TO: The Justice Committee of the Parliament of New Zealand

FROM: Margaret Dore, Esq., MBA, President
Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia

RE: Reject End of Life Choice Bill Seeking to Legalize Assisted Suicide and Euthanasia

• Prevent People With Years or Decades to Live From Throwing Away Their Lives
• Don’t Provide Cover for Murder
• Prevent Family Trauma

DATE: December 11, 2018

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I. INTRODUCTION

I am president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia.\(^1\) I am also an attorney in Washington State USA where these practices are legal.\(^2\) Our law is based on a similar law in Oregon.\(^3\)

My background includes providing legal analysis and/or testimony against assisted suicide and euthanasia, in 22 US states, South Africa and Australia. I have participated in public debates as well as public interest litigation.

The “End of Life Choice Bill” seeks to legalize assisted dying, which means assisted suicide and euthanasia.\(^4\) If enacted, the bill will apply to people with years or decades to live, and provide cover for murder. I urge you to reject this bill.

II. DEFINITIONS (TRADITIONAL)

“Assisted suicide” occurs when a person provides the means or information for another person to commit suicide, for example, by providing a rope or lethal drug.\(^5\) If the assisting person is

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\(^1\) Choice is an Illusion is a nonprofit corporation founded in 2010. For more information, see [www.choiceillusion.org](http://www.choiceillusion.org) and [www.margaretdore.org](http://www.margaretdore.org)

\(^2\) A copy of my CV is attached hereto in the Appendix, at pages 1-4.

\(^3\) Oregon’s law, enacted by a ballot measure, went into effect in 1997. Washington’s law, passed by another ballot measure, went into effect in 2009.

\(^4\) The bill is attached hereto in the Appendix, at pages 101 to 115.

a physician, a more precise term is “physician-assisted suicide.”

“Euthanasia” is the administration of a lethal agent to cause another person’s death. Euthanasia is also known as “mercy killing.”

**III. ASSISTING PERSONS CAN HAVE AN AGENDA**

Persons assisting a suicide or euthanasia can have an agenda. Consider Graham Morant, recently convicted of counseling his wife to kill herself in Australia. Per the court, his motive was life insurance. Consider also Tammy Sawyer, trustee for Thomas Middleton in Oregon. Two days after his death by legal assisted suicide, she sold his home and deposited the proceeds into bank accounts for her own benefit.

Medical professionals too can have an agenda. Michael Swango, MD, now incarcerated, got a thrill from killing his patients. Consider also Harold Shipman, a doctor in the UK,

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6 The American Medical Association Code of Medical Ethics, Opinion 5.7 (defining physician-assisted suicide). Attached in the Appendix at page 7.

7 Id., lower half of the page, Opinion 5.8, “Euthanasia.”

8 “Mercy killing” - The Free Dictionary, in the Appendix at p. 8.


10 KTVZ.com, “Sawyer Arraigned on State Fraud Charges,” updated 07/14/11, in the Appendix at page 9.

11 Charlie Leduff, “Prosecutors Say Doctor Killed to Feel a Thrill,” The New York Times, 09/07/2000 (“Basically, Dr. Swango liked to kill people. By his own admission in his diary, he killed because it thrilled him”), attached
who not only killed his patients, but stole from them and in one case made himself a beneficiary of the patient’s will.  

**IV. PUSHBACK AGAINST ASSISTED SUICIDE IN THE US**

US territory includes 50 states, the District of Columbia, five major territories and various minor islands. There are 5 states and the District of Columbia where assisted suicide/euthanasia is legal. Other states have defeated laws seeking to legalize these practices and/or have affirmatively strengthened their laws against these practices. One state, New Mexico, overturned prior legality. Please find more information below.

**A. This Year, the State of Utah Passed a Law Making Assisted Suicide a Felony**


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13 https://en.wikipedia.org/wiki/List_of_states_and_territories_of_the_United_States

14 Assisted suicide/euthanasia is legal in California, Colorado, Oregon, Washington State and Vermont. Hawaii has enacted a law to legalize, which is not in effect.

passed the legislature by a 2 to 1 margin.\textsuperscript{16}

B. Last Year, the State of Alabama Passed an Act Banning Assisted Suicide

Last year, Alabama enacted an “Assisted Suicide Ban Act,” which renders any person who deliberately assists a suicide, guilty of a felony.\textsuperscript{17} The vote was nearly unanimous.\textsuperscript{18}

C. Two Years Ago, the New Mexico Supreme Court Overturned Assisted Suicide

Two years ago, the New Mexico Supreme Court overturned a lower court decision recognizing a right to “physician aid in dying,” meaning physician-assisted suicide.\textsuperscript{19} Physician-assisted suicide is no longer legal in New Mexico.

V. “ELIGIBLE” PERSONS WILL HAVE YEARS OR DECADES TO LIVE

A. If New Zealand Follows Oregon, the Bill Will Apply to People With Chronic Conditions, Such as Diabetes

Oregon’s law applies to people with a terminal disease who are predicted to have less than six months to live. The law states:

\begin{footnotesize}
\begin{enumerate}
\item[16] The Utah bill passed the House 51 to 18, and the Senate, 19 to 5. For more information, go to this link and click “status” \url{https://le.utah.gov/~2018/bills/static/HB0086.html}
\item[17] Alabama: Assisted Suicide Ban Act to Go Into Effect,” \url{http://www.choiceillusion.org/2017/07/alabama-assisted-suicide-ban-act-to-go.html}
\item[18] Scroll down to view roll calls at \url{https://legiscan.com/AL/bill/HB96/2017}
\end{enumerate}
\end{footnotesize}
“Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.\textsuperscript{20}

In Oregon, this definition is interpreted to include chronic conditions such as diabetes mellitus, better known as “diabetes.”\textsuperscript{21} Oregon doctor, William Toffler, explains:

Chronic conditions such as diabetes are a “terminal disease” sufficient for assisted suicide, if, without treatment such as insulin, the person has less than six months to live.

This is significant when you consider that without insulin, a typical insulin-dependent 20 year old will live less than a month.

Such persons, with insulin, are likely to have decades to live; in fact, most diabetics have a normal life span given appropriate control of their blood sugar. (Spacing changed).\textsuperscript{22}

Dr. Toffler also addresses the New Zealand bill:

I have ... been provided with an excerpt of the ... bill, which states:

In this Act, person who is eligible for assisted dying means a person who— ... 

(c) suffers from—

(i) a terminal illness that is likely to end his or her life

\textsuperscript{20} ORS 127.800 s.1.01(12), attached hereto in the Appendix at page 23.

\textsuperscript{21} See Oregon’s most recent report regarding its law, attached to the Declaration of William Toffler MD, in the Appendix, at pages 20-25; the report excerpt is at page 24 (listing “diabetes” as an “underlying illness” sufficient for assisted suicide).

\textsuperscript{22} Toffler Declaration, supra, the quote is in the Appendix at page 21, paragraphs 3 & 4.
within 6 months; or

(ii) a grievous and irremediable medical condition; and

(d) is in an advanced state of irreversible decline in capability .... (Emphasis added).  

Dr. Toffler also testifies:

In my professional judgment, this definition will [also] include insulin dependent diabetes if, like Oregon, New Zealand makes the eligibility determination without treatment.

If so, the typical insulin dependent person will have a life expectancy of less than a month due to being in "an advanced state of irreversible decline in capability" to produce insulin. He or she will have a "terminal illness."

If New Zealand follows Oregon practice to determine eligibility without treatment, the proposed bill will apply to people with chronic conditions such as insulin dependent diabetes. Such persons, with treatment, can have years or decades to live happy, healthy and productive lives.

B. Predictions of Life Expectancy Can Be Wrong

"Eligible" persons may also have years or decades to live because predictions of life expectancy can be wrong. This is true due to actual mistakes (the test results got switched) and

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23 Id., at page 21.

24 Id. at page 22.
because predicting life expectancy is not an exact science.\textsuperscript{25}

Consider John Norton, diagnosed with ALS at age 18.\textsuperscript{26} He was told that he would get progressively worse (be paralyzed) and die in three to five years.\textsuperscript{27} Instead, the disease progression stopped on its own.\textsuperscript{28} In a 2012 affidavit, at age 74, he states:

If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.\textsuperscript{29}

C. Treatment Can Lead to Recovery

In 2000, Jeanette Hall was diagnosed with cancer in Oregon and made a settled decision to use Oregon’s law.\textsuperscript{30} Her doctor convinced her to be treated instead, which eliminated the cancer.\textsuperscript{31} Her declaration states:

It has now been 18 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.\textsuperscript{32}

\begin{footnotes}
\textsuperscript{25} See: Jessica Firger, "12 million Americans misdiagnosed each year," CBS NEWS, 4/17/14; and 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?,” \textit{The Seattle Weekly}, 01/14/09. (Excerpts attached in the Appendix at pages 26 to 30).

\textsuperscript{26} Affidavit of John Norton, attached in the Appendix, at pages 31 to 33.

\textsuperscript{27} Id., ¶ 1.

\textsuperscript{28} Id., ¶ 4.

\textsuperscript{29} Id., ¶ 5.

\textsuperscript{30} See: Affidavit of Kenneth Stevens, MD, in the Appendix at pages 34 & 35; and the Declaration of Jeanette Hall, in the Appendix at page 37.

\textsuperscript{31} Id.

\textsuperscript{32} Declaration of Jeanette Hall, ¶4, attached in the Appendix at page 37.
\end{footnotes}
VI. THE BILL ALLOWS ASSISTED SUICIDE AND EUTHANASIA

Per the bill, the attending medical practitioner must:

(a) tell the person [patient] about the following methods for the administration of a lethal dose of medication:

(i) ingestion, triggered by the person:
(ii) intravenous delivery, triggered by the person:
(iii) ingestion through a tube: [and]
(iv) injection .... (Emphasis added). 33

The first two methods, (i) and (ii), describe physician-assisted suicide as traditionally defined in which the person “triggers,” i.e., initiates the life-ending act. 34

The bill also says that for the purpose of these two methods, the medical practitioner must administer the lethal dose by providing it to the person. 35 This direction too is consistent with physician-assisted suicide in which a physician administers a lethal dose by dispensing it to a patient, who

33 The bill, section 15(3)(a), attached in the appendix, at page 109.

34 Dictionary definitions for “trigger” include “initiate.” See Dictionary.com excerpt attached hereto in the Appendix at page 47.

35 The bill, section 16(4)(a), states:

If the person [patient] chooses to receive the medication [lethal dose], the attending medical practitioner must administer it by -

(a) providing it to the person, for the methods described in section 15(3)(a)(i) and (ii) [assisted suicide] .... (Emphasis changed).

Attached hereto, at Appendix page 110.
applies it to himself or herself.\textsuperscript{36}

With regard to the last two methods, “ingestion through a tube” and “injection,” the bill says that the attending medical practitioner “must administer [the lethal dose] by providing it,” which can be read as euthanasia.\textsuperscript{37}

VII. THE BILL WILL CREATE A PERFECT CRIME

A. Even If the Patient Struggled, Who Would Know?

The drugs typically used for assisted suicide and euthanasia are water and/or alcohol soluble, such that they can be injected into a sleeping or restrained person without consent.\textsuperscript{38}

In addition, the bill has no prohibition another person being alone with the patient when the lethal dose is ingested and/or the patient dies.\textsuperscript{39} In other words, the bill allows two

\textsuperscript{36} Dictionary definitions of “administer” include “dispense” and “apply.” See definitions in the Appendix at page 48.

\textsuperscript{37} The bill, Section 16(4)(b), states:

\begin{quote}
If the person chooses to receive the medication [lethal dose], the attending medical practitioner must administer it by- ...
\end{quote}

\textsuperscript{38} The drugs used include Secobarbital, Morphine Sulfate, Pentobarbital and Phenobarbital, which are water and/or alcohol soluble. See excerpts from Oregon’s and Washington’s most recent annual reports and regarding morphine sulfate, in the Appendix at pages 38 to 42. For more information, see http://www.drugs.com/pr/seconal-sodium.html, http://www.drugs.com/pro/nembutal.html and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2977013

\textsuperscript{39} See the bill in its entirety in the Appendix, pages 101 - 115.
people to be there, with one leaving alive and the other leaving dead.

The one leaving alive is allowed to be a medical practitioner, who is required to be “available” to the patient until the patient dies, or to arrange for another medical practitioner to be available.\textsuperscript{40} Per the bill, this means being in the “same room” with the patient, or in “close proximity” to the patient, which is not defined.\textsuperscript{41} In a published discussion paper cited below, the authors define close proximity as “within 30 miles.”\textsuperscript{42}

With the medical practitioner thereby allowed, but not required to be present when a patient dies, the opportunity is created for another person, such as the patient’s heir, to administer the lethal dose in private, without witnesses. Even if the patient struggled, who would know?

