TO: Maine Legislature, Joint Committee on Health and Human Services
FROM: Margaret Dore, Esq., MBA, President
Choice is an Illusion, a nonprofit corporation
RE: Death with Dignity Act, LD 1313, H.P. 948
Say "No" to Assisted Suicide and Euthanasia
MEETING: Wednesday, April 10, 2019, 9:00 AM
Cross Building, Room 209
MEMO
DATE: April 8, 2019

INDEX

I. INTRODUCTION ............................................. 1

II. DEFINITIONS. ........................................... 1

A. Physician-Assisted Suicide, Assisted Suicide
   and Euthanasia ........................................ 1

B. Withholding or Withdrawing Treatment ............... 2

III. ASSISTING PERSONS CAN HAVE AN AGENDA .......... 2

IV. PUSHBACK AGAINST ASSISTED SUICIDE AND EUTHANASIA ... 3

V. HOW THE BILL WORKS .................................... 4

VI. THE BILL WILL APPLY TO PEOPLE WITH YEARS OR DECADES
    TO LIVE .................................................. 4

   A. If Maine Follows Oregon Practice, the Bill
      Will Apply to Young Adults with Chronic
      Conditions Such as Diabetes ...................... 4

   B. Predictions of Life Expectancy Can Be Wrong .... 5

   C. Treatment Can Lead to Recovery .................. 6
VII. THE BILL WILL CREATE A PERFECT CRIME

A. The Definition of “Self-Administer” Does Not Require the Patient to Know or Understand That He or She Is Taking a Lethal Dose

B. The Cause of Death Will Be a Terminal Illness

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

IX. “EVEN IF THE PATIENT STRUGGLED, WHO WOULD KNOW?”

X. EUTHANASIA IS ALLOWED OR WILL NONETHELESS OCCUR

XI. PARTICIPANTS WILL BE TRAUMATIZED

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

B. My Clients Suffered Trauma in Oregon and Washington State

XII. OREGON

A. Oregon’s Data Collection Protocol for its Annual Reports Does Not Record Patient Identities in Any Manner; Source Documentation Is Destroyed

B. If Maine Follows Oregon’s Interpretation of “Not a Public Record,” the Department of Health & Human Services Will Be Insulated from Review

C. If Maine Enacts the Proposed Bill and Follows Oregon Practice, Assisted Suicide/Euthanasia Advocate, Compassion & Choices, Will Effectively Displace the Department of Health and Human Services as the Entity Overseeing the Bill

XIII. CONCLUSION

APPENDIX
I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.\(^1\) Our law is based on a similar law in Oregon. In the fine print, both laws allow euthanasia. Both laws are similar to the proposed bill (H.B. 948, LD 1313).\(^2\)

The proposed bill seeks to legalize physician-assisted suicide and euthanasia as those terms are traditionally defined. If enacted, the bill will apply to people with years or decades to live. Individuals with money, meaning the middle class and above, will be especially at risk. I urge you to reject the proposed bill.

II. DEFINITIONS

A. Physician-Assisted Suicide, Assisted Suicide and Euthanasia

The American Medical Association (AMA) defines physician-assisted suicide as occurring 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."\(^3\) For example:

[T]he physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.\(^4\)

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\(^1\) See my CV attached hereto in the Appendix, at pp. A-1 through A-4.

\(^2\) The proposed bill is attached hereto at pp. A-5 to A-15 & A-34 to A-36.

\(^3\) The AMA Code of Medical Ethics, Opinion 5.7, Appendix, page A-16.

\(^4\) Id.
Assisted suicide is a general term in which an assisting person is not necessarily a physician. Euthanasia is the administration of a lethal agent “by another person.”

B. Withholding or Withdrawing Treatment

Withholding or withdrawing treatment ("pulling the plug") is not euthanasia if the purpose is to remove burdensome treatment, as opposed to an intent to kill the patient. More importantly, the individual will not necessarily die. Consider this quote from Washington State regarding a man removed from a ventilator:

[I]nstead of dying as expected, [he] slowly began to get better.\(^6\)

III. ASSISTING PERSONS CAN HAVE AN AGENDA

Persons assisting a suicide or euthanasia can have an agenda. Consider 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.\(^7\) Consider also Graham Morant, recently convicted of counseling his wife to kill herself in Australia, to get the life insurance. The Court found:

[Y]ou counseled and aided your wife to kill herself because you wanted . . . the 1.4

\(^5\) The AMA Code of Medical Ethics, Opinion 5.8, Appendix, page A-17.

\(^6\) 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?," Seattle Weekly, 01/13/09; Appendix, pp. A-18 to A-20, quote at A-20.

\(^7\) KTVZ.com, "Sawyer Arraigned on State Fraud Charges," Appendix page 21.
million.\(^8\)

Medical professionals too can have an agenda. Michael Swango, MD, now incarcerated, got a thrill from killing his patients.\(^9\) Consider also Harold Shipman, a doctor in the UK, who not only killed his patients, but stole from them and in one case made himself a beneficiary of the patient’s will.\(^10\)

**IV. PUSHBACK AGAINST ASSISTED SUICIDE AND EUTHANASIA**

In 2016, the New Mexico Supreme Court overturned a lower court decision recognizing a right to “physician aid in dying,” meaning physician-assisted suicide.\(^11\) Physician-assisted suicide is no longer legal in New Mexico. In the last eight years, seven other states have strengthened their laws against assisted suicide and/or euthanasia. They are: Alabama, Arizona, Louisiana, Georgia, Idaho, Ohio, and Utah.\(^12\)

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V. HOW THE BILL WORKS

The bill has an application process to obtain the lethal dose, including a lethal dose request form.\textsuperscript{13} Once the lethal dose is issued by the pharmacy, there is no oversight.\textsuperscript{14} No witness, not even a doctor, is required to be present at the death.\textsuperscript{15}

VI. THE BILL WILL APPLY TO PEOPLE WITH YEARS OR DECADES TO LIVE

The proposed bill applies to people with a "terminal disease," meaning those predicted to have less than six months to live.\textsuperscript{16} Such persons may, in fact, have years or decades to live. This is true for three reasons:

A. If Maine Follows Oregon Practice, the Bill Will Apply to Young Adults With Chronic Conditions Such as Diabetes

The bill states:

"Terminal disease" means an incurable and irreversible disease that has been medically
confirmed and will, within reasonable medical 
judgment, produce death within 6 months.\textsuperscript{17}

Oregon’s law has a nearly identical definition:

"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{18}

In Oregon, this nearly identical definition is interpreted to 
include chronic conditions such as insulin dependent diabetes.\textsuperscript{19}

Oregon doctor, William Toffler, explains:

5. In Oregon, people with chronic conditions 
are "terminal," if without their medications, 
they have less than six months to live. This 
is significant when you consider that a 
typical insulin-dependent 20 year-old will 
live less than a month without insulin.

6. 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. 
They can live happy, healthy and productive 
lives.\textsuperscript{20}

\textbf{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

\textsuperscript{17} Id.

\textsuperscript{18} Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-40.

\textsuperscript{19} See Except from Oregon Annual Report attached hereto at A-37 (listing 
"diabetes" as a qualifying underlying illness).

\textsuperscript{20} Declaration of William Toffler, MD, 04/20/17, attached hereto at A-38 to 
because predicting life expectancy is not an exact science.\textsuperscript{21}

Consider John Norton, who was diagnosed with ALS (Lou Gehrig's disease) at age 18.\textsuperscript{22} He was told that he would get progressively worse (be paralyzed) and die in three to five years.\textsuperscript{23} Instead, the disease progression stopped on its own.\textsuperscript{24} In a 2012 affidavit, at age 74, he states:

\begin{quote}
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{25}
\end{quote}

\section*{C. Treatment Can Lead to Recovery}

Consider also Jeanette Hall, who was diagnosed with cancer in 2000 and made a settled decision to use Oregon's law.\textsuperscript{26} Her doctor convinced her to be treated instead.\textsuperscript{27} In a 2018 declaration, she states:

\begin{quote}
It has now been 18 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.\textsuperscript{28}
\end{quote}


\textsuperscript{22} Affidavit of John Norton, attached hereto at A-44 to A-46.

\textsuperscript{23} Id., ¶ 1.

\textsuperscript{24} Id., ¶ 4.

\textsuperscript{25} Id., ¶ 5.

\textsuperscript{26} Affidavit of Kenneth Stevens, MD, attached at A-47 to A-49; Jeanette Hall discussed at A-47 to A-48; Hall declaration attached at A-50.

\textsuperscript{27} Id.

\textsuperscript{28} Declaration of Jeanette Hall, ¶ 4, at A-50.
VII. THE BILL WILL CREATE A PERFECT CRIME

A. The Definition of "Self-Administer" Does Not Require the Qualified Patient to Know or Understand That He or She Is Taking a Lethal Dose

The bill states:

"Self-administer" means, for a qualified patient, to voluntarily ingest medication to end the qualified patient's life in a humane and dignified manner. 29

With this definition, the qualified individual is not required to know or understand that the medication being taken is a lethal dose.

B. The Cause of Death Will Be a Terminal Illness

The bill states:

A patient's death certificate, pursuant to section 2842 [Registration of deaths], must list the underlying terminal disease as the cause of death. (Emphasis added). 30

The significance of requiring a terminal disease to be listed as the cause of death on the death certificate is that it will create a legal inability to prosecute. Even if the qualified patient thought that he or she was taking a cold medication instead of the lethal dose, the official legal cause of death will be a terminal disease (not murder) as a matter of law.

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29 The bill, § 2140.2.L., attached in the Appendix at page A-6.
30 Id., § 2140.20, attached in the Appendix at page A-12.
VIII. DR. SHIPMAN AND THE CALL FOR DEATH CERTIFICATE REFORM

Per 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.”\(^{31}\) The inquiry also found:

that by issuing death certificates stating natural causes, the serial killer [Shipman] was able to evade investigation by coroners.\(^{32}\)

Per a subsequent article in 2015, proposed reforms included having a medical examiner review death certificates, so as to improve patient safety.\(^{33}\) 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.

IX. “EVEN IF THE PATIENT STRUGGLED, WHO WOULD KNOW?”

The bill has no required oversight over administration of the lethal dose.\(^{34}\) In addition, the drugs used are water and alcohol soluble, such that they can be injected into a sleeping

\(^{31}\) David Batty, supra, attached in the Appendix at page A-27.

\(^{32}\) Id., at Appendix, page A-29, second full paragraph (“The third report found that by issuing death certificates stating natural causes, the serial killer was able to evade investigation by coroners”).


