Appendix
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Expert Witness
Walter v. Ministry of Health
January 28, 2021
Oregon’s Death with Dignity Act: The First Year’s Experience

Department of Human Resources
Oregon Health Division
Center for Disease Prevention and Epidemiology

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Oregon’s Death with Dignity Act:  
The First Year’s Experience

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INTRODUCTION

On October 27, 1997 physician-assisted suicide became a legal medical option for terminally ill Oregonians. The Oregon Death with Dignity Act requires that the Oregon Health Division (OHD) monitor compliance with the law, collect information about the patients and physicians who participate in legal physician-assisted suicide, and publish an annual statistical report. This report describes the monitoring and data collection system that was implemented under the law, and summarizes the information collected on patients and physicians who had participated in the Act through December 31, 1998. To better understand the impact of physician-assisted suicide on the care of and decisions made by terminally ill Oregonians, we also present the results of two studies conducted by the OHD. Each study compared the characteristics of physician-assisted suicide participants with a sample of Oregon patients and physicians who did not participate in the Death with Dignity Act.

THE OREGON DEATH WITH DIGNITY ACT

The Oregon Death with Dignity Act, a citizens’ initiative, was first passed by Oregon voters in November 1994 by a margin of 51% in favor and 49% opposed. Immediate implementation of the Act was delayed by a legal injunction. After multiple legal proceedings, including a petition that was denied by the United States Supreme Court, the Ninth Circuit Court of Appeals lifted the injunction on October 27, 1997 and physician-assisted suicide then became a legal option for terminally ill patients in Oregon. In November 1997, Measure 51 (authorized by Oregon House Bill 2954) was placed on the general election ballot and asked Oregon voters to repeal the Death with Dignity Act. Voters chose to retain the Act by a margin of 60% to 40%.

The Death with Dignity Act allows terminally ill Oregon residents to obtain from their physicians and use prescriptions for self-administered, lethal medications. The Act states that ending one’s life in accordance with the law does not constitute suicide. However, we have used the term “physician-assisted suicide” rather than “Death with Dignity” to describe the provisions of this law because physician-assisted suicide is the term used by the public, and by the medical literature, to describe ending life through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose. The Death with Dignity Act legalizes physician-assisted suicide, but specifically prohibits euthanasia, where a physician or other person directly administers a medication to end another’s life.

To request a prescription for lethal medications, the Death with Dignity Act requires that a patient must be:

- An adult (18 years of age or older);
- A resident of Oregon;
- Capable (defined as able to make and communicate health care decisions);
THE OREGON DEATH WITH DIGNITY ACT
OREGON REVISED STATUTES

127.800 – 127.995

Note: The division headings, subdivision headings and headlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

(Generic Provisions)
(Section 1)

127.800 §1.01. Definitions.
The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

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

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

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

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

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

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

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
   (a) His or her medical diagnosis;
   (b) His or her prognosis;
   (c) The potential risks associated with taking the medication to be prescribed;
   (d) The probable result of taking the medication to be prescribed; and
   (e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

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

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

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

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

(2) One of the witnesses shall be a person who is not:
   (a) A relative of the patient by blood, marriage or adoption;
   (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

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

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

127.815 §3.01. Attending physician responsibilities.

1. The attending physician shall:
   (a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;
   (b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;
   (c) To ensure that the patient is making an informed decision, inform the patient of:
      (A) His or her medical diagnosis;
      (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;
   (d) 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;
   (e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;
   (f) Recommend that the patient notify next of kin;
   (g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;
   (h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the time the patient makes the patient’s second oral request pursuant to ORS 127.840;
   (i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;
   (j) Fulfill the medical record documentation requirements of ORS 127.855;
   (k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and
   (l) (A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient’s discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or
      (B) With the patient’s written consent:
         (i) Contact a pharmacist and inform the pharmacist of the prescription; and
         (ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.
(2) Notwithstanding any other provision of law, the attending physician may sign the patient’s death certificate. [1995 c.3 §3.01; 1999 c.423 §3]

127.820 §3.02. Consulting physician confirmation.
Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician’s diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision. [1995 c.3 §3.02]

127.825 §3.03. 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 causing impaired judgment. [1995 c.3 §3.03; 1999 c.423 §4]

