's death.

If the deceased was known to be seriously ill and if that person has made an effort to choose a method that leaves no obvious physical signs, or if the person and/or friends and family have ensured that any evidence of suicide is removed from the scene, the doctor will likely certify death *and* sign the death certificate.

While Graeme Wylie had dementia, he had no other underlying physical illness that could have explained as the cause of his death. He was only 71 and physically fit when he died. His death was, therefore, immediately suspicious. Knowing this in advance, Caren and Shirley attempted to suggest that the cause of his death was to the dementia medication, Aricept, he was taking. They did this by showing the attendant police an article from the *New York Times*, that highlighted the link between Aricept and heart attack in some dementia patients. The police did not buy their story and at autopsy, Graeme Wylie's body was found to contain lethal levels of pentobarbital (Nembutal).

When attending a death, police are usually very sensitive and respectful. However, they are there to do a job and this may involve the questioning of those who were in the house at the time. The police may also look at the degree of incapacitation of the person who has died. If an obvious suicide they will note whether or not the method used could have been carried out solely by the individual. Any need for help or assistance to suicide is evidence of a crime.

If there is any doubt, the questioning of those left behind may intensify. The issue of whether anyone was present when the suicide took place may also arise. In this situation, there is no guarantee that legal action will not be taken against a person who admits to simply being present, even if they say they did nothing to assist.

Cleaning Away

There are several practical steps that can be taken to increase the likelihood that a death will be seen as 'natural'. The first of these is the act of cleaning up after a death.

Given that the deaths that we are talking about are peaceful and dignified, the act of cleaning up generally involves the removal of equipment such as an Exit Bag or empty drug packets from the death scene. In some situations, this can be done well ahead of time. Many people ending their lives clean away themselves. They remove drug packaging, and rinse glasses after a lethal drug has been consumed. If this is done, the attending doctor will be more likely to assume that the cause of death is the underlying disease.

However, if the person who has died was not known to be suffering from a life threatening illness, the act of cleaning away may cause more problems. In the case of Graeme Wylie, because there was no illness (other than dementia), the fact that there was no obvious cause of death only served to heighten the mystery of how he died?

If Graeme Wylie had written a note and left the bottle of Nembutal alongside him, instead of the bottle being removed by his wife so it would never be found, the police would have known immediately that his death was a suicide.

If a person ends their life using an Exit Bag, from Hypoxia, then the cleaning away will involve much more. For example, the Exit bag will need to be removed from the person's head and the helium canister, along with tubing and other pieces ofequipment will also need to be taken away and conceiled.

Occasionally Exit members present at Helium deaths remove the gas control fitting from the canister, reattached the black and white plastic nozzle that came with the balloon kit, and re-boxed the cylinder. This way it appears that the kit had been used inflating balloons for a party.

For a death to appear normal, there must be no evidence of equipment that could have been used in the suicide. While some people might not care whether their death is listed as 'suicide' or as 'natural', the legal risk to those close to the deceased is, of course higher if the death is a known suicide.

Cleaning Away and the Law

While it is a crime to interfere with the 'circumstances of a death', in the scheme of things it is not a particularly serious crime. For example, removing an Exit bag from a loved one's head once they have died, is a different matter entirely to assisting that same person to put the bag on their head in the first place. This latter action is clearly assisting a suicide, a crime for which there are severe penalties.

If, by chance, the authorities do discover that cleaning up has taken place, family or friends often explain their actions by saying that they were protecting the family's reputation. They say it would be a blemish on the family's good name if the suicide of a family member were ever to be made public. Generally speaking, the act of 'cleaning away' is unlikely to attract anything more than a legal slap on the wrist.

Death Certificates

On arriving at the scene, the attending family doctor will perform two tasks. Firstly, they will confirm death. They will do this by carrying out a number of simple tests to establish that the person is indeed dead, not simply in a catatonic or comatose state. Having confirmed death, the next issue is the signing of the death certificate. There are a number of requirements that must be satisfied before this can be done. The two of particular interest are:

- The doctor must know the patient. Usually there is the requirement that the doctor has seen the patient in a professional capacity - not just to say hello at the golf club - in the past two months (the time period varies depending on the jurisdiction).
- The doctor must be satisfied that the death is natural.

The requirement that the doctor be known to the patient can sometimes cause difficulty. Often, very sick people have little contact with the medical profession. This means that finding a doctor who could even sign the certificate can be a problem. It may therefore be wise to call your doctor for a visit prior to the planned death, complaining of a developing fever or breathlessness, perhaps some pain on deep inspiration.

When the doctor is then called back some days later, it would reasonable for them to assume a natural death involving pneumonia.

Some people worry a great deal about the way their death will be recorded on their death certificate. They fear being known as someone who 'committed suicide.' Others have no preference, saying 'who cares what they write, I'll be dead anyway?'

If a person who is about to die from a terminal disease takes their own life, the death will be recorded as 'suicide.' If that person does not want 'suicide' recorded on the death certificate, they will need to take steps to disguise the truth. A method of death that leaves no obvious signs is of course the first consideration.

Dying without Trace

Most drugs used to end life leave no obvious identifying signs. Death from sterile veterinary Nembutal is one example. The person will appear as if they had simply succumbed to their cancer or heart disease. However, there is also a dyed form of the drug, Pentobarbital (see Chapter 11). If Lethobarb (the dyed form) is consumed, the person's lips will be stained green; hence the name the 'green dream'. Green lips are a giveaway to a death that is not natural. And remember, if an autopsy is performed, as was the case with Graeme Wylie, the pentobarbital (Nembutal or Lethobarb) will be discovered and questions about where it came from will begin to be asked. This is true of any death brought about by a consumed drug, or inhaled poisen like carbon monoxide.

The *only method* that leaves no trace, even at autopsy, is the Exit Bag with helium. But for the death to be recorded as natural, the bag and the helium canister would need to be removed. It can be useful if a family member or friend can 'discover' the body in the morning. This person will then be in a position to call the family doctor and remind the doctor of the underlying illness. One can also claim that everyone in the house was asleep during the evening when the death took place.

Autopsies

If there is any doubt about the cause of death, the doctor will contact the coroner and an autopsy may be arranged. An autopsy involves the dissection of the body by a pathologist, the visual and microscopic inspection of organs, and the biochemical testing of body fluids, stomach contents etc. At autopsy, the existence of any drugs (and alcohol) in the body will be discovered. If the drug is uncommon or difficult to obtain, questions will be asked about whether or not assistance was provided in obtaining, preparing or administering the substance.

Although permission for an autopsy will be sought, and next of kin have the right to refuse, it is as well to remember that refusal can be overridden. Autopsies are only sought if there is some legal or medical mystery associated with the death - if there is uncertainty about how or why the person died. In these situations, especially if there is possibility of a criminal act (eg. the assistance of a suicide), the decision will be made irrespective of family wishes.

In cases where the death is clearly a suicide, an autopsy will not necessarily be performed. Autopsies are expensive and only undertaken if possible benefit can be established. Or for political reasons. When Caren Jenning took her own life in September 2008, a month before she was due to be sentenced for the manslaughter of Graeme Wylie, she left a suicide note and the bottle of Nembutal by her bed. Nevertheless an autopsy was still performed. Her reputation preceded her, even in death.

Even though autopsies are by no means routine, and their use is becoming less frequent, they can never be ruled out (O'Connor, 2004). Still, in the case of a seriously ill person who takes an overdose of prescription propoxyphene they have had prescribed, *and* leaves the empty packets by the bed, *and* a suicide note, there is little likelihood of an autopsy being performed.

Grief Counselling

The suicide of a seriously ill person will evoke mixed reactions in those close to that person. The broader community's reaction may also be mixed. While most people support the concept of voluntary euthanasia there is still a significant minority who do not. It cannot be assumed that there will always be sympathy for those left behind.

When Caren Jenning died, some particularly unpleasant comments were made in letters to the editor that appeared in the *Sydney Morning Herald*. The first of these was by Graeme Wylie's daughter Nicola Dumbrell. The title of her letter 'Prosecution was the only way to deal death' says it all!

For most deaths, however, the wider world is not privy to the details and family and friends will be free to decide just what they want to say about the death and to whom.

