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# Elder Law Newsletter

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## Advance directives...do they work?

*By Kelly T. Hagan*

Research by Dr. Susan Tolle and her colleagues at OHSU (see article on page 2) paints an encouraging picture of respect for Oregonians' preferences in medical decision-making, particularly at the end of life.[1] Patients in other states, especially the elderly, are reportedly less fortunate.[2] There are reports, for example, that Washington State officials have sanctioned long-term care facilities in the Vancouver area for withdrawing life-sustaining treatment at the direction of attorneys-in-fact. Apparently, state authorities have interpreted RCW 11.94.010(3) as permitting surrogate consent to life-sustaining treatment, but not to its refusal or withdrawal.[3]

Advance directives figure prominently in Oregon's progress in end-of-life care. (See chapter 767 Oregon Laws 1993; ORS 127.505 –127.642.) An advance directive combines the functions of a directive to physicians and a power of attorney for health care. (Compare RCW 11.94.010—power of attorney—and RCW 70.122.030—directive to physicians.)

The patient's attorney-in-fact, a "health care representative," is authorized to make medical decisions for the patient in accordance with his or her appointment, up to and including refusal or withdrawal of life-sustaining care, so long as the patient is incapable. The patient also may limit the health care representative's authority to withdraw life-sustaining care. (ORS 127.540) The health care representative named in an advance directive has priority over any other person, including a guardian, to act for the patient in health care decisions.
In the absence of an advance directive, a hierarchy of guardians, relatives and close friends is authorized to act for the patient in specified circumstances. (Id.; ORS 127.635) These dire medical situations are the only circumstances in which Oregon law authorizes surrogate health care decisions in the absence of patient appointment or a court order.

The advance directive statutes provide not only the form of advance directive, but also useful authority on many medical planning questions: mental capacity, medical decision-making in the absence of an advance directive, procedures for adjudicating the effect of an advance directive, liability and immunity for health care decisions by providers, and other medical-legal issues. In the absence of an advance directive, state statutory and common law supply the standards for end-of-life care.

As useful as they are, advance directives do not translate automatically into treatment decisions and orders. If an advance directive is lost or unavailable, or if the provider on the scene lacks the understanding necessary to translate the patient's written directions

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### In this issue..

## OHSU study says advance directives are respected

Most people would likely include in their definitions of a "good death" a desire to have their wishes followed regarding their end-of-life care. Each year, many Oregonians execute advance directives for health care, often on the advice of an elder law attorney. The document spells out in detail one's wishes regarding the use of ventilators, tube feeding, and other life-sustaining devices. When a dying person can no longer speak for him or herself, are the provisions of the advance directive followed? In a recent Oregon study reported in *Nursing Research*, data indicate a high level of respect by doctors and nurses for patient-family decisions about end-of-life care. ("Family Reports of Barriers to Optimal Care of the Dying" by Susan W. Tolle, Virginia P. Tilden, Anne G. Rosenfeld, and Susan E. Hickman; *Nursing Research* Nov/Dec 2000, Vol 49. No. 6).

The researchers interviewed families of 475 Oregonians who had died, and asked them a series of questions about their experiences. 68% of the decedents had executed "living wills," but 93% of those interviewed said that with or without such a document, they knew what the patient wanted when it came to life-sustaining devices. 97% of those who knew the patients' wishes said they believed they had received what was wanted. The authors were of the opinion that Oregonians are more likely than other Americans to plan in advance for end-of-life care. They note that "intense media coverage of debates over physician-assisted suicide and public education efforts about citizen rights to good palliative care both have raised public awareness and likely made families in this study relatively sophisticated informants."

Requests for reprints of the article should be addressed to Virginia Tilden, SN-ORD, Oregon Health Sciences University, 3181 SW Sam Jackson Park Rd.; Portland, OR 97201-3098; e-mail: tildenv@ohsu.edu

## Advance Directives continued from Page 1

into actual treatment of particular medical conditions, the patient's expressed wishes may be thwarted.

### POLST form supplements advance directive

In Oregon, filling the gap between the advance directive and the actual delivery of care is the Physician Orders for Life-Sustaining Treatment (POLST). The POLST form is an attending physician's order. The POLST form does not replace the advance directive, but is intended to complement it by embodying the patient's expressed wishes in more precise medical terminology, specifically directed to health care personnel. Emergency medical technicians and other certified "first-responders" are required by Board of Medical Examiners rule to respect POLST instructions.