\(^{34}\) See the bill in its entirety, attached in the Appendix at pp. A-15 and pp. A-34 to A-36.
or restrained person without consent. Alex Schadenberg, Executive Director for the Euthanasia Prevention Coalition, puts it this way:

With assisted suicide laws in Washington and Oregon [and with the proposed bill], perpetrators can . . . take a “legal” route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. Even if a patient struggled, “who would know?” (Emphasis added).  

X. EUTHANASIA WILL BE ALLOWED OR NONETHELESS OCCUR

The bill refers to the lethal dose as “medication,” which may be self-administered. The bill does not say that the lethal dose “must” be self-administered. Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer medication to a patient.

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35 The drugs used include Secobarbital, Pentobarbital and Phenobarbital, which are water and/or alcohol soluble. See excerpts from Oregon and Washington annual reports, attached hereto at A-53 & A-54 (listing these drugs and other drugs). See also 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


37 The bill states:

"Qualified patient" means a competent adult who is a resident of this State and who has satisfied the requirements of this Act in order to obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life ..... (Emphasis added).

The bill, § 2140.2.K, attached hereto at A-6.

38 Oregon doctor, Kenneth Stevens, MD, testifies:

Generally accepted medical practice allows a doctor,
With the medication a lethal dose, the bill allows euthanasia as traditionally defined.

The bill, however, also says that state reports must refer to acts committed under the bill as "self-administering life-ending medication." 39

If for the purpose of argument, another person administering the lethal dose is not allowed, it will nonetheless occur due to the bill’s complete lack of oversight at the death and motives such as life insurance and inheritance money. Consider also the quote below from an article in the New England Journal of Medicine, regarding a study of assisted suicide versus euthanasia. Problems were experienced more frequently with assisted suicide, which led to euthanasia:

The physician decided to administer a lethal medication in 21 of the cases of assisted suicide (18 percent), which thus became cases of euthanasia. The reasons for this decision included problems with completion (in 12 cases) and the inability of the patient to take all the medications (in 5). 40

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 ... adult children who act under the direction of a doctor to administer drugs to their parents in a home setting. (Spacing changed).

Stevens’ Declaration, ¶ 10, attached in the Appendix at A-49.

39  The bill, § 2140.20, attached hereto at A-12.

XI. PARTICIPANTS WILL BE TRAUMATIZED

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. 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. 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.

B. My Clients Suffered Trauma in Oregon and Washington State

In Oregon and Washington State, I have had two cases where my clients and their family member patients suffered severe emotional 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


42 Id.

43 Id.
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.

**XII. OREGON**

**A. Oregon’s Data Collection Protocol for its Annual Reports Does Not Record Patient Identities in Any Manner; Source Documentation Is Destroyed**

Oregon’s website describes the data collection protocol for its annual reports, as follows:

The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication
of the Annual Report, all source documentation is destroyed. (Emphasis added).  

Alicia Parkman, Mortality Research Analyst for the Oregon Health Authority [similar to Maine’s Department of Health and Human Services], makes a similar representation as follows:

To ensure confidentiality, our office does not maintain source information on participants. (Emphasis added).

The significance is that Oregon’s annual reports are unverifiable. With this being the case, should Maine now enact a similar law based on the Oregon experience as presented by its unverifiable reports? Given that the instant bill involves life and death, the answer would seem to be an obvious “No.”

B. If Maine Follows Oregon’s Interpretation of “Not a Public Record,” the Department of Health & Human Services Will Be Insulated from Review

The bill charges the Department of Health and Human Services with issuing its own annual report. The bill also

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45 E-mail from Alicia Parkman to Margaret Dore, 01/04/12, attached hereto at A-57 to A-58.

46 The bill, § 2140.17 states:

The department shall: ...

D. Generate and make available to the public an annual statistical report of information collected under paragraph C and submit a copy of the report to the joint standing committee of the Legislature having jurisdiction over health matters annually by March 1st. (Emphasis added).
states:

Except as otherwise provided by law, the information collected is confidential, is not a public record and may not be made available for inspection by the public ... (Emphasis added). 47

Oregon’s law has a similar provision, as follows:

Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public. (Emphasis added). 48

In Oregon, this similar provision is interpreted to bar release of information about individual cases, to everyone, including the media, researchers, students, advocates and law enforcement. Oregon’s website states:

[T]he Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority [which oversees Oregon’s Department of Health] from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.... (Emphasis added). 49

Consider also this e-mail from Alicia Parkman, Mortality

Attached hereto in the Appendix at A-11

47 The bill, § 2140.17.C (last sentence), attached in the Appendix at A-11.

48 ORS 127.865 s.3.11(2), attached in the Appendix at A-55.

49 “Release of Information Regarding the Death with Dignity Act, Oregon Health Authority website, printed April 7, 2019, copy attached hereto at A-56.
Research Analyst for the Oregon Health Authority, which states:

We have been contacted by law enforcement . . . in the past, but have not provided identifying information of any type. (Emphasis added).\textsuperscript{50}

If Maine enacts the proposed bill and follows Oregon’s interpretation of “not a public record,” there will be a similar lack of transparency in which even law enforcement will have no access to information about individual cases. How can the bill be considered safe?

C. If Maine Enacts the Proposed Bill and Follows Oregon Practice, Assisted Suicide/Euthanasia Advocate, Compassion & Choices, Will Effectively Displace the Department of Health and Human Services as the Entity Overseeing the Bill

In 2010, I had client who wanted to know if his father had died under Oregon’s law. I referred him to Oregon attorney Isaac Jackson, who asked the police to investigate. Jackson’s subsequent declaration states:

3. In 2010, I was retained by a client whose father had apparently died under Oregon’s law. The client wanted to know whether that was true. I therefore made inquiry on his behalf. However and unlike other deaths I have investigated, it was difficult to get information . . .

6. I . . . received a copy of the decedent’s death certificate, which is the official death record in Oregon. A true and correct,

\textsuperscript{50} E-mail from Alicia Parkman to me, 01/04/12, attached hereto at A-57.
but redacted copy, is attached hereto . . . .
The “immediate cause of death” is listed as
“cancer.” The “manner of death” is listed as
“Natural.”

7. **Per my request, a police officer was assigned to the case.** Per the officer’s confidential report, he did not interview my client, but he did interview people who had witnessed the decedent’s death.

8. **The officer’s report describes how he determined that the [father’s] death was under Oregon’s assisted suicide law due to records other than from the State of Oregon.** The officer’s report also describes that he was unable to get this information from the Oregon Health Authority, which was not willing to confirm or deny whether the deceased had used the act . . . . (Emphasis added).

I also read the officer’s report. According to the report, Compassion & Choices provided the records necessary for the officer to determine that the decedent had, in fact, died under Oregon’s law. In Oregon, Compassion & Choices, a non-governmental entity, has effectively displaced the Oregon Health Authority as the agency overseeing Oregon’s law.

**XIII. CONCLUSION**

If enacted, the bill will apply to people with years or decades to live. This will be especially true if Maine follows Oregon practice to determine life expectancies without treatment. Young adults with chronic conditions, such as insulin dependent diabetes, will be considered terminal and therefore subject to

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51 Isaac Jackson, Declaration of Testimony, 09/18/12, at A-60 to A-65.
assisted suicide/euthanasia.

Assisting persons, including doctors and family members, can have an agenda, with the more obvious reasons being inheritance and life insurance, but also, as in the case of Dr. Swango, the thrill of seeing someone die. The lack of required oversight at the death, coupled with the mandatory falsification of the death certificate will provide cover for murder. Families and individuals will be traumatized.

Don’t make Oregon and Washington’s mistake. I urge you to reject the proposed bill (H.P. 948, LD 1313).

Respectfully submitted this 8th day of April 2019

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Appendix

Reject

Maine Death with Dignity Act

H.P. 948 & LD 1313

April 8, 2019
CURRICULUM VITAE

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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.

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- 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


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 and J. Mark Weiss, "Lawrence and Nunn Reject the 'Friendly Parent' Concept", Domestic Violence Report, Vol. 6, No. 6, August/September 2001;


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.683, 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).

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

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An Act To Enact the Maine Death with Dignity Act

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA c. 418 is enacted to read:

CHAPTER 418
PATIENT-DIRECTED CARE

§ 2140. Patient-directed care at the end of life

1. Short title. This chapter may be known and cited as "the Maine Death with Dignity Act."

2. Definitions. As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

A. "Adult" means a person who is 18 years of age or older.

B. "Attending physician" means the physician who has primary responsibility for the care of a patient and the treatment of that patient's terminal disease.

C. "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

D. "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's disease.

E. "Counseling" means one or more consultations between a state-licensed psychiatrist, state-licensed psychologist, state-licensed clinical social worker or state-licensed clinical professional counselor and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

F. "Health care provider" means:

(1) A person licensed, certified or otherwise authorized or permitted by law to administer health care services or dispense medication in the ordinary course of business or practice of a profession; or

(2) A health care facility.
G. "Informed decision" means a decision by a qualified patient to request and obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner that is based on an appreciation of the relevant facts and that is made after being fully informed by the attending physician of:

(1) The qualified patient's medical diagnosis;

(2) The qualified patient's prognosis;

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

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

(5) The feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options.

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

I. "Patient" means an adult who is under the care of a physician.

J. "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this State.

K. "Qualified patient" means a competent adult who is a resident of this State and who has satisfied the requirements of this Act in order to obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner.

L. "Self-administer" means, for a qualified patient, to voluntarily ingest medication to end the qualified patient's life in a humane and dignified manner.

M. "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within 6 months.

3. Right to information. A patient has a right to information regarding all treatment options reasonably available for the care of the patient, including, but not limited to, information in response to specific questions about the foreseeable risks and benefits of medication, without a physician's withholding requested information regardless of the purpose of the questions or the nature of the information.

4. Written request for medication. An adult who is competent, is a resident of this State, has been determined by an attending physician and a consulting physician to be suffering from a terminal disease and has voluntarily expressed the wish to die may make a written request for medication that the adult may self-administer in accordance with this Act. An adult does not qualify under this Act solely because of age or disability.
5. Form of written request. A valid request for medication under this Act must be substantially in the form described in subsection 24, signed and dated by the patient and witnessed by at least 2 individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, is acting voluntarily and is not being coerced to sign the request.

A. The language of a written request for medication under this Act must be the language in which any conversations or consultations or interpreted conversations or consultations between a patient and the patient’s attending physician or consulting physician are held.

B. Notwithstanding paragraph A, the language of a written request for medication under this Act may be English when the conversations or consultations or interpreted conversations or consultations between a patient and the patient’s attending physician or consulting physician were conducted in a language other than English if the form described in subsection 24 contains the attachment described in subsection 25.

