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.

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
Table 4. Duration between ingestion and death, DWDA deaths, 2001-2019

<table>
<thead>
<tr>
<th>Drug(%)</th>
<th>Total</th>
<th>Unknown duration</th>
<th>Known duration</th>
<th>&lt;1hr</th>
<th>1-6 hours</th>
<th>&gt;6 hours</th>
<th>Median</th>
<th>Mean</th>
<th>Range</th>
<th>Regained consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secobarbital(^1)</td>
<td>791</td>
<td>402</td>
<td>389 (100.0)</td>
<td>293  (75.3)</td>
<td>69  (17.7)</td>
<td>27  (6.9)</td>
<td>25</td>
<td>137</td>
<td>2min - 83 hrs</td>
<td>5</td>
</tr>
<tr>
<td>Pentobarbital(^1)</td>
<td>384</td>
<td>156</td>
<td>228 (100.0)</td>
<td>188  (82.5)</td>
<td>31  (13.6)</td>
<td>9  (3.9)</td>
<td>20</td>
<td>97</td>
<td>1min - 104 hrs</td>
<td>0</td>
</tr>
<tr>
<td>DDMP-2(^2)</td>
<td>168</td>
<td>70</td>
<td>98 (100.0)</td>
<td>42   (42.9)</td>
<td>35  (35.7)</td>
<td>21  (21.4)</td>
<td>86</td>
<td>258</td>
<td>5min - 47 hrs</td>
<td>2</td>
</tr>
<tr>
<td>DDMA(^3)</td>
<td>87</td>
<td>25</td>
<td>62 (100.0)</td>
<td>31   (50.0)</td>
<td>30  (48.4)</td>
<td>1   (1.6)</td>
<td>58</td>
<td>83</td>
<td>1min - 19 hrs</td>
<td>0</td>
</tr>
<tr>
<td>DDMP-1(^2)</td>
<td>71</td>
<td>47</td>
<td>24 (100.0)</td>
<td>12   (50.0)</td>
<td>7   (29.2)</td>
<td>5   (20.8)</td>
<td>67</td>
<td>203</td>
<td>10min - 21 hrs</td>
<td>0</td>
</tr>
<tr>
<td>Phenobarbital(^4)</td>
<td>65</td>
<td>43</td>
<td>22 (100.0)</td>
<td>4    (18.2)</td>
<td>13  (59.1)</td>
<td>5   (22.7)</td>
<td>73</td>
<td>439</td>
<td>20min - 72 hrs</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>5</td>
<td>16 (100.0)</td>
<td>7    (43.8)</td>
<td>7   (43.8)</td>
<td>2   (12.5)</td>
<td>68</td>
<td>174</td>
<td>1min - 14 hrs</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,587</strong></td>
<td><strong>748</strong></td>
<td><strong>839 (100.0)</strong></td>
<td><strong>577</strong> (68.8)</td>
<td><strong>192</strong> (22.9)</td>
<td><strong>70</strong> (8.3)</td>
<td><strong>30</strong></td>
<td><strong>147</strong></td>
<td><strong>1min - 104 hrs</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

1. Pentobarbital has been unavailable for DWDA use since 2015; secobarbital since 2019.
2. DDMP is a combination of diazepam, digoxin, morphine sulfate, and propranolol. DDMP-1 contains 10g of morphine sulfate; DDMP-2 contains 15g.
3. DDMA is a combination of diazepam, digoxin, morphine sulfate, and amitriptyline.
4. Phenobarbital is dispensed as a combination of phenobarbital, chloral hydrate, and morphine sulfate.
5. Patients who regained consciousness after ingestion are not considered DWDA deaths, and are not included in the other columns in this table.

NOTE: Table includes all reported durations, not just those from licensed providers. Complete information not available before 2001. Unknown values are excluded when calculating percentages.
Seconal Sodium Description

The barbiturates are nonselective central nervous system (CNS) depressants that are primarily used as sedative hypnotics. In subhypnotic doses, they are also used as anticonvulsants. The barbiturates and their sodium salts are subject to control under the Federal Controlled Substances Act.

Seconal Sodium® (Secobarbital Sodium Capsules, USP) is a barbituric acid derivative and occurs as a white, odorless, bitter powder that is very soluble in water, soluble in alcohol, and practically insoluble in ether. Chemically, the drug is sodium 5-allyl-5-(1-methylbutyl) barbiturate, with the molecular formula C_{12}H_{17}N_{2}NaO_{3}. Its molecular weight is 260.27. The structural formula is as follows:
Phenobarbital Oral Solution

Dosage Form: oral solution

Medically reviewed by Drugs.com. Last updated on Sep 1, 2020.

Disclaimer: This drug has not been found by FDA to be safe and effective, and this labeling has not been approved by FDA. For further information about unapproved drugs, click here.