In many circumstances where a person has died of their own hand, counselling of loved ones left behind may be of assistance. The ability to talk things through can be therapeutic and can go a long way towards easing the inevitable grief and despair.

Fig 15.1: Nicola Dumbrell outside Sydney Supreme Court

Private counsellors list their services in most countries' White and Yellow Page telephone directories. Community health centres also commonly offer counselling as part of their staple range of health services. In addition, there are a number of community telephone help lines. A further source of specialised counselling can be found with the Nancy's Friends Network.

Exit US Store

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Exit Online Store - www.Peacefulpill.com

Exit Drug Test Kit

Price: Australia US $65 (incl GST $5) Rest of World: US $80 (incl shipping worldwide)

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Missoulian

Legalization of assisted suicide brought 'Dr. Death'

ONLINE ONLY letter to the editor | Posted: Thursday, July 8, 2010 12:15 am

I live in Washington state, where assisted suicide is legal. Thank you for running Sen. Greg Hinkle's column regarding problems with legalization ("Suicide ruling ignores abuse," June 29).

I am a freelance journalist who often writes on assisted suicide. I also care for my elderly mother. This combination of my work and my responsibilities has made me keenly aware of the very real dangers of legalizing assisted suicide. I agree with Hinkle's statement that a key concern is elder abuse, in that these laws provide a convenient cover for those not wishing the "burden" and "expense" of caring for aging and ill family members.

Adding to the problem in Washington, we now have the arrival of Phillip Nitschke (Australia's "Dr. Death"). Nitschke is the director of the suicide/euthanasia promotion group, Exit International. With our favorable law, his people are now selling suicide paraphernalia out of our state, while Australia, on the other hand, is trying to block access to his website and curtail the killing spree there.

When I interviewed him in October 2009, he said that our assisted suicide legislation in Washington "is helpful to us, and, has not limited the interest and questions coming... from people in this state." He went on to claim that he is targeting the "well elderly, who have become our core activity."

In the UK, a recent article uncovered the apparent suicide deaths of two students whose inspiration came from Nitschke's recent exploration in finding better ways to bring about death. Top students, they had killed themselves via laptops, reminiscent of a suicide machine he developed in Australia. Soon to be the next phase for Montana?

Elenor K. Schoen,

Shoreline, Washington

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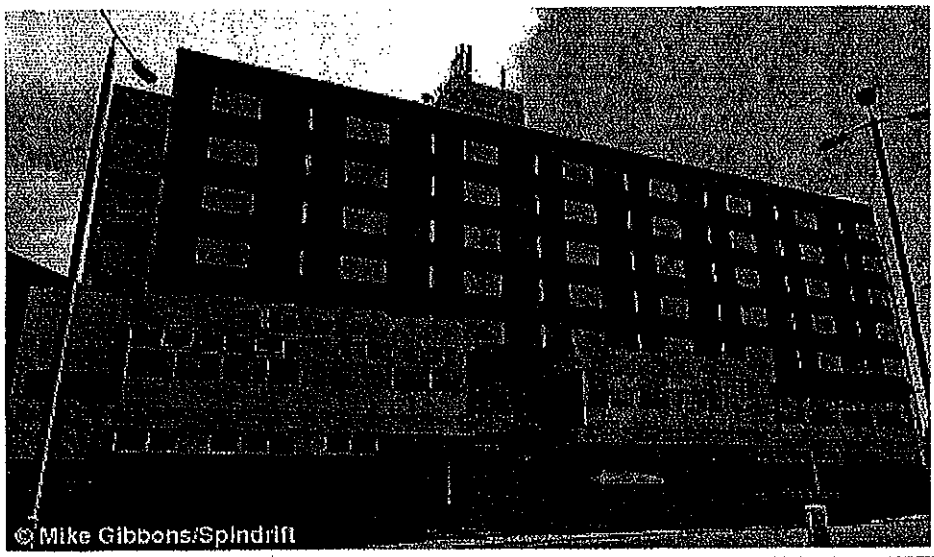
'Suicide by laptop' riddle of two brilliant students found dead in hotel room

By Jane Simpson And Patricia Kane
Last updated at 1:23 PM on 14th June 2010

Two brilliant university students were found dead together in a hotel room after apparently rigging up a laptop to deliver lethal injections in what is thought to have been a suicide pact.

Friends Robert Miller, 20, and 19-year-old James Robertson – both described as highly intelligent – were found slumped in chairs.

Their bodies were discovered facing each other at the £65-a-night Ramada Jarvis Hotel in Ayr – 80 miles from where they were both studying for joint maths and physics degrees at Edinburgh University.



Grim discovery: The Ramada Hotel where the pair were found slumped in chairs

Staff entered the room after becoming concerned that the young men hadn't checked out.

The tragedy has raised fears the pair were influenced by Australian doctor Philip Nitschke, dubbed Dr Death, inventor of the so-called 'Deliverance Machine'.

Pro-euthanasia campaigner Dr Nitschke's device involved a computer connected to a syringe driver which could deliver a lethal dose of medication at the touch of a button. It killed four terminally ill Australians before being outlawed in 1997.

The students' deaths have sent shockwaves through the remote Orkney communities where they were raised.

A friend, who asked not to be named, said: 'No one can understand why this has happened. They were just boys next door – good fun and good friends to have.'

B.41

Bright future: Orkney lad James Robertson was a gifted musician as well as a top class maths and physics student

Mr Robertson had attended Stromness Academy, while Mr Miller, who was just days away from his 21st birthday, went to Kirkwall Grammar on the other side of the Orkney mainland.

However, Mr Miller's page on social networking site Facebook shows that they shared mutual friends.

They had arrived at the seafront hotel on Tuesday and were said to have been 'happy and chatty' when they spoke to staff.

When they did not appear back at reception the next day, staff made the grim discovery. Strathclyde Police examined the laptop and said they are not treating the deaths as suspicious.

B.42

KATU.com - Portland, Oregon
Print this article

Letter noting assisted suicide raises questions

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

By Susan Harding and KATU Web Staff July 30, 2008

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

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

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

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

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

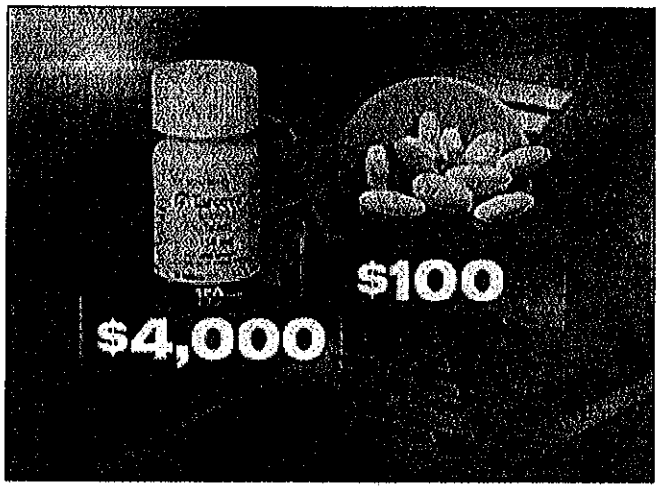
An unfortunate interpretation?

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

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

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

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



Saha said state health officials do not consider whether it is cheaper for someone in the health plan to die than live. But he admitted they must consider the state's limited dollars when dealing with a case such as Wagner's.

"If we invest thousands and thousands of dollars in one person's days to weeks, we are taking away those dollars from someone," Saha said.

But the medical director at the cancer center where Wagner gets her care said some people may have incredible responses to treatment.

Health plan hasn't evolved?

The Oregon Health Plan simply hasn't kept up with dramatic changes in chemotherapy, said Dr. David Fryefield of the Willamette Valley Cancer Center.

Even for those with advanced cancer, new chemotherapy drugs can extend life.

Yet the Oregon Health Plan only offers coverage for chemo that cures cancer - not if it can prolong a patient's life.

"We are looking at today's ... 2008 treatment, but we're using 1993 standards," Fryefield said. "When the Oregon Health Plan was created, it was 15 years ago, and there were not all the chemotherapy drugs that there are today."