C. At least one of the 2 or more witnesses required under this subsection and any interpreter required under this subsection must be a person who is not:

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

   (2) 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 any law; or

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

D. The patient’s attending physician at the time the written request is signed may not be a witness.

E. If the patient is a patient in a long-term care facility at the time the patient makes the written request, one of the witnesses must be an individual designated by the facility who has the qualifications specified by the department by rule.

6. Attending physician responsibilities. The attending physician shall:

A. Make the initial determination of whether a patient has a terminal disease, is competent and has made the written request under subsection 4 voluntarily;

B. Request that the patient demonstrate state residency as required by subsection 15;

C. To ensure that the patient is making an informed decision, inform the patient of:

   (1) The patient’s medical diagnosis;

   (2) The patient’s prognosis;
(3) The potential risks associated with taking the medication to be prescribed;
(4) The probable result of taking the medication to be prescribed; and
(5) The feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options;

D. Refer the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is competent and acting voluntarily;

E. Confirm that the patient's request does not arise from coercion or undue influence by another individual by discussing with the patient, outside the presence of any other individual, except for an interpreter, whether the patient is feeling coerced or unduly influenced;

F. Refer the patient for counseling, if appropriate, as described in subsection 8;

G. Recommend that the patient notify the patient's next of kin;

H. Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this Act, and counsel the patient about not taking the medication prescribed under this Act in a public place;

I. Inform the patient that the patient has an opportunity to rescind the request at any time and in any manner and offer the patient an opportunity to rescind the request at the end of the 15-day waiting period pursuant to subsection 11;

J. Verify, immediately before writing the prescription for medication under this Act, that the patient is making an informed decision;

K. Fulfill the medical record documentation requirements of subsection 14;

L. Ensure that all appropriate steps are carried out in accordance with this Act before writing a prescription for medication to enable a qualified patient to end the qualified patient's life in a humane and dignified manner; and

M. Dispense medications directly, including ancillary medications intended to minimize the patient's discomfort, if the attending physician is authorized under state law or rule to dispense medications and has a current drug enforcement administration certificate or with the patient's written consent:

(1) Contact a pharmacist and inform the pharmacist of the prescription; and

(2) Deliver the written prescription personally, by mail or electronically to the pharmacist, who may dispense the medications in person to the patient, the attending physician or an expressly identified agent of the patient.

7. Consulting physician confirmation. Before a patient is determined to be a qualified patient under this Act, a consulting physician shall examine the patient and the patient's
relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease and verify that the patient is competent, is acting voluntarily and has made an informed decision.

8. **Consulting referral.** If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, the physician shall refer the patient for counseling. Medication to end a patient's life in a humane and dignified manner may not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

9. **Informed decision.** A qualified patient may not receive a prescription for medication under this Act unless the qualified patient has made an informed decision. Immediately before writing a prescription for medication under this Act, the attending physician shall verify that the qualified patient is making an informed decision.

10. **Notification of next of kin.** A patient who declines or is unable to notify the patient's next of kin may not have the patient's request for medication denied for that reason.

11. **Written and oral requests.** To receive a prescription for medication that the qualified patient may self-administer under this Act, a qualified patient must make an oral request and a written request and reiterate the oral request to the qualified patient's attending physician at least 15 days after making the initial oral request. At the time the qualified patient makes the qualified patient's 2nd oral request, the attending physician shall offer the qualified patient an opportunity to rescind the request.

12. **Right to rescind request.** A patient may rescind the patient's request at any time and in any manner without regard to the patient's mental state. A prescription for medication may not be written under this Act without the attending physician's offering the qualified patient an opportunity to rescind the request.

13. **Waiting periods.** At least 15 days must elapse between the patient's initial oral request and the date the patient signs the written request under subsection 11. At least 48 hours must elapse between the date the patient signs the written request and the writing of a prescription under this Act.

14. **Medical record documentation requirements.** The following must be documented or filed in a patient's medical record:

   A. All oral requests by the patient for medication to end that patient's life in a humane and dignified manner;

   B. All written requests by the patient for medication to end that patient's life in a humane and dignified manner;

   C. The attending physician's diagnosis and prognosis and the attending physician's determination that the patient is competent, is acting voluntarily and has made an informed decision;
D. The consulting physician's diagnosis and prognosis and the consulting physician's verification that the patient is competent, is acting voluntarily and has made an informed decision;

E. A report of the outcome and determinations made during counseling, if counseling is provided as described in subsection 8;

F. The attending physician's offer to the patient to rescind the patient's request at the time of the patient's 2nd oral request under subsection 11; and

G. A note by the attending physician indicating that all requirements under this Act have been met, including the requirements of subsection 6, and indicating the steps taken to carry out the patient's request, including a notation of the medication prescribed.

15. Residency requirement. For purposes of this Act, only requests made by residents of this State may be granted. The residence of a person is that place where the person has established a fixed and principal home to which the person, whenever temporarily absent, intends to return. The following factors may be offered in determining a person's residence under this Act and need not all be present in order to determine a person's residence:

A. Possession of a valid driver's license issued by the Department of the Secretary of State, Bureau of Motor Vehicles;

B. Registration to vote in this State;

C. Evidence that the person owns or leases property in this State;

D. The location of any dwelling currently occupied by the person;

E. The place where any motor vehicle owned by the person is registered;

F. The residence address, not a post office box, shown on a current income tax return;

G. The residence address, not a post office box, at which the person's mail is received;

H. The residence address, not a post office box, shown on any current resident hunting or fishing licenses held by the person;

I. The residence address, not a post office box, shown on any driver's license held by the person;

J. The receipt of any public benefit conditioned upon residency, defined substantially as provided in this subsection; or

K. Any other objective facts tending to indicate a person's place of residence.

16. Disposal of unused medications. A person who has custody of or control over any unused medications prescribed pursuant to this Act after the death of the qualified patient shall personally deliver the unused medications to the nearest facility qualified to dispose of controlled substances or, if such delivery is impracticable, personally dispose of the unused medications by any lawful means, in accordance with any guidelines adopted by the department.
17. Reporting of information; adoption of rules; information collected not a public record; annual statistical report. The department shall:

A. Annually review all records maintained under this Act;

B. Require any health care provider upon writing a prescription or dispensing medication under this Act to file a copy of the prescription or dispensing record, and other documentation required under subsection 14 associated with writing the prescription or dispensing the medication, with the department.

(1) Documentation required to be filed under this paragraph must be mailed or otherwise transmitted as allowed by rules of the department no later than 30 calendar days after the writing of the prescription or the dispensing of medication under this Act, except that all documents required to be filed with the department by the prescribing physician after the death of the qualified patient must be submitted no later than 30 calendar days after the date of the death of the qualified patient.

(2) In the event that a person required under this Act to report information to the department provides an inadequate or incomplete report, the department shall contact the person to request an adequate or complete report;

C. Within 6 months of the effective date of this Act, adopt rules, which are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A, to facilitate the collection of information regarding compliance with this Act. Except as otherwise provided by law, the information collected is confidential, is not a public record and may not be made available for inspection by the public; and

D. Generate and make available to the public an annual statistical report of information collected under paragraph C and submit a copy of the report to the joint standing committee of the Legislature having jurisdiction over health matters annually by March 1st.

18. Effect on construction of wills, contracts and other agreements. Any provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end the person's life in a humane and dignified manner, is not valid. Any obligation owing under any currently existing contract may not be conditioned upon or affected by the making or rescinding of a request by a person for medication to end the person's life in a humane and dignified manner.

19. Insurance or annuity policies. The sale, procurement or issuance of any life, health or accident insurance or annuity policy or the rate charged for any life, health or accident insurance or annuity policy may not be conditioned upon or affected by the making or rescinding of a request by a person for medication that the person may self-administer to end the person's life in a humane and dignified manner. A qualified patient's act of ingesting medication to end the qualified patient's life in a humane and dignified manner does not have an effect upon a life, health or accident insurance or annuity policy. A qualified patient whose life is insured under a life insurance policy issued under the provisions of Title 24-A, chapter 29 and the beneficiaries of the policy may not be
denied benefits on the basis of self-administration of medication by the qualified patient in accordance with this Act. The sale, procurement or issuance of any medical professional liability insurance policy issued under the provisions of Title 24-A and the rate charged by the insurer for the policy may not be conditioned upon or affected by the participation by the health care provider in the provision of medication to a qualified patient in accordance with this Act.

20. Authority of Act; references to acts committed under Act; applicable standard of care. This Act does not authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act do not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide under the law. State reports may not refer to acts committed under this Act as "suicide" or "assisted suicide." Consistent with the provisions of this Act, state reports must refer to acts committed under this Act as obtaining and self-administering life-ending medication. A patient's death certificate, pursuant to section 2842, must list the underlying terminal disease as the cause of death. Nothing contained in this Act may be interpreted to lower the applicable standard of care for the attending physician. The consulting physician, a psychiatrist or a psychologist or other health care provider providing services under this Act.

21. Basis for prohibiting persons or entities from participation; notification; penalties; permissible actions. The following provisions govern the basis for prohibiting persons or entities from participating in activities under this Act, notification, penalties and permissible actions.

A. Subject to compliance with paragraph B and notwithstanding any other law, a health care provider may prohibit its employees, independent contractors or other persons or entities, including other health care providers, from participating in activities under this Act while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

B. A health care provider that elects to prohibit its employees, independent contractors or other persons or entities, including other health care providers, from participating in activities under this Act, as described in paragraph A, shall first give notice of the policy prohibiting participation under this Act to those employees, independent contractors or other persons or entities, including other health care providers. A health care provider that fails to provide notice to those employees, independent contractors or other persons or entities, including other health care providers, in compliance with this paragraph may not enforce such a policy against those employees, independent contractors or other persons or entities, including other health care providers.

C. Subject to compliance with paragraph B, the prohibiting health care provider may take action, including, but not limited to, the following, as applicable, against an employee, independent contractor or other person or entity, including another health care provider, that violates this policy:

(1) Loss of privileges, loss of membership or other action authorized by the bylaws or rules and regulations of the medical staff;
(2) Suspension, loss of employment or other action authorized by the policies and practices of the prohibiting health care provider;

(3) Termination of any lease or other contract between the prohibiting health care provider and the employee, independent contractor or other person or entity, including another health care provider, that violates the policy; or

(4) Imposition of any other nonmonetary remedy provided for in any lease or contract between the prohibiting health care provider and the employee, independent contractor or other person or entity, including another health care provider, in violation of the policy.

D. Nothing in this section may be construed to prevent, or to allow a prohibiting health care provider to prohibit, an employee, independent contractor or other person or entity, including another health care provider, from any of the following:

(1) Participating, or entering into an agreement to participate, in activities under this Act while on premises that are not owned or under the management or direct control of the prohibiting health care provider or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the prohibiting health care provider; or

(2) Participating, or entering into an agreement to participate, in activities under this Act as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the prohibiting health care provider.