On This Page

Description
Clinical Pharmacology
Indications and Usage
Contraindications
Warnings
Precautions
Patient Counseling Information
Expand

Rx only

Description

The barbiturates are nonselective central nervous system (CNS) depressants that are primarily used as sedative-hypnotics. In sub hypnotic doses, they are also used as anticonvulsants. The barbiturates and their sodium salts are subject to control under the Federal Controlled Substances Act.

Phenobarbital is a barbituric acid derivative and occurs as white, odorless, small crystals or crystalline powder that is very slightly soluble in water; soluble in alcohol, in ether, and in solutions of fixed alkali hydroxides and carbonates; sparingly soluble in chloroform. Phenobarbital is 5-ethyl-5-phenylbarbituric acid and has the empirical formula C_{12}H_{12}N_2O_3. Its molecular weight is 232.24. It has the following structural formula:
accordance

(aˈkôrdəns/ n.)

noun

1. accordance

in a manner conforming with.

- "the product is dispensed in accordance with federal regulations."  
- "in agreement with, in conformity with, in line with, true to, in the spirit of, observing, following, heading.
- "a ballot held in accordance with union rules."

Origin

OLD FRENCH accordance

accorder

OLD FRENCH accordance

accord

ENGLISH

Middle English: from Old French accordance, from acorder 'bring to an agreement' (see accord).

Translate accordance to Choose language

Use over time for: accordance

Show less

Accordance | Definition of Accordance by Merriam-Webster

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

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

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

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

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

Accordance | Define Accordance at Dictionary.com

www.dictionary.com/browse/according

Accordance definition, agreement; conformity: in accordance with the rules. See more.

accordance (noun) definition and synonyms | Macmillan Dictionary

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

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

Accordance - definition of accordance by The Free Dictionary

www.thefreedictionary.com/according

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

In accordance with | Idioms by The Free Dictionary

Idioms.thefreedictionary.com/in+acccordance+with
What's the meaning of "In the spirit of"? - English Language & Usage...
https://english.stackexchange.com/questions/.../What%20is%20the%20meaning%20of%20In%20the%20spirit%20of
Apr 22, 2014 - In the spirit of full disclosure, the writer in question turned out to be my editor at Salon...
Source: https://english.stackexchange.com/questions/.../What%20is%20the%20meaning%20of%20In%20the%20spirit%20of

the spirit of the law (phrase) definition and synonyms | Macmillan...
Define the spirit of the law (phrase) and get synonyms. What is the spirit of the law (phrase)? The spirit of the law (phrase) meaning, pronunciation and more by...

in (or in the) spirit phrase of spirit
1. a thought or intention though not physically.
   "He couldn't be here in person, but he is with us in spirit."

Translations, word origin, and more definitions

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

in the spirit of synonym | English synonyms dictionary | Reverso
dictionary.reverso.net/english-synonyms/in%20the%20spirit%20of
in the spirit of synonyms, antonyms, English dictionary, English language, definition, see also: spirit, espirtu, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, spirit, 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Americans with Disabilities Act

Access To Medical Care For Individuals With Mobility Disabilities

PART 1: OVERVIEW AND GENERAL REQUIREMENTS

PART 2: COMMONLY ASKED QUESTIONS

PART 3: ACCESSIBLE EXAMINATION ROOMS
PART I: OVERVIEW AND GENERAL REQUIREMENTS

Accessibility of doctors' offices, clinics, and other health care providers is essential in providing medical care to people with disabilities. Due to barriers, individuals with disabilities are less likely to get routine preventative medical care than people without disabilities. Accessibility is not only legally required, it is important medically so that minor problems can be detected and treated before turning into major and possibly life-threatening problems.

The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services. Section 504 of the Rehabilitation Act of 1973 (Section 504) is a civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance, including health programs and services. These statutes require medical care providers to make their services available in an accessible manner. This technical assistance publication provides guidance for medical care providers on the requirements of the ADA in medical settings with respect to people with mobility disabilities, which include, for example, those who use wheelchairs, scooters, walkers, crutches, or no mobility devices at all.

The ADA requires access to medical care services and the facilities where the services are provided. Private hospitals or medical offices are covered by Title III of the ADA as places of public accommodation. Public hospitals and clinics and medical offices operated by state and local governments are covered by Title II of the ADA as programs of the public entities. Section 504 covers any of these that receive federal financial assistance, which can include Medicare and Medicaid reimbursements. The standards adopted under the ADA to ensure equal access to individuals with disabilities are generally the same as those required under Section 504.

Services and Facilities

Both Title II and Title III of the ADA and Section 504 require that medical care providers provide individuals with disabilities:

- full and equal access to their health care services and facilities; and
- reasonable modifications to policies, practices, and procedures when necessary to make health care 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 the services).

The ADA sets requirements for new construction of and alterations to buildings and facilities, including health care facilities. These requirements are found in the regulations for the ADA, at 28 CFR 35.151, for Title II entities and at 28 CFR Part 36, Subpart D, for Title III entities. The regulations are available at www.ada.gov/reg2.htm and www.ada.gov/reg3a.html.