127.830 §3.04. Informed decision.
No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision. [1995 c.3 §3.04]

127.835 §3.05. Family notification.
The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason. [1995 c.3 §3.05; 1999 c.423 §6]

127.840 §3.06. Written and oral requests.
(1) In order to receive a prescription for medication to end his or her 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 his or her attending physician no less than 15 days after making the initial oral request.
(2) Notwithstanding subsection (1) of this section, if the qualified patient’s attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to his or her attending physician at any time after making the initial oral request.
(3) At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request. [1995 c.3 §3.06]

127.845 §3.07. Right to rescind request.
A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request. [1995 c.3 §3.07]
127.850 §3.08. Waiting periods.
(1) No less than 15 days shall elapse between the patient’s initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient’s written request and the writing of a prescription under ORS 127.800 to 127.897. [1995 c.3 §3.08]
(2) Notwithstanding subsection (1) of this section, if the qualified patient’s attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die before the expiration of at least one of the waiting periods described in subsection (1) of this section, the prescription for medication under ORS 127.800 to 127.897 may be written at any time following the later of the qualified patient’s written request or second oral request under ORS 127.840.

127.855 §3.09. Medical record documentation requirements.
The following shall be documented or filed in the patient’s medical record:
(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
(3) The attending physician’s diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
(4) The consulting physician’s diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
(5) A report of the outcome and determinations made during counseling, if performed;
(6) Any medically confirmed certification of the imminence of the patient’s death;
(7) The attending physician’s offer to the patient to rescind his or her request at the time of the patient’s second oral request pursuant to ORS 127.840; and
(8) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 §3.09]

127.860 §3.10. Residency requirement.
Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:
   (1) Possession of an Oregon driver license;
   (2) Registration to vote in Oregon;
   (3) Evidence that the person owns or leases property in Oregon; or
   (4) Filing of an Oregon tax return for the most recent tax year. [1995 c.3 §3.10; 1999e.423 §8]

127.865 §3.11. Reporting requirements.
(1) (a) The Department of Human Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.
(b) The department shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the department.

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

(3) The department shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 §3.11; 1999 c.423 §9; 2001 c.104 §40]

127.870 §3.12. Effect on construction of wills, contracts and statutes.
(1) 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 his or her life in a humane and dignified manner, shall be valid.

(2) 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 his or her life in a humane and dignified manner. [1995 c.3 §3.12]

127.875 §3.13. Insurance or annuity policies.
The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient’s act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 §3.13]

Nothing in ORS 127.800 to 127.897 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 ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 §3.14]

(Immunities and Liabilities)
(Section 4)

127.885 §4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.
Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) 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 ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) 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 his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient’s request under ORS 127.800 to 127.897, and the patient transfers his or her 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.

(5) (a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider’s policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider’s medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioning provider’s capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider’s capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider’s capacity as an employee or independent contractor of the sanctioning health care provider.
(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS 127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (2) or (3).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community. [1995 c.3 §4.01; 1999 c.423 §10]

Note: As originally enacted by the people, the headline to section 4.01 read "Immunities." The remainder of the headline was added by editorial action.

127.890 §4.02. Liabilities.

(1) 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.

(2) 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.

(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.
(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897. [1995 c.3 §4.02]

127.892 Claims by governmental entity for costs incurred.
Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to the provisions of ORS 127.800 to 127.897 in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim. [1999 c.423 §5a]

(Severability)
(Section 5)

127.895 §5.01. Severability.
Any section of ORS 127.800 to 127.897 being held invalid as to any person or circumstance shall not affect the application of any other section of ORS 127.800 to 127.897 which can be given full effect without the invalid section or application. [1995 c.3 §5.01]

(Form of the Request)
(Section 6)

127.897 §6.01. Form of the request.
A request for a medication as authorized by ORS 127.800 to 127.897 shall be in substantially the following form:

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

I, ____________________________, am an adult of sound mind.

I am suffering from ________, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, 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 three 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: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person’s estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

[1995 c.3 §6.01; 1999 c.423 §11]

PENALTIES

127.990: [Formerly part of 97.990; repealed by 1993 c.767 §29]

127.995 Penalties.
(1) It shall be a Class A felony for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument or any other evidence or document reflecting the principal’s desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration which hastens the death of the principal.