Patients like Wagner can appeal a decision if they are denied coverage. Wagner appealed twice but lost both times.

However, her doctors contacted the pharmaceutical company, Genentech, which agreed to give her the medication without charging her. But doctors told us, that is unusual for a company to give away such an expensive medication.

Legislature rejected euthanasia

Dear Editor:

I have several concerns with the article in the recent August, 2010 Advocate by Kathryn Tucker entitled "Aid in Dying: Law, Geography and Standard of Care in Idaho." Whatever one may think of Euthanasia, whether denominated "Aid in Dying" as the author calls it, or "physician assisted suicide" or "mercy killing", as it is also known, the article's suggestion that Idaho, like Montana, could legally adopt that practice by judicial decision, simply by changing the standard of care for doctors, is a gross misunderstanding of Idaho law. The article's statement that "Most medical care is not governed by statute or court decision, but is instead governed by the standard of care," relies solely on 61 Am. Jur. 2d, for that statement, without recognizing that the standard of care for doctors in Idaho is established by statute, I.C. 6-1012. The article's implication that Idaho courts can change that standard simply by judicially adopting the statutory euthanasia policies of Washington, Oregon or Montana is simply an attempt to conduct an end run around the legislature with the kind of judicial activism that prevailed in many U.S. courts during the 1970s and 80s, and which not only diminished the public's respect for the courts, but has turned judicial elections into expensive partisan contests. The author's suggestion that Idaho can judicially adopt euthanasia is false and dangerous, and fails to recognize that in both the Idaho criminal statutes as well as I.C.6-1012, the Idaho legislature has rejected physician assisted suicide.

Hon. Robert E. Bakes
Retired Chief Justice
Idaho Supreme Court

Montana doesn't permit it

Dear Editor:

I am a Montana State Senator. I disagree with Kathryn Tucker's discussion of our law in her article, "Aid in Dying: Law, Geography and Standard of Care in Idaho." (August, 2010). Contrary, to her implication, a physician can still find himself criminally or civilly liable for assisting a suicide in Montana. The recent Supreme Court decision merely gives physicians a potential defense to criminal liability. I have also proposed a bill, "The Montana Patient Protection Act," which would overrule the Supreme Court decision to eliminate the defense and render it clear that assisted suicide is prohibited in Montana.

The vast majority of states to consider legalizing assisted suicide, have rejected it. The most recent states to reject it are Connecticut and New Hampshire. Only two states allow it.

Assisted suicide, regardless, provides a path to elder abuse and steers citizens to take their own lives. These results are contrary to our state's public policies designed to value all of our citizens regardless of age.

Senator Greg Hinkle
Thompson Falls, MT

Heirs will abuse older people

Dear Editor:

I am a State Representative in New Hampshire where, in January, we voted down an Oregon-style "aid in dying" law. I write in response to Kathryn Tucker's article promoting such laws, which she claims promote "choice" for patients at the end of life. [Tucker & Salmi, "Aid in Dying: Law, Geography and Standard of Care in Idaho," August 2010]

Aid in dying is more commonly known as assisted suicide. In New Hampshire, many legislators who initially thought they were for the law, became uncomfortable when they studied it further. Contrary to promoting "choice," it was a prescription for abuse. The vote to defeat it was 242 to 113 (nearly 70%).

Assisted suicide laws empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money. There is NO assisted suicide law that you can write to correct this huge problem.

Do not be deceived.

Representative Nancy Elliott
Merrimack, New Hampshire

No assisted suicide in Idaho

To the Editor:

This letter questions your decision to publish "Aid in Dying: Law, Geography and Standard of Care in Idaho" in the August 2010 edition of *The Advocate*. Either the legal reasoning contained in the "Aid in Dying" article was reviewed prior to its publication in *The Advocate* or it was not. Hopefully, no attorney associated with the Bar read and endorsed the legal arguments contained in this article. I will only cite two of the most obvious fallacies in the authors' reasoning:

(1) the claim that a recent Montana Supreme Court case recognizing the possibility of using a "consent defense" to a charge of homicide as is allowed under Montana statutory law in cases of physician assisted suicide would provide any defense to a charge of homicide for the same conduct in Idaho, and

(2) the claim that, because Oregon, Washington and Montana allegedly permits physician assisted suicide, Idaho courts would likely find that physician assisted suicide meets the local community standard of care for doctors practicing in Idaho.

At its core, the authors' argument in "Aid in Dying: Law, Geography and the Standard of Care" amounts to no more than a plea to Idaho doctors that they ignore Idaho law and instead act based upon the law of the surrounding states. What Idaho lawyer would provide this advice to any doctor client?

Perhaps "Aid in Dying" was published in *The Advocate* out of some misguided notion of free speech rights as providing Idaho attorneys a platform to express their personal views. Although the authors certainly have a right to advocate for their personal views, they have no right to do so in *The Advocate*. And, even if one were to contend that allowing such advocacy in *The Advocate* is a good idea, that would not justify *The Advocate* allowing publication of an article falsely claiming that assisted suicide was already legal under Idaho law.

False claims about what the law of Idaho actually is, published in *The Advocate*, cannot possibly benefit public debate on this issue. If presented to Idaho doctors as a peer reviewed legal analysis of the law related to assisted suicide in Idaho, "Aid in Dying" could actually lead some Idaho doctor to assist a patient take his or her life in reliance upon the legal analysis presented in this article. While achieving this result may be understood as an important milestone in the authors'

quest to legalize assisted suicide in Idaho, the particular doctor used by those authors to make their point may feel betrayed if an Idaho court fails to find the legal analysis contained in their article applicable to the Idaho doctor's conduct. And, whatever the court ultimately decides about the legality of the doctor's conduct will come too late for the doctor's former "patient" by now likely buried in Idaho.

Richard A. Hearn, M.D.
Racine Olson Nye Budge & Bailey, Chtd.

Wrong article for *The Advocate*

Dear Editor:

I was appalled to read the article "Aid in Dying: Law, Geography and Standard of Care in Idaho" in the last issue of *The Advocate*. What was your rationale for publishing such malarkey? Was this a vain attempt on your part to increase readership, or do you have a more sinister political motive?

According to your website:

"*The Advocate* features articles written by attorneys on topics of interest to members of the legal community."

Kathryn L. Tucker is not an Idaho attorney. She is an extremely well-paid political activist stirring up controversy through her erroneous rhetoric. I find it extremely difficult to believe that this subject matter would be of interest to the majority of your readers. Which leads me to ask why publish such an article? Are you using your position as editor to help promote your own political agenda?

Robin Sipe
Eagle, ID

Oregon's law doesn't work

Dear Editor:

I am a doctor in Portland Oregon where assisted suicide is legal. I disagree with Kathryn Tucker's rosy description of our assisted suicide law, which she terms "aid in dying."

In Oregon, the so-called safeguards in our law have proved to be a sieve. Although we are reassured that "only the patient" is supposed to take the lethal dose, there are documented cases of family members administering it.

Family members often have their own agendas and also financial interests that dovetail with a patient's death. Yet the true extent of such cases is not known as the only data published comes from second-and even third-hand reports (often from doctors who themselves who were not present at the death and who are active suicide promoters). What we do know about assisted suicide in Oregon is essentially shrouded in secrecy.

The scant information provided by the "official" Oregon statistics report that the majority of patients who have died via Oregon's law have been "well educated" with private health insurance. See official statistics at http://www.oregon.gov/DHS/ph/pas/docs/year12.pdf.

In other words, they were likely people with money. Was it really their "choice?"

Preserve choice in Idaho. Reject assisted suicide.

William L. Toffler MD
Professor of Family Medicine
OHSU--FM
Portland, OR

Doctors not always right

Dear Editor:

I live in Idaho, but formerly lived in Washington state where assisted suicide is legal. I was appalled to see Kathryn Tucker's article promoting "aid in dying," which is not only a euphemism for assisted suicide, but euthanasia. Indeed, in 1991, an "aid in dying" law was proposed in Washington State, which would have legalized direct euthanasia "performed in person by a physician." Legalizing these practices is bad public policy for many reasons. One personal to me is that doctors are not always right.

