TO: The New Hampshire Legislature

FROM: Margaret Dore, Esq., MBA, President
Choice is an Illusion, a nonprofit corporation

RE: Reject HB 1659, Death With Dignity Act
Say "No" to Non-Voluntary Euthanasia

HEARING: February 12, 2020, 1pm, LOB 208

MEMO
DATE: February 3, 2020

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I. INTRODUCTION

I am a licensed attorney in Washington State where "death with dignity" (assisted suicide and euthanasia) is legal. Washington's law is based on a similar law in Oregon. Both laws are similar to the proposed Act set forth in HB 1659-FN.¹

I am also a former Law Clerk to the Washington State Supreme Court and the Washington State Court of Appeals. I worked for a year with the United States Department of Justice and have been in private practice since 1990. I am also president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia.

I have personally appeared and testified against assisted suicide and/or euthanasia in at least 20 US legislatures, including New Hampshire, and also internationally. For more information see www.margaretdore.org and www.choiceillusion.org.

II. DEFINITIONS (TRADITIONAL)

A. Physician-Assisted Suicide, Assisted Suicide, Euthanasia and Mercy Killing

The American Medical Association defines physician-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."² For example:
The physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.\(^3\)

Assisted suicide is a general term in which the assisting person is not necessarily a physician. Euthanasia is the administration of a lethal agent by another person.\(^4\) Euthanasia is also known as mercy killing.\(^5\)

**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 regarding a man removed from a ventilator:

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

### III. FACTUAL AND LEGAL BACKGROUND

**A. 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

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\(^3\) Id.


\(^5\) See "Mercy Killing" definition, attached hereto at page A-10.

\(^6\) 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, 1/13/09, attached at pp. A-11 to A-14; quote at A-13.
sold his home and deposited the proceeds into bank accounts for her own benefit. Consider also, Graham Morant, convicted of counseling his wife to kill herself in Australia, to get the life insurance. The Court found:

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

Medical professionals too can have an agenda. New York physician, Michael Swango, got a thrill from killing his patients. 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.

B. Most States Reject Assisted Suicide

Most states reject assisted suicide and euthanasia. In July 2016, the Supreme Court of New Mexico overturned a lower court ruling allowing assisted suicide. In the last ten years, eight

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7 "Sawyer Arraigned on State Fraud Charges," KTVZ.COM, 08/16/16, attached in the appendix at page A-15.


9 Morant opinion, ¶ 78, attached in the appendix at page A-17.

10 Charlie Leduff, “Prosecutors Say Doctor Killed to Feel a Thrill,” The New York Times, 09/07/00, attached in the appendix at pages A-18 to A-20, https://choiceisanillusion.files.wordpress.com/2019/03/ny-times-killed-to-feel-a-thrill-1.pdf (“Basically, Dr. Swango liked to kill people. By his own admission in his diary, he killed because it thrilled him.”)


other states have strengthened their laws against assisted suicide and/or euthanasia.\textsuperscript{13}

\textbf{C. The Swiss Study: Physician-Assisted Suicide Can Be Traumatic for Family Members and Friends}

A European research study addressed trauma suffered by persons who witnessed legal physician-assisted suicide in Switzerland.\textsuperscript{14} The study found that one out of five family members or friends present at an assisted suicide was traumatized. These people, experienced full or sub-threshold PTSD [Post Traumatic Stress Disorder] related to the loss of a close person through assisted suicide.\textsuperscript{15}

\textbf{IV. HOW THE ACT WORKS}

The Act has an application process to obtain the lethal dose.\textsuperscript{16} Once the lethal dose is issued by the pharmacy, there is no oversight. No witness, not even a doctor, is required to present at the death.\textsuperscript{17}

\textsuperscript{13} Margaret Dore, “U.S. States Strengthen Their Laws Against Assisted Suicide, April 2, 2019, attached in the appendix at A-24, also available at https://www.choiceillusion.org/2019/04/in-last-ten-years-at-least-nine-us.html


\textsuperscript{15} Id.

\textsuperscript{16} The Act, §§ 137-M:3 to M:10, attached hereto at A-2 through A-4.

\textsuperscript{17} See the Act in its entirety, attached hereto at A-1 to A-7.
V. "ELIGIBLE" PERSONS WILL HAVE YEARS OR DECADES TO LIVE

A. If New Hampshire Follows Oregon Practice, the Act Will Apply to Young Adults With Diabetes

The Act applies to people with a terminal disease expected to produce death within six months. The Act 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. (Emphasis added).

In Oregon, a nearly identical definition is construed to include diabetes if the patient is insulin dependent. Oregon doctor, William Toffler, explains:

In Oregon, chronic conditions such as insulin dependent diabetes are sufficient for assisted suicide, if, without treatment, the patient has less than six months to live.

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

B. Predictions of Life Expectancy Can Be Wrong, John Norton

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

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18 The Act, attached in the appendix at page A-2, 137-M:2, XIII.

19 Oregon’s definition can be viewed in the appendix at p. A-28.

20 Declaration of William Toffler, MD, May 1, 2018, attached in the appendix at pages A-25 through A-30; quote at page A-26. See also Oregon report excerpt, attached at page A-29 (listing diabetes as an underlying illness sufficient for assisted suicide).

Consider John Norton, now 82 years old. Diagnosed with ALS at age 18, he was told that he would get progressively worse (be paralyzed) and die in three to five years. His affidavit, submitted to a Canadian court, states:

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.\footnote{22}{Affidavit of John Norton in Opposition to Assisted Suicide and Euthanasia, 08/18/12, attached hereto at A-31 to A-33, quote at A-32.}

Six years after my initial diagnosis, the disease progression stopped.... I still can’t grip with my hands.... But, I have a wonderful life.... I help other people by working as a volunteer driver.\footnote{23}{Id.}

C. Treatment Can Lead to Recovery, Jeanette Hall

Consider also Jeanette Hall, who was diagnosed with cancer in 2000 and made a settled decision to use Oregon’s law.\footnote{24}{Declaration of Kenneth Stevens, MD, ¶ 3 to 7; attached in the appendix at A-34 to A-36; Hall declaration attached at A-37, ¶ 3.} Her doctor convinced her to be treated for cancer instead.\footnote{25}{Id.} Her declaration states:


\footnote{22}{Affidavit of John Norton in Opposition to Assisted Suicide and Euthanasia, 08/18/12, attached hereto at A-31 to A-33, quote at A-32.}

\footnote{23}{Id.}

\footnote{24}{Declaration of Kenneth Stevens, MD, ¶ 3 to 7; attached in the appendix at A-34 to A-36; Hall declaration attached at A-37, ¶ 3.}

\footnote{25}{Id.}
It has now been 19 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.26

VI. THE AMERICANS WITH DISABILITY ACT WILL REQUIRE EUTHANASIA

The proposed Act’s “Statement of Purpose” implies that the Act will be limited to self-administered lethal medication (assisted suicide).27 If for the purpose of argument, the Act does in fact require self-administration, any such requirement will be unenforceable due to the Americans with Disability Act (“ADA”).