\textbf{B. Legal Cover Up}

Once death via the lethal dose occurs, the death is treated for all purposes as if the lethal dose had not been provided. In other words, there is a required official legal cover up. The

\footnotesize
\textsuperscript{40} The bill, section 16, attached in the Appendix at page 110.

\textsuperscript{41} Id. See also the bill in its entirety.

\textsuperscript{42} Compton, Janice & Pollak, Robert, 2013. "Proximity and Coresidence of Adult Children and their Parents in the United States: Description and Correlates," IZA Discussion Papers 7431, Institute for the Study of Labor (IZA). Attached in the Appendix at page 50 (“if the individual coresides with, or lives in close proximity (i.e., within thirty miles) to, his or her mother.”) Available at http://ftp.iza.org/dp7431.pdf
bill states:

A person who dies as a result of the provision of assisted dying is taken for all purposes to have died as if assisted dying had not been provided. (Emphasis added).  

In Washington State, we have a similar requirement. The death certificate is required to list a terminal disease as the cause of death, without even a hint as to the actual cause of death (a lethal drug). The death is reported as “Natural,” which allows perpetrators to inherit, collect the life insurance and/or forgo being charged with murder. The bill, if enacted, will create a perfect crime.

VIII. DR. SHIPMAN AND THE CALL FOR DEATH CERTIFICATE REFORM

According to a 2005 article in the UK’s Guardian newspaper, there was a public inquiry regarding Dr. Shipman’s conduct, which determined that he had “killed at least 250 of his patients over 23 years.” The inquiry also found:

that by issuing death certificates stating natural causes, the serial killer [Shipman] was able to evade investigation by coroners.

43 The bill, Section 25, attached in the Appendix, at page 114.

44 Washington State Death Certificate Instruction, in the Appendix, page 43, which can also be viewed at this link: https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-148-DWDAInstructionsForMedicalExaminers.pdf

45 Id.

46 David Batty, supra, quote in the Appendix at page 13.

47 Id., page 15, second paragraph, “What are its findings?”
According to a subsequent article in 2015, proposed reforms included having a medical examiner review death certificates, so as to improve patient safety.\(^{48}\) Instead, the instant bill moves in the opposite direction to require a legal coverup in which doctors and other perpetrators will be able to kill patients with impunity. The death will be “natural” as a matter of law. For this reason alone, the proposed bill must be defeated.

**IX. TRAUMA TO FAMILY MEMBERS AND FRIENDS**

**A. The Swiss Study: Physician-Assisted Suicide Can Be Traumatic for Family Members and Friends**

In 2010, a European research study addressed trauma suffered by persons who witnessed legal physician-assisted suicide in Switzerland.\(^{49}\) The study found that one out of five family members or friends present was traumatized, with the most severe mental health problems occurring 14 to 24 months post loss.\(^{50}\) An article describing the study states that these people, experienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.\(^{51}\)


\(^{50}\) Id.

\(^{51}\) Id.
B. My Clients Suffered Trauma in Oregon and Washington State

In Washington State and Oregon, I have had two cases where my clients and their family member patients suffered severe trauma due to legal assisted suicide. In the first case, one side of the family wanted the father/patient to take the lethal dose, while the other side did not. The father spent the last months of his life caught in the middle and torn over whether or not he should kill himself. My client, his adult daughter, was severely traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it’s not clear that administration of the lethal dose was voluntary. A man who was present told my client that his (my client's) father had refused to take the lethal dose when it was delivered, stating: "You're not killing me. I'm going to bed." The man also said that my client’s father took the lethal dose the next night when he (the father) was already intoxicated on alcohol. The man who told this to my client subsequently changed his story.

My client, although he was not present, was severely traumatized over the incident, and also by the sudden loss of his father. He also followed the pattern of the Swiss cases described above, becoming especially traumatized about a year and a half after the death.
X. CONCLUSION

If enacted, the bill will encourage people with years or decades to live to throw away their lives. The bill will allow doctors and other persons to cut lives short. There will be legal murder and legal cover up, which will allow perpetrators to keep their inheritances and the life insurance. Some patients and their families will be severely traumatized.

Don’t make Washington and Oregon’s mistake. I urge you to recommend to Parliament that the proposed bill be rejected.

Respectfully Submitted

/S/

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Appendix

Margaret Dore Memo

Reject

End of Life Choice Bill

as of

December 11, 2018
CURRICULUM VITAE

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ATTORNEY EXPERIENCE:

Law Offices of Margaret K. Dore, P.S., Seattle, Washington USA.  
Attorney/President. Work has included litigation, civil appeals, probate,  
guardianship and bankruptcy. Also participate in legislation and court cases  
involving assisted suicide and euthanasia in the US, Canada, Australia, South  
Africa and other jurisdictions. (October 1994 to present).

Lanz & Danielson, Seattle, Washington USA.  
Attorney: Private practice emphasizing real estate litigation, bankruptcy,  
guardianship and appeals. (December 1990 to October 1994).

Self-Employed Attorney, Seattle, Washington USA.  
Worked for other attorneys and private clients. Work emphasized appeals and  
litigation generally. (September 1989 to December 1990).

The United States Department of Justice, Office of the United States Trustee,  
Seattle, Washington USA.  
Attorney: Government practice, emphasizing bankruptcy. (September 1988 to  
August 1989)

JUDICIAL CLERKSHIPS:

The Washington State Supreme Court, Olympia, Washington USA.  

The Washington State Court of Appeals, Tacoma, Washington USA.  
ADMITTED TO PRACTICE:

- Supreme Court of the United States, 2000-present.
- United States Court of Appeals for the Ninth Circuit, 1988-present.
- United States District Court, Western District of Washington 1988-present.

PROFESSIONAL MEMBERSHIPS:

- American Bar Association, 2001 to present.
- American Bar Association, Elder Law Committee of the Family Law Section, Chair 2007.
- Choice is an Illusion, President, 2010 to present.
- Fellows of the American Bar Foundation, Life Fellow, 2007 to present.
- King County Bar Association, 1989 to present.
- King County Bar Elder Law Section, Chair, 1995-96.

PUBLICATIONS:

Assisted Suicide and Euthanasia

Margaret Dore, "California's New Assisted Suicide Law: Whose Choice Will it Be?," JURIST - Professional Commentary, October 24, 2015;

Margaret Dore, "Preventing Abuse and Exploitation: A Personal Shift in Focus" (An article about elder abuse, guardianship abuse and assisted suicide), The Voice of Experience, ABA Senior Lawyers Division Newsletter, Winter 2014;


State Senator Jim Shockley & Margaret Dore, "No, Physician-Assisted Suicide is not Legal in Montana: It's a recipe for elder abuse and more." The Montana Lawyer, November 2011;


Margaret Dore, "Death with Dignity: A Recipe for Elder Abuse and Homicide (Albeit not by Name)," Marquette Elder's Advisor, Vol. 11, No. 2, Spring 2010;
Margaret K. Dore, "Death with Dignity: What Do We Tell Our Clients?," Washington State Bar Association, Bar News, July 2009; and

Margaret K. Dore, "'Death with Dignity': What Do We Advise Our Clients?," King County Bar Association, Bar Bulletin, May 2009.

**Guardianship, Elder Abuse and Family Law**


Margaret K. Dore, A Call for Executive Oversight of Guardians, King County Bar Association, Bar Bulletin, March 2007;


Margaret K. Dore, The "Friendly Parent" Concept: A Flawed Factor for Child Custody, 6 Loyola Journal of Public Interest Law 41 (2004);


Margaret K. Dore, “Parenting Evaluators and GALs: Practical Realities,” King County Bar Association, Bar Bulletin, December 1999; and

AWARDS/RECOGNITIONS:

- Butch Blum Award of Excellence in the Legal Arena, for 2005, in association with Law & Politics Magazine (One of nine nominees, only solo practitioner).

PUBLISHED DECISIONS:

- In re Guardianship of Stamm, 121 Wn. App. 830, 91 P.3d 126 (2004) (3-0 opinion limiting the admissibility of guardian ad litem testimony);
- Lawrence v. Lawrence, 105 Wn. App.631, 20 P.3d 972 (2001) (3-0 opinion re: the “friendly parent” concept, that its use in a child custody determination would be an abuse of discretion);
- Jain v. State Farm, 130 Wn.2d 688, 926 P.2d 923 (1996), (7-2 opinion re: insurance coverage and retroactive application of decisional law); and
- In Re Alpine Group, Inc., 151 B.R. 931 (9th Cir. BAP 1993) (3-0 opinion re: attorney fees in bankruptcy).

EDUCATION:


University of Washington Foster School of Business, Seattle, Washington USA. Masters of Business Administration, 1983; Concentration: Finance.

University of Washington Foster School of Business, Seattle, Washington USA. Bachelor of Arts, Business Administration, 1979; Concentration: Accounting. Honors: Graduated Cum Laude; Phi Beta Kappa.

PROVO, Utah (KSTU) -- A judge will decide if a Spanish Fork man will face trial on a murder charge in the suicide of a 16-year-old girl.

Utah County prosecutors argue that Tyerell Przybycien’s actions led Jchandra Brown to kill herself, and he should be tried for first-degree felony murder and a
class B misdemeanor charge of failure to report a body. His defense lawyers argued that Brown was responsible for her own actions.

Przybycien, 18, sat next to his lawyers, looking straight ahead as arguments were made here on Tuesday.

Deputy Utah County Attorney Chad Grunander argued that Przybycien bought the rope, tied the noose and picked the tree. He also took video of the girl’s suicide. Her body was found the next day by hunters in Payson Canyon.

Utah has no assisted suicide law, and prosecutors argued Przybycien’s actions merited a murder charge. Grunander argued that Przybycien wanted to see someone die.

"He used her suicidal ideations for his own purpose," Grunander told the judge. "The defendant bragged about getting away with murder."

RELATED: Teen accused of helping friend commit suicide could face murder trial
Physicians may offer palliative sedation to unconsciousness to address refractory clinical symptoms, not to respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control. Existential suffering should be addressed through appropriate social, psychological or spiritual support.

*AMA Principles of Medical Ethics: I, VII*

5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

*AMA Principles of Medical Ethics: I, IV*

5.8 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.

However, permitting physicians to engage in euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life.

Appendix page 7
Mercy killing - definition of mercy killing by The Free Dictionary

https://www.thefreedictionary.com/mercy+killing

Mercy killing

Also found in: Thesaurus, Medical, Legal, Acronyms, Encyclopedia, Wikipedia.

n. (Medicine) another term for euthanasia


eu•than•as•ia (ˌyu ðəˈnēz ə, -zə ə)

n.

Also called mercy killing, the act of putting to death painlessly or allowing to die, as by withholding medical measures from a person or animal suffering from an incurable, esp. a painful, disease or condition,

[1640–50; < New Latin < Greek euthanasia easy death]

Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

News sources
BEND, Ore. -

Former Bend real estate broker Tami Sawyer was arraigned Thursday on state charges of criminal mistreatment and aggravated theft, four days after her arrest at Portland International Airport.

Sawyer was taken into custody by Port of Portland police after arriving on a flight back from Mexico, where she was allowed to go and check on rental property.

She appeared before Deschutes County Circuit Judge Wells Ashby, who continued her bond at $50,000 but set no travel restrictions, prosecutors said.

Ashby said she can travel outside of Oregon but has to sign and submit a waiver of extradition, should that be needed.

Sawyer faces charges of first-degree criminal mistreatment and aggravated theft, accused of selling Thomas Middleton's home and pocketing the proceeds.

The judge set her next court appearance for Sept. 6 at 8:30 a.m., when she is scheduled to enter a plea.

Sawyer and husband Kevin are scheduled for trial in December on federal fraud and money-laundering charges.

Former Bend real estate broker Tami Sawyer was arrested Sunday night at Portland International Airport on a Deschutes County warrant issued late last week after her indictment on felony charges of criminal mistreatment and aggravated theft.

Sawyer, 48, was booked into the Multnomah County Jail around 9 p.m. Sunday, about a half-hour after her arrest, reportedly having just flown back to Oregon after a judge agreed to let her go check on rental property that she and husband Kevin own in Cabo San Lucas, Mexico.

Deschutes County Circuit Judge Alta Brady signed an arrest warrant with $50,000 bail last Thursday, two days after she was indicted on a first-degree criminal mistreatment charge that alleges she took custody of Thomas Middleton, a dependent or elderly person, for the purpose of fraud.

The first-degree aggravated theft charge alleges that in October 2008, Sawyer stole more than $50,000 from the Thomas Middleton Revocable Trust.