In 2005, I was diagnosed with a rare form of terminal endocrine cancer. This, along with having contracted Parkinson's disease, has made for a challenging life. Like most people, I sought a second opinion from the premier hospital in the nation that treats this form of cancer, M.D. Anderson, in Houston. But they refused to even see me, indicating they thought it was hopeless. Now five years later, it's obvious they were wrong.

Tucker's article refers to "aid in dying" is an "option." A patient hearing this "option" from a doctor, who he views as an authority figure, may just hear he has an obligation to end his life. A patient, hearing of this "option" from his children, may feel that he has an obligation to kill himself, or in the case of euthanasia, be killed. As for me, I would have missed some of the best years of my life. These are but some of the tragedies of legalized "aid in dying."

I can only hope that the people of Idaho will rise up to chase this ugly issue out of town.

Chris Carlson
Medimont, ID

Article's lousy legal analysis

Dear Editor:

I read with some dismay the article on aid in dying in the August *Advocate*. While I realize that Ms. Tucker and Ms. Salmi have strong opinions on the subject, that is no excuse for *The Advocate* to publish a diatribe so lacking in rational analysis.

The authors first address an Idaho statute dealing with "euthanasia, mercy killing, ... or... an affirmative or deliberate act or omission to end life" and, in conclusory fashion, state that this passage does not include "aid in dying." Worse, they go on to cite the Montana Supreme Court case on the application of homicide statutes in support of the conclusion that Idaho physicians "should feel safe" in helping their patients to kill themselves. I wonder what percentage of the Idaho Bar would be willing to give this advice to a physician client when that client faces loss of liberty and/or their license to practice medicine should the attorney prove to be wrong? This article is editorial comment masquerading as legal analysis and, at the very least, should have been accompanied by someone making a counter-argument.

Robert Moody
Boise, ID

Oregon mistake cost lives

Dear Editor:

I was disturbed to see that the suicide lobby group, Compassion & Choices, is beginning an attempted indoctrination of your state, to accept assisted suicide as somehow promoting individual rights and "choice." I have been a cancer doctor in Oregon for more than 40 years. The combination of assisted-suicide legalization and prioritized medical care based on prognosis has created a danger for my

patients on the Oregon Health Plan (Medicaid).

The Plan limits medical care and treatment for patients with a likelihood of 5% or less 5-year survival. My patients in that category who have a good chance of living another three years and who want to live, cannot receive surgery, chemotherapy or radiation therapy to obtain that goal. The Plan guidelines state that the Plan will not cover "chemotherapy or surgical interventions with the primary intent to prolong life or alter disease progression." The Plan WILL cover the cost of the patient's suicide.

Under our law, a patient is not supposed to be eligible for voluntary suicide until they are deemed to have six months or less to live. In the cases of Barbara Wagner and Randy Stroup, neither of them had such diagnoses, nor had they asked for suicide. The Plan, nonetheless, offered them suicide. Neither Wagner nor Stroup saw this event as a celebration of their "choice." Wagner said: "I'm not ready, I'm not ready to die," They were, regardless, steered to suicide.

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

Kenneth Stevens, MD
Sherwood, OR

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

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

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

END-OF-LIFE CHOICES

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

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

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

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

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

PROVOKING CHANGE

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

Sensationalizing a sad case cheats the public of sound debate

Posted by rattig November 29, 2008 19:30PM

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

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

Barbara Coombs Lee

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

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

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

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

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

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

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

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

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

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

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

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

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

Coombs Lee is president of the group Compassion & Choices.

Categories:

Comments

LetDocDecide says...

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

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

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

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

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

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

Respectfully
Bob

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

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

THE EUTHANASIA SOCIETY OF AMERICA

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

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

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

Potter's efforts to promote humanism coincided with the signing of the 1933 Humanist Manifesto, a document chiefly scripted by two Unitarian ministers, Curtis W. Reese and John H. Dietrich, and signed by Potter and sixty Unitarian pastors. Their ideal was a universal church of humanity based on firm ethical commitments. Rejecting all notions of a transcendental God or an order of divine truth outside mankind, they believed in the sweeping improvability of human nature through scientifically based social engineering, and in whatever social causes freed individuals from traditional moral codes that limited human choice. These ideals led prominent Americans such as John Dewey to sign the manifesto. Dewey's emphasis on the development of the individual and learning through experience as keys to the growth of democracy dovetailed with the postulates of the Humanist Manifesto.[15]

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

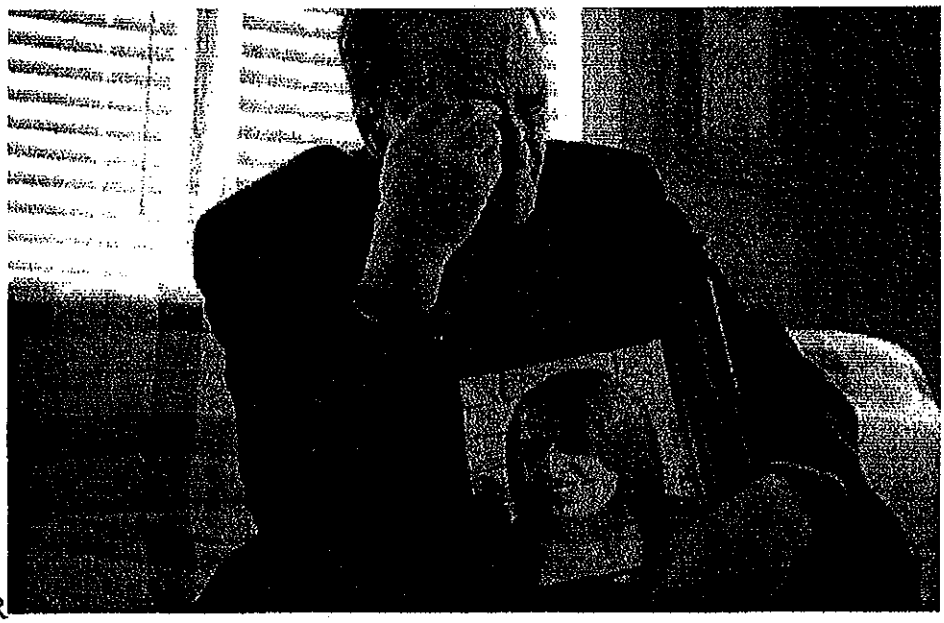
Despite his repeated invocations of individual freedom as a political goal, Potter, a supporter of involuntary eugenics and euthanasia, was no defender of laissez-faire personal choice. This was less of a contradiction than it appears. Although he and other Unitarians and humanists attacked traditional codes of conduct for blocking human freedom, they were not libertarians. If human beings were to be freed from long-standing moral and ethical beliefs, it was to enable them to make the right choices, not any choice whatsoever. Choice did not mean freedom to do what individuals pleased, but empowerment to do what a scientifically grounded humanism taught them to do.

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

Minnesota man linked to death of Carleton student admits encouraging five suicides: affidavit

Posted: May 11, 2009, 10:15 AM by Karen Hawthorne

Crime, Canada



POPULAR

By Ian MacLeod, Canwest News Service

OTTAWA – William Melchert-Dinkel, the American suspected of coaxing a depressed young Carleton University student to kill herself, admits he urged at least four others via the Internet to end their misery in suicide, according to a police affidavit.

Further, U.S. police Sunday said there is a possibility the number of cases could expand.

The affidavit, sworn by St. Paul, Minnesota, police to secure a search warrant for Melchert-Dinkel's personal computer files, has been unsealed by a Minnesota court to reveal fiendish new details of his online prodding of emotionally vulnerable individuals to choose death over life.

Posing as a suicidal young woman, the 46-year-old nurse trolled Internet suicide chat rooms using the screen name "Cami," and befriended people contemplating ending their lives. He encouraged others to join him in suicide pacts, typically by hanging, according to a statement he gave to St. Paul police.

Since about 2005, Melchert-Dinkel "believes he has advised and encouraged approximately five persons to commit suicide via the Internet on his home computer," says the affidavit by police Sgt. William Haider.

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which led to a Dalton Mc
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B-53

He "admitted he has asked persons to watch their suicide via webcams." But, he said he never watched them.