(2) Except as provided in subsection (1) of this section, it shall be a Class A misdemeanor for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal’s desires and interests with the intent or effect of affecting a health care decision. [Formerly 127.585]
What is Medication?

A medication is a substance that is taken into or placed on the body that does one of the following things:

\(\checkmark\) Most medications are used to cure a disease or condition. For example, antibiotics are given to cure an infection.

\(\times\) Medications are also given to treat a medical condition. For example, anti-depressants are given to treat depression.

\(\checkmark\) Medications are also given to relieve symptoms of an illness. For example, pain relievers are given to reduce pain.

\(\checkmark\) Vaccinations are given to prevent diseases. For example, the Flu Vaccine helps to prevent the person from complications of having the flu.

Note from Margaret Dore:

*Provided by the New Hampshire Department of Health and Human Services, Bureau of Developmental Services. Available at https://www.dhhs.nh.gov/debcs/bds/nurses/documents/sectionII.pdf*
ETHICS

Physician-Assisted Suicide

Code of Medical Ethics Opinion 5.7

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

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

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

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

(a) Should not abandon a patient once it is determined that cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I, IV

Read more opinions about this topic

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

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

Euthanasia

Code of Medical Ethics Opinion 5.8

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

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

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

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

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

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

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

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

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

AMA Principles of Medical Ethics: I, IV

Read more opinions about this topic
**mercy killing**

A popular term for the termination of a person's life as a humane act

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**mercy killing**  Medical ethics The termination of a person's life as a humane act. See Euthanasia.


**mer·cy kill·ing**  (mɛr'sɛ kɪl'ɪŋ)

The intentional putting to death of a person with an incurable or painful disease, intended as an act of mercy.

Compare: euthanasia

Medical Dictionary for the Health Professions and Nursing © Farlex 2012

https://medical-dictionary.thefreedictionary.com/mercy+killing
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

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. (Pemtrexate 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 2007 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 better judgment because her family insisted. “I thought she would live days to weeks,” he says of the woman, who was suffering from septic shock and multiple organ failure. Instead she improved enough to eventually leave the hospital and come back for a visit some six or eight months later.

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

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.

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

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

Deschutes County Circuit Judge Alta Brandy 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, 7a dependent or elderly person, for the purpose of fraud.

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

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

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

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

A federal judge twice gave permission for her to travel to Mexico, once in May and again in June.
SUPREME COURT OF QUEENSLAND

R v Morant [2018] QSC 251

PARTIES:

R

v

GRAHAM ROBERT MORANT
(defendant)

FILE NO/S:

Indictment No 1424 of 2018

DIVISION:

Trial Division

PROCEEDING:

Trial

DELIVERED ON:

2 November 2018 (delivered ex tempore)

DELIVERED AT:

Brisbane

HEARING DATE:

17 to 21 September 2018; 24 to 28 September 2018;
2 October 2018; 26 October 2018; 2 November 2018

JUDGE:

Davis J

ORDER:

Convictions recorded.

On count 1, the defendant is sentenced to 10 years imprisonment.

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

The sentences are to be served concurrently.

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

CATCHWORDS:

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

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

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.

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

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.

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.

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.

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.

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.

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 vehicle. After initially denying to polic
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."
Q&A: Harold Shipman

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

David Batty
Thu 25 Aug 2005 10.19 EDT

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

What triggered the inquiry?
Shipman was convicted at Preston crown court in January 2000 of the murder of 15 elderly patients with lethal injections of morphine. A public inquiry was launched in June 2001 to investigate the extent of his crimes, how they went undetected for so long, and what could be done to prevent a repeat of the tragedy.

What do we know about his crimes?
His first victim, Eva Lyons, was killed in March 1975 on the eve of her 71st birthday while...
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.

Topics
- Harold Shipman
- Health
- Health & wellbeing
- Crime
- q&as
was working at the Abraham Darmerod medical practice in Todmorden. The following year the first clues emerged that Shipman was no ordinary respectable GP. In February 1976, he was convicted of obtaining the morphine-like drug pethidine by forgery and deception to supply his addiction to the drug. Later that year, in the name of a dying patient, he obtained enough morphine to kill 360 people. After receiving psychiatric and drug treatment in York, he re-emerged as a GP in Hyde, Greater Manchester. His method of murder was consistent: a swift injection of diamorphine - pharmaceutical heroin. He killed 71 patients while at the Donnebrook practice in the town and the remainder while a single-handed practitioner at his surgery in Market Street. The majority of his victims - 171 - were women, compared with 44 men. The oldest was 93-year-old Anne Cooper and the youngest 41-year-old Peter Lewis.