State and court documents show Middleton, who suffered from Lou Gehrig's disease, moved into Sawyer's home in July 2008, months after naming her trustee of his estate, The Bulletin reported Saturday. Middleton deeded his home to the trust and directed her to make it a rental until the real estate market improved.

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than $200,000, the documents show, and it was deposited into an account for one of Sawyer's businesses, Starboard LLC, and $90,000 of that was transferred to two other Sawyer companies, Genesis Futures and Tami Sawyer PC.

Sawyer and her husband, a former Bend police captain, face trial scheduled for December in Eugene on federal charges of money laundering, wire fraud and conspiracy to commit wire fraud. They are accused of using investor money to pay for personal property, causing investors to lose $4.4 million.

Appendix page 9
Prosecutors Say Doctor Killed To Feel a Thrill

By CHARLIE LEDUFF    SEPT. 7, 2000

Most people in the courtroom knew how the small, skittish man had managed to murder at least four of his patients without getting caught: he injected them with poison, he admitted today. The question observers wanted answered was "Why?"

And then prosecutors offered five scrawled pages from the killer's spiral-bound diary as the motive. It seems that Michael J. Swango, a former doctor, killed for the pure joy of watching and smelling death.

Reading from a notebook confiscated from Mr. Swango when he was arrested in a Chicago airport in 1997 on his way to Saudi Arabia, where he had a job in a hospital, prosecutors painted a portrait of a delusional serial killer. The written passages show that Mr. Swango, 45, was a voracious reader of macabre thrillers about doctors who thought they had the power of the Almighty.

In small, tight script, Mr. Swango transcribed a passage from what prosecutors said was "The Torture Doctor," which they described as an obscure true-to-life novel published in 1975 about a 19th-century doctor who goes on a quiet murder spree and tries to poison his wife with succinylcholine chloride, a powerful muscle relaxant.

"He could look at himself in a mirror and tell himself that he was one of the most powerful and dangerous men in the world -- he could feel that he was a god in disguise," the notebook read.

Another of Mr. Swango's favorite books, according to prosecutors, was "The Traveler," written by John Katzenbach. One passage that prosecutors contended offered a window into Mr. Swango's mind was: "when I kill someone, it's because I want to. It's the only way I have of reminding myself that I'm still alive."

With the victim's relatives weeping in the rear of the courtroom, Assistant United States Attorney Gary R. Brown read more excerpts from the notebook. From
what he identified as the text of "My Secret Life," Mr. Swango was inspired to copy: "I love it. Sweet, husky, close smell of an indoor homicide."

Mr. Brown, on the steps of United States District Court, said today: "Basically, Dr. Swango liked to kill people. By his own admission in his diary, he killed because it thrilled him."

Wearing prison blues and faded slippers, Mr. Swango stood in the courtroom and admitted that he murdered three of his patients at a Long Island hospital with lethal injections.

Each time Judge Jacob Mishler asked Mr. Swango how he pleaded, he answered impassively: "Guilty, your honor."

Accusations, incriminations and death followed Mr. Swango wherever he went, from the time he began medical school at Southern Illinois University in the early 1980's to his tenure as a physician in Zimbabwe. And although an inordinate amount of his patients died over the years -- some officials estimate as many as 60 -- Mr. Swango always managed to find employment.

Prosecutors in New York could charge him only with the three murders in their jurisdiction, committed when he worked for three months as a resident at the Veterans Affairs Medical Center in Northport in 1993. His victims were Thomas Sammarco, 73; George Siano, 60; and Aldo Serini, 62, all of Long Island. He faced federal, rather than state, charges because those three murders were committed at a federal institution.

And for the first time, Mr. Swango acknowledged today that he killed Cynthia McGee, 19, a student who was in his care at Ohio State University Hospitals in 1984 when he worked there as a resident.

He was not charged with her murder, because it was not a federal crime, but he pleaded guilty to lying about his role in her death, and also to falsifying records about prison time he served in the mid-1980's for poisoning co-workers' coffee and doughnuts with ant poison.

When Judge Mishler asked for an explanation of the death of Mr. Siano, Mr. Swango read from a prepared text. "I intentionally killed Mr. Siano, who was at the time a patient at the veterans' hospital in Northport," he read. "I did this by administering a toxic substance which I knew was likely to cause death. I knew it was wrong."
Not only did Mr. Swango administer the lethal injection to Mr. Siano, prosecutors said, he did it on his day off, a day when he was not even on call. Prosecutors said that a nurse saw Mr. Swango sitting on a radiator near Mr. Siano's bed watching the man die from the lethal dose.

"I'm still shaking my head that a madman got a plea bargain today," said Mr. Siano's stepdaughter, Roselinda Conroy. "He's worse than an animal. Animals don't kill for pleasure."

Judge Mishler sentenced Mr. Swango to three consecutive life sentences, without the possibility of parole, in a maximum-security prison in Colorado.

Mary A. Dowling, director of the hospital in Northport, tried to answer the wider question of how a man with Mr. Swango's background could find employment there.

She said that he was hired by the State University of New York at Stony Brook, and rotated through Northport as part of his Stony Brook residency training.

"Michael Swango failed to truthfully disclose the reason for a prior criminal conviction on his application," Ms. Dowling said, explaining that Mr. Swango had told administrators that his jail time had to do with a barroom brawl. "It was an offense he pled guilty to and for which he served three years in prison."

That explanation was not good enough for the relatives of the dead men. "He left a trail of death wherever he went," Ms. Conroy said. "Because of the gross negligence of these institutions, Swango was allowed to kill. They, too, should be held accountable."

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A version of this article appears in print on September 7, 2000, on Page B00001 of the National edition with the headline: Prosecutors Say Doctor Killed To Feel a Thrill.

Appendix page 12
Q&A: Harold Shipman

A report has found that the prison where Britain's most prolific serial killer hanged himself 'could not have prevented' his death. David Batty explains the background of the case

David Batty
Thu 25 Aug 2005 10.19 EDT

Who was Harold Shipman?
Harold Shipman was Britain's most prolific serial killer. According to the public inquiry into his crimes, the former family doctor killed at least 250 of his patients over 23 years. He was found dead in his cell at Wakefield prison on January 13 2004, having hanged himself. The 57-year-old was serving 15 life sentences.

What triggered the inquiry?
Shipman was convicted at Preston crown court in January 2000 of the murder of 15 elderly patients with lethal injections of morphine. A public inquiry was launched in June 2001 to investigate the extent of his crimes, how they went undetected for so long, and what could be done to prevent a repeat of the tragedy.
What do we know about his crimes?
His first victim, Eva Lyons, was killed in March 1975 on the eve of her 71st birthday while Shipman was working at the Abraham Ormerod medical practice in Todmorden. The following year the first clues emerged that Shipman was no ordinary respectable GP. In February 1976, he was convicted of obtaining the morphine-like drug pethidine by forgery and deception to supply his addiction to the drug. Later that year, in the name of a dying patient, he obtained enough morphine to kill 360 people. After receiving psychiatric and drug treatment in York, he re-emerged as a GP in Hyde, Greater Manchester. His method of murder was consistent: a swift injection of diamorphine - pharmaceutical heroin. He killed 71 patients while at the Donnebrook practice in the town and the remainder while a single-handed practitioner at his surgery in Market Street. The majority of his victims - 171 - were women, compared with 44 men. The oldest was 93-year-old Anne Cooper and the youngest 41-year-old Peter Lewis.

How did he get away with it?
When Shipman was fired from the Todmorden medical practice for forging prescriptions, he received a heavy fine but was not struck off by the General Medical Council (GMC), the regulatory body for doctors. Instead, it sent him a stiff warning letter and allowed him to carry on practising. This meant that from this point any employer or patients who asked about Shipman would probably not have been told about his conviction. By the late 1990s, his crime was forgotten and he appeared to be a dedicated, caring professional. But in 1998, Hyde undertakers became suspicious at the number of his patients who were dying, and the neighbouring medical practice discovered that the death rate of Shipman's patients was nearly 10 times higher than their own. They reported their concerns to the local coroner who in turn called in Greater Manchester police. But the police investigation failed to carry out even the most basic checks, including whether Shipman had a criminal record. Nor did they ask the GMC what was on his file. Neither Shipman himself nor relatives of the dead patients were contacted. The officers did ask the local health authority to check the records of 19 deceased patients for any inconsistencies between the medical notes and the cause of death on the death certificate. But the medical adviser was unaware that the doctor he was investigating had a history of forging documents - and Shipman had added false illnesses to his victims' records to cover his tracks. As a result the investigation found no cause for concern and the GP was free to kill three more of his patients before finally being arrested in February 1999.

What led to his conviction?
Shipman's crimes were finally uncovered after he forged the will of one of his victims, Kathleen Grundy, leaving him everything. Having administered a lethal dose of morphine to the 81-year-old former mayoress on June 24 1998, he ticked the cremation box on the will form. But she was buried. Her daughter, Angela Woodruff, was alerted about the will by Hyde solicitors Hamilton Ward. She immediately suspected foul play and went to the police. Mrs Grundy's body was exhumed on August 1 1998 and morphine was found in her muscle tissues. Shipman was arrested on September 7 1998. The bodies of another 11 victims were exhumed over the next two months. Meanwhile a police expert checked Shipman's surgery computer and found that he had made false entries to support the causes of death he gave on his victims' death certificates.

Why did he kill his patients?
Various theories have been put forward to explain why Shipman turned to murder. Some suggest that he was avenging the death of his mother, who died when he was 17. The more charitable view is that he injected old ladies with morphine as a way of easing the burdens on the NHS. Others
suggest that he simply could not resist playing God, proving that he could take life as well as save it.

**What is the scope of the inquiry?**

The inquiry, chaired by Dame Janet Smith, was split into two parts. The report of the first part examined the individual deaths of Shipman’s patients. The second part is examining the systems in place that failed to identify his crimes during the course of his medical career. The inquiry team is also carrying out a separate investigation into all deaths certified by Shipman during his time as a junior doctor at Pontefract General infirmary, West Yorkshire, between 1970 and 1974. A separate investigation by the prisons and probation ombudsman, Stephen Shaw, concluded that Shipman’s death "could not have been predicted or prevented".

**What are its findings?**

The inquiry has published six reports. The first concluded that Shipman killed at least 215 patients. The second found that his last three victims could have been saved if the police had investigated other patients’ deaths properly. The third report found that by issuing death certificates stating natural causes, the serial killer was able to evade investigation by coroners. The fourth report called for stringent controls on the use and stockpiling of controlled drugs such as diamorphine.

The fifth report on the regulation and monitoring of GPs criticised the General Medical Council (GMC) for failing in its primary task of looking after patients because it was too involved in protecting doctors. The sixth and final report, published in January 2005, concluded that Shipman had killed 250 patients and may have begun his murderous career at the age of 25, within a year of finishing his medical training.

**Could this happen again?**

A range of measures is being considered to improve checks on doctors. The government is considering piloting schemes to monitor GPs’ patient death rates. These might include recording causes of death, each patient’s age and sex, the time of death and whether other people were present. The fourth report called for stringent controls on the use and stockpiling of controlled drugs such as diamorphine. The fifth report recommends an overhaul of the GMC’s constitution to ensure it is more focused on protecting patients than doctors. It proposes that the body is no longer dominated by its elected medical members and should be directly accountable to parliament.

$190,823 contributed
$1,000,000 our goal

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Healthcare Serial Killers: Doctors and Nurses Who Kill

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For victims and their families this is an unimaginable crime. The so called ‘angel of death’ nurse is a nurse who has taken it upon themselves to kill their patients. While thankfully quite rare, serial killer nurses can go undetected for many years, exerting their power and control over the vulnerable, often telling themselves they are delivering an act of mercy.

Nurses train for many years as a healthcare professional in order treat and support patients within their care. They have a level of responsibility to their patients and a level of trust which is seen in few other relationships between individuals. In the early years, such cases were often referred to as ‘angel of mercy’ killings. This comes from the notion that some of those responsible carry out their crimes to, in their eyes, relieve the patient of their suffering.

However, not all cases fit this mould and it is not uncommon for what may have started as an act of perceived mercy, turns into something else over time, where a perpetrator begins to expand their victim pool out with
Nurses Who Kill

There have been numerous cases of Healthcare Serial Killers (HSKs), as they are preferably known, around the world. Charles Cullen in New Jersey who may have killed over 400 patients within 16 years as a nurse across nine hospitals, Kimberly Saenz also in America who murdered five patients in Texas by injecting them with bleach.

Italian nurse Daniela Poggiali who murdered 38 patients using potassium chloride and took pictures of herself next to the deceased bodies of patients and shared them on social media. Then there is Genene Jones, a paediatric nurse in San Antonio in Texas known to have killed four children by injecting them with drugs.