In addition, all buildings, including those built before the ADA went into effect, are subject to accessibility requirements for existing facilities. Under Title III, existing facilities are required to remove architectural barriers where such removal is readily achievable. Barrier removal is readily achievable when it is easily accomplishable and able to be carried out without much difficulty or expense. If barrier removal is not readily achievable, the entity must make its services available through alternative methods, if those methods are readily achievable. Under Title II, a public entity must ensure that its program as a whole is accessible, this may entail removing architectural barriers or adopting alternative measures such as relocating activities to accessible locations. This same program accessibility standard applies under Section 504.
Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands

Johanna H. Groenewoud, M.D., Agnes van der Heide, M.D., Ph.D., Bregje D. Onwuteaka-Philipsen, Ph.D., Dick L. Willems, M.D., Ph.D., Paul J. van der Maas, M.D., Ph.D., and Gerrit van der Wal, M.D., Ph.D. et al.

February 24, 2000
DOI: 10.1056/NEJM200002243420805

Abstract

BACKGROUND AND METHODS
The characteristics and frequency of clinical problems with the performance of euthanasia and physician-assisted suicide are uncertain. We analyzed data from two studies of euthanasia and physician-assisted suicide in the Netherlands (one conducted in 1990 and 1991 and the other in 1995 and 1996), with a total of 649 cases. We categorized clinical problems as technical problems, such as difficulty inserting an intravenous line; complications, such as myoclonus or vomiting; or problems with completion, such as a longer-than-expected interval between the administration of medications and death.

RESULTS
In 444 cases, the physician's intention was to provide assistance with suicide, and in 535, the intention was to perform euthanasia. Problems of any type were more frequent in cases of assisted suicide than in cases of euthanasia. Complications occurred in 7 percent of cases of assisted suicide, and problems with completion (a longer-than-expected time to death, failure to induce coma, or induction of coma followed by awakening of the patient) occurred in 16 percent of the cases; complications and problems with completion occurred in 3 percent and 6 percent of cases of euthanasia, respectively. The physician d
to administer a lethal medication in 21 of the cases of assisted suicide (18 percent), which thus became cases of euthanasia. The reasons for this decision included problems with completion (in 12 cases) and the inability of the patient to take all the medications (in 5).

CONCLUSIONS
There may be clinical problems with the performance of euthanasia and physician-assisted suicide. In the Netherlands, physicians who intend to provide assistance with suicide sometimes end up administering a lethal medication themselves because of the patient’s inability to take the medication or because of problems with the completion of physician-assisted suicide.

Introduction

Although euthanasia and physician-assisted suicide are illegal in most countries, they are performed in several parts of the world. Oregon has made physician-assisted suicide legal under specified conditions. In the Netherlands, a physician who performs euthanasia or provides assistance with suicide will not be prosecuted if the act has been carried out under strict conditions, which have been formulated by the courts and the medical profession. One of these conditions is that euthanasia or assistance with suicide must be carried out in a professionally responsible way. In 1987, the Royal Dutch Association of Pharmacy issued guidelines on the use and preparation of drugs for euthanasia. The guidelines were revised on the basis of doctors' experiences in 1994 and 1998.

The incidence of physician-assisted suicide and euthanasia and attitudes toward these practices have been studied extensively, but the few reports on the clinical aspects of these practices are based on limited data or small numbers of cases. We performed a study to determine whether there are problems with the clinical aspects of euthanasia and physician-assisted suicide as reported by the physicians involved, including complications and problems with completion, such as a prolonged interval between the administration of medications and the patient’s death.

Methods

STUDY DESIGN
In 1990 and 1991 and in 1995 and 1996, we performed two studies of euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands. Detailed information about the design of these studies has been reported elsewhere. In three parts of the studies, detailed information on the clinical aspects of euthanasia and physician-assisted suicide was collected.

In 1990 and 1991, we interviewed a stratified random sample of 405 physicians that included 152 general practitioners, 50 nursing home physicians, and 203 physicians in the specialties of cardiology, surgery, etc.
ORS 146.003

Definitions for ORS 146.003 to 146.189 and 146.710 to 146.992

As used in ORS 146.003 (Definitions for ORS 146.003 to 146.189 and 146.710 to 146.992) to 146.189 (Use of records to identify human remains and missing persons) and 146.710 (Definition for ORS 146.710 to 146.780) to 146.992 (Penalties), unless the context requires otherwise:

(1) "Approved laboratory" means a laboratory approved by the Chief Medical Examiner as competent to perform the blood sample analysis required by ORS 146.113 (Authority to order removal of body fluids) (2).

(2) "Assistant district medical examiner" means a physician appointed by the district medical examiner to investigate and certify deaths within a county or district.

(3) "Cause of death" means the primary or basic disease process or injury ending life.

(4) "Death requiring investigation" means the death of a person occurring in any one of the circumstances set forth in ORS 146.090 (Deaths requiring investigation).