Police believe one of the five cases was that of Carleton's Nadia Kajouji, 18, who disappeared March 9, 2008, and was found dead in the Rideau River of an apparent suicide on April 20, 2008.

Transcripts of online conversations the Brampton native had with Melchert-Dinkel recommended she kill herself by hanging. In one, he explained he would tell her exactly what to use and how to do it. In another, he instructed her to look around her "apartment for somewhere to hang from."

The affidavit contains details of an April 12, 2007, suicide-pact e-mail from Melchert-Dinkel to someone at rippersonic@yahoo.com.

"Most important is the placement of the noose on the neck as I've said before, which of course, they don't tell you about on any (web) site," the message said.

"I can also die on Friday the 20th too! that would be a very good for me as the next day my parents will be here, of course, and it won't happen."

"I hope we can talk that day and go somewhat close to same time if possible." (Melchert-Dinkel refers to a seven- to eight-hour time difference, suggesting the other person was outside North America.)

"It's good to have support at this time of need ... hugs and love ... Cami."

St. Paul police said in March they expected charges to be laid soon against Melchert-Dinkel, possibly for alleged violation of the state law against aiding suicide.

But Peter Panos, a department spokesman, said Sunday because of the unusual and sensitive nature of the case, investigators are proceeding slower than initially anticipated.

One issue is finding, approaching and winning co-operation from people who have contemplated suicide and may be ashamed, much less willing to co-operate with a high-profile case.

"We're talking about people who are often times very vulnerable," Panos said. Detectives also are cautious "of how they go about finding other possible victims and how information that they might get might be used."

Another issue, is "where this case is best charged ... state, federal or an international basis."

The Ottawa Citizen

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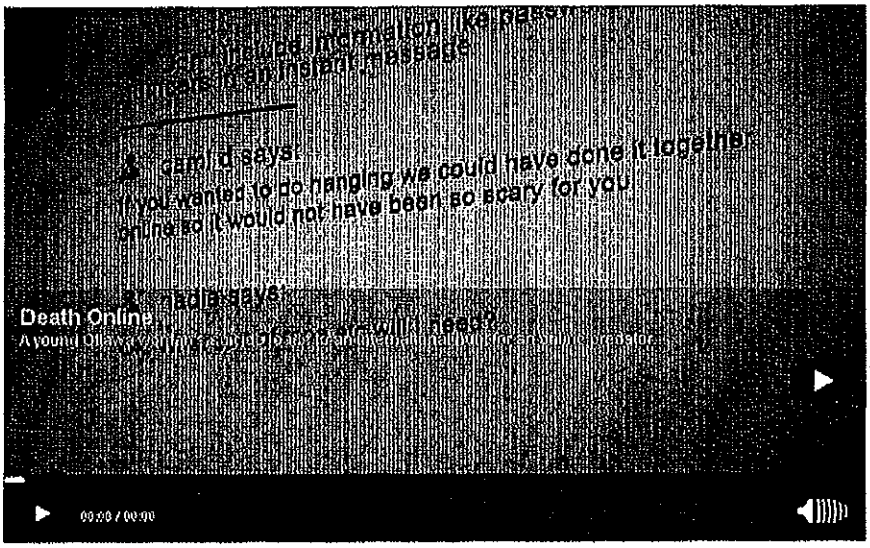
DEATH ONLINE | Broadcast premiere: October 9, 2009 at 9 p.m. on CBC-TV



Death Online Synopsis

Her name is Nadia Kajouji: eighteen years old, pretty, self-confident, an ambitious student with her sights set on a career in law and politics. Her world seems bright, and her future limitless as she begins her first year at Ottawa's Carleton University in the fall of 2007.

But, as *the fifth estate* reports in Death Online, Nadia's world is about to change. In a tragic way, and what happens to her will lead to an international search for an Internet predator.

Nadia's world began to fall apart soon after her arrival at Carleton University. In never-before-seen personal video diaries, Nadia records her descent into suicidal depression. The university assigns her a counselor, a doctor prescribes anti-depressants, but Nadia's parents are never told about their daughter's desperate mental state. Nor does anyone know of Nadia's secret online friend, identified only as Cami D, who is pushing the fragile girl towards suicide. On March 9, 2008, Nadia jumped into the Rideau River. Her body would not be found for six weeks.

Far away from Nadia's despair, in the English countryside, Celia Blay stumbles upon a cyber-world of websites, chat rooms and newsgroups all dedicated to suicide. More chilling, she discovers that one person, in particular, is encouraging severely depressed people to commit suicide. The retired schoolteacher turns amateur sleuth and tracks down the identity of this

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B-55

predator. She identifies him as William Melchert-Dinkel, a middle-aged nurse and father of two living in Faribault, Minnesota. Melchert-Dinkel has several online pseudonyms. One of them is Nadia Kajouji's friend, Cami D.

The fifth estate's Bob McKeown tells the story of Celia's shocking discovery and her attempts to get police, first in England, then in the United States, to investigate William Melchert-Dinkel. When they finally do pick up the case, it is too late to save Nadia.

In Death Online, *the fifth estate* talks to Nadia's parents and friends, to the amateur sleuth Celia Blay, and McKeown confronts William Melchert-Dinkel himself, asking him: why?

Death Online Credits

producer/director: OLEH J. RUMAK
producer: RACHEL HOULIHAN
written by: BOB McKEOWN
editor: DOMINIQUE BANOUN
cinematography: DOUG HUSBY, BRIAN KELLY, JOHN BADCOCK, SAT NANDLALL, PAUL SEELER, RICHARD FURLONG
audio: JOE PASSARETTI, KARNDEEP JASSAL, LARRY KENT
graphic designers: TIM KINDRACHUK, AMEDEO DE PALMA
audio mix: DON DICKSON
colourist: PETER JORGENSEN
archival material: CBC OTTAWA, /A\ OTTAWA CTVGLOBEMEDIA, JEFFREY THOMPSON PHOTOGRAPHY
special thanks: SARAH WHITE, CAROLINE GILLIS, LINDA GREARSON
website producer: ROBERT BALLANTYNE
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Jones said 'no' to the transplant that will save her life.

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He had it all and lost it. Now, Theo Fleury finally may have found himself.

Death Online
A young Ottawa woman's suicide leads to an international hunt for an online predator.

The Education of Brian Nicholl
Learning lessons about the economic downturn, the hard way.

Riding on Risk
Disturbing allegations about our safety in the air. How well is our government protecting our safety and security?

B-56

KAJOUJI: My parents don't live in this city, so how will that work? My family lives about a six-hour drive away.

MELCHERT-DINKEL: If they find you in the river, they will have to identify you somehow. That can take time for sure. Then they have to find your parents, who have to come identify you—more time. So most likely no viewing due to time and trauma. If you are carried away in the river current, they may never find you. You would be a missing person. That's why I'm keeping everything here at home. Easy for my mom.

KAJOUJI: I'm sure they'll find me because I'm not jumping in the actual river. I'm jumping in the canal. It won't take me too far. I guess I should have my wallet in a zippered pocket so I have some I.D. on me.

MELCHERT-DINKEL: Um, yeah. I will be here starting about 8:00 a.m. on Monday, if you need me. If you are still here (I hope not, for your sake), then try to come on early so we can do it if you want to.

KAJOUJI: Okay, what sort of rope will I need?

MELCHERT-DINKEL: Get a yellow nylon rope, about eight feet. That is all you need. And look around your apartment for somewhere to hang from. I can help you with the cam when you need to.

MARCH 9, 6:56 P.M.

MELCHERT-DINKEL: How are you doing?

KAJOUJI: I'm good. I'm glad things are going to end tonight.

MELCHERT-DINKEL: So you think you'll be all done tonight?

KAJOUJI: Yup, for sure. I've got all my affairs in order. I'm feeling confident.

MELCHERT-DINKEL: I think tomorrow will be it.

KAJOUJI: Well, you will not be alone.

MELCHERT-DINKEL: I know.

KAJOUJI: I want to go now, but there are too many people up and about. I'm going to have to wait a couple of hours.

MELCHERT-DINKEL: I wish we could have done it together, but I understand why. Did you get rope in case you need a backup plan?

KAJOUJI: No. There is a store close by if I need to.

