
NO
on SB128

**Assisted Suicide
Opposition Kit**

NO **on SB128**

Why Oppose SB 128

Assisted suicide legalization has failed more times than it has succeeded. There have been well over 100 legalization attempts in the past 20 years, yet only 3 states have actually legalized it through legislative or voter action.

1. **End-of-life prognoses are difficult and can be inaccurate**; years of living a good life could be taken. People who are told they have 6 months to live often go on to live many years past the initial prognosis. Nothing prevents these laws from being expanded to include individuals with longer prognoses or people “suffering” from other illnesses or disability. The longest and most studied examples of assisted suicide laws in Europe provide evidence for the expansion argument.
2. **Doctors could inaccurately determine a patient's state of mind** given there is no requirement for a psychiatrist or mental health professional to do an evaluation if the patient's doctor believes the patient is of sound mind.
3. Recent evidence suggests that **attempts at physician-assisted suicide often meet with unexpected complications**. Barbiturates are the most common substances used for assisted suicide overdoses in Oregon and are known to cause distress. While people look to physician-assisted suicide to relieve pain, these drugs are also known to cause extreme gasping and muscle spasms. They can cause a person to vomit and then inhale the vomit. They can also cause feelings of panic or terror along with violent behavior that takes place from the drug-induced confusion.
4. What we are talking about is legalizing death by prescription, which would **allow insurers to steer patients toward death** instead of paying for expensive treatment. This already is happening. Oregon state health insurance companies have refused to cover expensive treatments.
5. Nothing in SB 128 can protect from explicit or implicit family pressures to commit suicide or personal fears of “being a burden”.

Assisted suicide: help the rich to not get too much care

By Debra J. Saunders

April 10, 2015

The assisted-suicide movement is the rare self-proclaimed civil rights movement that exists to cater to the wishes of affluent Americans. Tuesday, the state Senate Judiciary Committee held a hearing on SB128, a bill to legalize assisted suicide in California. (Proponents don't like the word suicide, so they call the measure the "End of Life Option Act.") Supporters talked of their fear of medical personnel prolonging their lives, of pain and lack of autonomy; opponents fear that the bill's passage would represent a callous act of cultural abandonment of the sick and disabled.

I don't mean to suggest that life is easy for those who have a personal stake in the bill's passage. Christina Symonds, 43, gave heart-wrenching testimony about her battle with ALS. Because she wants the ability to choose assisted suicide, her family moved to Oregon, which legalized assisted suicide 17 years ago. "I do not want to live my last days in a wheelchair, fully paralyzed, connected to a breathing machine," she said. "To me, that is the picture of horror." That is certainly not the end any young mother would choose.

Clearly, California should have a system that provides Symonds the best care and best pain control possible. Pain control has come a long way since Oregon legalized assisted suicide. But there's this sleight of hand on the part of supporters of assisted suicide. They talk about the need to avoid pain, when their real focus is their fear of losing control. It is an understandable, human fear, but it would be wrong to change the emphasis of medicine on healing to assuage that fear.

State Sen. Hannah Beth Jackson, D-Santa Barbara, a bill co-sponsor, referred to "the lack of dignity" that can occur toward the end of life. That language implies that sick people who choose to live lack dignity.

Marilyn Golden of the Disability Rights Education & Defense Fund is living proof that a disabled woman can face unwanted obstacles and thrive. She tried to prompt committee Democrats to think about the many things that can and do go wrong. Doctors misdiagnose. Family members have the ability to make elderly relatives feel unwanted and alone. Lethal prescriptions are cheaper than complicated treatment. Disease can lead to depression, which can be treated. When people first get a horrific diagnosis, they think they want to die; later many find that their prognosis turned out to be wrong, or that they want to live what life they have left.

Golden's group compiled a list of troubling cases from Oregon — including a woman with dementia, a potentially depressed woman who had breast cancer for 20 years, sick people with financial problems. The [Oregon Health Plan would not cover chemotherapy treatment for a lung cancer](#)

patient and a man with prostate cancer, but offered to pay for physician-assisted suicide. Golden chalks up the low numbers to Oregon's toothless law that has no mechanism to uncover abuses.

Jackson dismissed these cases as numerically insignificant.

The hearing room was filled with supporters wearing yellow Compassion & Choices T-shirts. Many talked about their determination to end their lives on their own terms. I often am struck by proponents' — how can I put this? — affluence, assurance and sense of entitlement. SB128 is a bill designed to make suicide more available, palatable and friendly.