(5) "District medical examiner" means a physician appointed by the Chief Medical Examiner to investigate and certify deaths within a county or district, including a Deputy State Medical Examiner.

(6) "Law enforcement agency" means a county sheriff's office, municipal police department, police department established by a university under ORS 352.121 (University police departments and officers) or 353.125 (Creation of police department and commission of police officers) and the Oregon State Police.

(7) "Legal intervention" includes an execution pursuant to ORS 137.463 (Death warrant hearing), 137.467 (Delivery of warrant when place of trial changed) and 137.473 (Means of inflicting death) and other legal use of force resulting in death.

(8) "Manner of death" means the designation of the probable mode of production of the cause of death, including natural, accidental, suicidal, homicidal, legal intervention or undetermined.

(9) "Medical examiner" means a physician appointed as provided by ORS 146.003 (Definitions for ORS 146.003 to 146.189 and 146.710 to 146.992) to 146.189 (Use of records to identify human remains and missing persons) to investigate and certify the cause and manner of deaths requiring investigation, including the Chief Medical Examiner.
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 Donnebrook practice in the town and the remainder while a single-handed practitioner at his surgery in Market Street. The majority of his victims - 171 - were women, compared with 44 men. The oldest was 93-year-old Anne Cooper and the youngest 41-year-old Peter Lewis.

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

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

**What led to his conviction?**

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

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

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

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

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

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

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
Death certificate reform delays ‘incomprehensible’

Press Association
Wed 21 Jan 2015 05.09 EST

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

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

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

Chris Bird, whose mother, Violet, was murdered by Shipman, said the delay in implementing the changes was “criminal”.

Lishman said changes that would see a medical examiner review death certificates had not been implemented, possibly because of confusion created by the coalition government's NHS shakeup.

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

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

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

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

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

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

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

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

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

Since you're here ...
ORS 112.465
Slayer or abuser considered to predecease decedent

(1) Property that would have passed by reason of the death of a decedent to a person who was a slayer or an abuser of the decedent, whether by intestate succession, by will, by transfer on death deed, by trust, or otherwise, passes on death and vests as if the slayer or abuser had predeceased the decedent.

(2) Property that would have passed by reason of the death of an heir or devisee of a decedent to a person who was the slayer or abuser of the decedent, whether by intestate succession, by will, by transfer on death deed or by trust, passes and vests as if the slayer or abuser had predeceased the decedent unless the heir or devisee specifically provides otherwise in a will or other instrument executed after the death of the decedent. [1969 c.591 §59; 2005 c.270 §2; 2005 c.535 §1a; 2011 c.212 §26; 2015 c.387 §22]

Death with Dignity Act

(OHA/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/)

(OHA)

/Public Health Division (OHA/PH/Pages/index.aspx)
> Provider and Partner Resources (OHA/PH/PROVIDERPARTNERRESOURCES/Pages/index.aspx)
> Evaluation and Research (OHA/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/Pages/index.aspx)
> Death with Dignity Act
(OHA/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/index.aspx)
> Release of Information Regarding the Death with Dignity Act


Release of Information Regarding the Death with Dignity Act

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

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

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

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

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

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

Contact Us

Center for Health Statistics staff can answer questions about Oregon’s Death with Dignity Act
Release of Information Regarding the Death with Dignity Act

January 23, 2021

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IN THE HIGH COURT OF SOUTH AFRICA
(GAUTENG DIVISION, JOHANNESBURG)

CASE NO: 31396/2017

In the application to adduce expert evidence of:

CENTRE FOR APPLIED LEGAL STUDIES

Applicant / First Amicus Curiae

In re: the matter between:

WALTER, SUZANNE

First Plaintiff

HARCK, DIETHELM GUNTHER

Second Plaintiff

WALTER, SUZANNE N.O.

Third Plaintiff

HARCK, DIETHELM GUNTHER N.O.

Forth Plaintiff

GRUBB, LYNNE N.O.

Fifth Plaintiff

SODERHOLM, KAREN N.O.

Sixth Plaintiff

And

THE MINISTER OF HEALTH

First Defendant

THE MINISTER FOR JUSTICE AND CORRECTIONAL SERVICES

Second Defendant

THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

Third Defendant

THE NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS

Fourth Defendant

THE PARLIAMENT OF THE REPUBLIC OF SOUTH AFRICA

Fifth Defendant

CAUSE FOR JUSTICE

Second Amicus Curiae

SOUTH AFRICAN HUMAN RIGHTS COMMISSION

Third Amicus Curiae

DR PAUL ALEXANDER ROWE & ANOTHER

Fourth Amicus Curiae
PLEASE TAKE NOTICE that the summary of evidence of the Centre for Applied (CALS) in terms of CALS' notice in terms of the provision of Rule 36(9)(a) dated 20 April 2020, namely MS ANN JACKSON shall be as follows:

1. QUALIFICATIONS

Ms Jackson has the following qualifications:

1.1. Bachelor of Science, Elementary Education, from Portland State University, Portland, Oregon, United States of America ("USA"), 1969; and

1.2. Master of Business Administration, Not-for-Profit Management, from Geo. H. Atkinson Graduate School of Management, Willamette University, Salem, Oregon, USA, 1984.