E. In taking actions pursuant to paragraph C, a health care provider shall comply with all procedures required by law, its own policies or procedures and any contract with the employee, independent contractor or other person or entity, including another health care provider, in violation of the policy, as applicable.

F. Any action taken by a prohibiting health care provider pursuant to this subsection is not reportable to the appropriate licensing board under Title 32, including, but not limited to, the Board of Licensure in Medicine and the Maine Board of Pharmacy. The fact that a health care provider participates in activities under this Act may not be the sole basis for a complaint or report by another health care provider to the appropriate licensing board under Title 32, including, but not limited to, the Board of Licensure in Medicine and the Maine Board of Pharmacy.

G. As used in this subsection, unless the context otherwise indicates, the following terms have the following meanings.

(1) "Notice" means a separate statement in writing advising of the prohibiting health care provider's policy with respect to participating in activities under this Act.

(2) "Participating, or entering into an agreement to participate, in activities under this Act" means doing or entering into an agreement to do any one or more of the following:
(a) Performing the duties of an attending physician as specified in this Act;

(b) Performing the duties of a consulting physician as specified in this Act;

(c) Performing the duties of a state-licensed psychiatrist, state-licensed psychologist, state-licensed clinical social worker or state-licensed clinical professional counselor, in the circumstance that a referral to one is made pursuant to subsection 8;

(d) Delivering the prescription for, dispensing or delivering the dispensed medication pursuant to this Act; or

(e) Being present when the qualified patient takes the medication prescribed pursuant to this Act.

"Participating, or entering into an agreement to participate, in activities under this Act" does not include doing, or entering into an agreement to do, any of the following: diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis or determining whether a patient has the capacity to make decisions; providing information to a patient about this Act; or providing a patient, upon the patient's request, with a referral to another health care provider for the purposes of participating in the activities authorized by this Act.

22. Willful alteration or forgery; coercion or undue influence; penalties; civil damages; other penalties not precluded. The following provisions govern criminal and other penalties for certain violations of this Act.

A. A person who, without authorization of the patient, willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing a patient's death commits a Class A crime.

B. A person who coerces or exerts undue influence on a patient to request medication to end the patient's life or to destroy a rescission of a request commits a Class A crime.

C. This Act does not limit liability for civil damages resulting from negligent conduct or intentional misconduct by a person.

D. The penalties in this Act do not preclude criminal penalties applicable under other law for conduct that is inconsistent with this Act.

23. Claims by governmental entity for costs incurred. Any governmental entity that incurs costs resulting from a person ending the person's life under this Act in a public place has a claim against the estate of the person to recover the costs and reasonable attorney's fees related to enforcing the claim.
24. **Form of the request.** A request for medication as authorized by this Act must be in substantially the following form:

25. **Form of interpreter attachment.** The form of an attachment for purposes of providing interpretive services as described in subsection 5, paragraph B must be in substantially the following form:

This bill enacts the Maine Death with Dignity Act authorizing a person who is 18 years of age or older, who meets certain qualifications and who has been determined by the person’s attending physician to be suffering from a terminal disease, as defined in the Act, to make a request for medication prescribed for the purpose of ending the person’s life. The bill establishes the procedures for making these requests, including 2 waiting periods and one written and 2 oral requests and requires a 2nd opinion by a consulting physician. The bill requires specified information to be documented in the person’s medical record, including all oral and written requests for a medication to hasten death.

The bill requires the attending and consulting physicians to assess the patient for depression or other mental health condition that impairs judgment. If the attending or consulting physician, in the physician’s professional opinion, believes such a condition exists, the patient must be evaluated and treated by a state-licensed psychiatrist, psychologist, clinical social worker or clinical professional counselor. Medication to end a patient’s life in a humane and dignified manner may not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

The bill prohibits a provision in a contract, will or other agreement from being conditioned upon, or affected by, a person’s making or rescinding a request for medication under the Act. The bill prohibits the sale, procurement or issuance of any life, health or accident insurance or annuity policy or the rate charged for any life, health or accident insurance or annuity policy from being conditioned upon or affected by the making or rescinding of such a request.

The bill authorizes a health care provider to prohibit its employees, independent contractors or other persons or entities, including other health care providers, from participating in activities under the Act while on premises owned by or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

The bill makes it a Class A crime to knowingly alter or forge a request for medication to end a person’s life without that person’s authorization or to conceal or destroy a withdrawal or rescission of a request for medication, if it is done with the intent or effect of causing the person’s death. The bill makes it a Class A crime to knowingly coerce or exert undue influence on a person to request medication for the purpose of ending that person’s life or to destroy a withdrawal or rescission of a request. The bill provides that the Act does not authorize ending a patient’s life by lethal injection, mercy killing or active euthanasia and provides that action taken in accordance with the Act does not constitute, among other things, suicide or homicide.
ETHICS

Physician-Assisted Suicide

Code of Medical Ethics Opinion 5.7

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*

Read more opinions about this topic

Code of Medical Ethics: Caring for Patients at the End of Life

Visit the Ethics main page to access additional Opinions, the Principles of Medical Ethics and more information about the Code of Medical Ethics.
ETHICS

Euthanasia

Code of Medical Ethics Opinion 5.8

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.

Instead of engaging in euthanasia, 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 a 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

Read more opinions about this topic
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.
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.”
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, 74, a dependent 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.

A federal judge twice gave permission for her to travel to Mexico, once in May and again last month.

A-21
SUPREME COURT OF QUEENSLAND

CITATION: R v Morant [2018] QSC 251

PARTIES: R
v
GRAHAM ROBERT MORANT
(defendant)

FILE NO/S: Indictment No 1424 of 2018
DIVISION: Trial Division
PROCEEDING: Trial
DELIVERED ON: 2 November 2018 (delivered ex tempore)
DELIVERED AT: Brisbane
HEARING DATE: 17 to 21 September 2018; 24 to 28 September 2018;
2 October 2018; 26 October 2018; 2 November 2018
JUDGE: Davis J

ORDER: Convictions recorded.
On count 1, the defendant is sentenced to 10 years imprisonment.

On count 2, the defendant is sentenced to 6 years imprisonment.

The sentences are to be served concurrently.

Pursuant to s 159A of the Penalties and Sentences Act 1992, it is declared that 32 days spent in pre-sentence custody between 2 October 2018 and 2 November 2018 be deemed time already served under the sentence

CATCHWORDS: CRIMINAL LAW – PARTICULAR OFFENCES – OFFENCES AGAINST THE PERSON – MISCELLANEOUS OFFENCES – OTHER MISCELLANEOUS OFFENCES AND MATTERS – where the defendant was charged with one count of counselling suicide and one count of aiding suicide pursuant to s 311 – where the defendant was convicted of both counts after trial – where no comparatives are available for the offence of counselling suicide

CRIMINAL LAW – SENTENCE – SENTENCING PROCEDURE – FACTUAL BASIS FOR SENTENCE – PARTICULAR CASES – where the Crown pressed for sentencing on the basis that the defendant counselled and aided his wife to commit suicide motivated by financial
the fact that you paid the premiums on the policies and inconsistent with your involvement with Mr Macallan and Mrs Morant in July 2014 and November 2014.

[73] I do not find that you counselled Mrs Morant to take out the first policy, that held with Guardian, which was established in 2010.

[74] It might be open to find that you counselled Mrs Morant to take out the other two policies, the later ones, thinking that there was a chance you could persuade her to suicide at some point more than 13 months later. There is support for such a conclusion in some of the statements made by Mrs Morant to the three ladies.

[75] Mr Lehane, though, did not press for such a finding. Instead, he submitted that I should find that the plan was hatched in early 2014 when Mrs Morant first told her sister that you were trying to convince her to kill herself and that you had made statements to her, Mrs Morant, related to the insurance policies. I find, having regard to section 132C(4) of the Evidence Act that you began counselling Mrs Moran to suicide in about February of 2014.

[76] It is unnecessary to make detailed findings as to Mrs Morant’s emotional state or her mental health. However, she had what appears to be a chronic back condition which was causing her immense pain. She was on medication for that pain and was taking medication for depression. She was freely discussing, with various people, the prospect of her ending her own life. She was obviously a vulnerable person.

[77] The note she left and the statement she made, which painted you in a good light and criticised others, are explained, in my view, by her state of mind. Here was a lady who suicided. The evidence of what she told the three ladies is, in my view, a more reliable account of what was actually occurring.

[78] Against that backdrop, I find that you said the things which Mrs Morant told the three ladies you said. Those conversations and other evidence that I have identified show that you had an acute awareness that upon Mrs Morant’s death, you would benefit from the payout of the insurance policies. I draw the inference that you were motivated by the money to counsel and to aid her to suicide. In other words, you counselled and aided your wife to kill herself because you wanted to get your hands on the 1.4 million. I make that finding on the balance of probabilities after having directed myself carefully to the provisions of section 132C(4) of the Evidence Act and taking all the evidence into account.

[79] I have, as yet, said little specifically about the aiding, which is count 2. As I have already observed, you initially denied any knowledge of the generator which Mrs Morant used to kill herself.

[80] Mrs Morant died in her car in a lonely place. The cause of death was carbon monoxide poisoning from the exhaust fumes of the petrol generator which was placed in the boot of the vehicle.

[81] The evidence shows that you attended with Mrs Morant upon a Bunnings Warehouse the day before she used the generator to kill herself. You stayed in the carpark while she entered the store and purchased the generator. You helped her place it in the boot of the car at Bunnings. After initially denying to police any knowledge of the
Prosecutors Say Doctor Killed To Feel a Thrill

By CHARLIE LEDUFF  SEPTEMBER 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."
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
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.

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4 ARTICLES REMAINING

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A-26
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.

Since you’re here...
... we have a small favour to ask. More people around the world are reading The Guardian’s independent, investigative journalism than ever before. We’ve now been funded by over one million readers. And unlike many news organisations, we have chosen an approach that allows us to keep our journalism open to all. We believe that each one of us deserves access to accurate information with integrity at its heart.

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Brewer signs bill targeting assisted suicide

Gov. Jan Brewer has signed the bill that aims to make it easier to prosecute people who help someone commit suicide.

Republican Rep. Justin Pierce of Mesa says his bill makes it easier for prosecutors to追究 people who assist in suicide by more precisely defining what it means to “assist.”

House Bill 2565 defines assisting in suicide as providing the physical means used to commit suicide such as a gun. The bill originally also defined assisted suicide as “offering” to help someone commit suicide, but a Senate amendment omitted that word.

The proposal was prompted by a difficult prosecution stemming from a 2007 assisted suicide case in Maricopa County.

Brewer signed the bill on Wednesday.