California has world-class medical care. This bill seeks to address a "First World problem," noted Tim Rosales from the opposition. Rosales steered me toward Ken Barnes, a San Diego management consultant who used to be on the executive committee of the California conference of the NAACP. Barnes handily summed up SB128 supporters: They tend to be white, educated, affluent and able to navigate the health system. While they think they are "progressive," they are as oblivious to the downside for "people of color and people who don't know how to advocate for themselves." They're like white guys who don't understand why black men are leery of police.

To that point: Ann Getty hosts Compassion & Choices fundraisers. U.S. Sen. Dianne Feinstein of Pacific Heights supports SB128. The bill's sponsors, Democratic state Sens. Bill Monning and Lois Wolk, hail from Carmel and Davis, with co-sponsors from Santa Barbara and San Francisco. The always affable Bob Hertzberg, the Democratic state senator representing the San Fernando Valley, confessed he once blocked a similar bill, but now he would support SB128. Because: "What's the role of government?"

Surely Hertzberg and the other proponents know that the state cannot stop people from committing suicide. More than 40,000 sad, desperate Americans do it every year. So Hertzberg must see it as a fit role for government to encourage suicide and change the face of medicine by giving doctors a license to prescribe intentionally lethal overdoses. In a world with premium medical care, that is dignity.

Gov. Jerry Brown spent time with Mother Teresa in Calcutta. His office won't say if he'll sign or veto an assisted-suicide bill. He knows what he should do. True compassion engenders striving to cure illness, relieve pain and offer warmth to those who are suffering. That is dignity.

Those who say they want the option of assisted suicide, said, Barnes, essentially are "pointing at a disabled person and saying, 'I don't want to live like that.'" That's not dignity.

Debra J. Saunders is a San Francisco Chronicle columnist.



Assisted suicide: Is it simply death over disability?

By Ken Barnes
November 22, 2014

The public policy debate surrounding assisted suicide, and whether or not it should become a normalized component of our health care system, has once again intensified in California. While proponents have waged an aggressive public relations campaign to re-brand assisted suicide as “death with dignity” and “aid in dying,” we must ask ourselves if this is really just death over disability. The debate concerning end of life care has historically been rooted in left versus right, progressive versus conservative, and religious versus secular views, but in reality it is a fight between those with means and the unfortunate masses without.

During my life I’ve had an opportunity to view end of life, disability, and general health care from multiple angles. I’ve engaged it from a public policy perspective as the former health committee chairman of the California State Conference of the NAACP, as a young adult when a family member was given a terminal diagnosis, and from the painful yet inspiring viewpoint of having a severely disabled twin brother who suffered with cerebral palsy.

In recent months an organization formerly known as the Hemlock Society, now called Compassion & Choices, has led the charge for the right to assisted suicide. To raise the profile of their advocacy, they have highlighted the sad and unfortunate death by (legally assisted) suicide of a young lady named Brittany Maynard. Earlier this year Ms. Maynard was diagnosed with terminal brain cancer at just 29 years of age, and faced with this devastating news, she terminated her life. However, suicide was not the only option for her to avoid a painful death. Palliative and hospice care, which address physical pain as well as the emotional and spiritual needs of the terminally ill, is readily available to comfort persons at the end of life.

While Ms. Maynard’s death in Oregon has been heralded as an example of why assisted suicide should be legalized in California, there’s also a darker side to end of life care. It’s no secret that America’s health care system is profit-oriented, and introducing the low-cost alternative of assisted suicide could have devastating effects.

Proponents uphold Oregon’s assisted suicide law as a model to be followed, but they ignore evidence from cancer patients such as Barbara Wagner who had her request for chemotherapy medication denied. Although Oregon Health Plan was unwilling to approve the \$4,000-a-month drug, they offered to cover the one-time \$100 expense for life-ending medication. Unfortunately, she is not the exception, as there are many other non-celebrated cases facing these challenges on a daily basis.

While hospitalized on life support, my low-income uncle was given a terminal diagnosis. There was extreme pressure applied to my mother to end her brother's life, as they emphasized his inability to care for himself, the cost to maintain care, and the unlikelihood of living a dignified life should he survive. He did survive, for another 12 years in a wheelchair and I'm sure he would say despite needing occasional assistance, he lived a very dignified life.

Numerous polls and studies have shown the overriding concern and fear of people who support assisted suicide is the thought of living with a disability, and experiencing an undignified life. This is a troubling outlook, as it diminishes the value of those who live full, robust lives with many of the disabilities cited as reasons to enact assisted suicide laws.