B-57

EFile ID:

STATE OF MINNESOTA

COUNTY OF RICE

COPY

DISTRICT COURT

THIRD JUDICIAL DISTRICT

COURT FILE NO.: 66-CR-10-1193

PROSECUTOR FILE NO.: A-10-0316

State of Minnesota,

Plaintiff,

v.

William Francis Melchert-Dinkel DOB: 07/20/1962
510 Littleford Lane
Faribault, MN 55021

Defendant.

☒ Summons ☐ Warrant
☐ Order of Detention

☐ Amended
☐ Tab charge Previously Filed

The Complainant, being duly sworn, makes complaint to the above-named Court and states that there is probable cause to believe that the Defendant committed the following offense(s):

Count 1

Suicide - Aiding
In Violation Of: **609.215 subd. 1**
Penalty: **Imprisonment for not more than 15 years or a fine of not more than $30,000 or both**

On or about July 27, 2005, within the County of Rice, defendant William Francis Melchert-Dinkel did advise, encourage, or assist another in taking the other's own life, to-wit: did advise and encourage Mark Drybrough, of Coventry, UK, using internet correspondence, and Mark Drybrough did take his own life.

Count 2

Suicide - Aiding
In Violation Of: **609.215 subd. 1**
Penalty: **Imprisonment for not more than 15 years or a fine of not more than $30,000 or both**

On or about March 9-10, 2008, within the County of Rice, defendant William Francis Melchert-Dinkel did advise and encourage another in taking the other's own life, to-wit: did advise and encourage Nadia Kajouji of Ottawa, Ontario, Canada using internet correspondence and Nadia Kajouji did take her own life.

RICE COUNTY, MN
FILED
APR 23 2010
COURT ADMINISTRATOR

STATEMENT OF PROBABLE CAUSE

The Complainant states that the following facts establish probable cause:
Your Complainant and/or Signing Officer designated below, being duly sworn, has reviewed police reports relating to the above-named Defendant and the allegations contained herein, and/or has spoken with peace officers having knowledge of the incident, and based upon that information, believes the following to be true and correct.

On March 25, 2008, Sargent William Haider of the St. Paul Police Department, on assignment to the Internet Crimes Against Children Task force, received information from a person identified as Celia Blay, from White Waltham, Maidenhead Berks, in the United Kingdom, reporting an online predator using deception to manipulate people to commit suicide. The information from Blay stated the predator encouraged people to hang themselves and use a web cam to allow him to view the death. Blay identified the individual and reported the person using the online name of "li dao", "falcon girl", "falcongirl", "cami", "cami D" and "cami M-D" as Bill Francis Melchert-Dinkel. Blay also gave Sgt. Haider Mr. Melchert-Dinkel's numerous email addresses which included falcongirl2@gmail, falcongirl507@yahoo, li_dao05@yahoo, falcongirl2@gmail, falcon_girl_507@hotmail. Sgt. Haider received additional information from Blay on March 26, 2008, and over the next several months, indicating that Mr. Melchert-Dinkel was continuing to use various on-line identities, posing as a young, kind, sympathetic woman who worked as an emergency room nurse, and encouraging people to commit suicide.

On March 26th, 2008, the Faribault Police Department was contacted to check the welfare of an individual located at the the Melchert-Dinkel residence in Faribault, Minnesota. The report indicated it was regarding a suicide pact made by someone at the Melchert-Dinkel residence with another party who was believed at the time to be deceased in Canada. The Faribault PD confirmed that William Frances Melchert-Dinkel (dob 07/20/1962) lived in Faribault at the noted address. Officers went to the address and found no one was present. It was subsequently learned the family had been gone for a vacation at the time the officers stopped to check on the welfare of Mr. Melchert-Dinkel. Mr. Melchert-Dinkel eventually contacted the Faribault PD and advised everyone living at his home was fine. Officer Kosanda of the Faribault PD spoke with Mr. Melchert-Dinkel and gave him contact information for the Canadian law enforcement office investigating the disappearance of Nadia Kajouji.

On January 7, 2009, Sergeant Haider and Commander Neil Nelson traveled to the residence of William Francis Melchert-Dinkel in the city of Faribault, in Rice County, Minnesota, to ask about his involvement with discussions of suicide on the internet. After being invited into the Melchert-Dinkel home by Mr. Melchert-Dinkel, the officers identified themselves and explained they wished to speak to him regarding internet related issues. Mr. Melchert-Dinkel stated "I think I know what you mean". When asked to explain his statement he stated he had "some concerns about some of the internet activity that has been going on here regarding issues with suicide and so forth." He further explained there had been discussions on internet chat rooms, such as Yahoo and Google, involving people dealing with depression from his residence. He stated he and his wife work in the health care field and they had discussions on the internet with people dealing with depression and suicide, and that the discussions had gotten inappropriate. He stated he had personally been involved in inappropriate discussions. When asked if his wife should be involved in the interview, he further stated his wife had nothing to do with the discussions and she had no involvement.

Mr. Melchert-Dinkel admitted to being an internet advisor in suicide methods, such as pharmaceuticals, because of his health care background as a nurse. He stated he specifically goes on Google, ash.methods which is a website people use to find suicide methods. He would use the online names Cami, Li Dao,

and Falcongirl, and tell people he was a female nurse. He admitted to telling people he was a nurse and advising he was familiar with suicide methods such as hanging or narcotics. He admitted to being more of an advocate than a counselor. He further stated he stopped the contacts and discussions after the holidays(referring to Christmas of 2008) due to moral , ethical and legal reasons. Mr. Melchert-Dinkel indicated his interest in death and suicide could be considered an obsession and that his daughters had seen his discussions on the internet and he had told them his discussions were not right.

Mr. Melchert-Dinkel admitted to encouraging and advising people about suicide by hanging, and "what they could expect to experience with it". He explained how he would explain instructions for hanging using a slip knot. The knot would be placed behind the left ear because that would be the most effective position for compression of the left and right carotid artery which would cause unconsciousness in 10 to 15 seconds, brain death and total death in 10 to 20 minutes. The rope could be hung from a beam or using other methods. Mr. Melchert-Dinkel was asked to give specific examples of someone he might have had this discussion with and he stated he had spoken with people from England. He did not know of any specific outcome, but presumed the outcome was suicide because he had not heard back from them. Mr. Melchert-Dinkel was specifically asked what his role was and if he believed he assisted anyone in committing suicide and he stated he held the role of advocate to commit suicide, and he believed he had aided people to commit suicide. At this point in the interview Mr. Melchert-Dinkel indicated he felt terrible regarding the advice to commit suicide he provided to others.

Mr. Melchert-Dinkel was asked about any suicide pact he might have made in the last six months. He stated he had made a suicide pact with a woman from Ottawa, Canada and explained the woman had jumped into a frozen river. He had learned about the successful suicide from his contact with the Ottawa Police Department which had traced him through his computer. He described the suicide pact as between him and the woman in Ottawa as they had agreed to commit suicide and that he had played a larger role in her death than he had initially disclosed. He admitted to making other suicide pacts prior to and after the Ottawa woman's suicide which he descibed as being an "accessory to someone ending their life". He would advise the person as to how and what methods were best for suicide success and painlessness. Mr. Melchert-Dinkel estimated he had assisted 5 or less individuals in killing themselves.

Mr. Melchert-Dinkel was asked about an email address retrospook@ntlworld.com or the name Mark Drybrough from England. He did not specifically recall the name or "handle", but vaguely remembered that it was related to a hanging. He stated he remembered seeing in another chat room that a paper had reported that a person in the United States of America had "assisted him in doing it". He indicated he knew it was himself that the paper was referring to, due to the fact that the "handle" given was "Li Dao", which was his "handle". He also confirmed he had claimed to have watched a party in England hang themselves via web cam. However, he denied watching anyone's suicide, though in his suicide pacts with others he would agree to view through a web cam.