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LA. assisted-suicide ban strengthened

The Associated Press

Published: Tuesday, April 24, 2012 at 8:37 a.m.

Last Modified: Tuesday, April 24, 2012 at 8:37 a.m.

BATON ROUGE -- The House unanimously backed a proposal Monday to strengthen Louisiana's ban on euthanasia and assisted suicide.

House Bill 1086 by Rep. Alan Seabaugh, R-Shreveport, would spell out that someone authorized to approve medical procedures for another person may not approve any procedure that would be considered assisted suicide. That prohibition also would be extended to include surgical or medical treatment for the developmentally disabled or nursing home residents who may be unable to make their own medical decisions.

Louisiana already has a prohibition in criminal law against euthanasia and assisted suicide. But Seabaugh said he wanted to make sure it was clear in the state's medical consent law.
Homicide; offering to assist in commission of suicide; repeal certain provisions

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(5) Lindsey, Edward 54th
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Committees

HC: Judiciary Non-Civil
SC: Judiciary

First Reader Summary

A BILL to be entitled an Act to amend Article 1 of Chapter 5 of Title 16 of the O.C.G.A., relating to homicide, so as to repeal certain provisions regarding offering to assist in the commission of a suicide; to prohibit assisted suicide; to provide for definitions; to provide for criminal penalties; to provide for certain exceptions; to provide for reporting requirements with respect to being convicted of assisting in a suicide; to amend Title 51 of the O.C.G.A., relating to torts, so as to provide for civil liability for wrongful death caused by assisted suicide; to provide for definitions; to provide an effective date; to repeal conflicting laws; and for other purposes.

Status History

May/01/2012 - Effective Date
May/01/2012 - Act 639
May/01/2012 - House Date Signed by Governor
Apr/10/2012 - House Sent to Governor
Mar/29/2012 - Senate Agreed House Amend or Sub
Mar/29/2012 - House Agreed Senate Amend or Sub As Amended
Mar/27/2012 - Senate Passed/Adopted By Substitute
Mar/27/2012 - Senate Third Read
Mar/22/2012 - Senate Read Second Time
Mar/22/2012 - House Committee Favorably Reported By Substitute
Mar/07/2012 - Senate Read and Referred
Mar/07/2012 - House Immediately Transmitted to Senate
Mar/07/2012 - House Passed/Adopted By Substitute
Mar/07/2012 - House Third Readers
Feb/28/2012 - House Committee Favorably Reported By Substitute
Feb/23/2012 - House Second Readers
Feb/22/2012 - House First Readers
Feb/21/2012 - House Hopper

Footnotes

3/7/2012 Modified Structured Rule; 3/7/2012 Immediately transmitted to Senate; 3/29/2012 House agrees to the Senate Substitute as House amended; 3/29/2012 Senate agreed to House amendment to Senate substitute

Votes

Mar/29/2012 - Senate Vote #BBB Yea(38) Nay(11) NV(7) Exc(0)
Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

On April 5, 2011, Idaho Governor Butch Otter signed Senate Bill 1070 into law.[1] The bill explicitly provides that causing or aiding a suicide is a felony.[2]

Senate bill 1070 supplements existing Idaho law, which already imposed civil and criminal liability on doctors and others who cause or aid a suicide.[3] The bill's "Statement of Purpose" says: "This legislation will supplement existing common law and statutory law by confirming that it is illegal to cause or assist in the suicide of another."[4]

The bill was introduced in response to efforts by Compassion & Choices to legalize physician-assisted suicide in Idaho. The issue came to a head after that organization's legal director wrote articles claiming that the practice, which she called "aid in dying," was already legal in Idaho. Compassion & Choices was formerly known as the Hemlock Society.[5]

The legal director's articles included "Aid in Dying: Law, Geography and Standard of Care in Idaho," published in The Advocate, the official publication of the Idaho State Bar.[6] Responding letters to the editor stated that the article was a "gross misunderstanding of Idaho law" and that "[i]t also claims about what the law of Idaho actually is, published in The Advocate, cannot possibly benefit public debate on this issue."

These letters and other letters can be viewed here, here and here. A direct rebuttal to the article can be viewed here.

The vote to pass the new bill was overwhelming: the Senate vote was 31 to 2; the house vote was 61 to 8.[7] The new law will be codified as Idaho Code Ann., Section 18-4017 and go into effect on July 1, 2011.[8]

[3] Then existing civil law included Cramer v. Slater, 146 Idaho 868, 878, 204 P.3d 508 (2009), which states that doctors "can be held liable for [a] patient's suicide." Existing law also included a common law crime in which an "aider and abettor" of suicide is guilty of murder. Assisted suicide can also be statutorily charged as murder. See Margaret K. Dore, "Aid in Dying: Not Legal in Idaho; Not About Choice," The Advocate, official publication of the Idaho State Bar, Vol. 52, No. 9, pages 18-20, September 2010 (describing existing law prior to the new bill's enactment); and The Hon. Robert E. Bakes, Retired Chief Justice of the Idaho Supreme Court, Letter to the Editor, "Legislature rejected euthanasia," The Advocate, September 2010 ("in both the Idaho criminal statutes as well as I.C.6-1012, the Idaho legislature has rejected physician-assisted suicide"). Entire issue, available here: http://www.isb.idaho.gov/pdf/advocate/issues/adv10sep.pdf
a patient, upon the patient's request, with a referral to another health care provider
for the purposes of participating in the activities authorized by this Act.

22. Willful alteration or forgery; coercion or undue influence; penalties; civil
damages; other penalties not precluded. The following provisions govern criminal and
other penalties for certain violations of this Act.

A. A person who, without authorization of the patient, willfully alters or forges a
request for medication or conceals or destroys a rescission of that request with the
intent or effect of causing a patient's death commits a Class A crime.

B. A person who coerces or exerts undue influence on a patient to request
medication to end the patient's life or to destroy a rescission of a request commits a
Class A crime.

C. This Act does not limit liability for civil damages resulting from negligent
conduct or intentional misconduct by a person.

D. The penalties in this Act do not preclude criminal penalties applicable under other
law for conduct that is inconsistent with this Act.

23. Claims by governmental entity for costs incurred. Any governmental entity
that incurs costs resulting from a person ending the person's life under this Act in a public
place has a claim against the estate of the person to recover the costs and reasonable
attorney's fees related to enforcing the claim.

24. Form of the request. A request for medication as authorized by this Act must
be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND
DIGNIFIED MANNER

I, ........................................... am an adult of sound mind. I am suffering from
..........................................., which my attending physician has determined is a terminal
disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis and prognosis, the nature of medication to
be prescribed and potential associated risks, the expected result and feasible
alternatives, including palliative care and comfort care, hospice care, pain control and
disease-directed treatment options.

I request that my attending physician prescribe medication that I may self-administer
to end my life in a humane and dignified manner and contact any pharmacist to fill
the prescription.

INITIAL ONE:

........... I have informed my family of my decision and taken their opinions into
consideration.

........... I have decided not to inform my family of my decision.

........... I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.
I understand the full import of this request, and I expect to die when I take the medication to be prescribed. I further understand that, although most deaths occur within 3 hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: .............................................
Dated: .............................................

DECLARATION OF WITNESSES

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request:

Initials of Witness 1:

1. Is personally known to us or has provided proof of identity;
2. Signed this request in our presence on the date of the person's signature;
3. Appears to be of sound mind and not under duress, fraud or undue influence; and
4. Is not a patient for whom either of us is the attending physician.

Printed Name of Witness 1: .............................................
Signature of Witness 1/Date: .............................................

Initials of Witness 2:

1. Is personally known to us or has provided proof of identity;
2. Signed this request in our presence on the date of the person's signature;
3. Appears to be of sound mind and not under duress, fraud or undue influence; and
4. Is not a patient for whom either of us is the attending physician.

Printed Name of Witness 2: .............................................
Signature of Witness 2/Date: .............................................

NOTE: One witness must be a person who is not a relative by blood, marriage or adoption of the person signing this request, is not entitled to any portion of the person's estate upon death and does not own or operate or is not employed at a health care facility where the person is a patient or resident. The person's attending physician at the time the request is signed may not be a witness. If the person is an inpatient at a long-term care facility, one of the witnesses must be an individual designated by the facility.

25. Form of interpreter attachment. The form of an attachment for purposes of providing interpretive services as described in subsection 5, paragraph B must be in substantially the following form:
I am fluent in English and (language of patient).

On (date) at approximately (time) I read the "REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER" to (name of patient) in (language of patient).

Mr./Ms. (name of patient) affirmed to me that he/she understands the content of this form, that he/she desires to sign this form under his/her own power and volition and that he/she requested to sign the form after consultations with an attending physician and a consulting physician.

Under penalty of perjury, I declare that I am fluent in English and (language of patient) and that the contents of this form, to the best of my knowledge, are true and correct.

Executed at (name of city, county and state) on (date).

Interpreter's signature: ....................

Interpreter's printed name: ....................

Interpreter's address: ....................

SUMMARY

This bill enacts the Maine Death with Dignity Act authorizing a person who is 18 years of age or older, who meets certain qualifications and who has been determined by the person's attending physician to be suffering from a terminal disease, as defined in the Act, to make a request for medication prescribed for the purpose of ending the person's life. The bill establishes the procedures for making these requests, including 2 waiting periods and one written and 2 oral requests and requires a 2nd opinion by a consulting physician. The bill requires specified information to be documented in the person's medical record, including all oral and written requests for a medication to hasten death.

The bill requires the attending and consulting physicians to assess the patient for depression or other mental health condition that impairs judgment. If the attending or consulting physician, in the physician's professional opinion, believes such a condition exists, the patient must be evaluated and treated by a state-licensed psychiatrist, psychologist, clinical social worker or clinical professional counselor. Medication to end a patient's life in a humane and dignified manner may not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

The bill prohibits a provision in a contract, will or other agreement from being conditioned upon, or affected by, a person's making or rescinding a request for medication under the Act. The bill prohibits the sale, procurement or issuance of any life, health or accident insurance or annuity policy or the rate charged for any life, health or accident insurance or annuity policy from being conditioned upon or affected by the making or rescinding of such a request.

The bill authorizes a health care provider to prohibit its employees, independent contractors or other persons or entities, including other health care providers, from
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<th>1998–2016 (N=1,132)</th>
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<td>Coastal counties (%)</td>
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<td><strong>Insurance</strong></td>
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<td>Private (%)</td>
<td>36 (31.3)</td>
<td>569 (53.8)</td>
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<td>Medicare, Medicaid or other governmental (%)</td>
<td>78 (67.8)</td>
<td>474 (44.8)</td>
<td>552 (47.1)</td>
</tr>
<tr>
<td>None (%)</td>
<td>1 (0.9)</td>
<td>14 (1.3)</td>
<td>15 (1.3)</td>
</tr>
<tr>
<td>Unknown</td>
<td>28</td>
<td>75</td>
<td>103</td>
</tr>
<tr>
<td><strong>Underlying illness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer (%)</td>
<td>110 (76.9)</td>
<td>883 (78.0)</td>
<td>993 (77.9)</td>
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<tr>
<td>Lung and bronchus (%)</td>
<td>23 (16.1)</td>
<td>193 (17.0)</td>
<td>216 (16.9)</td>
</tr>
<tr>
<td>Breast (%)</td>
<td>6 (4.2)</td>
<td>86 (7.6)</td>
<td>92 (7.2)</td>
</tr>
<tr>
<td>Colon (%)</td>
<td>6 (4.2)</td>
<td>73 (6.4)</td>
<td>79 (6.2)</td>
</tr>
<tr>
<td>Pancreas (%)</td>
<td>15 (10.5)</td>
<td>74 (6.5)</td>
<td>89 (7.0)</td>
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<tr>
<td>Prostate (%)</td>
<td>10 (7.0)</td>
<td>48 (4.2)</td>
<td>58 (4.5)</td>
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<tr>
<td>Ovary (%)</td>
<td>4 (2.8)</td>
<td>41 (3.6)</td>
<td>45 (3.5)</td>
</tr>
<tr>
<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 (%)</td>
<td>1 (0.7)</td>
<td>8 (0.7)</td>
<td>9 (0.7)</td>
</tr>
</tbody>
</table>
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 South Dakota.

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.

Exhibit A, attached hereto.

3. In practice, this definition is interpreted to include people with chronic conditions such as "chronic lower respiratory disease" and "diabetes mellitus," better known as "diabetes."

4. Attached hereto, as Exhibits B-1 & B-2, are excerpts from Declaration of William Toffler, MD - page 1
the most recent government statistical report regarding our law. The excerpts list chronic lower respiratory disease and diabetes mellitus as "underlying illnesses" sufficient to justify assisted suicide. The full report can be read at this link:

5. In Oregon, people with chronic conditions are "terminal," if without their medications, they have less than six months to live. This is significant when you consider that a typical insulin-dependent 20 year-old will live less than a month without insulin.

6. 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. They can live happy, healthy and productive lives.

Signed under penalty of perjury, this 20th day of April 2017

William L. Toffer MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
Oregon Revised Statute

Chapter 127

Note: The division headings, subdivision headings and lead lines for 127.800 to 127.897, 127.985 and 127.987 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

Please browse this page or download the statute for printing - (or read the statute at https://www.oregonlegislature.gov). If you are looking for data, you can find it on our Annual Report page.

127.800 s.1.01. Definitions.

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

1. "Adult" means an individual who is 18 years of age or older.

2. "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

3. "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

4. "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

5. "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

6. "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

7. "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

   (a) 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.1.01; 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.

TOFFLER EXHIBIT A

A-40
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2016 (N=133)</th>
<th>1998–2015 (N=994)</th>
<th>Total (N=1,127)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(          )</td>
<td>(          )</td>
<td>(          )</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro counties (Clackamas, Multnomah, Washington) (%)</td>
<td>54 (40.9)</td>
<td>427 (43.3)</td>
<td>481 (43.0)</td>
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<tr>
<td>Coastal counties (%)</td>
<td>10 (7.6)</td>
<td>70 (7.1)</td>
<td>80 (7.1)</td>
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<tr>
<td>Other western counties (%)</td>
<td>57 (43.2)</td>
<td>413 (41.8)</td>
<td>470 (42.0)</td>
</tr>
<tr>
<td>East of the Cascades (%)</td>
<td>11 (8.3)</td>
<td>77 (7.8)</td>
<td>88 (7.9)</td>
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<tr>
<td>Unknown</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td><strong>End of life care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled (%)</td>
<td>118 (88.7)</td>
<td>868 (90.4)</td>
<td>986 (90.2)</td>
</tr>
<tr>
<td>Not enrolled (%)</td>
<td>15 (11.3)</td>
<td>92 (9.6)</td>
<td>107 (9.8)</td>
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<tr>
<td>Unknown</td>
<td>0</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private (%)</td>
<td>35 (29.7)</td>
<td>534 (57.1)</td>
<td>569 (54.0)</td>
</tr>
<tr>
<td>Medicare, Medicaid or other governmental (%)</td>
<td>82 (69.5)</td>
<td>388 (41.5)</td>
<td>470 (44.6)</td>
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<td>None (%)</td>
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<td>14 (1.3)</td>
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<tr>
<td><strong>Underlying Illness</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Malignant-neoplasms (%)</td>
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<td>767 (77.2)</td>
<td>872 (77.4)</td>
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<tr>
<td>Lung and bronchus (%)</td>
<td>16 (12.0)</td>
<td>177 (17.8)</td>
<td>193 (17.1)</td>
</tr>
<tr>
<td>Breast (%)</td>
<td>12 (9.0)</td>
<td>74 (7.4)</td>
<td>86 (7.6)</td>
</tr>
<tr>
<td>Colon (%)</td>
<td>12 (9.0)</td>
<td>61 (6.1)</td>
<td>73 (6.5)</td>
</tr>
<tr>
<td>Pancreas (%)</td>
<td>9 (6.8)</td>
<td>64 (6.4)</td>
<td>73 (6.5)</td>
</tr>
<tr>
<td>Prostate (%)</td>
<td>6 (4.5)</td>
<td>41 (4.1)</td>
<td>47 (4.2)</td>
</tr>
<tr>
<td>Ovary (%)</td>
<td>3 (2.3)</td>
<td>37 (3.7)</td>
<td>40 (3.5)</td>
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<tr>
<td>Other (%)</td>
<td>47 (35.3)</td>
<td>313 (31.5)</td>
<td>360 (31.9)</td>
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<td>Amyotrophic lateral sclerosis (%)</td>
<td>9 (6.8)</td>
<td>80 (8.0)</td>
<td>89 (7.9)</td>
</tr>
<tr>
<td>Chronic lower respiratory disease (%)</td>
<td>2 (1.5)</td>
<td>44 (4.4)</td>
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<td>Heart disease (%)</td>
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<td>35 (3.1)</td>
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<tr>
<td>HIV/AIDS (%)</td>
<td>0 (0.0)</td>
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<td>10 (0.9)</td>
</tr>
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<td>Other illnesses (%)</td>
<td>8 (6.0)</td>
<td>67 (6.7)</td>
<td>75 (6.7)</td>
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<td><strong>DWDA process</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>5 (3.8)</td>
<td>52 (5.3)</td>
<td>57 (5.1)</td>
</tr>
<tr>
<td>Patient informed family of decision (%)</td>
<td>119 (89.5)</td>
<td>858 (93.6)</td>
<td>977 (93.0)</td>
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<tr>
<td><strong>Patient died at</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home (patient, family or friend) (%)</td>
<td>117 (88.6)</td>
<td>931 (94.0)</td>
<td>1,048 (93.4)</td>
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<td>Long term care, assisted living or foster care facility (%)</td>
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<td>Hospital (%)</td>
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<td>4 (0.4)</td>
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<td>Other (%)</td>
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**TOFFLER EXHIBIT B-1**
<table>
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<tr>
<th>Characteristics</th>
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<th>1998–2015 (N=994)</th>
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</thead>
<tbody>
<tr>
<td><strong>Timing of DWDA event</strong></td>
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<td></td>
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</tr>
<tr>
<td><strong>Duration (weeks) of patient-physician relationship</strong></td>
<td></td>
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</tr>
<tr>
<td>Median</td>
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<tr>
<td></td>
<td>132</td>
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<td>1,124</td>
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<tr>
<td><strong>Number of patients with information unknown</strong></td>
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</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Duration (days) between first request and death</strong></td>
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</tr>
<tr>
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<td>Range</td>
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<td>133</td>
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<td>1,127</td>
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<tr>
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<tr>
<td><strong>Minutes between ingestion and unconsciousness</strong></td>
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</tr>
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<td>5</td>
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<td>Range</td>
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<td>1–60</td>
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<tr>
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<tr>
<td></td>
<td>109</td>
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<td>571</td>
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<tr>
<td><strong>Minutes between ingestion and death</strong></td>
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</tr>
<tr>
<td>Median</td>
<td>27</td>
<td>25</td>
<td>25</td>
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<tr>
<td><strong>Range</strong></td>
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<td>1min–104hrs</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>25</td>
<td>537</td>
<td>562</td>
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<tr>
<td><strong>Number of patients with information unknown</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>108</td>
<td>457</td>
<td>565</td>
</tr>
</tbody>
</table>

1. Unknowns are excluded when calculating percentages.
2. Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.
3. First recorded beginning in 2001. Since then, 52 patients (4.9%) have chosen not to inform their families, and 21 patients (2.0%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and three in 2013.
4. Affirmative answers only ("Don’t know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.
6. A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.
7. There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwda) for more detail on these deaths.
12 million Americans misdiagnosed each year

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."

More from Morning Rounds with Dr. LaPook

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
PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.
PROCUREUR GÉNÉRAL DU CANADA,
defendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

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 15th, 2012

NAME: Heidi Pruzyanski
A notary in and for the
State of Washington MASSACHUSETTS

ADDRESS: 85 MAIN ST
Florence, MA 01062
EXPIRY OF COMMISSION: June 22, 2019

PLACE SEAL HERE:

Heidi Pruzyanski
My Commission Expires
Commonwealth of Massachusetts
NOTARY PUBLIC

AFFIDAVIT OF JOHN NORRIS- Page 3
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
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 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.
<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>
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<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>
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<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>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>
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<tr>
<td><strong>End of life concerns</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Losing autonomy (%)</td>
<td>125 (87.4)</td>
<td>1,029 (91.4)</td>
<td>1,154 (90.9)</td>
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<td>Less able to engage in activities making life enjoyable (%)</td>
<td>126 (88.1)</td>
<td>1,011 (89.7)</td>
<td>1,137 (89.5)</td>
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<tr>
<td>Loss of dignity (%)</td>
<td>96 (67.1)</td>
<td>769 (67.9)</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>
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<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>79 (55.2)</td>
<td>475 (42.2)</td>
<td>554 (43.7)</td>
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<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>
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<tr>
<td>Financial implications of treatment (%)</td>
<td>8 (5.6)</td>
<td>39 (3.5)</td>
<td>47 (3.7)</td>
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<tr>
<td><strong>Health-care provider present (collected since 2001)</strong></td>
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<td></td>
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<tr>
<td>When medication was ingested</td>
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<td></td>
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<tr>
<td>Prescribing physician</td>
<td>24</td>
<td>163</td>
<td>187</td>
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<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>Unknown</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>Unknown</td>
<td>0</td>
<td>23</td>
<td>23</td>
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<tr>
<td><strong>Complications</strong></td>
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<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>
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<tr>
<td>None</td>
<td>38</td>
<td>554</td>
<td>592</td>
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<tr>
<td>Unknown</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

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<tr>
<th></th>
<th>2017</th>
<th></th>
<th>2016</th>
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<th>2015¹</th>
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<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
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<tr>
<td><strong>Family and Psychiatric/Psychological Involvement</strong></td>
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<tr>
<td>Referred for psychiatric/psychological evaluation²</td>
<td>4</td>
<td>2</td>
<td>11</td>
<td>5</td>
<td>8</td>
<td>4</td>
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<tr>
<td>Patient informed family of decision³</td>
<td>174</td>
<td>94</td>
<td>224</td>
<td>95</td>
<td>174</td>
<td>93</td>
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<tr>
<td><strong>Medication⁴</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Secobarbital</td>
<td>66</td>
<td>34</td>
<td>77</td>
<td>32</td>
<td>109</td>
<td>51</td>
</tr>
<tr>
<td>Pentobarbital</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Secobarbital/Pentobarbital Combination</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Phenobarbital</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>&lt;1</td>
<td>10</td>
<td>5</td>
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<tr>
<td>Phenobarbital/Chloral Hydrate Combination</td>
<td>0</td>
<td>0</td>
<td>106</td>
<td>44</td>
<td>88</td>
<td>41</td>
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<tr>
<td>Chloral Hydrate</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>&lt;1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Morphine sulfate</td>
<td>130</td>
<td>66</td>
<td>53</td>
<td>22</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>&lt;1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
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<tr>
<td>Duration of patient-physician relationship⁵</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25 weeks</td>
<td>94</td>
<td>51</td>
<td>125</td>
<td>52</td>
<td>99</td>
<td>49</td>
</tr>
<tr>
<td>25 weeks – 51 weeks</td>
<td>21</td>
<td>11</td>
<td>25</td>
<td>10</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>1 year or more</td>
<td>71</td>
<td>38</td>
<td>88</td>
<td>37</td>
<td>81</td>
<td>40</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>2</td>
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<tr>
<td>Range (min – max)</td>
<td></td>
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<td></td>
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<tr>
<td>&lt;1 wk – 38 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 wk – 31 yrs</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>&lt;1 wk – 2 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Duration between first oral request and death⁶</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25 weeks</td>
<td>167</td>
<td>90</td>
<td>209</td>
<td>88</td>
<td>164</td>
<td>81</td>
</tr>
<tr>
<td>25 weeks or more</td>
<td>18</td>
<td>10</td>
<td>28</td>
<td>12</td>
<td>33</td>
<td>16</td>
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<td>Range (min – max)</td>
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<td></td>
</tr>
<tr>
<td>2 wks – 81 wks</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>2 wks – 112 wks</td>
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<td></td>
<td></td>
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<td></td>
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<tr>
<td>0 wks – 95 wks</td>
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<td></td>
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</tbody>
</table>

Notes:

2. Data are collected from the Attending Physician’s Compliance form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
3. Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.
4. Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 196 participants in 2017 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.
5. Data are collected from the After Death Reporting form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
6. Data are collected from the After Death Reporting form and Attending physician Compliance Form. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.
(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician’s diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;

(4) The consulting physician’s diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending physician’s offer to the patient to rescind his or her request at the time of the patient’s second oral request pursuant to ORS 127.840; and

(7) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 §3.09]

127.860 §3.10. Residency requirement. Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:

(1) Possession of an Oregon driver license;

(2) Registration to vote in Oregon;

(3) Evidence that the person owns or leases property in Oregon; or

(4) Filing of an Oregon tax return for the most recent tax year. [1995 c.3 §3.10; 1999 c.423 §8]

127.865 §3.11. Reporting requirements. (1)(a) The Department of Human Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The department shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the department.

(2) The department shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.
Release of Information Regarding the Death with Dignity Act

The Death with Dignity Act requires that the Oregon Health Authority collect information pertaining to compliance (ORS 127.865 (2)) and to make available to the public an annual statistical report (ORS 127.865 (3)).

The Oregon Health Authority's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation.

Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.

The Oregon Health Authority will NOT confirm on a case-by-case basis whether an individual has used, or a provider has been involved with, Death with Dignity. We will not release a report when the first case occurs and we will not respond to questions regarding number of cases within a specific time period.

Within the principles of confidentiality, the Oregon Health Authority will publish an annual report which will include information on how many prescriptions are written, and how many people actually take the prescribed medication. The specificity of any data released will depend upon whether we can ensure that confidentiality will not be breached.

To reiterate, the Oregon Health Authority's role in reporting on the Death with Dignity Act is similar to other public health data we collect. The data are population-based and our charge is to maintain surveillance of the overall effect of the Act. The data are to be presented in an annual report, but the information collected is required to be confidential. Therefore, case-by-case information will not be provided, and specificity of data released will depend on having adequate numbers to ensure that confidentiality will be maintained.

Contact Us

Center for Health Statistics staff can answer questions about Oregon's Death with Dignity Act

Email: dwda.info@state.or.us

FAX: 971-673-5332
Thank you for your email regarding Oregon's Death with Dignity Act. For all of your questions, the answer is no. Since our office is charged with maintaining absolute confidentiality, our policy is to never release identifying information. We cannot confirm or deny participation of any individual patient or physician. We have been contacted by law enforcement and legal representatives in the past, but have not provided identifying information of any type. To ensure confidentiality, our office does not maintain source documentation on participants.

Please let me know if you have further questions.

Thank you,
Alicia

Alicia Parkman
Mortality Research Analyst
Center for Health Statistics
Oregon Health Authority
Ph: 971-673-1150
Fax: 971-673-1201

From: Margaret Dore [mailto:margaretdore@margaretdore.com]
Sent: Monday, January 02, 2012 5:48 PM
To: alicia.a.parkman@state.or.us
Subject: Death with Dignity Act

Thank you for answering my prior questions about Oregon's death with dignity act.

I have these follow up questions:
1. Would your office release copies of completed reporting forms, e.g., a doctor's completed "Oregon Death with Dignity Act Attending Physician Follow-up Form," in response to a civil subpoena?

2. Would your office release copies of completed reporting forms in answer to a request by law enforcement?

3. Would your office confirm to law enforcement whether a person had in fact died under Oregon's Death with Dignity Act?

Margaret Dore
Law Offices of Margaret K. Dore, P.S.
www.margaretdore.com
1001 4th Avenue, 44th Floor
Seattle, WA 98154
206 389 1754
Q: What is Oregon’s Death with Dignity Act?
A: The Death with Dignity Act (DWDA) is a permissive law that allows terminally ill Oregonians to end their lives through the voluntary self-administration of a lethal dose of medication, expressly prescribed by a physician for that purpose.

The DWDA was a citizens' initiative passed twice by Oregon voters. The first time was in a general election in November 1994 when it passed by a margin of 51% to 49%. An injunction delayed implementation of the Act until it was lifted on October 27, 1997. In November 1997, a measure was placed on the general election ballot to repeal the DWDA. Voters chose to retain the DWDA by a margin of 60% to 40%.

There is no state "program" for participation in the DWDA. People do not "make an application" to the State of Oregon or the Oregon Health Authority. It is up to qualified patients and licensed physicians to implement the DWDA on an individual basis. No one is compelled to participate. The DWDA requires the Oregon Health Authority to collect data about DWDA participation and to issue an annual report (https://oha.PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx).

Q: Are there any other states that have similar legislation?
A: Yes. The Death with Dignity National Center, which advocates for the passage of death with dignity laws, tracks the status of these laws around the country. Visit its website at https://wwwdeathwithdignity.org/take-action (https://www.deathwithdignity.org/take-action).

Q: Who can participate in the DWDA?
A: The DWDA states that to participate, a patient must be: (1) 18 years of age or older, (2) a resident of Oregon, (3) capable of making and communicating health care decisions for him/herself, and (4) diagnosed with a terminal illness that will lead to death within six months. It is up to the attending physician to determine whether these criteria have been met.

Q: How long must a patient live in Oregon in order to participate? How does a patient demonstrate residency?
A: A patient must be a current Oregon resident. The law does not require a patient to have lived in Oregon for any minimum length of time. However, a patient must provide proof of residency to the attending physician. Forms of proof include, but are not limited to: an Oregon Driver License, a lease agreement or property ownership document showing that the patient rents or owns property in Oregon, an Oregon voter registration, or a recent Oregon tax return. It is up to the attending physician to determine if the patient has adequately established residency.

Q: Are participating patients reported to the Oregon Health Authority by name?
A: The State does collect the names of patients in order to cross-check death certificates. However, the law guarantees the confidentiality of all participating patients (as well as physicians) and the Oregon Health Authority does not release this information to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed.

Q: Who can write a prescription for a patient under the DWDA?
A: Patients who meet certain criteria (https://oha.PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx#whocan) can request a prescription for lethal medication from a licensed Oregon physicians. The physician must be a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) licensed to practice medicine by the Oregon Medical Board. The physician must also be willing to participate in the DWDA. Physicians are not required to provide prescriptions to patients, and participation is voluntary. Additionally, some health care systems (for example, a Catholic hospital or the Veterans Administration) have prohibitions against participating in the DWDA.

Q: If a patient's doctor does not participate in the DWDA, how can the patient get a prescription?
A: The patient must find another M.D. or D.O. licensed to practice medicine in Oregon who is willing to participate. The Oregon Health Authority (https://oha.PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx#particip...)
DECLARATION OF TESTIMONY

I, Isaac Jackson, declare under penalty of perjury the following:

1. I am a lawyer licensed to practice law in the State of Oregon, USA. I am in private practice with my own law firm specializing in injury claims, including wrongful death cases. I previously served as a Law Clerk to Judge Charles Carlson of the Lane County Circuit Court. I was also an associate lawyer with a firm that specializes in insurance defense and civil litigation.

2. I write to inform the court regarding a lack of transparency under Oregon’s assisted suicide act. Even law enforcement is denied access to information collected by the State of Oregon. Moreover, according to the current Oregon State website, this lack of access is official Oregon State Policy.

3. In 2010, I was retained by a client whose father had apparently died under Oregon's law. The client wanted to know whether that was true. I therefore made inquiry on his behalf. However and unlike other deaths I have investigated, it was difficult to get information.

4. I wrote Dr. Hedberg, the State epidemiologist. Attached hereto as Exhibit 1 is a true and correct copy of a letter I received back from the Office of the Attorney General of Oregon dated November 3, 2010. The letter describes that the Oregon Health Authority is only allowed to release annual statistical information about assisted suicide deaths. The letter states:

   ORS [Oregon Revised Statutes] 127.865 prevents OHA [Oregon Health Authority] from releasing any information to you or your client. OHA may only make public annual statistical information.

5. I also wrote the Oregon Medical Board. Attached hereto as Exhibit 2 is a true and correct redacted copy of a letter I received back, dated November 29, 2010, which states in part:

   While sympathetic to [your client’s] concerns about the circumstances of his father’s death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Health collects these documents for their purposes. Further, if the Board did have the documents as a part of an investigation, the Board would be prevented from releasing them by ORS 676.175. See Exhibit 2.

6. I also received a copy of the decedent’s death certificate, which is the official death record in Oregon. A true and correct, but redacted copy, is attached hereto as Exhibit 3. The “immediate cause of death” is listed as “cancer.” The “manner of death” is listed as “Natural.”

///
7. Per my request, a police officer was assigned to the case. Per the officer's confidential report, he did not interview my client, but he did interview people who had witnessed the decedent's death.

8. The officer's report describes how he determined that the death was under Oregon's assisted suicide law act due to records other than from the State of Oregon. The officer's report also describes that he was unable to get this information from the Oregon Health Authority, which was not willing to confirm or deny whether the deceased had used the act. The officer closed the case.

9. Attached hereto as Exhibit 4 is a true and correct copy of the Oregon Health Authority's data release policy, as of September 18, 2012, which states in part:

The Death with Dignity Act requires that the Oregon Health Authority collect information pertaining to compliance (ORS 127.865 (2)) and to make available to the public an annual statistical report (ORS 127.865 (3)).

The Oregon Health Authority's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation. Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.

The Oregon Health Authority will NOT confirm on a case-by-case basis whether an individual has used, or a provider has been involved with, Death with Dignity. We will not release a report when the first case occurs and we will not respond to questions regarding number of cases within a specific time period. (Emphasis in original).

Pursuant to Oregon Rules of Civil Procedure 1E, I hereby declare that the above statement is true to the best of my knowledge and belief, and that I understand it is made for use as evidence in court and is subject to penalty for perjury.

Dated Sept. 18 2012

Isaac Jackson, OSB 055494
Jackson Law Office, LLC

Post Office Box 41240
Eugene, OR 97404
541.225.5061
Jackson@irjlaw.com
Isaac Jackson  
Jackson Law Office, LLC  
P.O. Box 279  
Eugene, OR 97440  

Re: Death with Dignity Act Records Request  

Dear Mr. Jackson:  

Dr. Hedberg, the state epidemiologist, received your letter dated October 27, 2010, requesting certain Death with Dignity Act records that may have been filed under OAR 333-009-0010. If records cannot be provided, you also ask Dr. Hedberg to investigate the existence of the documents and report findings to you, or lastly, to at least verify whether the Oregon Health Authority (OHA) has any record of contact with your client's deceased father. In sum, your client would like any information that might shed light on his father's death.  

While Dr. Hedberg understands the difficult time your client must be going through, ORS 127.865 prevents OHA from releasing any information to you or your client. OHA may only make public annual statistical information. Please be assured that if irregularities are found on paperwork submitted to the OHA under OAR 333-009-0010, OHA can and has reported information to the Oregon Medical Board who can then investigate the matter.  

I understand that you are in the process of getting the death certificate for your client's father and that may shed some light on the matter for your client. If your client believes that some nefarious actions have taken place he certainly could contact law enforcement.  

Please contact me if you have additional questions.  

Sincerely,  

[Signature]  
Shannon K. O'Fallon  
Senior Assistant Attorney General  
Health and Human Services Section  

SKO:vdo/JusticeF 2345752  
CC: Katrina Hedberg, M.D, DHS
November 29, 2010

Isaac Jackson
Jackson Law Office
PO Box 279
Eugene, OR 97440

Dear Mr. Jackson:

The Oregon Medical Board has received your letter regarding and his death, apparently under the Oregon Death with Dignity Act. In order for the Board to proceed with a formal investigation, a medical and/or legal basis must exist to support an allegation that a physician licensed by the Board may have violated Oregon law. In our review of the information that you presented we did not find a physician identified nor was there a specific allegation of misconduct on the part of a physician. As such, the board is not able to initiate a formal investigation.

While sympathetic to concerns about the circumstances of his father's death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Human Services collects these documents for their purposes. Further, if the Board did have the documents as a part of an investigation, the Board would be prevented from releasing them by ORS 676.175.

Thank you for bringing your concerns to the attention of the Oregon Medical Board. If you have any further questions regarding this matter, you may contact me at 971-673-2702.

Sincerely,

Randy H. Day
Complaint Resource Officer
Investigations/Compliance Unit
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Data Release Policy

Release of Information Regarding the Death with Dignity Act

The Death with Dignity Act requires that the Oregon Health Authority collect information pertaining to compliance (ORS 127.865 (2)) and to make available to the public an annual statistical report (ORS 127.865 (3)).

The Oregon Health Authority's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation.

Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.

The Oregon Health Authority will NOT confirm on a case-by-case basis whether an individual has used, or a provider has been involved with, Death with Dignity. We will not release a report when the first case occurs and we will not respond to questions regarding number of cases within a specific time period.

Within the principles of confidentiality, the Oregon Health Authority will publish an annual report which will include information on how many prescriptions are written, and how many people actually take the prescribed medication. The specificity of any data released will depend upon whether we can ensure that confidentiality will not be breached.

To reiterate, the Oregon Health Authority's role in reporting on the Death with Dignity Act is similar to other public health data we collect. The data are population-based and our charge is to maintain surveillance of the overall effect of the Act. The data are to be presented in an annual report, but the information collected is required to be confidential. Therefore, case-by-case information will not be provided, and specificity of data released will depend on having adequate numbers to ensure that confidentiality will be maintained.

Appendix

Frequently Asked Questions Related to Additional Data Requests
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.1 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.
in (or in the) spirit

1. In thought or intention though not physically.
   "he couldn't be here in person, but he is with us in spirit"

Translations, word origin, and more definitions

What's the meaning of "In the spirit of"? - English Language & Usage
https://english.stackexchange.com/questions/304/what-the-meaning-of-in-the-spirit-of-
Apr 22, 2014 - In the spirit of full disclosure, the latter in question turned out to be my editor at Salon... Source: http://english.stackexchange.com/questions/304/what-the-meaning-of-in-the-spirit-of-

the spirit of the law (phrase) definition and synonyms | Macmillan
www.macmillandictionary.com/us/dictionary/american/the-spirit-of-the-law
Define the spirit of the law (phrase) and get synonyms. What is the spirit of the law (phrase)? the spirit of the law (phrase) meaning, pronunciation and more by...

enter / get into the spirit of something (phrase) definition and... www.macmillandictionary.com/us/dictionary/american/enter-get-into-the-spirit-of-something
Define enter / get into the spirit of something (phrase) and get synonyms. What is enter / get into the spirit of something (phrase)? enter / get into the spirit of...

In the spirit - definition of In the spirit by The Free Dictionary
www.thefreedictionary.com/in-the-spirit
A force or principle believed to animate living beings. b. A force or principle believed to animate humans and often to endure after departing from the body of a person at death, the soul. 2. Spirit The Holy Spirit.

in the spirit of synonymy | English synonyms dictionary | Reverso
dictionary.reverso.net/english-synonyms/in-the-spirit-of
in the spirit of synonyms, antonyms, English dictionary, English language, definition, see also 'spirit', 'spirited', 'spiritedly', 'spirit', 'Reverso dictionary, English ...

Spirit | Definition of Spirit by Merriam-Webster
https://www.merriam-webster.com/dictionary/spirit
1: an existing or vital principle held to give life to physical organisms. 2: a supernatural being or essence; such are capitalized: holy spirit: soul 3: an often malevolent being that is bodiless but can become visible; specifically: ghost 4: a malevolent being that enters and possesses a human being.

In the spirit of - definition of In the spirit of - Diccionarist
www.diccionarist.com/in-the-spirit-of-
Definition of in the spirit of. What is the meaning of In the spirit of in various languages. Translation of in the spirit of in the dictionary.

spirit definition in the Cambridge English Dictionary
dictionary.cambridge.org/us/dictionary/english/spirit
- spirit definition, meaning, what is spirit: a particular way of thinking, feeling, or behaving, especially a way that is typical of a... Learn more.

Spirit Definition and Meaning - Bible Dictionary - Bible Study Tools
www.biblestudytools.com/dictionary/spirit
What is Spirit? Definition and meaning (article text)

Spirit | Define Spirit at Dictionary.com
www.dictionary.com/browse/spirit
Spirit definition, the principle of conscious life; the vital principle in humans, animating the body or mediating between body and soul. See more.

https://www.google.com/search?q=define+in+the+spirit+of&rlz=1C1RNVE_enUS657US657&op=define+%22in+the
accordance

/əˈkɔrdəns/ (verb)

noun, plural accordances

1. a manner conforming to: the product is disposed of in accordance with federal regulations.
2. in agreement with; conformity with; in line with; true to: in the spirit of, observing, following, heading.

Origin

Old French accordance (from Old French accorder, to agree). Middle English: from Old French accordance, from accorder ‘bring to an agreement’ (see accord).

Translate accordance to: Choose language

Use over time for: accordance

Accordance | Definition of Accordance by Merriam-Webster

https://www.merriam-webster.com/dictionary/accordance

Definitions of accordance, 1: agreement, conformity in accordance with a rule, 2: the act of granting something the accordance of a privilege.

In Accordance With | Definition of In Accordance With by Merriam ...

https://www.merriam-webster.com/dictionary/in%20accordance%20with

accordance: agreement, conformity, the act of granting something.

Accordance | Define Accordance at Dictionary.com

www.dictionary.com/browse/accordance

Accordance definition, agreement, conformity. In accordance with the rules. See more.

accordance (noun) definition and synonyms | Macmillan Dictionary

www.macmillandictionary.com/us/dictionary/american/accordance

Define accordance (noun) and get synonyms. What is accordance (noun)? accordance (noun) meaning, pronunciation and more by Macmillan Dictionary.

Accordance - definition of accordance by The Free Dictionary

www.thefreedictionary.com/accordance

1. conformity; agreement; accord (esp in the phrase in accordance with). 2. the act of granting; bestowed: accordance of rights. Collins English Dictionary...

In accordance with - Idioms by The Free Dictionary

idioms.thefreedictionary.com/in%20accordance%20with

https://www.google.com/search?q=Define+%22accordance%22&rlz=1C1RNVE_enUS557US557&aq=0&ei=0&ved=0ahUKEwiB3Ynhr9DoAhX5sI4KHZpMCaYQAhgUIAA&biw=1531&bih=900