My twin's life was one featuring a constant movement of life expectancy. Although Kevin required assistance and care, he enriched the lives of the persons he touched despite his disability. While caring for him and others with similar ailments is not always convenient, discarding lives which become inconvenient is not a display of compassion, but one of selfish cruelty.

It is important we separate the acts of removing life support from nonresponsive patients and that of actively terminating lives, as they are not the same thing. As a society we have long rallied together to provide support and encouragement for those seeking to kill themselves. Just as we would with any person wishing to commit suicide, we must embrace those facing end of life challenges with that same love and compassion, and help them live life fully until the end.

Barnes, a resident of Rancho Bernardo, is a former executive committee member of the California State Conference of the NAACP. He is an operations and management consultant and active in organizations supporting those living with disabilities.

Some Oregon and Washington State Assisted Suicide Abuses and Complications

Under Oregon and Washington State’s lax oversight, these are some of the documented abuses and complications that have come to light. This list includes abuses and medical complications, as well as other incidents showing some of the harms and dangers that accompany assisted suicide laws.

Doctor Shopping Gets Around Any “Safeguards”

- **Kate Cheney**,¹ 85, died by assisted suicide under Oregon’s law even though she had early dementia. Her physician had declined to provide the lethal prescription. Her managed care provider then found another physician to prescribe the lethal dose. The second physician ordered a psychiatric evaluation, which found that Cheney lacked “the very high level of capacity required to weigh options about assisted suicide.” Cheney’s request was denied, and her daughter “became angry.” Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her “choices may be influenced by her family’s wishes and her daughter, Erika, may be somewhat coercive.” Cheney soon took the drugs and died, but only after spending a week in a nursing home.

- **The first known assisted suicide death**² under the Oregon law was that of a woman in her mid-eighties who had been battling breast cancer for twenty-two years. Initially, two doctors, including her own physician who believed that her request was due to depression, refused to prescribe lethal drugs. Compassion & Choices—then operating under the name Compassion in Dying, although originally called The Hemlock Society—became involved in the case and referred the woman to a doctor willing to write the prescription.

Dr. Peter Goodwin, the group’s former Medical Director, said that about 75 percent of those who died using Oregon’s assisted suicide law through the end of 2002 did so with the organization’s assistance.³ In one example year, during 2003, the organization was involved in 79 percent of reported assisted suicide deaths.⁴ According to Dr. Elizabeth Goy of Oregon Health and Science University, Compassion in Dying sees “almost 90 percent of requesting Oregonians...”⁵ “In 2008 the proportion of C&C PAS deaths significantly increased to 88 percent (53/60) of all reported deaths.”⁶ And in 2009, 57 of the 59 assisted suicide deaths were Compassion & Choices clients. But then they ceased to provide further information.⁷

Depression and Psychiatric Disability

- **Michael Freeland**,⁸ age 64, had a 43-year medical history of acute depression and suicide attempts. Yet when Freeland saw a doctor about arranging an assisted suicide, the physician said he didn’t think that a psychiatric consultation was “necessary.” But the law’s supporters frequently insist that as a key safeguard, depressed people are ineligible. When Freeland chanced to find improved medical and suicide prevention services, he was able to reconcile with his estranged daughter and lived two years

post-diagnosis. Oregon's statistics for the years 2011 - 2014 show that each year, only 3% of patients (or fewer) were referred for psychological evaluation or counseling before receiving their prescriptions for lethal drugs.⁹

Gregory Hamilton, M.D., Distinguished Fellow of the American Psychiatric Association, demonstrated how Oregon's flimsy safeguards do not protect people with psychiatric and other mental health disabilities.¹⁰ Moreover, a majority of clinical and forensic psychiatrists believe "that the presence of major depressive disorder should result in an automatic finding of incompetence" to make decisions about assisted suicide.¹¹ And only six percent of Oregon psychiatrists are confident they can diagnose depression after one visit,¹² yet the Oregon and Washington State definitions of a psychiatric consultation permit one visit only.¹³

- **Absence of psychiatric consultation:** This case is about what can happen when competent psychiatric consultation is not provided. "[A] woman in her mid-fifties with severe heart disease...requested assisted suicide from her cardiologist, despite having little discomfort and good mobility. She was referred to another doctor, who in turn referred her to a physician willing to provide assisted suicide. That doctor determined that the woman had more than six months to live, according to his best estimate. She was eventually dismissed as ineligible. Rather than inquire further into possible causes of [her] suicidal despair [or refer her for psychiatric treatment], the physician apparently considered ... his responsibility ended. ... [H]e told her to go back and make yet another appointment with her original physician and dismissed her. She killed herself the next day."¹⁴

Economic Pressures and Coercion

- **Linda Fleming**, the first to use the WA state law, was divorced, had had financial problems, had been unable to work due to a disability, and was forced to declare bankruptcy. Yet the Director of Compassion & Choices of Washington said that her situation presented "none of the red flags" that might have given his group pause in supporting her request for death.¹⁵ But we are told by proponents that financial pressures have never played a role.