The ADA is “a federal civil rights law that prohibits discrimination against individuals with disabilities in every day activities, including medical services.”28 “Medical care providers are required to make their services available in an accessible manner.”29 This includes:

Reasonable modifications to policies, practices, and procedures to make healthcare services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e., alter the essential nature of

26 Hall Declaration, ¶4, attached in the appendix at A-37.
29 Id.
Here, the proposed Act legalizes assisted suicide as part of New Hampshire medical care. If for the purpose of argument, the Act does in fact require self-administration, the ADA will require a reasonable accommodation for individuals unable to self-administer. This will mean administration by another person. The proposed Act will thereby allow euthanasia as traditionally defined.

**VII. "EVEN IF THE PATIENT STRUGGLED, WHO WOULD KNOW?"**

The proposed Act has no required oversight over administration of the lethal dose. In addition, the drugs used are water or alcohol soluble, such that they can be injected into a sleeping 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 Act], 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.

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30 Id.

31 The proposed Act, § 137-M:1, Statement of Purpose, attached at page A-1.

32 See the Act in its entirety, attached hereto at A-1 through A-7.

33 The drugs used include Secobarbital, Pentobarbital, Phenobarbital and Morphine Sulfate, which are water and/or alcohol soluble. See also Oregon and Washington report excerpts in the appendix at pp. A-38 and A-39 (listing these drugs). See also [http://www.drugs.com/pro/pentobar.html](http://www.drugs.com/pro/pentobar.html) and [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2977013](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2977013)
Even if a patient struggled, "who would know?" (Emphasis added).\textsuperscript{34}

\textbf{VIII. AN UNTENABLE STANDARD}

The proposed Act uses the word, "capable," which is specially defined to allow another person to communicate on the patient’s behalf, as long as the person is "familiar with the patient’s manner of communicating." The Act states:

"Capable" means that, in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, 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. (Emphasis added).\textsuperscript{35}

This is an untenable standard. Consider, for example, a doctor’s assistant who is familiar with a patient’s “manner of communicating” in Spanish, but she herself does not understand Spanish. That would be good enough for her to communicate on the patient’s behalf. The patient would not be in control of his fate.

\textbf{IX. ACTIONS TAKEN IN ACCORDANCE WITH THE ACT WILL NOT CONSTITUTE SUICIDE OR HOMICIDE}

The Act states:

\begin{quote}
Actions taken in accordance with this chapter [the proposed act] shall not, for any
\end{quote}

\textsuperscript{34} Alex Schadenberg, Letter to the Editor, "Elder abuse a growing problem," The Advocate, Official Publication of the Idaho State Bar, October 2010.

\textsuperscript{35} The Act, Definitions, § 137-M:2.III, attached hereto at page A-2.
purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. (Emphasis added). 36

The Act does not define accordance. 37 Dictionary definitions include "in the spirit of," meaning "in thought or intention." 38 In other words, a mere thought or intention to comply with the Act is sufficient to prevent a death from being treated as suicide or homicide under the law. Actions taken in accordance with the Act will not be suicide or homicide as a matter of law.

X. DEATHS WILL BE REPORTED AS NATURAL

New Hampshire death registration forms require the manner of death to be reported as one of six categories, four of which are substantive: (1) natural; (2) accidental; (3) suicidal; and (4) homicidal. 39 The two other categories are: pending investigation; and undetermined. 40

As noted in the preceding section, a death occurring in accordance with the Act will not constitute suicide or homicide as a matter of law. The death will also not be accidental due

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36 The proposed Act, 137-M:13, IV, attached hereto at A-5.
37 See the proposed Act in its entirety, attached hereto at A-1 to A-7.
38 See definitions in the appendix at pages A-40 and A-41.
39 See New Hampshire Vital Records Administration, Death Registration Forms and Procedures, Section 5-C: 62 IV(c) - attached hereto at A-43, full document attached at A-42 to A-44.
40 Id.
its having been an intended event. This leaves “natural.”

The official legal manner of death will be natural.

XI. 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.”\(^4\) The inquiry also found:

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

Per a subsequent article in 2015, proposed reforms included having a medical examiner review death certificates, so as to improve patient safety.\(^4\) Instead, the proposed Act moves in the opposite direction to require that deaths be reported as natural. If enacted, doctors and other perpetrators will be able to kill under mandatory legal cover.

XII. PERPETRATORS WILL BE ALLOWED TO INHERIT


Deaths occurring in accordance with the Act, however, will

\(^4\) David Batty, supra, attached in the appendix at page A-21 to A-23.

\(^4\) Id., attached hereto at A-23.

be natural as a matter of law. More to the point, straight up perpetrators will be allowed to inherit. Maybe you trust your family, but what about your son’s new wife?

XIII. LOWER INCOME PEOPLE AND EVERYONE ELSE

In Oregon, people of all income levels are steered to suicide by health care providers. This was first highlighted by the media in 2008, concerning lower income people. See also the Seattle Times excerpt attached hereto, suggesting euthanasia for those without money for their old age. So, if you work hard all your life, pay taxes and then your pension plan goes broke, this is how society will pay you back? Is this what you want in New Hampshire?

IV. CONCLUSION

If passed into law, the proposed Act will apply to people with years or decades to live. This will be especially true if New Hampshire 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 the Act.

Assisting persons, including doctors and family members, can

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45 Jerry Large, “Planning for Old Age at a Premium,” The Seattle Times, March 8, 2012, attached hereto at page A-47.

46 Id.
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 registration form, to report a natural death, will create a perfect crime in which perpetrators will be legally allowed to inherit.

The Act’s passage will render people with money, meaning the middle class and above, sitting ducks to their heirs and other predators. As noted above, lower income people will also be at risk. Protect yourselves and the people you care about. Say “No” to HB 1659-FN.

Respectfully Submitted,

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Appendix

Margaret Dore, Esq., MBA

Reject

HB 1659-FN

February 3, 2020
HB 1659-FN - AS INTRODUCED

2020 SESSION

20-2036
01/10

HOUSE BILL 1659-FN

AN ACT relative to patient directed care and patient's rights with regard to end-of-life decisions.


COMMITTEE: Judiciary

ANALYSIS

This bill allows a mentally competent person who is 18 years of age or older and who has been diagnosed as having a terminal disease by the patient's attending physician and a consulting physician to request a prescription for medication which will enable the patient to control the time, place, and manner of such patient's death.