2. EXPERTISE & EXPERIENCE

Ms Jackson is an unaffiliated authority on "medical aid-in dying" in Oregon, the effect of its legalisation in Oregon, and the role that Oregon has played in guiding other states and countries by providing information in consideration of the legalisation of medical aid-in dying.

She writes factually about medical aid-in-dying in Oregon based on her extensive experience at all levels of end-of-life care, as well as her extensive research.

She has worked and gained experience as follows:

2.1. Ms Jackson has worked in hospice and end-of life-care since 1988;

2.2. Ms Jackson was executive director and Chief Executive Officer of the
Oregon Hospice and Palliative Care Association ("OHPCA"), previously the Oregon Hospice Association, from April 1988 to [July 2008. OHPCA is a non-profit organisation which provides public and professional education, advocacy, research, consultation and leadership about end of life care;

2.2.1. Ms Jackson has provided information in respect of end-of-life care to numerous persons diagnosed with various terminal diseases and conditions, as well as with the loved ones of such persons. Some of the terminal illnesses with the expectation of exceptionally distressing symptoms have included:

2.2.1.1. amyotrophic lateral sclerosis ("ALS"), which is a progressive neurodegenerative disease affecting nerve cells in the brain and spinal cord;

2.2.1.2. scleroderma, or systemic sclerosis, a chronic connective tissue disease affecting skin and sometimes lungs and other organs;

2.2.1.3. multiple sclerosis, an unpredictable and disabling disease of the central nervous system that affects communication between the brain and spinal cord and, in its later stages, may become terminal because of related complications;

2.2.1.4. cancer, a group of diseases involving the uncontrolled growth of abnormal cells in the body;

2.2.1.5. HIV/AIDS, the human immunodeficiency virus which may lead to acquired immunodeficiency syndrome, which attacks the body's immune system and thus make a person susceptible to opportunistic infections or infection related cancers; and
2.2.1.6. Alzheimer disease, a progressive type of dementia that causes problems with memory, thinking, and behaviour.

2.2.2. The information provided by Ms Jackson is considered expert in the field and has contributed as an expert in the following ways:

2.2.2.1. Ms Jackson is commonly called by other states in the USA, and countries to advise them in their consideration of the legalisation of medical aid-in-dying therein;

2.2.2.2. Ms Jackson is a co-investigator into the experience of hospice workers who deal with persons suffering from terminal illness and who consider hastening their death;

2.2.2.3. Ms Jackson has also participated in task forces designed to improve quality of care at end-of-life, specifically the:

2.2.2.3.1. Portable Orders for Life Sustaining Treatment (POLST) Task Force, from 1991 to date; and

2.2.2.3.2. Task Force to Improve Care of Terminally Ill Oregonians from 1994 to 2009, when this task force completed its agenda.

2.3. Ms Jackson also investigates the effectiveness of POLST in hospice and nursing settings;

2.4. Ms Jackson has participated in the Physician Aid-in-Dying Guideline Committee convened by Compassion and Choices in 2012, which guidelines have since been published in the Journal for Palliative Medicine in December 2015;
2.5. Ms Jackson has published approximately 40 articles in respect of medical aid-in-dying in Oregon between 1997 and 2019, as well as provided over 130 presentations on this subject matter over the same time period;

2.6. In 2011, Ms Jackson was requested by the legal representatives of the British Columbia Civil Liberties Association and others to provide expert opinion in the legal challenge brought against the laws that make physician assisted suicide illegal in the matter of *Carter v Canada* (Attorney General), 2015 SCC 5. [2015] before the Supreme Court of British Columbia. This legal challenge was launched to allow grievously and irredeemably ill, mentally competent adults to receive medical assistance to hasten their death with certain specific safeguards. Ms Jackson provided such expert opinion as requested. During February 2015, the Supreme Court of Canada unanimously ruled that Canadians suffering unbearably with serious, incurable medical conditions have the right to seek a compassionate death with the assistance of a physician;

2.7. Similarly, Ms Jackson addressed the House of Lords in the United Kingdom during 2006 and 2014, and has provided written evidence to the House of Commons in 2015 to address issues related to palliative care and medical aid-in-dying;

2.8. Ms Jackson has also provided evidence for the Maryland legislature in the USA, wherein she addressed matters regarding the integration of medical assistance-in-dying into hospice, palliative care, and nursing facilities. In 2015, she was asked by sponsors, State Delegate Shane Pendergrass and Senator Ronald Young, to provide expert opinion on the Richard E. Israel and Roger “Pip” Moyer End-of-Life Option Act, a bill in Maryland that would authorize competent individuals with a prognosis of life of less than 6 months to request medical aid-in-dying.