Mr. Melchert-Dinkel did state that he thought assisting suicide was illegal, and that it was illegal in Minnesota. He agreed to allow officers to search his home and signed a waiver agreeing to the search of his computer. He admitted to entering into 10 to 11 suicide pacts online with individuals all over the world. He admitted he moved from advising suicides to encouraging suicide. He stated age and circumstances would determine whether or not he discussed suicide methods or encouraged suicide. He explained suicide pacts were made with those "most intense" on committing suicide. He noted others on line would catch on to the suicide encouragement and would post warnings. The warnings would be posted messages such as, "Watch out, for Li Dao is out to encourage people to die rather than help". He

again estimated he most likely encouraged dozens of persons to commit suicide and characterized it as the thrill of the chase. He could not be certain as to the numbers because the successful suicide was hard to verify and that there could be dozens, which he found to be a scary thought. He stated he only encouraged suicide and never told anyone to do it, but told them it was up to them. He admitted there have been cases where people he counseled to commit suicide have died and he encouraged them by telling them it was ok to let go, that they would be better in heaven, and that his caring nature went too far.

After interviewing William Melchert-Dinkel, Sgt. Haider contacted Staff Sgt. Uday Jaswal of the Ottawa Police Department in Canada to relate information provided by Melchert-Dinkel about the suicide pact he had entered into with Nadia Kajouji. Sgt. Haider obtained further information from the Ottawa Police Department regarding Ms. Kajouji. Ms. Kajouji attended Carleton University in Ottawa, Canada, and on March 9, 2008 she had gone missing. Police investigating her disappearance had determined she had been online with a person from Faribault, Minnesota using an e-mail address of falcon_girl (screen name Cami), discussing suicide and entering into a suicide pact with the person. Cami (Mr. Melchert -Dinkel) and Nadia (Ms. Kajouji) discussed different methods of suicide, including jumping into a river, which Nadia said she intended to do, and hanging, which was was recommended by Cami (Mr. Melchert -Dinkel). They agreed on timing, with Nadia going first and jumping from a bridge over a river (to avoid creating a mess, per Mr. Melchert-Dinkel) and Cami (Mr. Melchert-Dinkel) going second by hanging the following day. Nadia Kajouji committed suicide sometime on March 9, 2008 or March 10, 2008. She told her roommate she was going skating on the evening of March 9, 2008, and was not seen again until her body was found in the Rideau River on April 20, 2008. The medical examiner determined the cause of death to be drowning and/or hypothermia consistent with suicide based on the facts surrounding her death.

The forensic examination of the computer belonging to William Melchert-Dinkel disclosed a photograph of Nadia Kajouji and emails and correspondence between Mr. Melchert-Dinkel and persons struggling with depression and suicidal thoughts, which corroborated his statements to law enforcement officers.

Sgt. Haider contacted Peter Faulkner, Intelligence Officer, West Midlands Police Department, Coventry Central, United Kingdom(UK), and requested all documentation related to the suicide on July 27, 2005 of UK resident Mark Drybrough, date of birth 04/13/1973, 48 King Edward Road, Hillfields, Coventry, CV1 5BJ. On March 19, 2010 Sgt. Haider received information from West Midlands Police Department which included police reports and Coventry Coroner reports. Although photos of the suicide scene had been taken by police in 2005, the photos were destroyed upon a ruling by the coroner of death by suicide. The police reports included a witness statement by Carol Drybrough (sister of the victim), indicating she had gone to her brother's apartment on July 27, 2005 and located a suicide note attached to the front door. She forced her way into Mr. Drybrough's bedroom and saw her brother hanging from a ladder. She untied the rope from his neck as the rope was too thick to cut. West Midlands PD Sudden Death Report of Officer James Edmonds, APS 5116, indicated that upon arrival by police, the victim's body was "lying down face up on the floor" with "deep marks around neck believed to be rope marks". A statement was taken from Elaine Drybrough (mother of the victim), dated August 16, 2005 indicating a computer belonging to the victim was turned over to West Midlands PD. A report by James Harper, West Midlands PD, dated August 16, 2005 lists the seizure of victim's computer, webcam, CD's and floppy discs. Harper's details state "It is believed that Mark was aided and abetted by a man called Li from Minnesota. The computer contains details of e-mails and shows various websites which have been visited by the deceased."

Property records reports indicate evidence recovered included a suicide note, a white climbing rope used during commission of the suicide, and the victim's computer.

The Coventry Coroner's information was in Coroner's Officer's Report No. 01005-2005, July 28, 2005. According to the "Circumstances" portion of this report, it was noted, "His sister immediately went up stairs and after forcing her way into a bedroom found the deceased hanging with a rope attached to a loft ladder and the other end tied around his neck." The Coroner's Office indicates an inquest was held on February 14, 2006, resulting in a verdict that "[Drybrough] took his own life when suffering a severe psychiatric illness". The Coroner's Memo states, "During the investigation and at the inquest it was revealed that the deceased had been using his computer to gain access to the Internet and had entered into a live chat for people considering suicide. No criminal offences were disclosed at the time."

The Coroner's Post Mortem Report, Pathology Department-Walsgrave Hospital, 07/28/2005: External Examination: states, "The body was that of a young man of average physique which showed a deep ligature groove 1cm wide in the upper part of the neck, 9.5cm above the sternal notch which was rising towards the left and to the back of the neck." During the interview of suspect William Melchert-Dinkel on January 7, 2009, he stated his instructions for hanging as "Slip knot. And knot behind the left ear" and that the knot behind the left ear was "the most effective position for compression of the left and right carotid".

Officer Edmonds of the Coventry and Warwickshire Police states "A loft ladder was positioned against a wall with a White Climbing rope attached."

The forensic analysis of Mark Dyrbrough's computer found the following correspondence online between Spooky AKA Mark Drybrough and li_dao, AKA William Melchert-Dinkel: "Spooky" wrote: "Does anyone have details of hanging methods where there isn't access to anything high up to tie the rope to. I've read that people have taken their own lives in jail, anybody know of inventive methods used, the ones you don't get to read in the paper".

An email was sent as a reply to this post on 07/01/2005 from IP address 68.190.155.172 from email address li_dao05@yahoo.com to email address retrospook@ntlworld.com stating in part:

"Depending on how tall you are, preferrable under 6 feet tal, you can easily hang from a door using the knob on onw [the other] side to tie the rope to, sling it over the top of the door, attach the noose or loop to yourself then step off and hang successfully. If you are a bit tall you can still do a partial suspension hanging that way by having the noose etc fairly high up and attaching it to yourself, then lowering yourself into a sitting position or kneeling down so you hang that way."

It was determined that email address li_dao05@yahoo.com belongs to suspect MELCHERT-DINKEL and email address retrospook@ntlworld.com to victim Mark Drybrough.

NOTICE: FAILURE TO APPEAR FOR A COURT APPEARANCE IS A CRIMINAL OFFENSE UNDER MINN. STAT. S. 609.49.

Complainant requests that Defendant, subject to bail or conditions of release, be:
(1) arrested or that other lawful steps be taken to obtain Defendant's appearance in court; or
(2) detained, if already in custody, pending further proceedings; and that said Defendant otherwise be dealt with according to law.

COMPLAINANT'S NAME:

Sergeant William Haider

COMPLAINANT'S SIGNATURE:

Subscribed and sworn to before the undersigned this 23 day of April, 2010

NAME/TITLE:

SIGNATURE:

Judge of Dist. Ct.

Being authorized to prosecute the offenses charged, I approve this complaint.

Date: 4-23-10

PROSECUTING ATTORNEY'S SIGNATURE:

Name: G. Paul Beaumaster
Rice County Attorney
Rice County Attorney's Office
218 Third St. N.W.
Faribault, MN 55021
(507) 332-6103
Attorney Registration Number: 196642

FINDING OF PROBABLE CAUSE

From the above sworn facts, and anysupporting affidavits or supplemental sworn testimony, I, the Issuing Officer, have determined that probable cause exists to support, subject to bail or conditions of release where applicable, Defendant's arrest or other lawfull steps to be taken to obtain Defendant's appearance in court, or Defendant's detention, if already in custody, pending further proceedings. Defendant is therefore charged with the above-stated offense(s).

[X] **SUMMONS**

THEREFORE, YOU THE ABOVE-NAMED DEFENDANT, ARE HEREBY SUMMONED to appear on the 25th day of May, 2010 at 10:30 am before the above-named court at Rice County Courthouse 218 N.W 3rd Street Faribault, MN 55021 to answer this complaint.