Under this bill, the request is witnessed and signed in essentially the same manner as an advance directive. The bill requires the division of public health services, department of health and human services, to collect certain information and compile a statistical analysis of such information.

Explanation: Matter added to current law appears in bold italics. Matter removed from current law appears [in brackets and struck through.] Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty

AN ACT relative to patient directed care and patient's rights with regard to end-of-life decisions.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; Death With Dignity Act. Amend RSA by inserting after chapter 137-L the following new chapter:

CHAPTER 137-M

DEATH WITH DIGNITY ACT

137-M:1 Statement of Purpose. The state of New Hampshire recognizes that persons have a right, founded in the autonomy of the person, to control the decisions relating to the rendering of their own medical care. The state of New Hampshire further recognizes that medical care for terminally ill patients who are capable of making informed decisions during the time of their illness includes the right, with assistance from their physicians, to choose to die with dignity. Many terminally ill patients experience severe, unrelenting suffering, mental anguish over the prospect of losing control and independence, and/or embarrassing indignities for long periods while they are waiting to die from terminal illness. To remedy these situations the state of New Hampshire hereby declares that the laws of the state shall permit a licensed physician, upon written request of a terminally ill patient in a condition of severe,
unrelenting suffering, to provide such patient with a prescription for lethal medication which will allow the patient, if the patient chooses to do so, to self-administer and thus control the time, place, and manner of death.

137-M:2 Definitions. In this chapter,
I. “Adult” means an individual who is 18 years of age or older.

II. “Attending physician” means the physician who has primary responsibility for treatment and care of the patient’s terminal disease.

III. “Capable” means that, in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, 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.

IV. “Consulting physician” means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient’s disease.

V. “Counseling” means a consultation between a licensed psychiatrist or psychologist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

VI. “Division” means the division of public health services, department of health and human services.

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

VIII. “Informed decision” means a decision by a qualified patient, to request and obtain a prescription to end the patient’s 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 the:
(a) Medical diagnosis.
(b) Prognosis.
(c) Potential risks associated with taking the medication to be prescribed.
(d) Probable result of taking the medication to be prescribed.
(e) Feasible alternatives, including, but not limited to, comfort care, hospice care, palliative treatment, and pain control.

IX. “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.

X. “Patient” means a person who is under the care of a physician.

XI. “Physician” means a person licensed by this state to practice medicine or osteopathy.

XII. “Qualified patient” means a capable adult who is a resident of New Hampshire or is a patient regularly treated in a New Hampshire health care facility and who has satisfied the requirements of this chapter in order to obtain a prescription for medication to end the patient’s life in a humane and dignified manner.

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

137-M:3 Initiating a Written Request for Medication.
I. An adult who is capable and a resident of New Hampshire, or who is a patient regularly treated in a New Hampshire health care facility, and who has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed a wish to die, may make a written request for medication for the purpose of ending such person’s life in a humane and dignified manner in accordance with this chapter.

II. No person shall be a qualified patient under the provisions of this chapter solely because of age or disability.

III. No person or agency including a legal guardian or agent under a durable health care power of attorney, shall be authorized to make a request for medication pursuant to this chapter on behalf of a patient who is not capable.

137-M:4 Form of the Written Request.
I. A valid request for medication under this chapter shall be in substantially the form described in paragraph IV of this section, 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 capable, acting voluntarily, and is not being coerced to sign the request.
II. The witnesses signing the request executed under paragraph I shall not be:
(a) A relative of the patient by blood, marriage, or adoption;
(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
(c) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

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

IV. 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, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control.
I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

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
We declare that the person signing this request:
(a) Is personally known to us or has provided proof of identity:
(b) Signed this request in our presence;
(c) Appears to be of sound mind and not under duress, fraud, or undue influence;
(d) Is not a patient for whom either of us is attending physician.

______________________________________ Witness 1/Date
______________________________________ Witness 2/Date

NOTE: No witness shall be a relative (by blood, marriage, or adoption) of the person signing this request, entitled to any portion of the person's estate upon death, or own, operate, or be employed at a health care facility where the person is a patient or resident.

137-M:5 Attending Physician Responsibilities. The attending physician shall:
I. Make the initial determination of whether a patient has a terminal disease and is in a condition of severe, unrelenting suffering; is capable; and has made the request voluntarily.
II. Inform the patient of the:
(a) Medical diagnosis.
(b) Prognosis.
(c) Potential risks associated with taking the medication to be prescribed.
(d) Probable result of taking the medication to be prescribed.
(e) Feasible alternatives, including, but not limited to, comfort care, hospice care, palliative treatment, and pain control.
III. Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily.
IV. Refer the patient for counseling, if appropriate, pursuant to RSA 137-M:7.
V. Recommend that the patient notify next of kin.
VI. Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to this chapter and of not taking the medication in a public place.

VII. 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 at the end of the 15-day waiting period pursuant to RSA 137-M:9.

VIII. Verify, immediately prior to writing the prescription for medication under this chapter, that the patient is making an informed decision.

IX. Fulfill the medical record documentation requirements of RSA 137-M:10.

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

137-M:6 Consulting Physician Confirmation. Before a patient is qualified under this chapter, 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 in a condition of severe, unrelenting suffering from a terminal disease and verify that the patient is capable, is acting voluntarily, and has made an informed decision.

137-M:7 Counseling 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, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder, or depression or any physical disorder causing impaired judgment.

137-M:8 Informed Decision; Family Notification.

I. No person shall receive a prescription for medication to end such person's life in a humane and dignified manner unless such person has made an informed decision as defined in RSA 137-M:2, VIII. Immediately prior to writing a prescription for medication under this chapter, the attending physician shall verify that the patient is making an informed decision.

II. The attending physician shall recommend that the patient notify next of kin of the patient's request for medication pursuant to this chapter. A patient who declines or is unable to notify next of kin shall not have the patient's request denied for that reason.

137-M:9 Written and Oral Requests; Rescinding a Request; Waiting Periods.

I. In order to receive a prescription for medication to end a patient's life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to the patient's attending physician no fewer than 15 days after making the initial oral request. At the time the qualified patient makes a second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

II. A patient may rescind such patient's request at any time and in any manner without regard to the patient's mental state. No prescription for medication under this chapter may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

III. No fewer than 15 days shall elapse between the patient's initial oral request and the writing of a prescription under this chapter. No fewer that 48 hours shall elapse between the patient's written request and the writing of a prescription under this chapter.