- **Thomas Middleton** was diagnosed with Lou Gehrig's disease, moved into the home of Tami Sawyer in July 2008, and died by assisted suicide later that very month. Middleton had named Sawyer his estate trustee and put his home in her trust. Two days after Thomas Middleton died, Sawyer listed the property for sale and deposited \$90,000 into her own account.¹⁶ It took a federal investigation into real estate fraud to expose this abuse. Sawyer was indicted for first-degree criminal mistreatment and first-degree aggravated theft, partly over criminal mistreatment of Thomas Middleton. But the Oregon state agency responsible for the assisted suicide law never even noticed.

Self-Administration

- **Patrick Matheny**¹⁷ received his assisted suicide prescription by Federal Express. He couldn't take the drugs by himself so his brother-in-law helped. Commenting on the Matheny case, Dr. Hedberg of Oregon Department of Human Services said that "we do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted ...". The state's official annual report on assisted suicide deaths did not take note of this violation of the Oregon law. Proponents regularly insist that the law's self-administration requirement is a key safeguard against abuse that is scrupulously followed, and that Oregon's reports have thoroughly reflected all key circumstances as the law has unfolded.

- **Another anonymous patient:** Dr. David Jeffrey wrote, "The question of administration is a delicate one, a patient even had a PEG feeding tube inserted solely to allow him to have PAS [physician

assisted suicide].”¹⁸ Concern about the fate of unused lethal barbiturates is compounded by the fact that the Oregon law does not necessarily require that the drugs be ingested by mouth. Barbara Glidewell, Patient Advocate at Oregon Health & Science University, said that patients who cannot swallow would “need to have an NG tube or G tube placement ... [Then, they could] express the medication through a large bore syringe that would go into their G tube.”¹⁹ Kenneth R. Stevens, Jr. MD, former Chairman of Radiation Oncology at Oregon Health & Science University, observed that since the lethal agent can be administered to a willing person through a feeding tube, it is equally possible to administer it to an unwilling person by the same means. Moreover, once injectable pentobarbital leaves the pharmacy, there is nothing to prevent it from being used through an intravenous (IV) line, or as a lethal injection. If a patient or someone assisting appears to have used a feeding tube or an injection, abuse is far more difficult to detect and prove.²⁰ Yet, supporters of the Oregon law allege that assisted suicide is totally voluntary by virtue of the fact that the individual alone must actually swallow the lethal agents.

Deadly Mix Between Our Broken Health Care System & Assisted Suicide

• **Barbara Wagner & Randy Stroup:** What happened to these patients underscores the danger of legalizing assisted suicide in the context of our broken U.S. health care system. **Wagner**, a 64-year-old great-grandmother, had recurring lung cancer. Her physician prescribed Tarceva to extend her life. Studies show the drug provides a 30 percent increased survival rate for patients with advanced lung cancer, and patients’ one-year survival rate increased by more than 45 percent. But the Oregon Health Plan sent Wagner a letter saying the Plan would not cover the beneficial chemotherapy treatment “but ... it would cover ... [among other things,] physician assisted suicide.” **Stroup** was prescribed Mitoxantrone as chemotherapy for his prostate cancer. His oncologist said the medication’s benefit has been shown to be “not huge, but measurable”; while the drug may not extend a patient’s life by very long, it helps make those last months more bearable by decreasing pain.²¹ Yet Stroup also received a letter saying that the state would not cover his treatment, but would pay for the cost of, among other things, his physician-assisted suicide.²²

These treatment denials were based on an Oregon Medicaid rule that denies surgery, radiotherapy, and chemotherapy for patients with a less than a five-percent expectation of five year survival. H. Rex Greene, M.D., retired, former Medical Director of the Dorothy E. Schneider Cancer Center at Mills Health Center in San Mateo, CA and formerly a member of the AMA Ethics Council, called this rule “an extreme measure that would exclude most treatments for cancers such as lung, stomach, esophagus, and pancreas. Many important non-curative treatments would fail the five-percent/five-year criteria.”²³ Though called free choice, when insurers won’t pay, assisted suicide is a phony form of freedom.