[ ] **WARRANT**

To the Sherriff of the aboved-named county; or other person authorized to execute this warrant: I hereby order, in the name of the State of Minnesota, that the above-named Defendant be apprehended and arrested without delay and brought promptly before the above-named court (if in session), and if not, before a Judge or Judicial Officer of such court without unnecessary delay, and in any event not later than 36 hours after the arrest or as soon as such Judge or Judicial Officer is available to be dealt with according to law.

[ ] *Execute in MN Only* [ ] *Execute Nationwide* [ ] *Execute in Border States*

[ ] **ORDER OF DETENTION**

Since the above-named Defendant is already in custody, I hereby order, subject to bail or conditions of release, that the above-named Defendant continue to be detained pending further proceedings.

Bail: _____

Conditions of Release:

This complaint, duly subscribed and sworn to, is issued by the undersigned Judicial Officer this 23 day of April, 2010.

JUDICIAL OFFICER:
NAME: Thomas Neuville
TITLE: Judge

SIGNATURE: Thomas M. Neuville

Sworn testimony has been given before the Judicial Officer by the following witnesses:

COUNTY OF RICE
STATE OF MINNESOTA

State of Minnesota
Plaintiff
vs.
William Francis Melchert-Dinkel
Defendant

Clerk's Signature or File Stamp:
COURT ADMINISTRATOR
APR 23 2010
RICE COUNTY, MINN.

RETURN OF SERVICE
I hereby Certify and Return that I have served a copy of this Summons upon the Defendant(s) therein-named.

Signature of Authorized Service Agent:

carotid artery, causing unconsciousness in ten to fifteen seconds, and death within ten to twelve minutes. Defendant stated that he corresponded with people from England about committing suicide, and assumed one or more of those persons committed suicide. Defendant also stated that he entered into a suicide pact with a woman in Ottawa, Canada, and he believed that the woman committed suicide by jumping into a frozen river.

At the hearing, Joyce Melchert-Dinkel testified that she was in the kitchen while Defendant was being interviewed by police. She testified that none of the officers prevented her from being in the dining room, but she felt like she could not enter because the police where there.

Defendant testified at the hearing that he felt he was being coerced by police into giving a statement. Specifically, Defendant said police were coercing them by asking Defendant if he knew he helped kill five people. Defendant testified that Sergeant Haider suggested that Defendant go into the kitchen to tell his wife what the interview was about. Defendant testified that he did so.

LEGAL ANALYSIS

I. Voluntariness of Defendant's Statement to Police

Defendant's motion to suppress his statement to police and the evidence obtained by police as a result of Defendant's statement was withdrawn. The Court will consider Defendant's statement to police for probable cause and obtain Defendant's waiver at the plea hearing.

II. Constitutional Vagueness Challenge

Defendant argues that Minn. Stat. § 609.215, subd. 1, is unconstitutionally vague as applied to his alleged conduct because the statute regulates protected speech.

"[A] penal statute or ordinance creating an offense should be sufficiently explicit to enable one of common knowledge to ascertain what conduct is prohibited thereby." *State v. Johnson*, 163 N.W.2d 750, 753-54 (Minn. 1968). "[T]he void-for-vagueness doctrine requires that a penal statute define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement." *State v. Newstrom*, 371 N.W.2d 525, 528 (Minn. 1985) (citing *Kolender v. Lawson*, 461 U.S. 352, 357 (1983).

Defendant, although challenging the statute on vagueness grounds, does not cite any part of the statute that would cause an ordinary person not to understand what conduct is prohibited,

Excerpts — Omibus Order & Memorandum, filed 11/8/10, State v. Melchert-Dinkel, Judge Neville

nor does Defendant explain how the statute encourages arbitrary and discriminatory enforcement. In fact, Defendant concedes that a state can permissibly criminalize assisted suicide.[4] Rather than presenting evidence of statutory vagueness, Defendant alleges that his conduct was speech, which he argues is not criminalized by Minn. Stat. § 609.215, subd. 1.[5] In the alternative, Defendant argues that if the Court finds that speech is prohibited by the statute, Defendant's speech is constitutionally protected. Even though Defendant does not technically allege statutory vagueness, the Court will address the issue since it was raised in Defendant's brief.

The statute Defendant is charged with imposes criminal liability for anyone who intentionally "advises, encourages, or assists another in taking the other's own life." Defendant argues that this language is unconstitutionally vague.

a. Definiteness of the Statute

The Court finds that Minn. Stat. § 609.215, subd. 1, is definitive enough to allow an ordinary person to know what conduct it prohibits. Under Minn. Stat. § 645.08, "words and phrases [in statutes] are construed according to rules of grammar and according to their common and approved usage." "Advise" means "to give an opinion or counsel, or recommend a plan of action." *Black's Law Dictionary*, 35 (5th ed. 1995). "Encourage" "[i]n criminal law, [means] to instigate; to incite to action; to give courage to; to inspirit; to embolden; to raise confidence; to make confident; to help; to forward; to advise." *Id.* at 364. "Assist" means "[t]o contribute effort in the complete accomplishment of an ultimate purpose intended to be effected by those engaged." *Id.* at 80. These are words of common knowledge and their meanings are clear and unambiguous. As written, an ordinary person would know what conduct that Minn. Stat. § 609.215, subd. 1, prohibits.

[4] Defendant cites *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997) as authority that "In almost every State . . . it is a crime to assist a suicide. The State's assisted suicide bans are not innovations. Rather they are longstanding expressions of the State's commitment to the protection and preservation of human life." Though, Defendant limits his concession to the realm of physician assisted suicides.

[5] "There are no allegations as to any direct or active participation in the suicides; all allegations relate to Internet Speech." Def.'s Br. 2. If anything, Defendant's argument is more akin to a challenge on the grounds that the statute is unconstitutionally overbroad, rather than vague; though Defendant does not raise such an argument. In actuality, Defendant's argument against prosecution is twofold: 1) Defendant's conduct was merely speech, which the statute does not prohibit; and 2) if the statute does regulate speech, the statute does not apply to Defendant because his speech was protected.

b. Arbitrary and Discriminatory Enforcement

Defendant has not alleged that Minn. Stat. § 609.215, subd. 1, is written in a way that encourages discriminatory enforcement, nor can the Court find that it does. The statute clearly describes the prohibited conduct and does not limit or classify the types of offenders that can be prosecuted thereunder. The statute does not encourage discriminatory enforcement.

c. Minn. Stat. § 609.215, subd. 1 is Not Unconstitutionally Vague

The Court finds that Minn. Stat. § 609.215, subd. 1, is written in a way that ordinary persons understand what conduct it prohibits and it is not written in a way that encourages discriminatory enforcement. Therefore, the Court finds that Minn. Stat. § 609.215, subd. 1, is not unconstitutionally vague according to the Constitutions of Minnesota and the United States.

III. Protected Speech Challenge

Defendant argues that Minn. Stat. § 609.215, subd. 1, does not prohibit the alleged actions of Defendant, because his actions constituted mere speech. If the statute does regulate Defendant's speech, he argues that his speech is protected under the Constitutions of Minnesota and the United States.

a. Statute's Governance of Speech

"Minnesota statutes are presumed constitutional, and our power to declare a statute unconstitutional should be exercised with extreme caution and only when absolutely necessary. The party challenging a statute has the burden of demonstrating beyond a reasonable doubt a violation of some provision of the Minnesota Constitution." *In re Haggerty*, 448 N.W.2d 363, 364 (Minn. 1989) (internal citations omitted).

The Minnesota Supreme Court has not directly defined the scope of Minn. Stat. § 609.215. Defendant cites case law on California's assisted suicide statute as persuasive authority to interpret Minnesota's statute. Cal. Penal Code § 401 states that "[e]very person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony."

A California appellate court held that

> Although on its face the statute may appear to criminalize simply giving advice or encouragement to a potential suicide, the courts have again by analogy to the law of aiding and abetting required something more than mere verbal solicitation of another person to commit a hypothetical act of suicide. Instead the courts have interpreted the statue as proscribing the direct aiding and abetting of a specific suicidal act . . . Some active and intentional