**How did he get away with it?**

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

**What led to his conviction?**

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

**Why did he kill his patients?**

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

By Margaret Dore, Esq., MBA

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

1. Alabama: In 2017, Alabama enacted the Assisted Suicide Ban Act;
2. Arizona: In 2014, Arizona strengthened its law against assisted suicide;
3. Georgia: In 2012, Georgia strengthened its law against assisted suicide;
4. Idaho: On April 5, 2011, Idaho strengthened its law against assisted suicide;
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. Physician-assisted suicide is no longer legal in New Mexico. See Morris v. Brandenburg, 376 P.3d 836 (2016).
7. Ohio: In 2017, Ohio strengthened its law against assisted suicide. See http://codes.ohio.gov/orc/1795
8. South Dakota: In 2017, the South Dakota Legislature passed Concurrent Resolution 11, opposing physician-assisted suicide. See Bill History.

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

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<td>Cancer</td>
<td>128 (68.1)</td>
<td>114 (64.0)</td>
<td>1,002 (77.6)</td>
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<tr>
<td>Lip, oral cavity, and pharynx</td>
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<td>34 (2.1)</td>
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<tr>
<td>Digestive organs</td>
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<td>29 (16.3)</td>
<td>264 (20.4)</td>
<td>332 (20.0)</td>
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<tr>
<td>Pancreas</td>
<td>10 (5.3)</td>
<td>9 (5.1)</td>
<td>91 (7.0)</td>
<td>110 (6.6)</td>
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<tr>
<td>Colon</td>
<td>6 (3.2)</td>
<td>7 (3.9)</td>
<td>79 (6.1)</td>
<td>92 (5.6)</td>
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<tr>
<td>Other digestive organs</td>
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<td>13 (7.3)</td>
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<td>Respiratory and intrathoracic organs</td>
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<td>17 (9.6)</td>
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<td>Lung and bronchus</td>
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<td>17 (9.6)</td>
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<td>Other respiratory and intrathoracic organs</td>
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<td>Melanoma and other skin</td>
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<td>Mesothelial and soft tissue</td>
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<td>Female genital organs</td>
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<td>Prostate</td>
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<td>Urinary tract</td>
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<td>Brain</td>
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<td>Ill-defined, secondary, and unspecified sites</td>
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<tr>
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<td>Other cancers</td>
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<td>Neurological disease</td>
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<td>Amyotrophic lateral sclerosis</td>
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<td>Respiratory disease [e.g., COPD]</td>
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<tr>
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<tr>
<td>Endocrine/metabolic disease [e.g., diabetes]</td>
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<td>2 (1.1)</td>
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<td><strong>DWDA process</strong></td>
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<tr>
<td>Referred for psychiatric evaluation</td>
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<td>66 (4.0)</td>
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<td><strong>Patient died at</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Home (patient, family or friend)</td>
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<tr>
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<td>1 (0.5)</td>
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<td>20 (1.2)</td>
</tr>
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<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Lethal medication</strong></td>
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<td></td>
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<tr>
<td>DDMP-2*</td>
<td>87 (46.3)</td>
<td>57 (32.0)</td>
<td>24 (1.9)</td>
<td>168 (10.1)</td>
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<tr>
<td>DDMA*</td>
<td>87 (46.3)</td>
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<td>0 (0.0)</td>
<td>87 (5.3)</td>
</tr>
<tr>
<td>Secobarbital</td>
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<td>98 (55.1)</td>
<td>754 (58.4)</td>
<td>859 (51.8)</td>
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<tr>
<td>DDMP-1*</td>
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<td>11 (6.2)</td>
<td>57 (4.4)</td>
<td>71 (4.3)</td>
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<tr>
<td>Phenobarbital compound*</td>
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<td>65 (3.9)</td>
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<tr>
<td>Pentobarbital</td>
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<td>0 (0.0)</td>
<td>386 (29.9)</td>
<td>386 (23.3)</td>
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<tr>
<td>Other</td>
<td>4 (2.1)</td>
<td>10 (5.6)</td>
<td>7 (0.5)</td>
<td>21 (1.3)</td>
</tr>
</tbody>
</table>
IN THE STATE OF SOUTH DAKOTA

IN RE AN INITIATED MEASURE

DECLARATION OF WILLIAM TOFFLER, MD

I, WILLIAM TOFFLER, declare the following under penalty of perjury.