Most nurses who kill work alone, however a case in Austria saw four nurses in Vienna who worked together between 1983 and 1991. Led by nurses aide Waltraud Wagner at Lainz General Hospital, they killed patients using morphine and later by drowning, holding the patient down, pinching their nose and pouring water down their throat, a truly horrific and terrifying way to die.

Maria Gruber, Irene Leidolf, Stephanija Mayer, and Waltraud Wagner, collectively known as the ‘Lainz Angels of Death’, have admitted killing 49 patients but as with many medical serial killers it is feared the true number of patients murdered may be as high as 200. They were caught when a doctor overheard them laughing about their latest victim, starting an investigation which resulted in their arrest in 1989.

When he was finally caught after family members raised concerns and a discovery of false medical records was made, it was believed this doctor murdered up to 250 of his patients between 1975 and 1988. Convicted of murder for 15 of his patients, Dr Harold Shipman was sentenced to life in prison and was recommended never to be released.

He hung himself in his prison cell in 2004.n the UK, the case of Dr Harold Shipman is one which caused shock across the country. A friendly local GP who had been murdering his elderly patients by injecting them with diamorphine and falsifying their medical notes. His choice of patients, their ailing heath and his cool and reassuring manner to family members ensured the deaths were attributed to poor health.

RELATED: FBI’S ROBERT RESSLER: THE PSYCHOLOGICAL PROFILING OF SERIAL KILLERS

Studies on Medical Serial Killers

Dr Eindra Khin Khin, Assistant Professor of Psychiatry and Behavioural Sciences at the University of Virginia has highlighted cases of healthcare serial killings have risen since the 1970’s. Ten cases were recorded within that decade, by 2001 to 2006 this number had risen to forty cases.

In a presentation at the annual meeting of the American Academy of Psychiatry and the Law, Dr Khin Khin showed the majority of cases took place within a hospital setting (72%), with 20% of cases happening in nursing homes and 6% within the patients homes. Over half of all cases were carried
Often victims are elderly or very sick and their deaths can be put down to natural causes rather than suspicions being raised. In most cases a cluster of deaths raise questions and the most common form of killing is through use of an injectable substance only detectable through toxicology. In many cases, the age and health conditions of patients mean such tests are not carried out and the crime remains undetected.

**Are There Common Traits In Serial Killer Healthcare Professionals?**

Criminologists have began to examine cases in order to try and identify common traits among such healthcare professionals, predominantly nurses, who turn on their patients. Using the term ‘healthcare serial killers’ or HSKs rather than ‘angel of death nurses’, criminologists have found some interesting results through their research.

Published in the Journal of Investigative Psychology and Offender Profiling, the research carried out by Dr Elizabeth Yardly and Dr David Wilson, both prominent criminologists, has been influential in the understanding of such crimes.

**Attention seeking, strange behaviour when a patient dies, frequent changes in hospital working locations and a disciplinary record** have all been flagged as common factors seen in health care serial killers.

This research examined 16 nurses, both male and female who have been convicted of murdering patients within a hospital setting. Cases examined included Beverley Allitt, probably the most well known ‘Angel of Death’ nurse serial killer in the UK. Allitt was a healthcare nurse who in April 1993 was convicted of the murder of four children, the attempted murder of three children and inflicting grievous bodily harm on a further six children, all over a 3 month period at Grantham and Kesteven Hospital in Lincolnshire, England.


In many cases of murder within healthcare settings, the perpetrator has carried out multiple killings before they are caught. This repetitive cycle suggests a pleasure is received from the acts leading some to believe there may be an addictive element to their murderous behaviour.

**RELATED: ADDICTIVE THINKING AND CRIME – ADDICTED TO MURDER?**

**Access and Opportunity**

Access to drugs appears to be the enabler for these crimes with the most common method of killing being poisoning with the majority of cases included in this study involving insulin.
Beverley Allitt was the only case in the study that used two methods of killing, poisoning and suffocation. Of the 16 offenders studied, over 50% had a history of mental health issues of some kind and signs of a personality disorder.

Charles Cullen is believed to have been murdering his patients for 16 years across nine different hospitals between 1987 and 2003 before he was caught. Some estimates on the actual number of patients who died at his hands are in the hundreds, as many as 400 patients.

The case of Charles Cullen is a complicated one with a personal history marked with suicide attempts, police investigations and stays in psychiatric wards, however no one raised the alarm when his working practices were dangerous and not up to standard.

A nurse who was reportedly fired five times from nursing roles however was still able to practice as a nurse at different hospitals and continue gaining access to patients.

A 2006 study examining 90 cases of healthcare serial killers from twenty different countries between 1970 and 2006, found that 86% of those who became serial killers within healthcare were nurses, both male and female.

Further research has categorized healthcare serial killers in accordance with their motives. These categories show the range of motivations and psychological rewards achieved by those in the medical profession who kill their patients. According to Dr Khin Khin they can often be categorized into the following groups:

- **Thrill Seekers** – these are individuals who achieve a thrill from the act of killing, a thrill which they want to repeat over and over again.

- **Power Oriented** – in this group, they kill to achieve a feeling of power and control. Dr Harold Shipman is an example of a healthcare serial killer who falls within this category.

- **Gain Motivated** – these individuals receive something from the act of killing, this may be relieving a burden by removing the patient from their care or they may be able to steal money or belongings from the patient.

- **Missionary Killers** – less common, these are serial killers within healthcare who believe they are doing a good deed by getting rid of people who are “immoral or unworthy” in some way.

Further to categorization by motives, studies have identified a number of character traits and behaviours which may, when combined, be a warning sign for a potential health care serial killer;

- History of mental instability

- Preference for night-shifts, or shifts with less staff and supervisors on duty

- History of difficult personal relationships

- Tendency to ‘predict’ when a patient will die

https://www.crimetraveller.org/2015/09/healthcare-serial-killers/
I, WILLIAM TOFFLER, declare the following under penalty of perjury:

1. I am a professor of Family Medicine and a practicing physician in Oregon for over 30 years. I write to provide some insight on the issue of physician-assisted suicide, which is legal in Oregon, and which I understand has been proposed for legalization in New Zealand.

2. Oregon’s law applies to persons with a terminal disease who are predicted to have less than six months to live. Our law states:

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

ORS 127.800 s.1.01(12), attached hereto at page A-1.

3. In practice, this definition is interpreted to include people with chronic conditions such as diabetes mellitus, better
known as "diabetes." Chronic conditions such as diabetes are a "terminal disease" sufficient for assisted suicide, if, without treatment such as insulin, the person has less than six months to live.

4. This is significant when you consider that, without insulin, a typical insulin-dependent 20 year old will live less than a month. Such persons, with insulin, are likely to have decades to live; in fact, most diabetics have a normal life span given appropriate control of their blood sugar.

5. Attached hereto, at page A-2, is an excerpt from the most recent Oregon government statistical report regarding our law. The excerpt lists "diabetes" as an "underlying illness" sufficient for assisted suicide.

6. I have also been provided with an excerpt of the proposed New Zealand bill, which states:

    In this Act, person who is eligible for assisted dying means a person who— ...

(c) suffers from—

    (i) a terminal illness that is likely to end his or her life within 6 months; or

    (ii) a grievous and irremediable medical condition; and

(d) is in an advanced state of irreversible decline in capability; .... (Emphasis added)

Bill, Section 4, attached hereto at A-3.
8. In my professional judgment, this definition will include insulin dependent diabetes if, like Oregon, New Zealand makes the eligibility determination without treatment. If so, the typical insulin dependent person will have a life expectancy of less than a month due to being in "an advanced state of irreversible decline in capability" to produce insulin. He or she will have a "terminal illness."

9. In short, if New Zealand follows Oregon practice to determine eligibility without treatment, the proposed bill will apply to people with chronic conditions such as insulin dependent diabetes. Such persons, with treatment, can have years or decades to live happy, healthy and productive lives.

Signed under penalty of perjury this 24th day of November 2018, at Portland Oregon.

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(c) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(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 by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1; 1999 c.423 s.1]

(Written Request for Medication to End One's Life in a Humane and Dignified Manner)

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 s.2; 1999 c.423 s.2]

127.810 s.2.02. Form of the written request.

(1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Oregon Health Authority by rule. [1995 c.3 s.2.02]

(Safeguards)

(Section 3)

127.815 s.3.01. Attending physician responsibilities.

(1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;
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<td>- Other cancers (%)</td>
<td>46 (32.2)</td>
<td>368 (32.5)</td>
<td>414 (32.5)</td>
</tr>
<tr>
<td>Neurological disease (%)</td>
<td>20 (14.0)</td>
<td>114 (10.1)</td>
<td>134 (10.5)</td>
</tr>
<tr>
<td>- Amyotrophic lateral sclerosis (%)</td>
<td>10 (7.0)</td>
<td>90 (8.0)</td>
<td>100 (7.8)</td>
</tr>
<tr>
<td>- Other neurological disease (%)</td>
<td>10 (7.0)</td>
<td>24 (2.1)</td>
<td>34 (2.7)</td>
</tr>
<tr>
<td>Respiratory disease [e.g., COPD] (%)</td>
<td>2 (1.4)</td>
<td>59 (5.2)</td>
<td>61 (4.8)</td>
</tr>
<tr>
<td>Heart/circulatory disease (%)</td>
<td>9 (6.3)</td>
<td>40 (3.5)</td>
<td>49 (3.8)</td>
</tr>
<tr>
<td>Infectious disease [e.g., HIV/AIDS] (%)</td>
<td>0 (0.0)</td>
<td>13 (1.1)</td>
<td>13 (1.0)</td>
</tr>
<tr>
<td>Gastrointestinal disease [e.g., liver disease] (%)</td>
<td>0 (0.0)</td>
<td>8 (0.7)</td>
<td>8 (0.6)</td>
</tr>
<tr>
<td>Endocrine/metabolic disease [e.g., diabetes] (%)</td>
<td>1 (0.7)</td>
<td>7 (0.6)</td>
<td>8 (0.6)</td>
</tr>
<tr>
<td>Other illnesses (%)²</td>
<td>1 (0.7)</td>
<td>8 (0.7)</td>
<td>9 (0.7)</td>
</tr>
</tbody>
</table>
Meaning of person who is eligible for assisted dying

In this Act, **person who is eligible for assisted dying** means a person who—

(a) is aged 18 years or over; and

(b) is—

(i) a person who has New Zealand citizenship as provided in the Citizenship Act 1977; or

(ii) a permanent resident as defined in section 4 of the Immigration Act 2009; and

(c) suffers from—

(i) a terminal illness that is likely to end his or her life within 6 months; or

(ii) a grievous and irremediable medical condition; and

(d) is in an advanced state of irreversible decline in capability; and

(e) experiences unbearable suffering that cannot be relieved in a manner that he or she considers tolerable; and

(f) has the ability to understand—

(i) the nature of assisted dying; and

(ii) the consequences for him or her of assisted dying.
Each year in the U.S., approximately 12 million adults who seek outpatient medical care are misdiagnosed, according to a new study published in the journal BMJ Quality & Safety. This figure amounts to 1 out of 20 adult patients, and researchers say in half of those cases, the misdiagnosis has the potential to result in severe harm.

Previous studies examining the rates of medical misdiagnosis have focused primarily on patients in hospital settings. But this paper suggests a vast number of patients are being misdiagnosed in outpatient clinics and doctors' offices.

"It's very serious," says CBS News chief medical correspondent Dr. Jon LaPook. "When you have numbers like 12 million Americans, it sounds like a lot -- and it is a lot. It represents about 5 percent of the outpatient encounters."

Getting 95 percent right be good on a school history test, he notes, "but it's not good enough for medicine, especially when lives are at stake."

For the paper, the researchers analyzed data from three prior studies related to diagnosis and follow-up visits. One of the studies examined the rates of misdiagnosis in primary care settings, while two of the studies looked at the rates of colorectal and lung cancer screenings and subsequent diagnoses.

To estimate the annual frequency of misdiagnosis, the authors used a mathematical formula and applied the proportion of diagnostic errors detected in the data to the number of all outpatients in the U.S. adult population. They calculated the overall annual rate of misdiagnoses to be 5.08 percent.

"Although it is unknown how many patients will be harmed from diagnostic errors, our previous work suggests that about one-half of diagnostic errors have the potential to lead to severe harm," write the authors in their study. "While this..."
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?

By Nina Shapiro
Tuesday, January 13, 2009 12:00am | NEWS & COMMENT

She noticed the back pain first. Driving to the grocery store, Maryanne Clayton would have to pull over to the side of the road in tears. Then 62, a retired computer technician, she went to see a doctor in the Tri-Cities, where she lived. The diagnosis was grim. She already had Stage IV lung cancer, the most advanced form there is. Her tumor had metastasized up her spine. The doctor gave Clayton two to four months to live.