The POLST form is a one-page, two-sided, bright pink document intended to be posted in a prominent location in the patient's home or kept with his medical record chart if he is in a long-term care facility. There is also a wallet-size version of the form, which a patient can carry with him. A useful tool for attorneys who are counseling terminally ill clients is the pamphlet *Ask Your Physician about the POLST*. It is available for a small fee from the Center for Ethics in Health Care at OHSU. Phone: 503.494.4466; e-mail: ethics@ohsu.edu; Web site: http://www.ohsu.edu/ethics/polst.htm

The POLST form must be filled out by or under the direction of the attending physician, and this should be done only after discussion with the patient or the patient's duly authorized health care representative. The form contains specific orders regarding resuscitation, medical interventions, use of antibiotics, the provision of artificially administered fluids and nutrition, and the use of comfort measures to relieve pain and suffering.

It is in concrete treatment decisions in advance directives and in POLST forms that the patient's wishes at the end of life find their practical realization.

### Footnotes

1 E.g., Tolle, et al. (1999), *Oregon's low in-hospital death rates: What determines where people die and satisfaction with decisions on place of death?* Annals of Internal Medicine, 130, 681-685.
2 See Sugarman, et al., J. Am. Geriatr. Soc. 1998; 46:517-24.
3 Proceedings, Ethics Committee, Southwest Washington Medical Center, January 25, 2001.

*Kelly T. Hagan is a shareholder in the Portland office of Schwabe, Williamson & Wyatt, P.C., where he specializes in health care law. Mr. Hagan is past chair both of the OSB Health Law Section and the OSB Joint Committee on the Medical Profession, and he currently serves on the Task Force to Improve the Care of Terminally Ill Oregonians.*

# Political challenges to Oregon's Death With Dignity Act expected

*By Barbara Coombs Lee*

Late last year, the 106th Congress adjourned without passing the Pain Relief Promotion Act (PRPA), which would have imposed criminal penalties for prescribing controlled substances in compliance with Oregon's Death with Dignity Act. The critical element of the bill's demise was probably not its implications for state's rights or recognition of the fact that Oregon's law is working well. It was instead the realization that creating a crime of prescribing certain drugs while "intending" death would scare doctors and jeopardize pain and symptom management at the end of life.

More than 50 medical organizations—including the American Cancer Society, American Academy of Family Physicians and American Nurses Association—opposed the bill. Senator Ron Wyden threatened to filibuster any vehicle for the bill, including a major tax bill that for a short time included the PRPA language.

There is some indication that Senator Don Nickles (R-OK), sponsor of the PRPA, will not introduce a similar bill in the 107th Congress. When he described his "wish list" to Oklahoma press, a bill outlawing assisted dying was notably absent. [1]

However, President Bush campaigned on a platform that included opposition to Oregon's assisted dying law. In a May 2000 campaign stop in Oregon, he declared that if he became president, his administration would be "more than likely" to rule that federal law already prohibits the use of controlled substances for assisted dying. [2]

This strategy has been used before. In 1997, urged on by Senator Orrin Hatch (R-UT) and Representative Henry Hyde (R-IL), the DEA Administrator issued an opinion that complying with Oregon law on assisted dying would not qualify as "legitimate medical purpose" under the Controlled Substances Act. Any use of controlled substances outside the medical purpose exception invokes the severe penalties for diversion and drug dealing. The DEA's interpretation was overruled when the Department of Justice decided the agency had no such authority and federal determination of the medical use of drugs was outside the scope of the CSA.

Oregon now faces the very real possibility that President Bush and Attorney General John Ashcroft will resurrect an Executive Branch strategy to pre-empt local regulation of medical practice. This action seems to be an important aspect of the agenda the religious right expects Mr. Ashcroft to pursue.[3] Mr. Ashcroft's history, which includes a legal battle to prevent a Missouri family from removing a feeding tube from a patient in a persistent vegetative state [4], seems to indicate support for that agenda.

Even if doctors and other health care providers conclude that Oregon's law has become legally dangerous, there is no expectation, even among the law's most vigorous opponents, that dying patients would cease to ask for and receive assistance in achieving a peaceful, planned death. What would come to an end would be Oregon's unique structure of safeguards and state oversight –– open dialogue about assisted dying as an option, second medical opinions, waiting periods, psychiatric consults, documentation of the voluntary and enduring nature of requests, and state Health Division review and reporting.

At the state level, the only challenge is Senate Bill 218, which would prohibit state funding. Again, this bill would have the perverse effect of removing regulation and state oversight without eliminating assisted dying. Early reports are that support for the bill is low.