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

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

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

Exhibit A, attached hereto.

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

4. Attached hereto, as Exhibits B-1 & B-2, are excerpts from Declaration of William Toffler, MD - page 1
the most recent government statistical report regarding our law. The excerpts list chronic lower respiratory disease and diabetes mellitus as "underlying illnesses" sufficient to justify assisted suicide. The full report can be read at this link: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf

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

6. Such persons, with insulin, are likely to have decades to live. In fact, most diabetics have a normal life span given appropriate control of their blood sugar. They can live happy, healthy and productive lives.

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

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

Chapter 127

Note: The division headings, subdivision headings and line numbers for 127.800 to 127.897 were enacted as part of Ballot Measure 16 (1984) and were not provided by Legislative Counsel.

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

127.800 s.1.01. Definitions.

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

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

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

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

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

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

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

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

(a) His or her medical diagnosis;

(b) His or her prognosis;

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

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

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

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

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

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

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

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

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2016 (N=133)</th>
<th>1998–2015 (N=994)</th>
<th>Total (N=1,127)</th>
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<tbody>
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<td>Residence</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Metro counties (Clackamas, Multnomah, Washington) (%)</td>
<td>54 (40.9)</td>
<td>427 (43.3)</td>
<td>481 (43.0)</td>
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<td>Coastal counties (%)</td>
<td>10 (7.6)</td>
<td>70 (7.1)</td>
<td>80 (7.1)</td>
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<td>Other western counties (%)</td>
<td>57 (43.2)</td>
<td>413 (41.8)</td>
<td>470 (42.0)</td>
</tr>
<tr>
<td>East of the Cascades (%)</td>
<td>11 (8.3)</td>
<td>77 (7.8)</td>
<td>88 (7.9)</td>
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<tr>
<td>Unknown</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>End of life care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled (%)</td>
<td>118 (88.7)</td>
<td>868 (90.4)</td>
<td>986 (90.2)</td>
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<td>Not enrolled (%)</td>
<td>15 (11.3)</td>
<td>92 (9.6)</td>
<td>107 (9.8)</td>
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<tr>
<td>Unknown</td>
<td>0</td>
<td>34</td>
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<tr>
<td>Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private (%)</td>
<td>35 (29.7)</td>
<td>534 (57.1)</td>
<td>569 (54.0)</td>
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<tr>
<td>Medicare, Medicaid or other governmental (%)</td>
<td>82 (69.5)</td>
<td>388 (41.5)</td>
<td>470 (44.5)</td>
</tr>
<tr>
<td>None (%)</td>
<td>1 (0.8)</td>
<td>13 (1.4)</td>
<td>14 (1.3)</td>
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<td>Unknown</td>
<td>15</td>
<td>59</td>
<td>74</td>
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<td>Underlying Illness</td>
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<tr>
<td>Malignant-neoplasms (%)</td>
<td>105 (78.9)</td>
<td>767 (77.2)</td>
<td>872 (77.4)</td>
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<tr>
<td>Lung and bronchus (%)</td>
<td>16 (12.0)</td>
<td>177 (17.8)</td>
<td>193 (17.1)</td>
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<tr>
<td>Breast (%)</td>
<td>12 (9.0)</td>
<td>74 (7.4)</td>
<td>86 (7.6)</td>
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<td>Colon (%)</td>
<td>12 (9.0)</td>
<td>61 (6.1)</td>
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<tr>
<td>Pancreas (%)</td>
<td>9 (6.8)</td>
<td>64 (6.4)</td>
<td>73 (6.5)</td>
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<td>Prostate (%)</td>
<td>6 (4.5)</td>
<td>41 (4.1)</td>
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<td>Ovary (%)</td>
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<td>37 (3.7)</td>
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<td>Other (%)</td>
<td>47 (35.3)</td>
<td>313 (31.5)</td>
<td>360 (31.9)</td>
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<td>Amyotrophic lateral sclerosis (%)</td>
<td>9 (6.8)</td>
<td>80 (8.0)</td>
<td>89 (7.9)</td>
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<td>Chronic lower respiratory disease (%)</td>
<td>2 (1.5)</td>
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<td>46 (4.1)</td>
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<td>Heart disease (%)</td>
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<td>HIV/AIDS (%)</td>
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<td>10 (0.9)</td>
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<td>Other Illnesses (%)</td>
<td>8 (6.0)</td>
<td>67 (6.7)</td>
<td>75 (6.7)</td>
</tr>
<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>5 (3.8)</td>
<td>52 (5.3)</td>
<td>57 (5.1)</td>
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<tr>
<td>Patient informed family of decision (%)</td>
<td>119 (89.5)</td>
<td>858 (93.6)</td>
<td>977 (93.0)</td>
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<td>Patient died at</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Home (patient, family or friend) (%)</td>
<td>117 (88.6)</td>
<td>931 (94.0)</td>
<td>1,048 (93.4)</td>
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<td>Long term care, assisted living or foster care facility (%)</td>
<td>9 (6.8)</td>
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<td>55 (4.9)</td>
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<td>Other (%)</td>
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**TOFFLER EXHIBIT B-1**