That was almost four years ago.

Prodded by a son who lives in Seattle, Clayton sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center. Too weak to endure the toxicity of chemotherapy, she started with radiation, which at first made her even weaker but eventually
built her strength. Given dodgy prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called pemetrexate.

Her response was remarkable. The tumors shrunk, and although they eventually grew back, they shrunk again when she enrolled in a second clinical trial. (Pemetrexate has since been approved by the FDA for initial treatment in lung cancer cases.) She now comes to the Hutch every three weeks to see Martins, get CT scans, and undergo her drug regimen. The prognosis she was given has proved to be “quite wrong.”

“I just kept going and going,” says Clayton. “You kind of don’t notice how long it’s been.” She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. “I had to have cancer to have nice hair,” she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip to Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

“We almost lost her because she was having too much fun, not from cancer,” Martins chuckles.

Her experience underscores the difficulty doctors have in forecasting how long patients have to live—a difficulty that is about to become even more pertinent as the Washington Death With Dignity Act takes effect March 4. The law, passed by initiative last November and modeled closely on a 14-year-old law in Oregon, makes Washington the only other state in the country to allow terminally ill patients to obtain lethal medication. As in Oregon, the law is tightly linked to a prognosis: Two doctors must say a patient has six months or less to live before such medication can be prescribed.
The law has deeply divided doctors, with some loath to help patients end their lives and others asserting it’s the most humane thing to do. But there’s one thing many on both sides can agree on. Dr. Stuart Farber, head of palliative care at the University of Washington Medical Center, puts it this way: “Our ability to predict what will happen to you in the next six months sucks.”

In one sense, six months is an arbitrary figure. “Why not four months? Why not eight months?” asks Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, adding that medical literature does not define the term “terminally ill.” The federal Medicare program, however, has determined that it will pay for hospice care for patients with a prognosis of six months or less. “That’s why we chose six months,” explains George Eighmey, executive director of Compassion & Choices of Oregon, the group that led the advocacy for the nation’s first physician-assisted suicide law. He points out that doctors are already used to making that determination.

To do so, doctors fill out a detailed checklist derived from Medicare guidelines that are intended to ensure that patients truly are at death’s door, and that the federal government won’t be shelling out for hospice care indefinitely. The checklist covers a patient’s ability to speak, walk, and smile, in addition to technical criteria specific to a person’s medical condition, such as distant metastases in the case of cancer or a “CD4 count” of less than 25 cells in the case of AIDS.

No such detailed checklist is likely to be required for patients looking to end their lives in Washington, however. The state Department of Health, currently drafting regulations to comply with the new law, has released a preliminary version of the form that will go to doctors. Virtually identical to the one used in Oregon, it simply asks doctors to check a box indicating they have determined that “the patient has six months or less to live” without any additional questions about how that determination was made.

Even when applying the rigid criteria for hospice eligibility, doctors often get it wrong, according to Nicholas Christakis, a professor of medicine and sociology at Harvard University and a pioneer in research on this subject. As a child, his mother was diagnosed with Hodgkin’s disease. “When I was six, she was given a 10 percent chance of living beyond three weeks,” he writes
Doctors also shade their prognoses according to their own biases and desires. Christakis’ study found that the longer a doctor knew a patient, the more likely their prognosis was inaccurate, suggesting that doctors who get attached to their patients are reluctant to talk of their imminent demise. What’s more, Christakis says, doctors see death “as a mark of failure.”

Oncologists in particular tend to adopt a cheerleading attitude “right up to the end,” says Brian Wicks, an orthopedic surgeon and past president of the Washington State Medical Association. Rather than talk about death, he says, their attitude is “Hey, one more round of chemo!”

But it is also true that one more round of chemo, or new drugs like the one that helped Clayton, or sometimes even just leaving patients alone, can help them in ways that are impossible to predict. J. Randall Curtis, a pulmonary disease specialist and director of an end-of-life research program at Harborview Medical Center, recalls treating an older man with severe emphysema a couple of years ago. “I didn’t think I could get him off life support,” Curtis says. The man was on a ventilator. Every day Randall tested whether the patient could breathe on his own, and every day the patient failed the test. He had previously made it clear that he did not want to be kept alive by machines, according to Curtis, and so the doctor and the man’s family made the wrenching decision to pull the plug.

But instead of dying as expected, the man slowly began to get better. Curtis doesn’t know exactly why, but guesses that for that patient, “being off the ventilator was probably better than being on it. He was more comfortable, less stressed.” Curtis says the man lived for at least a year afterwards.

Curtis also once kept a patient on life support against his better judgment because her family insisted. “I thought she would live days to weeks,” he says of the woman, who was suffering from septic shock and multiple organ failure. Instead she improved enough to eventually leave the hospital and come back for a visit some six or eight months later.

“It was humbling,” he says. “It was not amazing. That’s the kind of thing in medicine that happens frequently.”

Appendix page 30
AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO
ASSISTED SUICIDE AND EUTHANASIA

THE UNDERSIGNED, being first duly sworn on oath, STATES:

1. I live in Florence Massachusetts USA. When I was eighteen years old and in my first year of college, I was diagnosed with Amyotrophic Lateral Sclerosis (ALS) by the University of Iowa Medical School. ALS is commonly referred to as Lou Gehrig's disease. I was told that I would get progressively worse (be paralyzed) and die in three to five years.

2. I was a very physical person. The diagnosis was devastating to me. I had played football in high school and was extremely active riding bicycles. I also performed heavy labor including road construction and farm work. I prided myself for my physical strength, especially in my hands.

3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the
time. By then, I had twitching in both hands, which were also getting weaker. At some point, I lost the ability to grip in my hands. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor’s prescription and support, I would have taken that opportunity.

4. Six years after my initial diagnosis, the disease progression stopped. Today, my condition is about the same. I still can’t grip with my hands. Sometimes I need special help. But, I have a wonderful life. I am married to Susan. We have three children and one grandchild. I have a degree in Psychology and one year of graduate school. I am a retired bus driver (no gripping required). Prior to driving bus, I worked as a parole and probation officer. When I was much younger, I drove a school bus. We have wonderful friends. I enjoy singing tenor in amateur choruses. I help other people by working as a volunteer driver.

5. I will be 75 years old this coming September. If assisted suicide or euthanasia had been available to me in the 1950’s, I would have missed the bulk of my life and my life yet to come. I hope that Canada does not legalize these practices.
SWORN BEFORE ME at
MASSACHUSETTS, USA
on, AUGUST 14th, 2012

NAME: HERO BURZYNSKI
A notary in and for the
State of Washington MASSACHUSETTS

ADDRESS: 85 MAIN ST
Florence WA 01022
EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

[Seal]

[Signature] JOHN NORTON
BEFORE THE LEGISLATURE OF THE
STATE OF NEW YORK

IN RE NEW YORK BILLS

DECLARATION OF KENNETH STEVENS, MD

I, Kenneth Stevens, declare the following under penalty of
perjury.
1. I am a doctor in Oregon where physician-assisted suicide is
legal. I am also a Professor Emeritus and a former Chair of the
Department of Radiation Oncology, Oregon Health & Science
University, Portland, Oregon. I have published articles in
medical journals and written chapters for books on medical
topics. This has been for both a national and international
audience. I work in both hospital and clinical settings. I have
treated thousands of patients with cancer.
2. In Oregon, our assisted suicide law applies to patients
predicted to have less than six months to live. I write to
clarify that this does not necessarily mean that patients are
dying.
3. In 2000, I had a cancer patient named Jeanette Hall.
Another doctor had given her a terminal diagnosis of six months
to a year to live, which was based on her not being treated for
cancer. I understand that he had referred her to me.

4. At our first meeting, Jeanette told me plainly that she did not want to be treated and that was going to "do" our law, i.e., kill herself with a lethal dose of barbiturates. It was very much a settled decision.

5. I, personally, did not and do not believe in assisted suicide. I also believed that her cancer was treatable and that her prospects were good. She was not, however, interested in treatment. She had made up her mind, but she continued to see me.

6. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated and she is still alive today. Indeed, she is thrilled to be alive. It's been fifteen years.

7. For Jeanette, the mere presence of legal assisted suicide had steered her to suicide.

8. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.

Affidavit of Kenneth Stevens, Jr., MD - page 2
9. Finally, I have been asked to comment on generally accepted medical practice regarding the administration of prescription drugs to a patient.

10. Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer prescription drugs to a patient. Common examples of persons acting under the direction of a doctor, include: nurses and other healthcare professionals who act under the direction of a doctor to administer drugs to a patient in a hospital setting; parents who act under the direction of a doctor to administer drugs to their children in a home setting; and adult children who act under the direction of a doctor to administer drugs to their parents in a home setting.

Signed under penalty of perjury, this 6th day of January, 2016.

Kenneth Stevens, Jr., MD
Sherwood, Oregon
IN RE NEW ZEALAND END OF LIFE CHOICE BILL
DECLARATION OF JEANETTE HALL

I, JEANETTE HALL, declare as follows:

1. I live in Oregon where assisted suicide is legal. Our law was enacted in 1997 via a ballot measure that I voted for.

2. In 2000, I was diagnosed with cancer and told that I had 6 months to a year to live. I knew that our law had passed, but I didn’t know exactly how to go about doing it. I tried to ask my doctor, Kenneth Stevens MD, but he didn’t really answer me. In hindsight, he was stalling me.

3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!

4. It has now been 18 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 28th day of NOVEMBER 2018

Jeanette Hall
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2017 (N=143)</th>
<th>1998–2016 (N=1,132)</th>
<th>Total (N=1,275)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DWDA process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>5 (3.5)</td>
<td>57 (5.1)</td>
<td>62 (4.9)</td>
</tr>
<tr>
<td>Patient informed family of decision (%)</td>
<td>139 (97.9)</td>
<td>982 (93.1)</td>
<td>1,121 (93.7)</td>
</tr>
<tr>
<td><strong>Patient died at</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home (patient, family or friend) (%)</td>
<td>129 (90.2)</td>
<td>1,052 (93.4)</td>
<td>1,181 (93.1)</td>
</tr>
<tr>
<td>Long term care, assisted living or foster care facility (%)</td>
<td>13 (9.1)</td>
<td>55 (4.9)</td>
<td>68 (5.4)</td>
</tr>
<tr>
<td>Hospital (%)</td>
<td>0 (0.0)</td>
<td>4 (0.4)</td>
<td>4 (0.3)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>1 (0.7)</td>
<td>15 (1.3)</td>
<td>16 (1.3)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Lethal medication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secobarbital (%)</td>
<td>71 (49.7)</td>
<td>676 (59.7)</td>
<td>747 (58.6)</td>
</tr>
<tr>
<td>Pentobarbital (%)</td>
<td>0 (0.0)</td>
<td>386 (34.1)</td>
<td>386 (30.3)</td>
</tr>
<tr>
<td>Phenobarbital (%)</td>
<td>6 (4.2)</td>
<td>57 (5.0)</td>
<td>63 (4.9)</td>
</tr>
<tr>
<td>Morphine sulfate (%)</td>
<td>66 (46.2)</td>
<td>6 (0.5)</td>
<td>72 (5.6)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>0 (0.0)</td>
<td>7 (0.6)</td>
<td>7 (0.5)</td>
</tr>
<tr>
<td><strong>End of life concerns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Losing autonomy (%)</td>
<td>125 (87.4)</td>
<td>1,029 (91.4)</td>
<td>1,154 (90.9)</td>
</tr>
<tr>
<td>Less able to engage in activities making life enjoyable (%)</td>
<td>126 (88.1)</td>
<td>1,011 (91.7)</td>
<td>1,137 (95.9)</td>
</tr>
<tr>
<td>Loss of dignity (%)</td>
<td>96 (67.1)</td>
<td>769 (76.9)</td>
<td>865 (75.7)</td>
</tr>
<tr>
<td>Losing control of bodily functions (%)</td>
<td>53 (37.1)</td>
<td>526 (46.8)</td>
<td>579 (45.7)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>79 (55.2)</td>
<td>475 (42.2)</td>
<td>554 (43.7)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it (%)</td>
<td>30 (21.0)</td>
<td>297 (26.4)</td>
<td>327 (25.8)</td>
</tr>
<tr>
<td>Financial implications of treatment (%)</td>
<td>8 (5.6)</td>
<td>39 (3.5)</td>
<td>47 (3.7)</td>
</tr>
<tr>
<td><strong>Health-care provider present</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(collected since 2001)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When medication was ingested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician</td>
<td>24</td>
<td>163</td>
<td>187</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
<td>24</td>
<td>270</td>
<td>294</td>
</tr>
<tr>
<td>No provider</td>
<td>6</td>
<td>91</td>
<td>97</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>89</td>
<td>538</td>
<td>627</td>
</tr>
<tr>
<td>At time of death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician</td>
<td>23 (16.1)</td>
<td>149 (14.3)</td>
<td>172 (14.6)</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
<td>19 (13.3)</td>
<td>295 (28.4)</td>
<td>314 (26.6)</td>
</tr>
<tr>
<td>No provider</td>
<td>101 (70.6)</td>
<td>595 (57.3)</td>
<td>696 (58.9)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>0</td>
<td>23</td>
<td>23</td>
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<tr>
<td><strong>Complications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty ingesting/regurgitated</td>
<td>1</td>
<td>24</td>
<td>25</td>
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<tr>
<td>Seizures</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>None</td>
<td>38</td>
<td>554</td>
<td>592</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>101</td>
<td>537</td>
<td>638</td>
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Table 3. Death with Dignity Act process for the participants who have died