2.9. She has discussed, before the Maryland End-of-Life Option Workgroup, Oregon’s experience with medical aid-in-dying and her role in incorporating
same into the health care industry, with specific focus on hospice, nursing homes and mental health;

2.10. She has testified before the Joint House Health and Government Operations Committee and the Judiciary Committee in 2016 for the reintroduction of the Maryland bill; and

2.11. Ms Jackson has provided evidence before legislatures in many states throughout the USA about the impact of Oregon’s law on end-of-life care.

3. **OPINION**

3.1. Basis for opinion:

Ms. Jackson’s opinion expressed herein is based on her expertise and experience acquired as a professional who has been involved in the development of aid-in-dying in Oregon since its inception, from ground level working in palliative care to policy development.

3.2. Applicable definitions:

3.2.1. "attending physician" means the physician who is primarily responsible for the care and treatment of the patient;

3.2.2. "capable" means that in the opinion of a court, attending physician or consulting physician, psychiatrist or psychologist, a patient has the mental ability to understand, make and communicate health care decisions to health care providers;

3.2.3. "consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient’s disease;
3.2.4. "health care provider" means a person or health care facility licensed, certified or otherwise authorised or permitted by law to administer health care or dispense medication;

3.2.5. "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:

3.2.5.1. his/her medical diagnosis;

3.2.5.2. his/her prognosis;

3.2.5.3. potential risks associated with taking the prescribed medication;

3.2.5.4. probable results of taking the prescribed medication; and

3.2.5.5. feasible end-of-life care alternatives, _inter alia_, comfort care, hospice care and pain control.

3.2.6. "PAS" means physician-assisted suicide which encompasses the provision of a prescription for medication that will hasten the death of a patient requesting same in a dignified and peaceful manner; "PAD" used in other jurisdictions means physician-assisted death and has a corresponding meaning;

3.2.7. "patient" means a person under the care of a physician; and

3.2.8. "terminal disease" means a medically confirmed incurable and irreversible disease that will, according to reasonable medical judgment, result in death within six months.
3.3. Ms Jackson will testify that:

3.3.1. Oregon, as the first state in the USA to legalise PAS, has assumed the responsibility of collecting, maintaining, and providing data relevant to its experiences and the practices which have developed since its legalisation of PAS;

3.3.2. The Oregon Death with Dignity Act ("ODDA") allows terminally ill Oregonians to end their lives through voluntary self-administration of lethal medications expressly provided by a physician for such purpose;

3.3.3. In terms of the ODDA in order to be eligible to apply for a prescription, the patient must be:

3.3.3.1. a resident of Oregon;

3.3.3.2. 18 years or older;

3.3.3.3. mentally capable; and

3.3.3.4. diagnosed with a terminal illness by an attending physician and a consulting physician.

3.3.4. Accordingly, a person does not qualify for eligibility solely on the grounds of age or disability;

3.3.5. These requirements negate a possible slippery slope effect by providing a set of well set out criteria that limit the amount of persons eligible for PAS. This shows that well set out criteria in statute can give effect to the State’s duty to protect its citizens while taking into account the autonomy, values and beliefs of a diverse population;
3.3.6. There are safeguards contained in the ODDA to protect potentially vulnerable persons from coercion into requesting PAS. These safeguards include the following:

3.3.6.1. the imposition of a cooling off period of 15 days between the initial request and the second, written request;

3.3.6.2. the written request must be made to the attending physician who must certify that the patient is terminally ill, capable and making the request voluntarily;

3.3.6.3. the physician must also inform the patient of all other end-of-life care options such as palliative care, hospice, and pain management options;

3.3.6.4. where the physician determines that the patient's judgement is impaired, the patient would be deemed as ineligible or referred for psychological evaluation;

3.3.6.5. the written request must be witnessed by two individuals who must 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. One of these witnesses must be wholly independent of and unrelated to the patient, and should not be a heir of the patient;

3.3.6.6. the written request may be cancelled by the patient at any time; and

3.3.6.7. the patient must be able to self-administer and ingest the medication themselves.

3.3.7. These measures make an independent, informed decision a requirement to receiving PAS. The ODDA provides checks and
balances by requiring the opinion of the physicians attending to the patient, as well as two witnesses, one of whom should have no interest in the death or continued living of the patient. This shows that it is within the capabilities of statute and the legislature to prevent abuse of PAS provisions and undue influence of terminally ill patients through well set out statute containing checks and balances;

3.3.8. Value-free data collected and published by the Oregon Health Authority (OHA) shows that the ODDA is well-crafted and sets out, *inter alia*, the:

3.3.8.1. characteristics of patients requesting PAS;

3.3.8.2. motivations for requesting PAS;

3.3.8.3. underlying medical conditions of the person requesting PAS;

3.3.8.4. end-of-life care situation of said person, such as whether the person was enrolled in hospice;

3.3.8.5. compliance of PAS actions with the ODDA; and

3.3.8.6. particulars of the events surrounding the person’s assisted death such as medications used, the amount of time passed from ingestion to death, details of any complications such as regurgitation, and the particulars and characteristics of the physician in attendance.

3.3.9. Based on the data collected by the OHA, and her personal experiences, the ODDA, in Ms Jackson’s opinion:

3.3.9.1. ensures that persons suffering from clinical depression or
other afflictions which may impair judgement are unlikely to seek or obtain PAS;

3.3.9.2. has sufficient checks and balances to protect vulnerable persons and groups from coercion in making a decision to make use of PAS;

3.3.9.3. does not, however, have unnecessarily high requirements which serve to deter eligible persons from obtaining PAS;

3.3.9.4. is successfully structured so as to prevent abuse of its provisions, which can be shown by the fact that there have been no cases of abuse;

3.3.9.5. has not resulted in the 'slippery slope' effect alleged by critics, as can be shown by the fact that since its inception in 1997, there have been no calls to extend the law to make wider the provisions for eligibility for PAS;

3.3.9.6. has made a positive impact on the lives of the terminally ill by providing peace of mind, which in fact leads such persons choosing not to take the medication prescribed for PAS;

3.3.9.7. has similarly had a positive impact on the minds of those who are healthy or newly diagnosed with life-threatening illness, and on the minds of loved ones and family members of such newly diagnosed persons; and

3.3.9.8. has increased the quality of conversations and information provided about death and dying between front-line hospice workers or other health care professionals, and patients and their families.
3.3.10. Of all persons who qualify for a prescription under ODDA, most persons opt not to get a prescription;

3.3.11. PAS is a preferred option of patients who intend to die on their own terms but wish to prevent causing trauma to their families through other self-inflicted less peaceful modes of death;

3.3.12. Palliative care standards in Oregon remain among the best in the world, thus PAS has not negatively impacted the standard of other end-of-life care services in Oregon. This shows that PAS is not considered an alternative to palliative care by patients and health care providers alike;

3.3.13. The number of persons requesting PAS has not increased significantly since the enactment of the ODDA in 1997, showing that the 'contagion' effect predicted by detractors has not occurred;

3.3.14. In fact, the Oregon report of 2019 shows that:

3.3.14.1. 290 people received a prescription for life-ending medication in 2019 and 62 of them did not take the medication as they were sufficiently comforted by the mere option it provided them;

3.3.14.2. 90% of people who had an assisted death were enrolled in hospice care, showing that PAS is not being used as an alternative to palliative or hospice care; and

3.3.14.3. People who had an assisted death were aged between 33 and 98 and the majority suffered from terminal cancer and;

3.3.15. Ms Jackson voted more than once against the implementation of the ODDA as she initially believed PAS to be unnecessary if high quality hospice and palliative care was available to terminally ill Oregonians, however, continued exposure to terminally ill persons
lead Ms Jackson to realise that hospice and palliative care professionals simply cannot in every single case meet the specific needs of all terminally ill persons, some of which include the need to direct one’s own life and death in line with one’s own beliefs and values in respect of autonomy, dignity, life and death. Ms Jackson realised that these needs or rights are as worthy as other needs and rights;

3.3.16. Many physicians and health care providers that Ms Jackson has personally engaged with express the view that end-of-life care is an important part of their compassionate, moral, ethical and professional duty and role;

3.3.17. Many of these aforementioned physicians and health care providers consider PAS, in the appropriate circumstances, to be an important component of the provision of health care, including palliative care;

3.3.18. Palliative care and PAS should not, and need not, be a binary either-or debate, but rather given the variety and complexity of patients’ illnesses, symptoms, needs, circumstances and individual beliefs and values, there is a need for the provision and availability of the best information and accessibility in practice of all of end-of-life options;

3.3.19. The outcomes of the ODDA in respect of legislating PAS are significantly different from predicted outcomes of its opponents. These predicted outcomes are similar to the outcomes predicted by the defendants in this case;

3.3.20. The quality of death experienced by those who have opted for PAS has been very high as judged by health care professionals and their respective families and loved ones; and

3.3.21. PAS continues to be responsibly committed in Oregon and is not
used by persons without access to hospice and palliative care as all Oregonians have such access.

3.4. Ms Jackson will testify that in her opinion:

3.4.1. All persons must be well-informed about end-of-life options and choices in order to make an informed decision about end-of-life care that best reflects their autonomy and upholds their dignity, as defined and understood by such persons themselves;

3.4.2. Accordingly, it is best to respond openly and honestly to all questions, including those about physician assisted dying and to provide sources of information on these topics;

3.4.3. It is best to be as value-free as possible in presenting information on the topic on PAS to persons who ask for same in order to refrain from unduly influencing the decisions of persons faced with such choices;

3.4.4. The provision of open and honest information in respect of PAS tends to lead to discussions on other end-of-life care options previously unknown and/or unconsidered by the person asking for such information and, as such, does not always lead to a decision to request PAS;

3.4.5. This is due to the fact that the ability to respond freely in respect of queries regarding PAS increases the likelihood of properly addressing the real fears and reasons of the person behind the request;

3.4.6. In cases where a person requests PAS after having been provided with all relevant information, such informed decision can be considered to be based on the subjective weighing up of all relevant information, and thus an autonomous decision rational to its maker.
Dated at JOHANNESBURG on the 20th April 2020.

CENTRE FOR APPLIED LEGAL STUDIES (CALS)
1st Floor DJ Du Plessis Building
West Campus, University of the Witwatersrand
1 Jan Smuts Avenue
Braamfontein
Ref: S Swemmer
Tel: (011) 717 8609
Fax: (011) 717 1702
Email: Sheena.Swemmer@wits.ac.za
Vuyo.Minola@wits.ac.za

TO: THE REGISTRAR OF THE ABOVE HONOURABLE COURT

AND TO:

Tshabalala Attorneys, Notaries & Conveyancers
Plaintiffs' Attorneys
1st Floor, 3 Gwen Lane
Sandton, Johannesburg
Tel: +27(0) 11 783 5677
Fax: +27(0) 11 783 8734
Email: jazmin@tshabalala.com
Ref: Mr T Tshabalala/jp/G0910

State Attorney Cape Town
1st, 2nd and 5th Defendant Attorneys
4th Floor, 22 Long Street
Cape Town
Ref: S Chothia

C/O State Attorney Johannesburg
10th Floor, North State Building
95 Market Street, Cnr Kruis Street
Johannesburg
Tel: (011) 330 7796
Fax: 086 507 5177
Email: WMBaaso@justice.gov.za
          sChothia@justice.gov.za
Ref: 6709/17/P4/PAC094

Moduka Attorneys
3rd Defendant Attorneys
C B Centre West Building
75 Durham Road
Club view East
Centurion
Pretoria
Tel: (012) 323 1137 / 940 1951
Email: law@modukalaw.co.za
Ref: MS MODUKA/MHPCSA 0062/17/Lmk

C/O Selebogo Inc
1st Floor, Marble Towers
208 – 212 Jeppe Street
Johannesburg
Tel: (011) 838 9000
AND TO

Nelson Borman & Partners Inc.
Second Amicus Curiae's Attorneys (Cause for Justice)
17th Floor Schreiner Chambers
94 Pritchard Street
Johannesburg
Tel: (011) 886 3674
Fax: (010) 601 6047/8
Email: mercy@nelsonborman.co.za
info@causeforjustice.org

South African Human Rights Commission
Third Amicus Curiae
Forum III – Braampark Offices,
33 Hoofd Street,
Braamfontein,
Tel: (011) 877 3600
Email: Pka-siboto@sahrc.org.za
bjones@sahrc.org.za

Werksmans Attorneys
Fourth Amicus Curiae's Attorneys (Advocate Leech & Dr Rowe)
The Central, 96 Rivonia Road
Sandton
Tel: (011) 535 8000
Fax: (011) 535 8600
Email: NKirby@werksmans.com
Ref: Mr N Kirby/nk/LEEC20210.2/#6320111v1
Bio/Curriculum Vitae
Ann Jackson, M.B.A.
19 May 2019

Contact Information
Ann Jackson, MBA
Post Office Box 5847
Portland Oregon 97228
Telephone 503-539-7827
Email jackson@ann-jackson.com
Website www.ann-jackson.com

Biographical Statement

Ann Jackson began her career with hospice and end of life care more than 30 years ago. As the CEO of the Oregon Hospice Association (OHA), she was its voice. Jackson retired from OHA in 2008, after 20 years. Her role then, and now as an unaffiliated and independent authority, was and is to write and present, openly and honestly, fact-based information about all end-of-life choices. The State of Oregon was the first jurisdiction in the world to adopt medical aid-in-dying as a legal option.

Jackson has an MBA in not-for-profit management, awarded by Willamette University’s Atkinson School in Salem, Oregon.

Curriculum Vitae

Ann Jackson began her career with hospice and end of life care more than 30 years ago. She currently facilitates conversations among individuals and families who are making decisions for themselves or loved ones about choices at the end-of-life, now and in the future; consults with boards and administrators in developing organizational policy about end-of-life choices; and provides expertise to governmental and legislative bodies who are wrestling with end-of-life policy and law.

In her role as executive director and chief executive officer of the Oregon Hospice Association (OHA), she was its spokesperson. OHA was a 501(c)(3) charitable, not-for-profit organization whose mission was to make sure that all Oregonians could have excellent care as they—or their loved ones—approached the end of life. OHA is now recognized as the Oregon Hospice and Palliative Care Organization (OHPCA).

Jackson retired from OHA in 2008, after 20 years. Her role then, and now as an unaffiliated authority, is to write and present, openly and honestly, fact-based information about Oregon’s role as a “laboratory” of the states—a role assigned to it in 1997 when the United States Supreme Court referred the issue of aid-in dying to the states (Washington v Glucksberg). Oregon became the first jurisdiction in the world...