APPENDIX PAGE 38
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**Timing of DWDA event**

**Duration (weeks) of patient-physician relationship**

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<td>13</td>
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<td>Number of patients with information unknown</td>
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**Duration (days) between first request and death**

<table>
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<th>1998–2015</th>
<th>Total</th>
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<td>56</td>
<td>46</td>
<td>48</td>
</tr>
<tr>
<td>Range</td>
<td>15–539</td>
<td>14–1,009</td>
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<tr>
<td>Number of patients with information available</td>
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<td>994</td>
<td>1,127</td>
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<tr>
<td>Number of patients with information unknown</td>
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**Minutes between ingestion and unconsciousness**

<table>
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<th>2016</th>
<th>1998–2015</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Range</td>
<td>1–60</td>
<td>1–38</td>
<td>1–60</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>24</td>
<td>532</td>
<td>556</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>109</td>
<td>462</td>
<td>571</td>
</tr>
</tbody>
</table>

**Minutes between Ingestion and death**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>1998–2015</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>27</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Range</td>
<td>7min–9hrs</td>
<td>1min–104hrs</td>
<td>1min–104hrs</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>25</td>
<td>537</td>
<td>562</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>108</td>
<td>457</td>
<td>565</td>
</tr>
</tbody>
</table>

1. Unknowns are excluded when calculating percentages.
2. Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.
3. First recorded beginning in 2001. Since then, 52 patients (4.9%) have chosen not to inform their families, and 21 patients (2.0%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and three in 2013.
4. Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Late unavailable for four patients in 2001.
6. A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.
7. There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (https://www.healthcare.org/dwda) for more detail on these deaths.
Each year in the U.S., approximately 12 million adults who seek outpatient medical care are misdiagnosed, according to a new study published in the journal BMJ Quality & Safety. This figure amounts to 1 out of 20 adult patients, and researchers say in half of those cases, the misdiagnosis has the potential to result in severe harm.
PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

C.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO
ASSISTED SUICIDE AND EUTHANASIA

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

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

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

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

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

5. I will be 75 years old this coming September. If assisted suicide or euthanasia had been available to me in the 1950’s, I would have missed the bulk of my life and my life yet to come. I hope that Canada does not legalize these practices.
SWORN BEFORE ME at
MASSACHUSETTS, USA
on, AUGUST 16th, 2012

NAME: Heidi PRUZINSKI

A notary public for the
State of Washington MASSACHUSETTS

ADDRESS: 85 MAIN ST.
Florence, WA 01062
EXPIRY OF COMMISSION: June 22, 2016

PLACE SEAL HERE:

[Seal]

JOHN NORTON

AFFIDAVIT OF JOHN NORTON- Page 3

INTERNATIONAL PATENT ATTORNEY JOHN NORTON AFFIDAVIT 199