<table>
<thead>
<tr>
<th>Family and Psychiatric/Psychological involvement</th>
<th>2017</th>
<th>2016</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred for psychiatric/psychological evaluation</td>
<td>4</td>
<td>11</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Patient informed family of decision</td>
<td>174</td>
<td>224</td>
<td>174</td>
<td>93</td>
</tr>
<tr>
<td>Medication</td>
<td>66</td>
<td>77</td>
<td>109</td>
<td>51</td>
</tr>
<tr>
<td>Secobarbital</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Pentobarbital</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Secobarbital/Pentobarbital Combination</td>
<td>0</td>
<td>106</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Phenobarbital</td>
<td>0</td>
<td>2</td>
<td>&lt;1</td>
<td></td>
</tr>
<tr>
<td>Phenobarbital/Chloral Hydrate Combination</td>
<td>0</td>
<td>1</td>
<td>&lt;1</td>
<td></td>
</tr>
<tr>
<td>Chloral Hydrate</td>
<td>130</td>
<td>53</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Morphine sulfate</td>
<td>0</td>
<td>1</td>
<td>&lt;1</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of patient-physician relationship</td>
<td>94</td>
<td>125</td>
<td>99</td>
<td>49</td>
</tr>
<tr>
<td>&lt;25 weeks</td>
<td>21</td>
<td>25</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>25 weeks – 51 weeks</td>
<td>71</td>
<td>88</td>
<td>81</td>
<td>40</td>
</tr>
<tr>
<td>1 year or more</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range (min – max)</td>
<td>&lt;1 wk</td>
<td>&lt;1 wk</td>
<td>&lt;1 wk</td>
<td>2 yrs</td>
</tr>
<tr>
<td>Duration between first oral request and death</td>
<td>167</td>
<td>209</td>
<td>164</td>
<td>81</td>
</tr>
<tr>
<td>&lt;25 weeks</td>
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Speak to a Morphine Intake Coordination Specialist now.

(tel:352-771-2700)

What to expect when I call?

As mentioned above, morphine is found in or is the precursor of many other medicines. It also has many variants of its own. One such variety is known as morphine sulfate. What exactly constitutes the difference between conventional morphine and morphine sulfate? Not much at all, as it turns out.

Morphine sulfate, as the name implies, is manufactured with an additional sulfate component within its chemical makeup — sulfates are more commonly referred to as salts. Morphine is not easily soluble in water in its base form. Sulfates, on the other hand, are highly water-soluble. When both are put together, morphine is more readily absorbed at the source of pain. Essentially, morphine sulfate allows the body to use morphine more efficiently.

Morphine Sulfate Side Effects

All prescription medications come with potential side effects, and morphine sulfate is no different. However, because morphine is an opioid, special care must be given in the use of such compounds. This is mainly due to the increased likelihood of patients developing unintended tolerances to the drug. Once a tolerance is built up, more of the medicine must be used to achieve the desired effect. The more that morphine is used, the more unpredictable the reactions and greater the concerns become. Though not technically a side effect in the traditional sense, an individual may end up with a dangerous substance use disorder after extended morphine sulfate usage. The rate of which an adverse side effect may emerge is...
dependent on numerous factors relating to the patient in question. Still, some side effects are generally considered more common than others. These reactions include:

- Dizziness
- Excessive sedation
- Constipation
- Nausea and vomiting
- Profuse sweating

Less frequent side effects can lead to maladies and disorders across various bodily systems, such as life-threatening respiratory failure, heart palpitations, tachycardia, dyspepsia, impaired vision, muscle twitching, anorexia, convulsions, anxiety, depression, rashes and hypertension. For all the above reason and more, it is not recommended that individuals with respiratory issues use morphine sulfate. The decision to do so must always be with the approval of a medical professional. In addition to side effects, it is helpful to be able to identify symptoms of a morphine sulfate overdose. Morphine overdoses, like those attributed to other opioids, have three characteristic indicators. All overdose symptoms can be placed within these designations of what is known as the opioid overdose triad:

1. Unconsciousness: Overdose victims may appear comatose or become unresponsive to questioning or outside stimuli.
2. Pinpoint pupils: An individual’s pupils will contract to an abnormally small size. Moreover, victims’ eyes may also move erratically or more slowly than usual.
3. Inhibited respiration: An overdose on morphine sulfate may also lead to respiratory depression.

Morphine sulfate overdoses can be deadly. Seek out proper intervention from medical responders if an overdose is suspected.

**Morphine Sulfate Dosage**

Proper morphine sulfate dosages are usually dependent on a patient’s previous experience with opioids. If an individual has little to no history of opioid usage, a twice-daily dose of 15 mg will often suffice. An increased prevalence of chronic pain may skew these numbers slightly in the favor of a higher dose. The medication is available in 100–200 mg dose ranges, too. This amount is strictly used for opioid-tolerant patients at the discretion of a physician.

**Morphine Sulfate Tablets**

Tablets of morphine sulfate come in five main strength varieties: 15 mg, 30 mg, 60 mg, 90 mg, and 100 mg. These pills can be differentiated by their unique colors of blue, purple...
respectively. Given the inherent dangers associated with the more potent tablets, the smaller dosages are more readily available for day-to-day patient use. Each of these tablets should be taken by mouth in their whole, unbroken form. Morphine sulfate tablets are often extended-release medicines, meaning the intended effects are gradually emitted in the body over time. Whenever the pills are crushed, as is routine during recreational use, the medicine is delivered in a hazardous manner all at once. This can very well lead to overdose and death.

**Morphine Sulfate Injection**

Morphine sulfate is also available in a 10 mg/ml injectable medication. This form is intended for the treatment of severe pain and allows the patient to inject themselves directly into a vein or muscle once every four hours if necessary. Injections of morphine sulfate are thought to be more direct and onset faster than the pill version. In tandem, medical and recreational opioid use has led to a widespread opioid epidemic across the United States. Suddenly, medicines that were intended to prevent pain have become the source of pain on an individual, familial and societal level. While the medical benefits of morphine and other opioids cannot be overstated, there is certainly a capacity for harm hidden within these compounds. Dealing with that aftermath will takes years, even decades. In the interim, it is vital to take in and understand as much as one can about morphine sulfate — both the good and the bad.

**Have more questions about Morphine abuse?**


Q. **How Do I Know If Someone Is On Morphine?** ([morphine-addiction/know-someone-morphine/](morphine-addiction/know-someone-morphine/))

Q. **Is Morphine an Opiate?** ([morphine-addiction/is-morphine-an-opiate/](morphine-addiction/is-morphine-an-opiate/))

Q. **How Long Does 30-mg Morphine Stay in Your System?** ([morphine-addiction/morphine-30-mg-pill/](morphine-addiction/morphine-30-mg-pill/))

An addiction to morphine can be difficult to overcome, but recovery is possible with the right treatment. The Recovery Village® has helped countless clients overcome substance use disorders involving morphine, alcohol and countless other drugs. Call [tel:352-771-2700] (352-771-2700) to talk to an intake coordinator.

https://www.therecoveryvillage.com/morphine-addiction/morphine-sulfate
Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys:
Compliance with the Death with Dignity Act

Washington's Death with Dignity Act (RCW 70.245) states that "...the patient's death certificate...shall list the underlying terminal disease as the cause of death." The act also states that, "Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law."

If you know the decedent used the Death with Dignity Act, you must comply with the strict requirements of the law when completing the death record:

1. The underlying terminal disease must be listed as the cause of death.
2. The manner of death must be marked as "Natural."
3. The cause of death section may not contain any language that indicates that the Death with Dignity Act was used, such as:
   a. Suicide
   b. Assisted suicide
   c. Physician-assisted suicide
   d. Death with Dignity
   e. I-1000
   f. Mercy killing
   g. Euthanasia
   h. Secobarbital or Seconal
   i. Pentobarbital or Nembutal

The Washington State Registrar will reject any death certificate that does not properly adhere to the requirements of the Death with Dignity Act. If a death certificate contains any reference to actions that might indicate use of the act, the Local Registrar and Funeral Director will be instructed, under RCW 70.58.030, to obtain a correction from the medical certifier before a permit to proceed with disposition will be issued.

Call the Department of Health's Center for Health Statistics (360-236-4307) for guidance on how to proceed if you have any questions regarding compliance with cause of death reporting under the Death with Dignity Act.

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1 Under state law, the State Registrar of Vital Statistics "shall prepare and issue such detailed instruction as may be required to secure the uniform observance of its provisions and the maintenance of a perfect system of registration. ... The State Registrar shall carefully examine the certificates received monthly from the local registrars, county auditors, and clerks of the court and, if any are incomplete or unsatisfactory, the State Registrar shall require such further information to be furnished as may be necessary to make the record complete and satisfactory." RCW 43.70.160.
Death certificate reform delays 'incomprehensible'

Royal College of Pathologists president Dr Suzy Lishman says changes to system for recording deaths are long overdue

Press Association
Wed 21 Jan 2015 05.09 EST

A senior pathologist has criticised the lack of reform to the death certificate system 15 years after the conviction of serial killer Dr Harold Shipman.

Dr Suzy Lishman, president of the Royal College of Pathologists, said changes to the system for recording deaths in England and Wales were long overdue and it was incomprehensible they had not happened.

Family doctor Shipman covered his tracks by signing the death certificates of his victims himself, avoiding the involvement of a coroner.

Chris Bird, whose mother, Violet, was murdered by Shipman, said the delay in implementing the changes was “criminal”.
Lishman said changes that would see a medical examiner review death certificates had not been implemented, possibly because of confusion created by the coalition government’s NHS shakeup.

She told BBC Radio 4’s Today programme: “I think it appears that the introduction of medical examiners may have got lost in the NHS reforms. Primary care trusts, for example, were initially meant to employ medical examiners and they were abolished in the latest reconfiguration.

“I know there were also concerns about funding mechanisms, but medical examiners in the pilot schemes have been shown to save money so this shouldn’t really be an obstacle.”

Lishman said in the pilot areas it cost less to pay a medical examiner to scrutinise all deaths than it cost for the cremation form system that relatives pay for following a bereavement.

“It also saves money because the pilot schemes found there is much less litigation,” she added. “If bereaved relatives get the answers that they need around the time of death, if all their questions are answered then, then they don’t feel the need to sue the NHS to get the answers they deserve.”

She said the legislation had been passed, and Prof Peter Furness was in place as the interim chief medical examiner “sitting there waiting to take on this role”.

Bird told Today: “Dr Lishman said in her statement today this was ‘incomprehensible’. It’s not, it is criminal. There is government stalling on implementing something like this that can save millions of lives.”

Shipman, who died in 2004, was jailed for life in 2000 for murdering 15 patients using the drug diamorphine while working in Hyde, Greater Manchester.

An official report later concluded he killed between 215 and 260 people over a 23-year period.

A Department of Health spokesman said: “We are committed to reforming the system of death certification. We now have working models of the medical examiner service in Sheffield and Gloucester and will be working to review how they fit with other developments on patient safety. The reforms will proceed in light of that review.”

$190,823 contributed
$1,000,000

our goal

**In these critical times** ...

... help us protect independent journalism at a time when factual, trustworthy reporting is under threat by making a year-end gift to support The Guardian. We’re asking our US readers to help us raise one million dollars by the new year so that we can report on the stories that matter in 2019. Small or big, every contribution you give will help us reach our goal.

The Guardian’s editorial independence means that we can pursue difficult investigations, challenging the powerful and holding them to account. No one edits our editor and no one steers our opinion.

In 2018, The Guardian broke the story of Cambridge Analytica’s Facebook data recorded the human fallout from family separations; we charted the rise documented the growing impact of gun violence on Americans’ lives.”

*Appendix page 45*
Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

B. Wagner a,⁎, J. Müller b, A. Maercker c

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ABSTRACT

Background: Despite continuing political, legal and moral debate on the subject, assisted suicide is permitted in only a few countries worldwide. However, few studies have examined the impact that witnessing assisted suicide has on the mental health of family members or close friends.