Breakdown in Rules Attendant to Changing the Law

The following cases were caused by **legal erosion and the breakdown in rules and codes of conduct** associated with assisted suicide laws, rules and codes that elsewhere protect health care patients.

• **Wendy Melcher**²⁴ died in August 2005 after two Oregon nurses, Rebecca Cain and Diana Corson, gave her overdoses of morphine and phenobarbital. They claimed Melcher had requested an assisted suicide, but they administered the drugs without her doctor’s knowledge, in clear violation of Oregon’s law. No criminal charges have been filed against the two nurses. The case prompted one newspaper to write, “If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon’s] Death with Dignity Act are for naught.”²⁵

• **Annie O. Jones, John Avery, and three other patients** were killed by illegal overdoses of medication given to them by a nurse, and none of these cases have been prosecuted in Oregon.²⁶

Medical Complications

Assisted suicide proponents and medical personnel alike have established that taking lethal drugs by mouth is often ineffective in causing a quick and simple death. The body sometimes expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly, as assisted suicide advocates wish. Such ineffective suicide attempts happen in a substantial percentage of cases—estimates range from 15 percent to 25 percent.²⁷

- **Peaceful death?** Speaking at Portland Community College, pro-assisted-suicide attorney Cynthia Barrett²⁸ described one botched assisted suicide. “The man was at home. There was no doctor there ... After he took it [the lethal dose], he began to have ... physical symptoms ... that were hard for his wife to handle. Well, she called 911.” He was taken to a local Portland hospital and revived, then to a local nursing facility. “I don’t know if he went back home. He died shortly – some ... period of time after that”

Commenting on this botched assisted suicide case, The Oregonian editorial columnist David Reinhard observed, “The Health Division knows nothing [about this case], ... through no fault of its own. Why? Because the doctor who wrote the prescription, the emergency medical technicians and the hospital reported nothing. Why? Because [the assisted-suicide law] reporting requirements are a sham.”

- **David Prueitt**²⁹ took his prescribed lethal overdose in the presence of his family and members of the assisted-suicide advocacy group Compassion & Choices. After being unconscious for 65 hours, he awoke. His family leaked the failed assisted suicide to the media. Oregon DHS issued a release saying it “has no authority to investigate individual Death with Dignity cases.”³⁰

Impacts by Doctors and Their Quality of Care

- **Kathryn Judson** wrote of bringing her seriously ill husband to the doctor in Oregon. “I collapsed in a half-exhausted heap in a chair once I got him into the doctor’s office, relieved that we were going to get badly needed help (or so I thought),” she wrote. “To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. ‘Think of what it will spare your wife, we need to think of her’ he said, as a clincher.”³¹ According to prescribing doctors, 40% of people who died by assisted suicide reported feeling like a burden on family and caregivers as a reason for requesting lethal drugs.³²

- **By contrast: Jeanette Hall** of Oregon was diagnosed with cancer in 2000 and told she had six months to a year to live. She knew about the assisted suicide law, and asked her doctor about it, because she didn’t want to suffer. Her doctor encouraged her not to give up, and she decided to fight the disease. She underwent chemotherapy and radiation. Eleven years later, she wrote, “I am so happy to be alive! If my doctor had believed in assisted suicide, I would be dead. ... Assisted suicide should not be legal.”³³ Unfortunately, not all doctors are like Jeanette Hall’s.

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¹ Erin Barnett, *A family struggle: Is Mom capable of choosing to die?* Oregonian, Oct. 17, 1999.

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³ Transcript of tape of Peter Goodwin, Oregon, January 11, 2003, Presentation at 13th National

Hemlock Society Biennial Conference, “Charting a New Course, Building on a Solid Foundation, Imagining a Brighter Future for America’s Terminally Ill,” January 9 – 12, 2003, Bahia Resort Hotel, San Diego, California.

⁴ Compassion in Dying of Oregon, *Summary of Hastened Deaths*, data attached to Compassion in Dying (now called Compassion and Choices) of Oregon’s IRS Form 990 for 2003.

⁵ Dr. Elizabeth Goy of Oregon Health and Science University (OHSU) is an Assistant Professor in the Department of Psychiatry, School of Medicine, OHSU and has worked with Dr. Linda Ganzini in surveys dealing with Oregon’s law. In 2004, members of the British House of Lords traveled to Oregon seeking information regarding Oregon’s assisted-suicide law for use in their deliberations about a similar proposal that was under consideration in Parliament. They held closed-door hearings on December 9 and 10, 2004 and published the proceedings on April 4, 2005. House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II: Evidence (London: The Stationery Office Limited, 2005), p. 291, Question 768, available at: <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf> (accessed March 10, 2015).

⁶ Kenneth R. Stevens, Jr. MD, former Chairman of Radiation Oncology at Oregon Health & Science University, *The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization*.

⁷ Stevens, *Concentration of Oregon’s Assisted Suicide Prescriptions & Deaths from a Small Number of Prescribing Physicians*.

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⁹ Oregon Death with Dignity Act Annual Reports, Oregon Health Authority Public Health Division, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>.

¹⁰ Hamilton, *op. cit.*

¹¹ Linda Ganzini, M.D., Gregory B. Leong, M.D., Darien S. Fenn, Ph.D., J. Arturo Silva, M.D., and Robert Weinstock, M.D., “Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists,” *American Journal of Psychiatry*, Vol. 157, April 2000, pp. 595 and 598.

¹² L. Ganzini, et al., “Attitudes of Oregon Psychiatrists Towards Assisted Suicide,” *American Journal of Psychiatry*, Vol. 153, 1996, pp. 1469 – 75.

¹³ Revised Code of Washington 70.245.010; Oregon Legislative Statute 127.800 §1.01.

¹⁴ N. Gregory Hamilton, *Oregon’s Culture of Silence*, in *The Case against Assisted Suicide: For the Right to End-of-Life Care*, supra note 2, at 175, 188.

¹⁵ First Death for Washington Assisted-Suicide Law, *New York Times*, 5/23/2009, http://www.nytimes.com/2009/05/23/us/23suicide.html?_r=0 (accessed March 10, 2015).

¹⁶ Sawyer Arraigned on State Fraud Charges, *KTVZ.com*, Sept. 7, 2011. <http://www.ktvz.com/news/Sawyer-Arraigned-on-State-Fraud-Charges/619440>

¹⁷ Erin Hoover, *Dilemma of assisted suicide: When?* *Oregonian*, Jan. 17, 1999 and Erin Hoover, *Man with ALS makes up his mind to die*, *Oregonian*, March 11, 1999.

¹⁸ Dr. David Jeffrey, Winston Churchill Fellow, 2006, “Physician-assisted suicide v Palliative Care: a Tale of Two Cities,” available at http://www.pccef.org/articles/PCCEF_June07_posting.pdf (accessed July 13, 2009).

¹⁹ Letter from Barbara Glidewell, included in testimony transcript, House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II, p. 268, number 3; p. 270, question 623; p. 275, question 653.

²⁰ Kenneth R. Stevens, Jr., M.D., personal communication to Marilyn Golden, Disability Rights Education & Defense Fund, July 8, 2009; information on lethal drugs based on data taken from Oregon

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²¹ Kenneth R. Stevens, Jr., M.D., *Oregon Rationing Cancer Treatment But Offering Assisted Suicide to Cancer Patients—Paying to Die But Not to Live*, Physicians for Compassionate Care Educational Foundation, June 6, 2008, available at <http://www.pccf.org/articles/art67.htm> (accessed July 9, 2009). Stevens is Professor Emeritus and former Chairman of Radiation Oncology at Oregon Health & Science University.

²² Dan Springer, “Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care,” *Fox News*, July 28, 2009, available at <http://www.foxnews.com/story/0,2933,392962,00.html> (accessed July 9, 2009).

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²⁹ Associated Press, *Assisted suicide attempt fails*, March 4, 2005.

³⁰ Oregon Dept. of Human Services, Press Release, March 4, 2005.

³¹ Kathryn Judson, *Assisted Suicide? “I was afraid to leave my husband alone again with doctors and nurses,”* Letter to the Editor, Hawai'i Free Press, February 15, 2011, accessed March 15, 2015, <http://hawaiifreepress.com/main/ArticlesDailyNews/tabid/65/articleType/ArticleView/articleId/3647/February-2011-Letters-to-the-Editor.aspx>.

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³³ Jeanette Hall letter to the editor, *Boston Globe*, October 4, 2011, accessed June 1, 2012, http://articles.boston.com/2011-10-04/bostonglobe/30243525_1_suicide-doctor-ballot-initiative.

NO **on SB128**

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