137-M:10 Medical Record Documentation Requirements. The following shall be documented or filed in the patient's medical record:

I. All oral requests by a patient for medication to end such patient's life in a humane and dignified manner.

II. All written requests by a patient for medication to end such patient's life in a humane and dignified manner.

III. The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily, and has made an informed decision.

IV. The consulting physician's diagnosis, prognosis, and verification that the patient is capable, acting voluntarily, and has made an informed decision.

V. A report of the outcome and determinations made during counseling, if performed.

VI. The attending physician's offer to the patient to rescind the patient's request at the time of the patient's second oral request pursuant to RSA 137-M:9.

VII. A note by the attending physician indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.
137-M:11 Applicability. This chapter shall apply only to requests made by New Hampshire residents or requests by patients regularly treated in a New Hampshire health care facility.

137-M:12 Reporting; Rulemaking.
I. The division shall adopt rules relative to the collection of information required under this chapter and relative to the qualifications of witnesses under RSA 137-M:4; IV. The information collected shall not be a public record under RSA 91-A and shall not be made available for inspection by the public.
II. The division shall annually review a sample of records maintained pursuant to this chapter and shall generate and make available to the public an annual statistical report of the information.

137-M:13 Exceptions.
I. No 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, shall be valid.
II. No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end such person’s life in a humane and dignified manner.
III. The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end the person’s life in a humane and dignified manner. Neither shall a qualified patient’s act of ingesting medication to end such patient’s life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. The rights and obligations of insurers shall not be otherwise altered by this chapter.
IV. Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient’s life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law.

137-M:14 Immunities. Except as provided in RSA 137-M:15:
I. No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end the patient’s life in a humane and dignified manner.
II. No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter.
III. No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this chapter shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.
IV. No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end the patient’s life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient’s request under this chapter, and the patient transfers such patient’s care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient’s relevant medical records to the new health care provider.

137-M:15 Liabilities.
I. 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 the patient’s death shall be guilty of a class A felony.
II. A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient’s life or to destroy a rescission of such a request shall be guilty of a class A felony.
III. Nothing in this chapter limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.
IV. The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this chapter.

137-M:16 Severability. If any provision of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.
Effective Date. This act shall take effect January 1, 2021.

LBAO
20-2036
12/13/19

HB 1659-FN - FISCAL NOTE
AS INTRODUCED

AN ACT relative to patient directed care and patient's rights with regard to end-of-life decisions.

FISCAL IMPACT:  [X] State  [X] County  [ ] Local  [ ] None

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METHODOLOGY:
This bill allows and establishes protocols for a mentally competent adult who has been diagnosed with a terminal disease to request a prescription for medication to control the time, place, and manner of their death. The bill requires the Department of Health and Human Services to: adopt a set of rules for the collection of information; review a sample of records on an annual basis; and prepare an annual statistical report and make it available to the public. The Department is not able to estimate the number of individuals who will choose to follow the end-of-life protocols established in the bill, and therefore cannot estimate the number of records to be reviewed or included in the annual report. The Department estimates that a 0.5 full-time equivalent (FTE) will be needed to implement the bill's provisions. Costs for the position are shown below, and assume the position will be in place for only the second half of FY 2021, as the bill has an effective date of January 1, 2021.

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In addition to the costs shown above, this bill contains penalties that may have an impact on the New Hampshire judicial and correctional systems. There is no method to determine how many charges would be brought as a result of the changes contained in this bill to determine the fiscal impact on expenditures. However, the entities impacted have provided the potential costs associated with these penalties below.
Many offenses are prosecuted by local and county prosecutors. When the Department of Justice has investigative and prosecutorial responsibility or is involved in an appeal, the Department would likely absorb the cost within its existing budget. If the Department needs to prosecute significantly more cases or handle more appeals, then costs may increase by an indeterminable amount.

AGENCIES CONTACTED:
Departments of Health and Human Services, Justice, and Corrections, Judicial Branch, and Judicial Council
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.
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
Mercy killing - definition of mercy killing by The Free Dictionary

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

mercyc killing
n.
Euthanasia.


mercyc killing
n.
(Medicine) another term for euthanasia


eu-tha-nasia (yu ə the' nas ə, -zə the'

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

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

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Thesaurus

Switch to new thesaurus

Noun 1. mercy killing - the act of killing someone painlessly (especially someone suffering from an incurable illness)

↔ euthanasia

↔ kill, putting to death, killing - the act of terminating a life


Translations

http://www.thefreedictionary.com/mercyc+killing

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Maryanne Clayton with her son, Eric, in the Fred Hutch waiting room: "I just kept going."

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 pemtrexate.

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.
National Hospice and Palliative Care Organization, which in 2017 showed that 13 percent of hospice patients around the country outlived their six-month prognoses.

It's not that prognostication is completely lacking in a scientific basis. There is a reason that you can pick up a textbook and find a life expectancy associated with most medical conditions: Studies have followed populations of people with these conditions. It's a statistical average. To be precise, it's a median, explains Martins. "That means 50 percent will do worse and 50 percent will do better."

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 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."

Every morning when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.

"There's always a little triumph," Bud chimes in. "I made it for another day."

It's been like this for years. A decade ago, after clearing a jungle of blackberries off a lot he had bought adjacent to his secluded ranch house south of Tacoma, Bud came down with a case of pneumonia. "Well, no wonder he's so sick," Heidi recalls the chief of medicine saying at the hospital where he was brought. "He's in congestive heart failure."

Then 75, "he became old almost overnight," Heidi says. Still, Bud was put on medications that kept him going—long enough to have a stroke five years later, kidney failure the year after that, and then the onset of severe chest pain known as angina. "It was scary," says Heidi, who found herself struggling at 3 a.m. to find Bud's veins so she could inject the morphine that the doctor had given Bud for the pain. Heidi is a petite blond nurse with a raucous laugh. She's 20 years younger than her husband, whom she met at a military hospital, and shares his cigar-smoking habit. Bud was a high-flying psychiatrist in the '80s when he became the U.S. Assistant Secretary of Defense, responsible for all Armed Forces health activities.

After his onslaught of illnesses, Bud says, his own prognosis for himself was grim. "Looking at a patient who had what I had, I would have been absolutely convinced that my chance of surviving more than a few months was very slim indeed."
Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

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.

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, 73, dependent or elderly person, for the purpose of fraud.

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

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

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 $280,600, the documents show, and it was deposited into an account for one of Sawyer's businesses, Shiloh LLC, and $90,600 of that was transferred to two other Sawyer companies, Genex Futures and Tam 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.
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.
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 Morant 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  SEPT. 7, 2000

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

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

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

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

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

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

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 Donnewbrook 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.

A civil conversation...
... has never been more important in American public life. Guardian journalism, driven by fact-based reporting, offers an independent voice of reason at a time when the national
U.S. States Strengthen Their Laws Against Assisted Suicide

By Margaret Dore, Esq., MBA

In the last ten years, at least nine states have strengthened their laws against assisted suicide/euthanasia. They are:

5. Louisiana: In 2012, Louisiana strengthened its assisted suicide/euthanasia ban.
6. New Mexico: In 2016, the New Mexico Supreme Court overturned a lower court decision recognizing a right to physician aid in dying, meaning physician assisted suicide is no longer legal in New Mexico. See Morris v. Branchburg, 376 P.3d 836 (2016).
7. Ohio: In 2017, Ohio strengthened its law against assisted suicide, See http://codes.ohio.gov/orc/3795
8. South Dakota: In 2017, the South Dakota Legislature passed Concurrent Resolution 11, opposing physician-assisted suicide. See Bill history.
9. Utah: In 2018, Utah amended its manslaughter statute to include assisted suicide. For more information, see http://legiscientific.gov/2018UTBILLS/HB1600038.html and click "status."

Labels: Alabama, Arizona, assisted suicide, euthanasia, Georgia, Idaho, Louisiana, New Mexico, Ohio, South Dakota, Utah

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https://www.choiceillusion.org/2019/04/in-last-ten-years-at-least-nine-us.html
I, WILLIAM TOFFLER, declare the following under penalty of perjury:

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

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

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

ORS 127.800 § 1.01(12), attached hereto as Exhibit A

3. In practice, this language is interpreted to include people with chronic conditions such as diabetes mellitus, better known as "diabetes."

4. Attached hereto, as Exhibit B, is an excerpt from the most recent Oregon government statistical report regarding our law. Note that the excerpt lists "diabetes" as an "underlying
illness” sufficient for assisted suicide.

5. In Oregon, chronic conditions such as insulin dependent diabetes are sufficient for assisted suicide, if, without treatment, the patient has less than six months to live.

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

7. I have also been provided with an excerpt of the proposed New York bill, which is similar to Oregon’s law. The bill states:

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

Exhibit C, NYS Bill, A. 2383–A, § 2899-d.17.

8. In my professional judgment, this language also includes insulin dependent diabetes because the illness or condition is a failure to produce insulin, such that an affected person is dependent on insulin to live. The disease at that point is an incurable and irreversible disease that will cause death within six months without treatment.

9. If New York State follows Oregon practice, the proposed bill will apply to people with chronic conditions such as insulin dependent diabetes. Such persons, with treatment, can have years or decades to live happy, healthy and productive lives.

10. I have also been asked to discuss self administration of medication, and when it would not be appropriate from a medical perspective. I provide the following response:

C:\Users\Margaret\Documents\ASE 2016 +\New Hampshire\Toffler Declaration 2018.wpd
11. In context of administering medication, a patient's physical condition and other factors can result in a determination that self-administration is not appropriate.

12. If a patient has trouble swallowing, it may be appropriate for a doctor to prescribe or order medication to be administered via injection. Depending on the medication, administration through an existing drip line or feeding tube could also be appropriate, for example, if the patient is sleeping and I don’t want to disturb her.

Signed under penalty of perjury this 1st day of May 2018, at Portland Oregon.

[Signature]

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
(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 §1.01; 1999 c.423 §1]

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

(Section 2)

127.805 §2.01. Who may initiate a written request for medication. (1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 §2.01; 1999 c.423 §2]

127.810 §2.02. Form of the written request. (1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.
<table>
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<tr>
<th>Characteristics</th>
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<th>1998-2016 (N=1,132)</th>
<th>Total (N=1,275)</th>
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<td><strong>Residence</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Metro counties (Clackamas, Multnomah, Washington) (%)</td>
<td>55 (38.5)</td>
<td>484 (43.1)</td>
<td>539 (42.6)</td>
</tr>
<tr>
<td>Coastal counties (%)</td>
<td>12 (8.4)</td>
<td>80 (7.1)</td>
<td>92 (7.3)</td>
</tr>
<tr>
<td>Other western counties (%)</td>
<td>65 (45.5)</td>
<td>471 (41.9)</td>
<td>536 (42.3)</td>
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<td>East of the Cascades (%)</td>
<td>11 (7.7)</td>
<td>88 (7.8)</td>
<td>99 (7.8)</td>
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<td><strong>End of life care</strong></td>
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<tr>
<td>Hospice</td>
<td></td>
<td></td>
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<td>Enrolled (%)</td>
<td>130 (90.9)</td>
<td>969 (90.1)</td>
<td>1119 (90.2)</td>
</tr>
<tr>
<td>Not enrolled (%)</td>
<td>13 (9.1)</td>
<td>109 (9.9)</td>
<td>122 (9.8)</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>34</td>
<td>34</td>
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<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private (%)</td>
<td>36 (31.3)</td>
<td>569 (53.8)</td>
<td>605 (51.6)</td>
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<tr>
<td>Medicare, Medicaid or other governmental (%)</td>
<td>78 (67.8)</td>
<td>474 (44.8)</td>
<td>552 (47.1)</td>
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<tr>
<td>None (%)</td>
<td>1 (0.9)</td>
<td>14 (1.3)</td>
<td>15 (1.3)</td>
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<td>Unknown</td>
<td>28</td>
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<td>103</td>
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<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>
</tr>
<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>
</tr>
<tr>
<td>Prostate (%)</td>
<td>10 (7.0)</td>
<td>48 (4.2)</td>
<td>58 (4.5)</td>
</tr>
<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><strong>Neurological disease (%)</strong></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>
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<tr>
<td>Endocrine/metabolic disease [e.g., diabetes] (%)</td>
<td>1 (0.7)</td>
<td>7 (0.6)</td>
<td>8 (0.6)</td>
</tr>
<tr>
<td>Other illnesses (%)^2</td>
<td>1 (0.7)</td>
<td>8 (0.7)</td>
<td>9 (0.7)</td>
</tr>
</tbody>
</table>

Exhibit B

Oregon Death with Dignity Act: Patient data.
(e) the feasible alternatives and appropriate treatment options, including but not limited to palliative care and hospice care.

8. "Medical aid in dying" means the medical practice of a physician prescribing medication to a qualified individual that the individual may choose to self-administer to bring about death.

9. "Medically confirmed" means the medical opinion of the attending physician that a patient has a terminal illness or condition and has made an informed decision which has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

10. "Medication" means medication prescribed by a physician under this article.

11. "Mental health professional" means a physician, nurse practitioner, physician assistant or psychologist, licensed or certified under the education law acting within his or her scope of practice and who is qualified, by training and experience, certification, or board certification or eligibility, to make a determination under section twenty-eight hundred ninety-nine of this article; provided that in the case of a nurse practitioner or physician assistant, the professional shall not have a collaborative agreement or collaborative relationship with or be supervised by the attending physician or consulting physician.

12. "Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care under article forty of this chapter.

13. "Patient" means a person who is eighteen years of age or older under the care of a physician.


15. "Qualified individual" means a patient with a terminal illness or condition, who has capacity, has made an informed decision, and has satisfied the requirements of this article in order to obtain a prescription for medication.

16. "Self-administer" means a qualified individual's affirmative, conscious, and voluntary act of using medication under this article.

17. "Terminal illness or condition" means an incurable and irreversible illness or condition that has been medically confirmed and will, within a reasonable medical judgment, produce death within six months.

§ 2899-c. Request process. 1. Oral and written request. A patient wishing to request medication under this article shall make an oral request and submit a written request to the patient's attending physi-
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 PRUZYN-SK

A notary in and for the
State of Washington MASSACHUSETTS

ADDRESS: 35 MAIN ST
Florence MA 01062
EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

[Seal]

JOHN NORTON

AFFIDAVIT OF JOHN NORTON- Page 3
BEFORE THE LEGISLATURE OF THE
STATE OF NEW YORK

IN RE NEW YORK BILLS

DECLARATION OF KENNETH STEVENS, MD

I, Kenneth Stevens, declare the following under penalty of perjury.

1. I am a doctor in Oregon where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have published articles in medical journals and written chapters for books on medical topics. This has been for both a national and international audience. I work in both hospital and clinical settings. I have treated thousands of patients with cancer.

2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify that this does not necessarily mean that patients are dying.

3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for...
cancer. I understand that he had referred her to me.

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

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

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

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

8. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.
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
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 19 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

I declare under penalty of perjury under the laws of the state of Oregon that the above is true and correct to the best of my knowledge.

Dated this 17th day of July, 2019.

Jeanette Hall
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<th>Family and Psychiatric/Psychological involvement</th>
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<td>Number</td>
<td>%</td>
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<td>%</td>
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<tr>
<td>Referred for psychiatric/psychological evaluation²</td>
<td>4</td>
<td>2</td>
<td>11</td>
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<tr>
<td>Patient informed family of decision³</td>
<td>174</td>
<td>94</td>
<td>224</td>
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<th>Medication⁴</th>
<th>2017</th>
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<th>2015</th>
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<tr>
<td>Secobarbital</td>
<td>66</td>
<td>34</td>
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<tr>
<td>Pentobarbital</td>
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<td>Secobarbital/Pentobarbital Combination</td>
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<td>Number</td>
<td>%</td>
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<td>%</td>
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<tr>
<td>Duration of patient-physician relationship⁵</td>
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<td>51</td>
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<tr>
<td>&lt;25 weeks</td>
<td>21</td>
<td>11</td>
<td>25</td>
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<tr>
<td>25 weeks – 51 weeks</td>
<td>71</td>
<td>38</td>
<td>88</td>
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<td>1 year or more</td>
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<td>Range (min – max)</td>
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<td>&lt;1 wk – 31 yrs</td>
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<th>Duration between first oral request and death⁶</th>
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<th>2015</th>
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<td>%</td>
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<td>%</td>
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<tr>
<td>25 weeks or more</td>
<td>18</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Unknown</td>
<td>Range (min – max)</td>
<td>2 wks – 2 wks</td>
<td>2 wks – 81 wks</td>
</tr>
</tbody>
</table>

Notes:
1. Data published in 2016 report:
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.
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Neurological disease (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amyotrophic lateral sclerosis (%)</td>
<td>15 (8.9)</td>
<td>117 (8.0)</td>
<td>10 (7.8)</td>
<td>16 (7.5)</td>
<td>23 (6.8)</td>
<td>53 (8.7)</td>
</tr>
<tr>
<td>Other neurological disease (%)</td>
<td>10 (6.0)</td>
<td>44 (3.0)</td>
<td>2 (1.6)</td>
<td>1 (0.5)</td>
<td>8 (2.4)</td>
<td>23 (3.8)</td>
</tr>
<tr>
<td>Respiratory disease e.g., COPD (%)</td>
<td>13 (7.7)</td>
<td>75 (5.1)</td>
<td>9 (7.0)</td>
<td>6 (2.8)</td>
<td>18 (5.3)</td>
<td>29 (4.8)</td>
</tr>
<tr>
<td>Heart/circulatory disease (%)</td>
<td>16 (9.5)</td>
<td>66 (4.5)</td>
<td>4 (3.1)</td>
<td>1 (0.5)</td>
<td>9 (2.6)</td>
<td>36 (5.9)</td>
</tr>
<tr>
<td>Infectious disease e.g., HIV/AIDS (%)</td>
<td>0 (0.0)</td>
<td>13 (0.9)</td>
<td>1 (0.8)</td>
<td>7 (3.3)</td>
<td>2 (0.6)</td>
<td>3 (0.5)</td>
</tr>
<tr>
<td>Gastrointestinal disease e.g., liver disease (%)</td>
<td>1 (0.6)</td>
<td>9 (0.6)</td>
<td>0 (0.0)</td>
<td>1 (0.5)</td>
<td>1 (0.3)</td>
<td>6 (1.0)</td>
</tr>
<tr>
<td>Endocrine/metabolic disease e.g., diabetes (%)</td>
<td>2 (1.2)</td>
<td>11 (0.8)</td>
<td>0 (0.0)</td>
<td>2 (0.9)</td>
<td>1 (0.3)</td>
<td>6 (1.0)</td>
</tr>
<tr>
<td>Other illnesses (%)4</td>
<td>6 (3.6)</td>
<td>17 (1.2)</td>
<td>1 (0.8)</td>
<td>0 (0.0)</td>
<td>4 (1.2)</td>
<td>6 (1.0)</td>
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<tr>
<td>DWDA process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>3 (1.8)</td>
<td>65 (4.5)</td>
<td>28 (22.8)</td>
<td>8 (3.8)</td>
<td>6 (1.8)</td>
<td>20 (3.3)</td>
</tr>
<tr>
<td>Patient informed family of decision (%)4</td>
<td>156 (94.0)</td>
<td>1,292 (93.7)</td>
<td>55 (94.8)</td>
<td>198 (94.3)</td>
<td>317 (93.5)</td>
<td>566 (93.4)</td>
</tr>
<tr>
<td>Patient died at</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Home (patient, family or friend) (%)</td>
<td>147 (88.6)</td>
<td>1,342 (92.4)</td>
<td>121 (93.8)</td>
<td>198 (93.4)</td>
<td>326 (96.7)</td>
<td>550 (90.3)</td>
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<tr>
<td>Assisted living or foster care facility (%)</td>
<td>12 (7.2)</td>
<td>72 (5.0)</td>
<td>4 (3.1)</td>
<td>11 (5.2)</td>
<td>10 (3.0)</td>
<td>35 (5.7)</td>
</tr>
<tr>
<td>Nursing home (%)</td>
<td>5 (3.0)</td>
<td>14 (1.0)</td>
<td>2 (1.6)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>7 (1.1)</td>
</tr>
<tr>
<td>Hospital (%)</td>
<td>0 (0.0)</td>
<td>4 (0.3)</td>
<td>1 (0.8)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>3 (0.5)</td>
</tr>
<tr>
<td>Hospice facility (%)</td>
<td>0 (0.0)</td>
<td>2 (0.1)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>2 (0.3)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>2 (1.2)</td>
<td>19 (1.3)</td>
<td>1 (0.8)</td>
<td>3 (1.4)</td>
<td>1 (0.3)</td>
<td>12 (2.0)</td>
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<tr>
<td>Unknown</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Lethal medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Secobarbital (%)</td>
<td>92 (54.8)</td>
<td>846 (58.0)</td>
<td>86 (66.7)</td>
<td>91 (42.9)</td>
<td>223 (65.6)</td>
<td>354 (58.0)</td>
</tr>
<tr>
<td>Pentobarbital (%)</td>
<td>0 (0.0)</td>
<td>386 (26.5)</td>
<td>41 (31.8)</td>
<td>120 (56.6)</td>
<td>117 (34.4)</td>
<td>108 (17.7)</td>
</tr>
<tr>
<td>DDMP1 (%)9</td>
<td>10 (6.0)</td>
<td>67 (4.6)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>57 (9.3)</td>
</tr>
<tr>
<td>DDMP2 (%)9</td>
<td>54 (32.1)</td>
<td>78 (5.3)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>24 (3.9)</td>
</tr>
<tr>
<td>Phenobarbital compound (%)9</td>
<td>2 (1.2)</td>
<td>65 (4.5)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>63 (10.3)</td>
</tr>
<tr>
<td>Other barbiturate compound (%)</td>
<td>10 (6.0)</td>
<td>17 (1.2)</td>
<td>2 (1.6)</td>
<td>1 (0.5)</td>
<td>0 (0.0)</td>
<td>4 (0.7)</td>
</tr>
</tbody>
</table>
What's the meaning of "in the spirit of"? - English Language & Usage
https://english.stackexchange.com/questions/83796/what-is-the-meaning-of-in-the-spirit-of
Apr 22, 2014 - In the spirit of full disclosure, the tester in question turned out to be my editor at Salon.
... Source: http://imgflip.com/typo/in-the-spirit-of-definition

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A force or principle believed to animate living beings. b. A force or principle believed to animate humans and often to endear after departing from the body of a person at death; the soul. 2. Spirit The Holy Spirit.

in the spirit of synonym | English synonyms dictionary | Reverso
dictionary.reverso.net/english-synonyms/1?20the%20spirit%20of
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1: an animating or vital principle held to give life to physical organisms. 2: a supernatural being or essence such as capitalized: holy spirit: soul 2b: an often malevolent being that is bodiless but can become visible; specifically: ghost 2d: a malevolent being that enters and possesses a human being.

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Spirit definition, the principle of conscious life; the vital principle in humans, animating the body or mediating between body and soul. See more.
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https://www.merriam-webster.com/dictionary/accordance

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

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www.thefreedictionary.com/accordance

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

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Feedback
TITLE I
THE STATE AND ITS GOVERNMENT

CHAPTER 5-C
VITAL RECORDS ADMINISTRATION

Death Registration Forms and Procedures

Section 5-C:62

5-C:62 Death Registration Forms. —
I. For every death that occurs in the state of New Hampshire, a death record shall be filed electronically by a funeral director, certifying physician, APRN, physician assistant, next of kin, designated agent, or clerk of the town or city with the division within 36 hours of death and prior to final disposition or entombment.
II. The funeral director, next of kin, or designated agent pursuant to RSA 290:1 shall provide the following information for the death record:
(a) The decedent's full name, sex, date of death, and social security number.
(b) The decedent's age on his or her last birthday in years or, if under one year old, the person's age in months or days lived and, if under one day old, the number of hours or minutes lived. The date of the person's birth by month, day and year.
(c) The person's place of birth, by city or town and state or foreign country.
(d) Whether the decedent was ever in the United States Armed Forces, indicated as yes or no.
(e) If the place of death is a hospital, the record shall indicate: whether the person was an in-patient or whether the person was an out-patient or emergency room patient, in which case the person shall have arrived alive at the hospital's emergency room and died while in the emergency room as an out-patient. The record shall also indicate whether the person was transported while alive to the hospital but determined by a physician, APRN, or physician assistant to be dead at the time the hospital received the body. The city or town where the hospital is located shall be shown as the city or town of death occurrence.
(f) If the place of death is a facility other than a hospital, the record shall indicate: whether the facility is a nursing home, residential, or other facility, the exact location of the facility, and the name of the facility.
(g) If the place of death is not a facility, the record shall indicate: the street name and number; the city, town, or location and the county.
(h) In the case of deaths as described in RSA 611-B:11, when the deceased had died at the scene but was transported on the instructions of the medical examiner to another place for viewing and pronouncement of death, the city or town of death shall be shown as that place where the death actually occurred. If the place of death is unknown but the body is found in the state of New Hampshire, the city or town where the body is found shall be shown as the place of death. When death occurs in a moving conveyance in the United States and the body is first removed from the conveyance in the state of New Hampshire, the death shall be registered in New Hampshire, and the city or town where the body is first removed shall be considered the place of death.
(i) When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in the state of New Hampshire, the death shall be registered in the state of New Hampshire, and the certificate shall show the actual place of death insofar as can be determined.
(j) The decedent's marital status.
(k) The name of the decedent's spouse and wife's maiden name, if applicable.
(l) Vocational information, including the decedent's usual occupation, which shall mean the kind of work done during most of the decedent's working life. The type of business or industry, if applicable, such as manufacturing, wholesale or retail and the name of the employer.
(m) Decedent's residence, as identified by the informant, which shall be identified by state; county; city, town or
other location; street number; and zip code.
(n) The facility if the decedent has been living in a facility where an individual usually resides for a long period of time, such as a group home, a mental institution, a nursing home, a penitentiary, a hospital for the chronically ill, or another location otherwise identified by the informant.
(o) The decedent's ancestry and race, educational level, and the father's full name and the mother's full maiden name.
(p) The informant's full name and mailing address by street, city or town, state and zip code.
(q) How the body is to be disposed of, to be specified as: burial, cremation, temporary entombment, mausoleum, donation, or other.
(r) Information regarding the place of burial or place cremated, including the name of the cemetery or crematory, the location of cemetery or crematory by city or town and state and the date of disposition; the location of final burial; and information regarding the funeral director, next of kin or designated agent, and the individual issuing the burial permit.