Methods: A cross-sectional survey of 85 family members or close friends who were present at an assisted suicide was conducted in December 2007. Full or partial Post-Traumatic Distress Disorder (PTSD; Impact of Event Scale—Revised), depression and anxiety symptoms (Brief Symptom Inventory) and complicated grief (Inventory of Complicated Grief) were assessed at 14 to 24 months post-loss.

Results: Of the 85 participants, 13% met the criteria for full PTSD (cut-off > 35), 6.5% met the criteria for subthreshold PTSD (cut-off ≥ 25), and 4.9% met the criteria for complicated grief. The prevalence of depression was 16%; the prevalence of anxiety was 6%.

Conclusion: A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although there seemed to be no complications in the grief process, about 20% of respondents experienced full or subthreshold PTSD related to the loss of a close person through assisted suicide.

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1. Introduction

Assisted suicide and euthanasia for terminally ill patients are punishable by law almost everywhere except Switzerland, the Netherlands, Belgium and the U.S. states of Oregon and Washington. Assisted suicide is generally defined as the prescribing or supplying of drugs with the explicit intention of enabling the patient to end his or her own life. In euthanasia, in contrast, it is the physician who administers the lethal drug. In the Netherlands and Belgium, physician-assisted euthanasia is legally permitted, meaning that physicians are allowed to administer drugs to end a patient’s life at his or her request. In Switzerland, in contrast, euthanasia is punishable by imprisonment (Article 114 of the Swiss penal code). It is only in the absence of self-serving motives that assisting another person’s suicide is permissible. Physicians in Switzerland are therefore allowed to prescribe or supply a lethal dose of barbiturates with the explicit intention of enabling a patient they have examined to end his or her own life. However, most assisted suicides in Switzerland are conducted with the assistance of non-profit organisations [23]. These right-to-die organisations offer personal guidance to members suffering diseases with “poor outcome” or experiencing “unbearable suffering” who wish to die.

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50,000 members, and between 100 and 150 people die each year with the organisation’s assistance. In comparison, Dignitas has about 6,000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient’s home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient’s home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.
5. **to initiate or precipitate** (a chain of events, scientific reaction, psychological process, etc.):

   *Their small protest triggered a mass demonstration.*

6. **to fire or explode** (a gun, missile, etc.) by pulling a trigger or releasing a triggering device:

   *He accidentally triggered his rifle.*

**verb (used without object)**

7. **to release a trigger.**

8. **to become active; activate.**

**Idioms**

9. **quick on the trigger**, *Informal*. quick to act or respond; impetuous; alert.

**Origin of trigger**

1615–25; earlier *tricker* < Dutch *trekker*, equivalent to *trekk(en)* to pull + *-er* -er¹

**Related forms**

un*·trig*·gered, adjective

---

**Related Words for trigger**

prompt, start, produce, spark, provoke, cause, generate, elicit, activate

**Examples from the Web for trigger**

**Contemporary Examples of trigger**

People felt that crossed all lines, and then it became a story, so there are tipping points that *trigger* a public response.

Laura Poitras on Snowden's Unrevealed Secrets
**administer**

Also found in: Thesaurus, Medical, Legal, Financial, Acronyms, Idioms, Encyclopedia.

*ad·min·is·ter* (ád-min’is-ter)

v. ad-min-is·tered, ad-min-is-ter·ing, ad·min-is-ters

v.tr.

1. To have charge of; manage.

2.
   a. To give or apply in a formal way: administer the last rites.
   b. To apply as a remedy: administer a sedative.
   c. To direct the taking of (an oath).

3. To mete out: dispense: administer justice.

4. To manage (a trust or estate) under a will or official appointment.

5. To impose, offer, or tender (an oath, for example).

v.intr.

1. To manage as an administrator.

2. To minister: administering to their every whim.

[Middle English administren, from Old French administrer, from Latin administrare: ad, ad-+ ministrare, to manage (from minister, ministr-, servant; see minister).]

ad·min·is·tra·ble (-i-stré-bol) adj.

ad·min·is·trant adj. & n.


**administer** (ad‘ministə)

vb (mainly tr)

1. (also intr) to direct or control (the affairs of a business, government, etc)

2. to put into execution; dispense: administer justice.

3. (when: intr, foll by to) to give or apply (medicine, assistance, etc) as a remedy or relief

4. to apply formally; perform: to administer extreme unction.

5. to supervise or impose the taking of (an oath, etc)

6. (Law) to manage or distribute (an estate, property, etc)

[C14: amynistre, via Old French from Latin administrare, from ad- to + ministrare to minister]
Proximity and Coresidence of Adult Children and their Parents in the United States: Description and Correlates

Janice Compton
University of Manitoba

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Washington University in St. Louis and IZA

Discussion Paper No. 7431
May 2013

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coresidents from their sample, creating a sample selection issue that compromises the interpretation of their results. Rogerson, Burr and Lin (1997) use multinomial logit models to assess the correlates of convergence and divergence in proximity. Only Glaser and Tomassini (2000) use the multinomial logit to model the correlates of proximity and coresidence, although they do not test the multinomial logit against alternative specifications.

Our descriptive regressions confirm the need to treat separately coresidence and close proximity rather than treating coresidence as a limiting case of proximity. Tobit and logit treat coresidence as a limiting case of proximity, while the multinomial logit does not. Table 6 presents the results of regressions on proximity and coresidence for the full sample, including both married and unmarried adult children. Column (A) shows the coefficients from a Tobit regression in which the dependent variable is distance from mother, treating coresidence as the limiting case of proximity. Column (B) presents the results from a logit regression in which the dependent variable equals one if the individual coresides with, or lives in close proximity (i.e., within thirty miles) to, his or her mother. We present the logit coefficients as odds ratios. Column (C) presents the results from a multinomial logit regression, our preferred specification, in which the dependent variable includes three alternatives: to coreside, to live close to, or to live far from.

The empirical results of this section confirm the superiority of the multinomial logit specification. The Tobit and logit specifications constrain regressors to affect living with mother and living close to mother in the same direction, but for some characteristics, the data are not consistent with these a priori constraints (e.g., Hispanic ethnicity; marital
David Seymour

End of Life Choice Bill
Member’s Bill

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**Part 1**

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**Part 2**

Assisted dying

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**Part 3**

Accountability

|   | SCENZ Group | 12 |

Appendix p.101
The Parliament of New Zealand enacts as follows:

1 Title
This Act is the End of Life Choice Act 2017.

2 Commencement
This Act comes into force 6 months after the date on which it receives the Royal assent.

Part 1
Preliminary provisions

3 Interpretation
In this Act, unless the context requires another meaning,—

assisted dying means the administration by a medical practitioner of a lethal dose of medication to a person to relieve his or her suffering by hastening death

attending medical practitioner means a person’s medical practitioner

competent means having the ability described in section 4(f)

conscientious objection means an objection to doing anything authorised or required by this Act

Director-General means the Director-General of Health

health practitioner has the meaning given to it by section 5 of the Health Practitioners Competence Assurance Act 2003

independent medical practitioner means a medical practitioner who is independent of an attending medical practitioner and the person

medical practitioner means a health practitioner who—
(a) is registered with the Medical Council of New Zealand as a practitioner of the profession of medicine or is deemed to be so registered; and

(b) holds a current practising certificate

minister means the Minister of the Crown who is responsible for the administration of this Act—

(a) under the authority of a warrant; or

(b) under the authority of the Prime Minister

ministry means the Ministry of Health

person who is eligible for assisted dying has the meaning given to it in section 4

pharmacist means a health practitioner who—

(a) is registered with the Pharmacy Council as a practitioner of the profession of pharmacy or is deemed to be so registered; and

(b) holds a current practising certificate

psychiatrist means a medical practitioner whose scope of practice includes psychiatry

psychologist means a health practitioner who—

(a) is registered with the Psychologists Board as a practitioner of the profession of psychology or is deemed to be so registered; and

(b) holds a current practising certificate

registrar means the registrar (assisted dying) nominated under section 21

review committee means the committee established under section 20

SCENZ means Support and Consultation for End of Life in New Zealand

SCENZ Group means the body established under section 19

specialist means a psychiatrist or a psychologist.

4 Meaning of person who is eligible for assisted dying
In this Act, person who is eligible for assisted dying means a person who—

(a) is aged 18 years or over; and

(b) is—

(i) a person who has New Zealand citizenship as provided in the Citizenship Act 1977; or

(ii) a permanent resident as defined in section 4 of the Immigration Act 2009; and

(c) suffers from—

(i) a terminal illness that is likely to end his or her life within 6 months; or
(ii) a grievous and irremediable medical condition; and
(d) is in an advanced state of irreversible decline in capability; and
(e) experiences unbearable suffering that cannot be relieved in a manner that he or she considers tolerable; and
(f) has the ability to understand—
(i) the nature of assisted dying; and
(ii) the consequences for him or her of assisted dying.

5 Act binds the Crown
This Act binds the Crown.

Part 2
Assisted dying

6 Conscientious objection
(1) This Act does not require a person to do anything to which the person has a conscientious objection.
(2) **Subsection (1)—**
   (a) applies despite any legal obligation to which the person is subject, however the obligation arises; and
   (b) does not apply to the requirement in **section 7(2).**

7 Effect of conscientious objection
(1) This section applies when—
   (a) a person tells the attending medical practitioner under **section 8(1)** that the person wishes to have the option of receiving assisted dying; and
   (b) the attending medical practitioner has a conscientious objection.
(2) The attending medical practitioner must tell the person that—
   (a) the medical practitioner has a conscientious objection; and
   (b) the person may ask the SCENZ Group for the name and contact details of a replacement medical practitioner.
(3) If the person chooses to have the replacement medical practitioner, references in this Act to the attending medical practitioner mean the person’s replacement medical practitioner, except in **subsection (2) and section 8(1).**

8 Request made
(1) A person who wishes to have the option of receiving assisted dying must tell the attending medical practitioner of his or her wish.
(2) The attending medical practitioner must—
(a) give the person the following information:
  (i) the prognosis for the terminal illness or grievous and irremediable medical condition; and
  (ii) the irreversible nature of assisted dying; and
  (iii) the anticipated impacts of assisted dying; and
(b) talk with the person about his or her wish at intervals determined by the progress of his or her terminal illness or medical condition; and
(c) ensure that the person understands his or her other options for end of life care; and
(d) ensure that the person knows that he or she can change his or her mind at any time; and
(e) encourage the person to talk about his or her wish with others such as family, friends, and counsellors; and
(f) ensure that the person knows that he or she is not obliged to talk to anyone; and
(g) ensure that the person has had the opportunity to talk about his or her wish with those whom he or she chooses; and
(h) do his or her best to ensure that the person expresses his or her wish free from pressure from any other person by—
  (i) talking with other health practitioners who are in regular contact with the person; and
  (ii) talking with members of the person's family approved by the person; and
(i) complete the first part of the prescribed form requesting the option of assisted dying by recording the actions he or she took to comply with paragraphs (a) to (h).

9 Request confirmed

(1) This section applies after section 8 is complied with.

(2) If the person wishes to proceed, the attending medical practitioner must give the person the prescribed form requesting the option of assisted dying.

(3) The person must—
  (a) sign and date the second part of the form; or
  (b) be present when the second part of the form is signed and dated as described in subsection (4).

(4) The second part of the form may be signed and dated by a person other than the person to whom it relates if—
  (a) the person to whom it relates cannot write for any reason; and
(b) the person to whom it relates requests the other person to sign and date it; and

(c) the person who signs and dates the part notes on it that he or she did so in the presence of the person to whom the form relates; and

(d) the person who signs and dates the part is not—
   (i) a health practitioner caring for the person to whom the part relates; or
   (ii) a person who knows that he or she stands to benefit from the death of the person to whom the part relates; or
   (iii) a person aged under 18 years; or
   (iv) a person with a mental disability.

(5) The attending medical practitioner must—
   (a) be present when—
      (i) subsection (3)(a) is complied with; or
      (ii) subsections (3)(b) and (4) are complied with; and
   (b) collect the form; and
   (c) send the completed form to the registrar.

10 First opinion reached
(1) This section applies after section 9 is complied with.

(2) The attending medical practitioner must reach the opinion that—
   (a) the person is a person who is eligible for assisted dying; or
   (b) the person is not a person who is eligible for assisted dying; or
   (c) the person would be a person who is eligible for assisted dying if the person’s competence were established as described in section 12.

(3) The attending medical practitioner must—
   (a) complete a prescribed form recording his or her opinion; and
   (b) send the completed form to the registrar.

11 Second opinion reached
(1) This section applies if the attending medical practitioner reaches the opinion described in section 10(2)(a) or (c).