It is most important during the upcoming challenge that terminally ill patients do not feel abandoned and hopeless.

### Footnotes

1 Jim Myers, "Washington Wish List," *Tulsa World*, January 15, 2001 at A11.

2 Jeff Mapes, "Bush opposed doctor-aided suicide law," *The Oregonian,* May 17, 2000 at A1.

3 David Johnson and Neil A. Lewis, "Religious Right Made Big Push to Put Ashcroft in Justice Department," *The New York Times*, January 7, 2001 at A1.

4 Terry Ganey, "Father in Right-to-Die Case Opposes Ashcroft: Peter Busalacchi Says Attorney General Nominee is Too Rigid in Beliefs," *St. Louis Post Dispatch* January 4, 2001 at A4.

*Barbara Coombs Lee co-authored the Oregon Death with Dignity Act and served as chief petitioner during its ballot measure campaign. She is now President of Compassion in Dying Federation, an organization to improve care and expand options at the end of life through client services, legal advocacy, and public education.*

*Editor's note:* The Elder Law Section has taken no official stand on the Death with Dignity Act. The above article reflects the author's opinion. Section members who have a different point of view are invited to submit articles for possible publication in future issues of the newsletter.

## Oregon Health Division reports on third year of Death with Dignity Act

Twenty-seven patients used legal physician-assisted suicide in 2000, the same number who did so in 1999, according to a report by public health officials at the Oregon Department of Human Services.

"The number of deaths remained small in relation to 29,356 annual Oregon deaths," says Katrina Hedberg, M.D., deputy state epidemiologist with the Oregon Health Division, which is legally required to collect information on compliance with the Death with Dignity Act and to make that information available on a yearly basis. "Our role is a neutral one. In releasing the information for 2000, we recognize that it is critical to have accurate information on the Act so that informed ethical, legal, and medical decisions can be made.

"Physicians who were interviewed reported that, as in past years, patients had several reasons for requesting lethal medication," Hedberg says. " These include concerns about losing autonomy, losing control of bodily functions, physical suffering, and a decreasing ability to participate in activities that make life enjoyable. This year, physicians reported increasing patient concerns about being a burden on friends, family and caregivers."

Health Division epidemiologists identified patients who received prescriptions for lethal medication through required physician reporting, and collected additional information using physician interviews and death certificates. Report findings include:

- In 2000, 39 prescriptions were written for lethal doses of medication and 27 patients died after using this medication.
- The median age of the 27 patients who took lethal medication in 2000 was 69 years.
- Twenty-one patients had end-stage cancer. All patients had health insurance and 23 were in hospice before death.

The full report is available on the World Wide Web at http://www.ohd.hr.state.or.us/chs/pas/ar-index.htm

*Source: Oregon Health Division press release*

## Physician-assisted suicide in Oregon: a chronology

**November 1994**
By a margin of 51% to 49%, Oregon voters passed Measure 16, Oregon Death with Dignity Act, legalizing physician-assisted suicide.

**1994 to 1997**
A lawsuit was filed, claiming the act violated various federal constitutional and statutory provisions. A federal court judge issued a permanent injunction preventing implementation of the act because it violated the Fourteenth Amendment's equal protection clause, *Lee v. Oregon*, 891 F. Supp. 1429 (D.Or. 1995). On appeal, a three-judge panel of the Ninth Circuit reversed for lack of standing, *Lee v. Oregon*, 107 F.3d 1382 (9th Cir.). The United States Supreme Court denied certiorari, *Lee v. Harcleroad*, 522 U.S. 927, 118 S.Ct. 328, 139 L.Ed.2d 254 (1997). In October, 1997, the Ninth Circuit directed trial court to dismiss the Lee case and the act went into effect. Despite the mandate, the trial court judge entertained arguments on the plaintiffs' motions to continue the litigation. Ultimately, however, he denied the motions and dismissed the case.

In 1997, several bills were introduced in the Oregon legislature to repeal or restrict the act, none of which survived. Meanwhile, in Washington, DC, Senator Orrin Hatch and Representative Henry Hyde (chairmen of the Senate and House Judiciary Committees) asked the administrator of the federal Drug Enforcement Administration for its view as to the act's possible violation of federal law.

**November 1997**
By rejecting Measure 51, Oregon voters approved the Oregon Death with Dignity Act for a second time by a margin of 60% to 40%. The DEA administrator issued an opinion that the act could result in its revoking a physician's license to prescribe controlled substances. Attorney General Janet Reno subsequently issued an opinion overruling the DEA.

**December 1998**
The Oregon Health Plan began covering physician-assisted suicide for low-income Oregonians. Because the Assisted Suicide Funding Restriction Act, passed by Congress in 1997, bans use of federal tax dollars to pay for physician-assisted suicide, only state funds are used.

**1998**
The Lethal Drug Abuse Prevention Act died in both houses of Congress. It would have amended the federal Controlled Substances Act to revoke the prescribing privileges of a physician who prescribes medication to assist suicide or euthanasia.

**1999**
The Oregon legislature passed Senate Bill 491 which made various changes to the act including (1) nonparticipating health care facilities, (2) location for taking medication, (3) proof of residence, (4) pharmacists' ability to opt out, and (5) record keeping with the Oregon Health Division. In November, 1999, the last aspect of the bill resulted in the Health Division's taking a stance that federal DEA officials would not be given access to physician reports.

**1999–2000**
The Pain Relief Promotion act of 1999 (S. 1272 and HR 2260) was introduced in Congress. The act would have (1) amended the federal Controlled Substances Act to prohibit dispensing, etc., drugs for purposes of assisted suicide or euthanasia, (2) instructed the Attorney General to "give no force and effect to State law authorizing or permitting assisted suicide or euthanasia," and (3) established research, educational, and training programs on pain management and palliative care. After passing in the House of Representatives, the bill stalled in the Senate largely due to Senator Ron Wyden's efforts in the fall of 2000.

**Possible developments in 2001**
Reintroduction of Pain Relief Promotion Act in Congress. Possible federal administrative sanctions by the DEA under the Controlled Substances Act. Possible suit filed in federal court by Oregon's Attorney General as well as by private parties such as physicians and patients, if either Congress or the federal administration seek to overturn the Oregon Death with Dignity Act.

*Above chronology adapted from Professor Valerie J. Vollmar's paper "Physician-Assisted Suicide—Oregon Approved, Federally Doomed?" presented on February 3, 2001, at the Health Care and Law Symposium sponsored by WILLAMETTE LAW REVIEW. For recent developments in physician-assisted suicide, see Professor Vollmar's Web site at www.willamtte.edu/wucl/pas.*

# Section's bills moving through Oregon legislature

The Elder Law Section proposed six law improvement bills in the 2001 Oregon legislative session. On February 7, Jennifer Wright, Ruth Simonis, Dady Blake and Ryan Gibb testified before the Civil Subcommittee of the House Judiciary Committee at a hearing on all six bills. Other members of the Section's legislative committee provided written testimony on the issues which led to the introduction of the bills, and the effect of the proposed legislation. The legislators responded positively to the bills and to the testimony.

Following the hearing, the subcommittee sent House Bills (HB) 2366 and 2368 to the full committee, which approved them and sent them on to the House floor for a vote with a "do pass" recommendation. HB 2366 was passed by the House on February 15, and HB 2368 was passed on February 16. Both bills are now before the Senate Judiciary Committee. The legislative committee is making some revisions to the other four bills in response to comments and suggestions by the legislators. In the box at right is a summary of the Section's bills. The full text of the bills, together with information about their status and the scheduled hearings, is available on the legislature's Web site, www.leg.state.or.us. For more information, contact the co-chairs of the legislative committee, Jennifer Wright and Ruth Simonis.

Thanks to Rick Mills, SDSD Legal Services Developer, for his informative postings of legislative updates on the Elder Law Discussion List

## Bills proposed by OSB Elder Law Section

**HB 2363:** Amends ORS Chapter 125 to clarify the notice requirements in conservatorship proceedings for adults. This is a housekeeping bill to fix a problem resulting from the guardianship procedural amendments made in the 1999 session.

**HB 2364:** Allows the attorney fees, fiduciary fees, and costs approved by the court in a medically necessary guardianship proceeding to be deducted from a Medicaid recipient's income in determining the amount of the recipient's "patient liability." Because this bill has a fiscal impact, it will have to go through the House Ways and Means Committee in addition to the House Judiciary Committee.

**HB 2365:** Creates disincentives for financial institutions and others to refuse to accept a durable financial power of attorney based on the amount of time which has passed since the document was executed.

**HB 2366**: Allows the court to authorize the creation of an irrevocable special needs trust for the assets of a beneficiary under the age of 65 who meets the requirements of 42 USC §1396p(d)(4)(A), regardless of whether the beneficiary is "financially incapable" within the meaning of ORS 125.005(3). This bill removes the limitation described in *Matter of Baxter*, 128 Or 91, 874 P2d 1361 (1994).

**HB 2367:** Clarifies the notice required prior to moving the protected person to a care facility after a guardianship has been established. ORS 125.320.

**HB 2368:** Allows issues involving an advance directive for health care to be determined in a guardianship proceeding. Under current law, a separate proceeding has to be filed under ORS Chapter 127, although the two cases can be consolidated.

## Member News

Leslie Kay is now with the Senior Law Project at Multnomah County Legal Aid. Leslie's previous experience includes coordinator of the elder law project at Marion-Polk County Legal Aid in the 1980s.

Matthew Mullaney has been invited to join the bioethics committee of Willamette Valley Medical Center in McMinnville as a community member.

Richard Pagnano and Penny Davis are pleased to welcome Ruth Simonis to The Elder Law Firm as an associate. Ruth is a member of the Section's executive committee and co-chair of the legislative sub-committee.

# Resources for elder law attorneys

## Events

**National Association of Professional Geriatric Care**
March 30-April 1, 2001.
Managers and National Guardianship Association, 2001 UnProgram,
Sheraton Gateway Suites O'Hare
Rosemont, Illinois
Contact Jenifer Mowery at
520.881.8008 x114 or jmowery@mgmtplus.com

**National Academy of Elder Law Attorneys 2001 Symposium,**
April 18-21, 2001
Hyatt Regency, Vancouver, B.C.
"Crossing Borders"
Special sessions on Cross Border Estate Planning, Basics Day, and Canadian Elder Law Basics Day. Contact Jenifer Mowery at 520.881.4005 x114 or jmowery@naela.com, fax 520.325.7925

**Planning for Your Clients' Social Security Benefits**
Friday, April 6, 2001
Oregon State Bar CLE
DoubleTree Inn at Lloyd Center
Portland
5.5 MCLE credits and 1 Ethics credit

Dealing with and planning for your clients' Social Security benefits can make you feel lost in a maze of regulations and forms. Find your way with the help of this seminar. The program focuses on the planning aspect of Social Security, including retirement, disability, and SSI. To register, call 503.684-7413 or 800-452-8260, ext. 413

This program will be videotaped and shown in its entirety in several locations around the state. The CLE Video Replay Hotline (800.452.8260, ext. 502) is updated each Tuesday with that week's schedule.

**Perfecting the Social Security Disability Claim**
May 4, 2001
Oregon State Bar CLE
Oregon Convention Center, Portland
First time in Oregon–the nuts and bolts of Social Security disability representation. A useful complement to OSB's April 6 program.
For information, call 503.431.6320

**Elder Law CLE at OSB's annual meeting**
Saturday, September 22, 2001
3:00 - 4:00 p.m.
Seaside, Oregon

**Elder Law CLE seminar**
October 2001
Details TBA

**National Academy of Elder Law Attorneys 2001 Elder Law Institute**
November 1-4, 2001
Hyatt Regency Union Station, St. Louis, Missouri.
Contact NAELA at 1604 N Country Club Road, Tucson, AZ 85716-3102; tel 520.881.4005; fax 520.325.7925

**Monthly Elder Law Discussion Groups**

Elder Law I meets second Thursday Lloyd Center Tower, NE Portland

Elder Law II meets first Thursday
Legal Aid Services, Downtown Portland
For details: Ann Stacey 503.224.4086

## Elder Law Internet Discussion List

To subscribe, send a message to:
lyris@lists.law.stetson.edu
Leave the subject line blank, and do not include a signature block.
The body of the message should be:
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Send messages to:
orelder@lists.law.stetson.edu

## OSB Publication

*Guardianships, Conservatorships, and Transfers to Minors* is a valuable reference guide for elder law attorneys. With dozens of practice tips, comments, and notes, the book is immediately applicable to your practice. It has been completely revised, with a new section on elder law issues. It also contains a discussion of the Multnomah County Pilot Project enacted by the 1999 legislature; legislative amendments to guardianship and conservatorship statutes; and timelines for motions, objections, and accountings. More than 40 new and revised forms are included.

The book is available in paperback and on CD-ROM. The price is $65.

To order with a credit card, call CLE Registration at 503.684.7413 or 800.452.8260, ext. 413.

## Important elder law numbers

Effective April 1, 2001, the Spousal Minimum Monthly Maintenance Allowance (MMMA) will increase from $1,407 to $1,452 and the Excess Shelter Allowance will increase from $422 to $436.

## Web sites you can use

*Susan Ford Burns*

I find that our elder law clients often expect us to understand a variety of legal and social issues. This newsletter I thought I would examine Web sites that help us counsel our clients in some of these areas.

**U.S. Department of Justice ADA home page**
http://www.usdoj.gov/crt/ada/adahom1.htm
This site gathers in one place information regarding the DOJ's Americans with Disabilities Act—enforcement, technical assistance, and proposed regulations. Many of the technical assistance documents can be fully downloaded in Adobe Acrobat form. (If you don't already have the Adobe Acrobat Reader you can download it free at http://www.adobe.com/store/products/reader.html. If you use WordPerfect 9, you can publish your WordPerfect documents in Adobe Acrobat form and send them via e-mail, even to those who do not have WordPerfect.)

**Northwest Seniors Online**
http://www.nw-seniorsonline.org/nwsites/othersites.html
This Web site addresses many of the concerns of elders, including housing, health, insurance, financial matters and just plain fun. Be aware that many of the links lead to commercial sites, some with a somewhat slanted point of view.

**Merck Manual Online**
http://www.merckhomeedition.com
This is the online version of this popular health manual. It contains well-written information about medical issues that elders (and others) face. It is well organized, with a text-only version as well as one with sound and video.

**Administration on Aging Caregiver Resources**
http://www.aoa.gov/NAIC/Notes/caregiverresource.html
Often we advise caregivers rather than the elders themselves. This resource has a variety of links to government, nonprofit, and commercial sites providing support and information to caregivers. The online book *Because We Care: A Guide for People Who Care* at http://www.aoa.gov/wecare/default.htm does a wonderful job of providing caregivers with information.

**Family Care America**
Another resource for caregivers is http://www.familycareamerica.com. This Web site has an extensive library of articles and checklists. It provides an opportunity for a caregiver to track information specific to her circumstances. However, I do not recommend that a client use this system because it asks for personal information with no assurance of privacy.

## Canadian task force targets fraudulent telemarketers

Anyone who works with elders is aware that they are often the victims of unethical telemarketers, who bilk them out of thousands of dollars of assets. Many of these telemarketing operations are located in Montreal, Quebec, which has prompted Canadian authorities to establish a multi-agency program to combat them.

According to Constable Sylvain L'Heureux of the Royal Canadian Mounted Police, the program targets a scam in which people are asked to send payments to cover the taxes on a large amount of money won in a Canadian lottery. "The telemarketers will continue contacting their victims until they don't have any more money," says L'Heureux, "and they will push it as far as getting them to take up mortgages or advances on their retirement funds." The process begins when a person fills out an entry form received in the mail. These filled-out entries are sold in bulk to telemarketers, who then call people who are less suspicious, because they think they have entered a drawing and are hoping to win something.

Project Colt, the Canadian government's anti-fraud program, includes the RCMP, the Montreal Urban Community Police, the Sûreté du Québec, and others. Since so many victims of telemarketing fraud are U.S. citizens, Project Colt works with U.S. authorities, including the Federal Bureau of Investigation, the Customs Service, and Postal Service.

During the program's first year, it returned $7.6 million to 695 victims, 632 of whom were in the United States. In order to recover funds, however, authorities must act quickly to intercept checks and money orders. If you suspect that a client has become a victim of this kind of telemarketing fraud, immediately contact Project Colt at 514.939.8304. Victims can call collect. Business hours are weekdays from 7:30 a.m. to 4.30 p.m. EST.

*Thanks to Rick Mills of SDSD for passing along information about Project Colt.*

# A message from the new Elder Law Section Chair

*Cinda M. Conroyd*

I am honored and excited to take over as chair of the Executive Committee of the Elder Law Section. My hat is off to former chairpersons Valerie Vollmar, Donna Meyer, and Richard Pagnano, who guided the Section through its formation and steady growth over the last three years. It is my hope that this year, the Section will continue to educate attorneys about elder law issues, to encourage professionalism in one another, to maintain a working and respectful relationship with Senior and Disabled Services Division, and to advocate for the elderly through legislation and our day-to-day work.

The subcommittees of the Section are actively working to meet these goals. As in most organizations, the subcommittees are where all of the work takes place. The Section can only be successful in meeting its goals if its members volunteer. I invite all interested members to volunteer to serve on a subcommittee and give your time to help direct the future of elder law in Oregon.




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