III. The pronouncing physician or pronouncing registered nurse, pursuant to RSA 290:1 and RSA 290:1-b, shall register the following information:
(a) The name of the deceased person.
(b) The date and time of death. If the exact date of death is unknown, it shall be approximated by the person completing the medical certification and noted as approximated or estimated on the death record. If the exact time of death is unknown, it shall be approximated by the person who pronounces the body dead and noted as approximated or estimated on the death record. If it is not possible to make an estimation of the time of death, the time shall be indicated as "unknown." "Unknown a.m." or "unknown p.m." shall not be an acceptable entry.
(c) The official capacity of the registered nurse or physician, which shall be: attending/associate physician or APRN or physician assistant; non-attending physician or APRN or physician assistant; pronouncing registered nurse; medical examiner/deputy medical examiner; temporary/assistant medical examiner; or assistant deputy medical examiner, non-physician.
(d) The date pronounced.
(e) Certification that the above information provided is true, which shall include but not be limited to the pronouncing person's signature; the name and title of the individual who pronounced death; the New Hampshire license number of the physician, APRN, if applicable, or physician assistant, if applicable; whether the death was referred to the medical examiner; and the name and address of the physician, APRN, or physician assistant responsible for determining the cause of death. The individuals listed above shall provide or verify for the death record whether or not the death was referred to the medical examiner.

IV. The individuals listed in paragraph III, except the pronouncing registered nurse, shall provide the following information:
(a) The immediate cause of death and the interval between onset and death; other factors or conditions of which death was a consequence, when applicable, and the interval between onset and death; other significant conditions contributing to death but not related to the immediate cause of death.
(b) Whether or not an autopsy was performed and whether or not autopsy findings were available prior to the determination of the cause of death.
(c) The manner of death, indicated as natural, accidental, suicidal, homicidal, pending investigation, or undetermined.
(d) If the death involved an injury, the month, day, year, and time of injury shall be provided. If the exact date of injury is unknown, it shall be approximated by the person completing the medical certification, noted as approximated or estimated on the death record, and, if it is not possible for the physician, APRN, or physician assistant to make an estimation, the date of injury shall be indicated as "unknown". If the exact time of injury is unknown, it shall be approximated by the person completing the medical certification and noted as approximated or estimated on the death record. If it is not possible for the physician, APRN, or physician assistant to make an estimation, the time shall be indicated as "unknown." "Unknown a.m." or "unknown p.m." shall not be an acceptable entry. The record shall also indicate whether the injury occurred while at work, a description of how the injury occurred, and the physical location or place of injury.
(e) The name, address, title, and license number of the certifier and the date certified.

V. The certifying physician, APRN, or physician assistant shall indicate whether he or she is or is not the same individual who pronounced the death. The certifying physician, APRN, or physician assistant shall indicate whether he or she is the medical examiner. He or she shall sign the form, attesting to the veracity of the
information as follows:
(a) A certifying physician, APRN, or physician assistant shall attest to the veracity of the stated time, date, and place that the death occurred.
(b) A medical examiner shall attest to the veracity of the stated time, date, place, cause, and manner of the death.

VI. The attending or certifying physician, APRN, or physician assistant shall provide the following information for a supplemental death certificate: the deceased's name; the date of death; the time of death; the place of death; the name of the pronouncer; the New Hampshire license number of the pronouncer; the official capacity of the pronouncer; the date pronounced dead; the signature of the pronouncer; the date signed; whether this death was referred to the medical examiner; the cause of death; the performance of autopsy, indicated as yes or no; the availability of autopsy findings prior to determination of cause of death, indicated as yes or no; the manner of death; the time, date, and place of injury; whether or not the injury occurred at work; the description of how the injury occurred; the location specified as street and number or rural route number, city or town, and state; the name of the certifier; the signature and title of the certifier; the New Hampshire license number of the certifier; the date signed; and the name and address of the person who determined the cause of death.

VII. The original paper death certificate shall be the official certificate and shall be filed with the division within 10 days from the date of death.

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”.

https://www.theguardian.com/uk-news/2015/jan/21/death-certificate-reform-delays-incomprehensible-senior-pathologist
Lishman said changes that would see a medical examiner review death certificates had not been implemented, possibly because of confusion created by the coalition government’s NHS shakeup.

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

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

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

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

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

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

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

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

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

$82,194
contributed
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Toxic America: Is modern life poisoning us?
Weedkiller in your breakfast cereal. Contaminated drinking water. Carcinogenic chemicals in your furniture.

https://www.theguardian.com/uk-news/2015/jan/21/death-certificate-reform-delays-incomprehensible-senior-pathologist
Planning for old age at a premium

By Jerry Large
Seattle Times staff columnist

Monday, I suggested exploring long-term health insurance as a way to deal with the costs of assisted living.

Like almost everything about managing when you can no longer live on your own, insurance can be complicated, frustrating and inadequate. Lots of readers shared stories about their experiences.

It was an email from a reader that led to the column. Roslyn Duffy wrote about her mother, who ran out of money and had to turn to Medicaid. She was told she'll have to move because the assisted-living facility where she lives no longer accepts Medicaid.

Care is expensive. I had no idea how costly until my wife and I began to deal with parents who needed it.

We didn't know about the paperwork and bureaucracy, or the difficult hunt for quality care that was accessible to people who hadn't managed to get rich. It's like college hunting — but with no joy attached to it.

There are good places out there, but they're harder to get into and usually cost more. Some of the most desirable places take Medicaid clients, but placements are limited.

The only certainty is that nothing is universally true.

The problem of what to do with old people who need help is a creation of modern society that we haven't committed ourselves to solving. It's almost like a monster that you don't believe exists until you answer its knock at your door.

After Monday's column, some readers were unsympathetic, a few suggested that if you couldn't save enough money to see you through your old age, you shouldn't expect society to bail you out.

At least a couple mentioned euthanasia as a solution.

But most readers were glad the topic was raised. Out of sight, out of mind is no way to deal with something so important.

So here's the deal. If you are rich, it's not a problem. If you are poor, Medicaid will pick up the tab for a nursing home.

If you are somewhere in the middle, you may want what the rich have, but be able to afford only what the poor get — and only until your money runs out, and then Medicaid will step in.