(2) The attending medical practitioner must—
   (a) ask the SCENZ Group for the name and contact details of an independent medical practitioner; and
   (b) ask the independent medical practitioner for his or her opinion on whether the person is a person who is eligible for assisted dying.

(3) The independent medical practitioner must—
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(a) read the person’s files; and
(b) examine the person; and
(c) reach the opinion that—
   (i) the person is a person who is eligible for assisted dying; or
   (ii) the person is not a person who is eligible for assisted dying; or
   (iii) the person would be a person who is eligible for assisted dying if
        the person’s competence were established as described in section 12.

(4) The independent medical practitioner must—
   (a) complete a prescribed form recording his or her opinion; and
   (b) send the completed form to the registrar; and
   (c) send a copy of the completed form to the attending medical practitioner.

12 Third opinion reached, if necessary

(1) This section applies if—
   (a) the following situation exists:
       (i) the attending medical practitioner reaches the opinion described in
           section 10(2)(a); and
       (ii) the independent medical practitioner reaches the opinion described in
            section 11(3)(c)(iii); or
   (b) the following situation exists:
       (i) the attending medical practitioner reaches the opinion described in
           section 10(2)(c); and
       (ii) the independent medical practitioner reaches the opinion described in
            section 11(3)(c)(i); or
   (c) the following situation exists:
       (i) the attending medical practitioner reaches the opinion described in
           section 10(2)(c); and
       (ii) the independent medical practitioner reaches the opinion described in
            section 11(3)(c)(iii).

(2) The medical practitioners must jointly—
   (a) ask the SCENZ Group for the name and contact details of a specialist;
        and
   (b) ask the specialist for his or her opinion on whether the person is competent.

(3) The specialist must—
   (a) read the person’s files; and
   (b) examine the person; and
(c) reach the opinion that—
   (i) the person is competent; or
   (ii) the person is not competent.

(4) The specialist must—
   (a) complete a prescribed form recording his or her opinion; and
   (b) send the completed form to the registrar; and
   (c) send a copy of the completed form to—
       (i) the attending medical practitioner; and
       (ii) the independent medical practitioner.

13 Negative decision made on request

(1) Subsection (2) applies if the attending medical practitioner reaches the opinion described in section 10(2)(b).

(2) The attending medical practitioner must explain the reasons for his or her opinion to the person.

(3) Subsection (4) applies if—
   (a) the independent medical practitioner reaches the opinion described in section 11(3)(c)(ii); or
   (b) the following situation exists:
       (i) a specialist is asked for his or her opinion under section 12(2)(b); and
       (ii) the specialist reaches the opinion described in section 12(3)(c)(ii).

(4) The independent medical practitioner or the specialist, as appropriate, must attend the person with the attending medical practitioner to explain the reasons for his or her opinion to the person.

(5) The attending medical practitioner must—
   (a) complete a prescribed form recording the actions taken to comply with subsection (2) or (4); and
   (b) send the completed form to the registrar.

14 Positive decision made on request

(1) This section applies if—
   (a) the following situation exists:
       (i) the attending medical practitioner reaches the opinion described in section 10(2)(a); and
       (ii) the independent medical practitioner reaches the opinion described in section 11(3)(c)(i); or
(b) the following situation exists:
   (i) a specialist is asked for his or her opinion under section 12(2)(b); and
   (ii) the specialist reaches the opinion described in section 12(3)(c)(i).

(2) The attending medical practitioner must—
   (a) tell the person that the person is a person who is eligible for assisted dying; and
   (b) discuss with the person the progress of the person’s terminal illness or grievous and irremediable medical condition; and
   (c) discuss with the person the likely timing of the assisted dying; and
   (d) make provisional arrangements to be available to administer the medication at the time indicated.

15 Medication chosen

(1) This section applies after section 14 is complied with.

(2) When the person wishes to exercise the option of receiving assisted dying, he or she must tell the attending medical practitioner.

(3) The attending medical practitioner must—
   (a) tell the person about the following methods for the administration of a lethal dose of medication:
      (i) ingestion, triggered by the person:
      (ii) intravenous delivery, triggered by the person:
      (iii) ingestion through a tube:
      (iv) injection; and
   (b) ask the person to choose one of the methods; and
   (c) ask the person to choose the time at which he or she wishes the medication to be administered; and
   (d) ensure that the person knows that he or she can change his or her mind at any time.

(4) At least 48 hours before the chosen time of administration, the attending medical practitioner must—
   (a) write the appropriate prescription for the person; and
   (b) advise the registrar of the method and time chosen; and
   (c) provide the registrar with the prescription.

(5) The registrar must check that the process in sections 8 to 14 has been complied with.
(6) If the registrar is satisfied that the process in sections 8 to 14 has been complied with, the registrar must—
   (a) co-sign the prescription for the person; and
   (b) provide the co-signed prescription to the attending medical practitioner.

16 Medication administered

(1) This section applies after section 15 is complied with.

(2) At the chosen time of administration, the attending medical practitioner must ask the person if he or she chooses to receive the medication.

(3) If the person chooses not to receive the medication, the attending medical practitioner must—
   (a) remove the medication from the room; and
   (b) return the medication to the pharmacist who dispensed it; and
   (c) complete a prescribed form recording the actions taken to comply with paragraphs (a) and (b); and
   (d) send the completed form to the registrar.

(4) If the person chooses to receive the medication, the attending medical practitioner must administer it by—
   (a) providing it to the person, for the methods described in section 15(3)(a)(i) and (ii); or
   (b) providing it, for the methods described in section 15(3)(a)(iii) and (iv).

(5) The attending medical practitioner must—
   (a) be available to the person until the person dies; or
   (b) arrange for another medical practitioner to be available to the person until the person dies.

(6) For the purposes of subsection (5), the medical practitioner is available to the person if the medical practitioner—
   (a) is in the same room as the person; or
   (b) is not in same room as the person but is in close proximity to the person.

17 Death reported

(1) Within 14 working days of a person dying as a result of the administration of medication under section 16, the attending medical practitioner must send the registrar a report in the prescribed form containing the information described in subsection (2).

(2) The information is—
   (a) the attending medical practitioner’s name; and
   (b) the person’s name; and
(c) the person's last known address; and

(d) the fact that the person died; and

(e) a description of how the attending medical practitioner complied with section 14(2); and

(f) which of the methods described in section 15(3)(a) was used; and

(g) a description of the administration of the medication; and

(h) whether any problem arose in the administration of the medication and, if so, how it was dealt with; and

(i) the place where the person died; and

(j) the date and time when the person died; and

(k) the name of the medical practitioner who was available to the person until the person died; and

(l) the names of any other health practitioners who were present when the person died.

(3) The registrar must send the report to the review committee.

18 Unused medication returned

(1) Subsection (2) or (3) applies if—

(a) a prescription is written under section 15(4)(a); and

(b) the medication is not dispensed before the person for whom the prescription was written dies.

(2) If the attending medical practitioner holds the prescription when the person dies, he or she must—

(a) destroy it; and

(b) complete a prescribed form recording the action taken to comply with paragraph (a); and

(c) send the completed form to the registrar.

(3) If the registrar holds the prescription when the person dies, he or she must—

(a) destroy it; and

(b) complete a prescribed form recording the action taken to comply with paragraph (a).

(4) Subsection (5) applies if—

(a) a prescription is written under section 15(4)(a); and

(b) the medication is dispensed but not used before the person for whom the prescription was written dies.

(5) The attending medical practitioner must—

(a) return the medication to the pharmacist who dispensed it; and
(b) complete a prescribed form recording the action taken to comply with paragraph (a); and
(c) send the completed form to the registrar.

Part 3
Accountability

19 SCENZ Group

(1) The Director-General must establish the SCENZ Group by appointing to it the number of medical practitioners that the Director-General considers appropriate.

(2) The functions of the SCENZ Group are—

(a) to make and maintain a list of medical practitioners who are willing to act for the purposes of this Act as—
   (i) replacement medical practitioners:
   (ii) independent medical practitioners:

(b) to provide a name and contact details from the list, when this Act requires the use of a replacement medical practitioner or independent medical practitioner, in such a way as to ensure that the attending medical practitioner does not choose the replacement medical practitioner or independent medical practitioner:

(c) to make and maintain a list of health practitioners who are willing to act for the purposes of this Act as specialists:

(d) to provide a name and contact details from the list, when this Act requires the use of a specialist, in such a way as to ensure that neither the attending medical practitioner nor the independent medical practitioner chooses the specialist:

(e) to make and maintain a list of pharmacists who are willing to dispense medication for the purposes of section 16:

(f) to provide a name and contact details from the list when section 16 is to be applied:

(g) in relation to the administration of medication under section 16,—
   (i) to prepare standards of care; and
   (ii) to advise on the required medical and legal procedures; and
   (iii) to provide practical assistance, if assistance is requested.

(3) The ministry must service the SCENZ Group.

20 Review committee

(1) The minister must appoint an end of life review committee consisting of—
(a) a medical ethicist; and
(b) a medical practitioner who practises in the area of end of life care; and
(c) another medical practitioner.

(2) The review committee has the following functions:

(a) to consider reports sent to it under section 17(3); and
(b) to report to the registrar about its satisfaction or otherwise with the cases reported; and
(c) to recommend actions that the registrar may take to follow up cases with which the review committee was not satisfied.

21 Registrar (assisted dying)

(1) The Director-General must nominate an employee of the ministry as the registrar (assisted dying).

(2) The registrar must establish and maintain a register recording the following:

(a) prescribed forms held by the registrar; and
(b) the review committee’s reports to the registrar; and
(c) the registrar’s reports to the minister.

(3) The registrar must consult the Privacy Commissioner—

(a) before establishing the register; and
(b) at regular intervals while maintaining the register.

(4) The registrar must establish and maintain a procedure to deal with complaints about breaches of this Act.

(5) The registrar must report to the minister by the end of 30 June each year on the following matters for the year:

(a) the total number of deaths occurring under section 16:
(b) the total broken down into deaths occurring through each of the methods described in section 15(3)(a):
(c) the number of complaints received about breaches of this Act:
(d) how the complaints were dealt with:
(e) any other matter relating to the operation of this Act that the registrar thinks appropriate.

(6) The registrar must perform any other functions that this Act requires the registrar to perform.

22 Review of operation of Act

(1) Three years after the commencement of this Act, the ministry must start a review of the operation of this Act and must complete it within 6 months of starting it.
(2) Every 5 years after the date of the last review, the ministry must start another review of the Act and must complete it within 6 months of starting it.

(3) Every review must consider whether any amendments to this Act are necessary or desirable.

(4) Every review must be the subject of a report to the minister.

(5) The minister must present every report to the House of Representatives as soon as practicable after receiving it.

**Part 4**

**Related matters**

**23 Regulations prescribing forms**

The Governor-General may, by Order in Council, make regulations prescribing forms for the purposes of this Act.

**24 Other rights and duties not affected**

(1) Nothing in this Act affects a person's rights to—

(a) refuse to receive nutrition:

(b) refuse to receive hydration:

(c) refuse to receive life-sustaining medical treatment.

(2) Nothing in this Act affects a medical practitioner's duty to alleviate suffering in accordance with standard medical practice.

**25 Effect of death under this Act**

A person who dies as a result of the provision of assisted dying is taken for all purposes to have died as if assisted dying had not been provided.

**26 Immunity in civil or criminal proceedings**

A person is immune from liability in civil or criminal proceedings for acts or omissions in good faith and without negligence in providing or intending to provide assisted dying.

**27 Offences**

(1) A person commits an offence who—

(a) wilfully fails to comply with a requirement in this Act; or

(b) completes or partially completes a prescribed form for a person without the person's consent; or

(c) alters or destroys a completed or partially completed prescribed form without the consent of the person who completed or partially completed it.

(2) The person is liable on conviction to either of both of—
(a) a term of imprisonment not exceeding 3 months:
(b) a fine not exceeding $10,000.

28 Amendments to Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995

(1) This section amends the Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995.

(2) Replace regulation 7(1)(a)(xiii) with:

(xiii) the cause or causes of the person’s death, subject to subparagraph (xiiiia):

(xiiiia) in respect of a person who died as a result of the provision of assisted dying under the End of Life Choice Act 2017, the cause or causes of death as if assisted dying had not been provided:

(xiiiib) in respect of a person who died as a result of the provision of assisted dying under the End of Life Choice Act 2017, the fact that the person died as a result of the provision of assisted dying under the End of Life Choice Act 2017:

(xiiiic) the interval between onset of the cause of death and death, in respect of each cause of death, subject to subparagraph (xiiiid):

(xiiiid) in respect of a person who died as a result of the provision of assisted dying under the End of Life Choice Act 2017, the interval between onset of the cause of death and death by assisted dying, in respect of each cause of death: