Vote “No” on Committee Bill 5898
Say “No” to Assisted Suicide and Euthanasia
An Act Concerning Aid in Dying

Hearing on Monday, March 18, 2019

Submitted by Margaret Dore, Esq., MBA
Choice is an Illusion, a nonprofit corporation
margaretdorc@margaretdorc.com
206 697 1217

1. The Act

The Act legalizes “aid in dying,” a traditional euphemism for active euthanasia and physician-assisted suicide.¹

2. Who May Be Most at Risk?

Individuals with money, meaning the middle class and above.

3. Assisting Persons Can Have an Agenda

Persons assisting a suicide or performing a euthanasia can have an agenda to benefit themselves. Consider Tammy Sawyer, trustee for Thomas Middleton in Oregon, which has a similar law. Two days after his death by legal assisted suicide, she sold his home and deposited the proceeds into bank accounts for her own benefit.² Consider also Graham Morant, recently convicted of counseling his wife to kill herself in Australia, to get the life insurance. The Court found:

[Y]ou counseled and aided your wife to kill herself because you wanted ... the 1.4 million.³

Medical professionals too can have an agenda. Michael Swango, MD, now incarcerated, got a


thrill from killing his patients. Consider also Harold Shipman, a doctor in the UK, who not only killed his patients, but stole from them and in one case made himself a beneficiary of the patient's will.

4.

"Even If the Patient Struggled, Who Would Know?"

The Act has no required oversight over administration of the lethal dose, not even a witness is required to be present at the death. The drugs used are water or alcohol soluble, such that they can be injected into a sleeping or restrained person without consent. Alex Schadenberg, Executive Director for the Euthanasia Prevention Coalition, puts it this way:

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

5.

The Death Certificate Will List a "Terminal Illness" as the Cause of Death, Which Will Create a Perfect Crime

The bill, Section 9(b), lines 273 to 274, states:

The person signing the qualified patient's death certificate shall list the underlying terminal illness as the cause of death. (Emphasis added).

With this language, the patient's death certificate will report a natural death as a matter of law. This will create a legal inability to prosecute criminal behavior, for example, in the case of an outright murder for the money. The Act will create a perfect crime.

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6 In Oregon, the drugs used include Secobarbital, and Pentobarbital (Nembutal), which are water and alcohol soluble. See http://www.drugs.com/pr/secobarbital-sodium.html and http://www.drugs.com/pr/nembutal.html.

7 The Advocate, Idaho State Bar, Letters to the Editor
6. **Euthanasia Is Allowed**

The Act defines "aid in dying" as a "medical practice" in which a physician prescribes "medication," which the patient may self-administer. (Bill, Section 1.(2), at lines 4-7)

Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer medication. With the lethal dose defined as "medication," other people are allowed to administer the lethal dose to the patient, which is euthanasia.

7. **"Eligible" Persons May Have Decades to Live**

The Act applies to persons with a terminal illness, which is expected to produce a patient's death "within six months." Oregon's law has a similar criteria, which is interpreted to include chronic conditions such as diabetes mellitus, better known as diabetes. This is because the six months to live is determined without treatment. With treatment (insulin), such persons can have years or decades to live.

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8 See the bill, section 1.(19), lines 76 to 79.
To: The Public Health Committee of Connecticut

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

Re: Vote "No" on Committee Bill No. 5898; Say "No" to Assisted Suicide and Euthanasia

Summary: The "Act Concerning Aid in Dying for Terminally Ill Patients" will apply to people with years or decades to live. It will legalize assisted suicide and euthanasia as those terms are traditionally defined. Individuals with money, meaning the middle class and above, may be especially at risk.

Hearing: Monday, March 18, 2018

Memo Date: March 16, 2019

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* Margaret Dore, Law Office of Margaret K. Dore, PS, Choice is an Illusion, a nonprofit corp., 1001 4th Avenue, Suite 4400, Seattle, WA 98154, 206 697 1217
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APPENDIX
I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.¹ Our law is based on a similar law in Oregon.² In the fine print, both laws allow euthanasia. Both laws are also similar to Committee Bill No. 5898.³

The bill seeks to legalize physician-assisted suicide and euthanasia as those terms are traditionally defined. The bill calls these practices, "aid in dying," which is a traditional euphemism for euthanasia.⁴ "Eligible" persons may have years or decades to live.

If the bill is enacted, individuals with money, meaning the middle class and above, will be especially at risk. I urge you to reject the proposed bill.

II. DEFINITIONS

A. Physician-Assisted Suicide; Assisted Suicide; and Euthanasia

The American Medical Association (AMA) defines physician-
assisted suicide as occurring when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." For example:

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

Assisted suicide is a general term in which an assisting person is not necessarily a physician. Euthanasia is the administration of a lethal agent "by another person."

B. Withholding or Withdrawing Treatment

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

[I]nstead of dying as expected, [he] slowly began to get better.

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6. Id.
7. The AMA Coce of Medical Ethics, Opinion 5.8, Appendix, page A-25.
8. Nina Shapiro, "Terminal Uncertainty - Washington's new 'Death with Dignity' law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong?,” The Seattle Weekly, 01/13/09; in the Appendix, beginning at page A-26; quote at page A-28.
III. ASSISTING PERSONS CAN HAVE AN AGENDA

Persons assisting a suicide or euthanasia can have an agenda. Consider Tammy Sawyer, trustee for Thomas Middleton in Oregon. Two days after his death by legal assisted suicide, she sold his home and deposited the proceeds into bank accounts for her own benefit.\(^9\) Consider also Graham Morant, recently convicted of counseling his wife to kill herself in Australia, to get the life insurance. The Court found:

\[Y\]ou counseled and aided your wife to kill herself because you wanted . . . the 1.4 million.\(^{10}\)

Medical professionals too can have an agenda. Michael Swango, MD, now incarcerated, got a thrill from killing his patients.\(^{11}\) Consider also Harold Shipman, a doctor in the UK, who not only killed his patients, but stole from them and in one case made himself a beneficiary of the patient’s will.\(^{12}\)

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\(^9\) KTVZ.com, “Sawyer Arraigned on State Fraud Charges,” Appendix page 29.


IV. PUSH BACK AGAINST ASSISTED SUICIDE AND EUTHANASIA

A. Last Year, Utah Passed a Law Making Assisted Suicide a Felony

Last year, Utah amended its manslaughter statute to clarify that aiding suicide is a felony.\textsuperscript{13} The bill, HB 86, passed the legislature by a 2 to 1 margin.\textsuperscript{14}

B. Three Years Ago, Alabama Passed an Act Banning Assisted Suicide

Two years ago, Alabama enacted an “Assisted Suicide Ban Act,” which renders any person who deliberately assists a suicide, guilty of a felony.\textsuperscript{15} The vote to pass was nearly unanimous.\textsuperscript{16}

C. Three Years Ago, the New Mexico Supreme Court Overturned Legal Assisted Suicide; Assisted Suicide Is No Longer Legal in New Mexico

Three years ago, the New Mexico Supreme Court overturned a lower court decision recognizing a right to “physician aid in dying,” meaning physician-assisted suicide.\textsuperscript{17} Physician-assisted suicide is no longer legal in New Mexico.

\begin{footnotes}
\item[14] HB 86 passed the House 51 to 18, and the Senate, 19 to 5. For more information, see https://le.utah.gov/~2018/bills/static/HB0086.html and click “status.”
\item[16] Scroll down to view roll calls: https://legiscan.com/AL/bill/HB96/2017
\end{footnotes}
V. HOW THE BILL WORKS

The bill has an application process to obtain the lethal dose, which includes a lethal dose request form.

Once the lethal dose is issued by the pharmacy, there is no oversight. No witness, not even a doctor, is required to be present at the death.¹⁸

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

The bill applies to persons diagnosed with a "terminal illness," as defined by the bill. Such persons may have years or decades to live due to the following reasons:

A. If Connecticut Follows Oregon, the Bill Will Apply to People with Chronic Conditions Such as Insulin Dependent Diabetes

The bill states:

"Terminal illness" means the final stage of an incurable and irreversible medical condition that an attending physician anticipates, within reasonable medical judgment, will produce a patient's death within six months.¹⁹

Oregon's law has a similar definition:

"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.²⁰

¹⁸ See the proposed bill in its entirety, attached hereto at A-1 to A-16.
¹⁹ The bill, § 1(19), attached hereto at A-4, lines 76 to 79.
In Oregon, this similar definition is interpreted to include chronic conditions such as diabetes.\textsuperscript{21} Oregon doctor, William Toffler, explains:

In Oregon, chronic conditions such as diabetes are sufficient for assisted suicide, if, without treatment such as insulin, the patient has less than six months to live.\textsuperscript{22}

Dr. Toffler also addresses the Connecticut definition of "terminal illness" set forth above.\textsuperscript{23} He states:

In my professional judgment, this definition includes insulin dependent diabetes because the final stage of the disease is a failure to produce insulin, such that the affected person is dependent on insulin to live.

The disease at that point is an incurable and irreversible medical condition that will cause death within six months without treatment.

In short, if Connecticut follows Oregon practice to determine eligibility without treatment, the proposed bill will apply to people with chronic conditions such as insulin dependent diabetes. (Spacing changed).\textsuperscript{24}

\textbf{B. Predictions of Life Expectancy Can Be Wrong}

Eligible persons may also have years to live because

\textsuperscript{21} See Excerpt of Oregon Death with Dignity Annual Report for 2017, listing diabetes as a terminal illness for the purpose of Oregon's Act, attached hereto at A-44.

\textsuperscript{22} Declaration of William Toffler, MD, 03/17/18, attached hereto at A-41.

\textsuperscript{23} Declaration of William Toffler, MD, 03/17/18, regarding last year's bill, H.R. 5417, which has the same definition of terminal illness as this year's bill, Committee Bill No. 5898.

\textsuperscript{24} Toffler declaration attached hereto at A-41 and A-42.
predictions of life expectancy can be wrong.\textsuperscript{25} Consider John Norton, who was diagnosed with ALS (Lou Gehrig's disease) at age 18.\textsuperscript{26} He was told that he would get progressively worse (be paralyzed) and die in three to five years.\textsuperscript{27} Instead, the disease progression stopped on its own.\textsuperscript{28} In a 2012 affidavit, at age 74, he states:

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

C. Treatment Can Lead to Recovery

Consider also Jeanette Hall, who was diagnosed with cancer in 2000 and made a settled decision to use Oregon's law.\textsuperscript{30} Her doctor convinced her to be treated instead.\textsuperscript{31} In a 2017 declaration, she states:

It has now been 18 years since my diagnosis.
If [my doctor] had believed in assisted

\textsuperscript{25} Cf. Jessica Firger, "12 million Americans misdiagnosed each year," CBS News, 4/17/14, attached hereto at A-46, and Nina Shapiro, "Terminal Uncertainty - Washington's new 'Death with Dignity' law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong?," The Seattle Weekly, 01/14/09. (Excerpts attached at A-26 through A-28).

\textsuperscript{26} Affidavit of John Norton, attached hereto at A-47 to A-49.

\textsuperscript{27} Id., ¶ 1.

\textsuperscript{28} Id., ¶ 4.

\textsuperscript{29} Id., ¶ 5.

\textsuperscript{30} Affidavit of Kenneth Stevens, MD, attached at A-50 to A-52; Jeanette Hall discussed at A-50 to A-51; Hall declaration attached at A-53.

\textsuperscript{31} Id.
suicide, I would be dead.\textsuperscript{32}

VII. THE BILL WILL CREATE A PERFECT CRIME

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

The bill has no required oversight over administration of the lethal dose.\textsuperscript{33} In addition, the drugs used are water and alcohol soluble, such that they can be injected into a sleeping or restrained person without consent.\textsuperscript{34} Alex Schadenberg, Executive Director for the Euthanasia Prevention Coalition, puts it this way:

With assisted suicide laws in Washington and Oregon [and with the proposed bill], perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. Even if a patient struggled, "who would know?" (Emphasis added).\textsuperscript{35}

B. The Death Certificate Will List a Terminal Illness as the Cause of Death

The bill states:

The person signing the qualified patient's

\textsuperscript{32} Declaration of Jeanette Hall, ¶4, at A-53.

\textsuperscript{33} See the bill in its entirety, attached hereto at A-1 to A-16.

\textsuperscript{34} The drugs used include Secobarbital, Pentobarbital and Phenobarbital, which are water and/or alcohol soluble. See excerpts from Washington's Oregon’s annual reports, attached hereto at A-21 & A-22 (listing these drugs and other drugs). See also http://www.drugs.com/pr/seconal-sodium.html, http://www.drugs.com/pro/nembutal.html and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2977013

\textsuperscript{35} Alex Schadenberg, Letter to the Editor, "Elder abuse a growing problem," The Advocate, Official Publication of the Idaho State Bar, October 2010, p. 14
death certificate shall list the underlying terminal illness as the cause of death. (Emphasis added).\textsuperscript{36}

The significance of requiring a terminal illness to be listed as the cause of death is that it will create a legal inability to prosecute for murder or manslaughter.\textsuperscript{37} The official legal cause of death will be a terminal illness.

\textbf{VIII. DR. SHIPMAN AND THE CALL FOR DEATH CERTIFICATE REFORM}

According to a 2005 article in the UK’s *Guardian* newspaper, there was a public inquiry regarding Dr. Shipman’s conduct, which determined that he had “killed at least 250 of his patients over 23 years.”\textsuperscript{38} The inquiry also found:

that by issuing death certificates stating natural causes, the serial killer [Shipman] was able to evade investigation by coroners.\textsuperscript{39}

According to a subsequent article in 2015, proposed reforms included having a medical examiner review death certificates, so as to improve patient safety.\textsuperscript{40} Instead, the instant bill moves in the opposite direction to require a legal coverup as a matter

\textsuperscript{36} The bill, § 9(b), lines 273-274, attached hereto at A-10.

\textsuperscript{37} Under current Connecticut law, causing a suicide is punishable as Murder (Sec. 53a-54a) or Manslaughter (Sec. 53a-56). Copies attached at A-63 & A-64.

\textsuperscript{38} David Batty, supra, attached in the Appendix at A-35.

\textsuperscript{39} Id., at Appendix, page A-37, second paragraph, “What are its findings?”

of law. Doctors and other perpetrators, such as family members, will be legally empowered to evade investigation.

IX. ACCORDANCE

A. Patient protections are unenforceable due to the Bill’s Accordance Standard

The bill features a seemingly endless list of patient protections, such as a mandatory waiting period and the required participation of a second doctor.\textsuperscript{41} The bill also states:

\textit{No action taken in accordance with sections 1 to 14, inclusive, of this act or sections 16 to 19, inclusive, of this act shall constitute causing or assisting another person to commit suicide in violation of section 53a-54a [murder] or 53a-56 [manslaughter] of the general statutes.} (Emphasis added).\textsuperscript{42}

The bill does not define “accordance.”\textsuperscript{43} Dictionary definitions include “in the spirit of,” meaning “in thought or intention.”\textsuperscript{44} With these definitions, participants in a patient’s death need only have a thought or intention to comply with patient protections. Actual compliance is not required. The purported patient protections are unenforceable.

\textsuperscript{41} The bill, Sections 2 to 10, lines 80 to 303, attached at A-4 to A-11. See also Section 3, lines 94 to 96 (regarding a waiting period) and Section 7, lines 221 to 229 (regarding the second “consulting” doctor).

\textsuperscript{42} The bill, Section 15(b), lines 389-392, attached in the Appendix at A-14

\textsuperscript{43} See the bill in its entirety, attached hereto at A-1 through A-16.

\textsuperscript{44} See attachments at A-57 and A-58 (defining these terms).
B. The Bill Does Not Prohibit Assisted Suicide or Euthanasia as Long as Actions Are Taken in Accordance with the Bill

The bill appears to prohibit “assisting a suicide,” which it defines as a type of “active euthanasia.” The bill, § 15(a), states:

Nothing in sections 1 to 14, inclusive, of this act or sections 16 to 19, inclusive of this act authorizes a physician or any other person to end another person's life by lethal injection, mercy killing, assisting a suicide or any other active euthanasia. (Emphasis added).45

This apparent prohibition is defined away by the following section, 15(b), stating that action taken in accordance with the bill does not constitute causing or assisting suicide. The bill states:

No action taken in accordance with sections 1 to 14, inclusive, of this act or sections 16 to 19, inclusive, of this act shall constitute causing or assisting another person to commit suicide in violation of section 53a-54a [murder] or 53a-56 [manslaughter] of the general statutes.46

In other words, actions taken in accordance with the bill to cause or assist suicide, which is considered a type of euthanasia, will not constitute assisted suicide or euthanasia for the purpose of Connecticut’s criminal statutes. Prosecution

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45 § 15(a), lines 384 to 388, attached hereto at A-14.

46 The bill, Section 15(b), lines 389-392, attached in the Appendix at A-14
will not be able to go forward.

X. THE BILL WILL ALLOW EUTHANASIA

A. Someone Else Is Allowed to Administer the Lethal Dose to the Patient

The bill defines aid in dying as a medical practice in which a patient "may" self-administer medication (the lethal dose).

The bill states:

"Aid in dying" means the medical practice of a physician prescribing medication to a qualified patient who is terminally ill, which medication a qualified patient may self-administer to bring about his or her death .... (Emphasis added).47

With use of the word, "may," self-administration is not mandatory; another person is allowed to administer the lethal dose to the patient. Self-administration is also not mandatory due to the defining of aid in dying as a medical practice.

Kenneth Stevens MD, explains:

Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer prescription drugs to a patient.48

With other people allowed to administer medication (the lethal dose), the patient is not necessarily in control of his or her fate.

47 The bill, § 1(2), lines 4-7, attached hereto at A-1.
48 Declaration of Kenneth Stevens, MD, ¶ 10, attached hereto at A-52.
B. Allowing Someone Else to Administer the Lethal Dose to the Patient is Euthanasia

Allowing someone else to administer the lethal dose to a patient is euthanasia under generally accepted medical terminology. As noted above, the AMA Code of Ethics, Opinion 5.8, states:

Euthanasia is the administration of a lethal agent by another person to a patient . . . .
(Emphasis added.)

Attached hereto at A-25.

XI. OTHER CONSIDERATIONS

A. Legal Physician-Assisted Suicide Can Be Traumatic for Family Members

In 2012, a research study was released addressing trauma suffered by persons who witnessed a legal assisted suicide in Switzerland.49 The study found that one out of five family members or friends present at an assisted suicide was traumatized. These people,

experienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.50


50 Id.
B. My Clients in Washington and Oregon.

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

In the other case, it is not clear that administration of the lethal dose was voluntary. A man who was present told my client that my client's father had refused to take the lethal dose when it was delivered, stating, "You're not killing me. I'm going to bed," but then he (the father) took it the next night when he was intoxicated on alcohol. My client, although he was not present, was traumatized over the incident, and also by the sudden loss of his father.

VI. CONCLUSION

I urge you to vote "No" on Committee Bill 5898.

Margaret Dore, Esq., MBA
Law Offices of Margaret K. Dore, P.S.
Choice is an Illusion, a nonprofit corporation
www.margaretdore.com
www.choiceillusion.org
1001 4th Avenue, Suite 4400
Seattle, WA 98154
206 697 1217
Appendix

Margaret Dore Memo

Reject Committee Bill 5898

as of

March 16, 2019
AN ACT CONCERNING AID IN DYING FOR TERMINALLY ILL PATIENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1. Section 1. (NEW) (Effective October 1, 2019) As used in this section and sections 2 to 19, inclusive, of this act:

2. (1) "Adult" means a person who is eighteen years of age or older;

3. (2) "Aid in dying" means the medical practice of a physician prescribing medication to a qualified patient who is terminally ill, which medication a qualified patient may self-administer to bring about his or her death;

4. (3) "Attending physician" means the physician who has primary responsibility for the medical care of a patient and treatment of a patient's terminal illness;

5. (4) "Competent" means, in the opinion of a patient's attending physician, consulting physician, psychiatrist, psychologist or a court, that a patient has the capacity to understand and acknowledge the nature and consequences of health care decisions, including the
benefits and disadvantages of treatment, to make an informed decision
and to communicate such decision to a health care provider, including
communicating through a person familiar with a patient's manner of
communicating;

(5) "Consulting physician" means a physician other than a patient's
attending physician who (A) is qualified by specialty or experience to
make a professional diagnosis and prognosis regarding a patient's
terminal illness, and (B) does not routinely share office space with a
patient's attending physician;

(6) "Counseling" means one or more consultations as necessary
between a psychiatrist or a psychologist and a patient for the purpose
of determining that a patient is competent and not suffering from
depression or any other psychiatric or psychological disorder that
causes impaired judgment;

(7) "Health care provider" means a person licensed, certified or
otherwise authorized or permitted by the laws of this state to
administer health care or dispense medication in the ordinary course
of business or practice of a profession, including, but not limited to, a
physician, psychiatrist, psychologist or pharmacist;

(8) "Health care facility" means a hospital, residential care home,
nursing home or rest home, as such terms are defined in section 19a-
490 of the general statutes;

(9) "Informed decision" means a decision by a qualified patient to
request and obtain a prescription for medication that the qualified
patient may self-administer for aid in dying, that is based on an
understanding and acknowledgment of the relevant facts and after
being fully informed by the attending physician of: (A) The qualified
patient's medical diagnosis and prognosis; (B) the potential risks
associated with self-administering the medication to be prescribed; (C)
the probable result of taking the medication to be dispensed or
prescribed; and (D) the feasible alternatives to aid in dying and health
care treatment options, including, but not limited to, palliative care;

(10) "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;

(11) "Palliative care" means health care centered on a seriously ill patient and such patient's family that (A) optimizes a patient's quality of life by anticipating, preventing and treating a patient's suffering throughout the continuum of a patient's terminal illness, (B) addresses the physical, emotional, social and spiritual needs of a patient, (C) facilitates patient autonomy, patient access to information and patient choice, and (D) includes, but is not limited to, discussions between a patient and a health care provider concerning a patient's goals for treatment and appropriate treatment options available to a patient, including hospice care and comprehensive pain and symptom management;

(12) "Patient" means a person who is under the care of a physician;

(13) "Pharmacist" means a person licensed to practice pharmacy pursuant to chapter 400j of the general statutes;

(14) "Physician" means a person licensed to practice medicine and surgery pursuant to chapter 370 of the general statutes;

(15) "Psychiatrist" means a physician specializing in psychiatry and licensed pursuant to chapter 370 of the general statutes;

(16) "Psychologist" means a person licensed to practice psychology pursuant to chapter 383 of the general statutes;

(17) "Qualified patient" means a competent adult who is a resident of this state, has a terminal illness and has satisfied the requirements of this section and sections 2 to 9, inclusive, of this act, in order to obtain aid in dying;
(18) "Self-administer" means a qualified patient's act of ingesting medication; and

(19) "Terminal illness" means the final stage of an incurable and irreversible medical condition that an attending physician anticipates, within reasonable medical judgment, will produce a patient's death within six months.

Sec. 2. (NEW) (Effective October 1, 2019) (a) A patient who (1) is an adult, (2) is competent, (3) is a resident of this state, (4) has been determined by such patient's attending physician to have a terminal illness, and (5) has voluntarily expressed his or her wish to receive aid in dying, may request aid in dying by making two written requests to such patient's attending physician pursuant to sections 3 and 4 of this act.

(b) No person, including, but not limited to, an agent under a living will, an attorney-in-fact under a durable power of attorney, a guardian, or a conservator, may act on behalf of a patient for purposes of this section, section 1 or sections 3 to 19, inclusive, of this act.

Sec. 3. (NEW) (Effective October 1, 2019) (a) A patient wishing to receive aid in dying shall submit two written requests to such patient's attending physician in substantially the form set forth in section 4 of this act. A patient's second written request for aid in dying shall be submitted not earlier than fifteen days after the date on which a patient submits the first request. A valid written request for aid in dying under sections 1 and 2 of this act and sections 4 to 19, inclusive, of this act shall be signed and dated by the patient. Each request shall be witnessed by at least two persons in the presence of the patient. Each person serving as a witness shall attest, in writing, that to the best of his or her knowledge and belief (1) the patient appears to be of sound mind, (2) the patient is acting voluntarily and not being coerced to sign the request, and (3) the witness is not: (A) A relative of the patient by blood, marriage or adoption, (B) entitled to any portion of the estate of the patient upon the patient's death, under any will or by operation of
law, or (C) an owner, operator or employee of a health care facility where the patient is a resident or receiving medical treatment.

(b) No person serving as a witness to a patient's request to receive aid in dying shall be: (1) A relative of such patient by blood, marriage or adoption; (2) at the time the request is signed, entitled to any portion of the estate of the patient upon the patient's death, under any will or by operation of law; (3) an owner, operator or employee of a health care facility where the patient is a resident or receiving medical treatment; or (4) such patient's attending physician at the time the request is signed.

(c) Any patient's act of requesting aid in dying or a qualified patient's self-administration of medication prescribed for aid in dying shall not provide the sole basis for appointment of a conservator or guardian for such patient or qualified patient.

Sec. 4. (NEW) (Effective October 1, 2019) A request for aid in dying as authorized by this section, sections 1 to 3, inclusive, of this act and sections 5 to 19, inclusive, of this act shall be in substantially the following form:

REQUEST FOR MEDICATION TO AID IN DYING

I, ..., am an adult of sound mind.

I am a resident of the State of Connecticut.

I am suffering from ..., which my attending physician has determined is an incurable and irreversible medical condition that will, within reasonable medical judgment, result in death within six months from the date on which this document is executed. This diagnosis of a terminal illness has been medically confirmed by another physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be dispensed or prescribed to aid me in dying, the potential associated risks, the expected result, feasible alternatives to
135 aid in dying and additional health care treatment options, including
136 palliative care and the availability of counseling with a psychologist,
137 psychiatrist or licensed clinical social worker.
138
139 I request that my attending physician dispense or prescribe
140 medication that I may self-administer for aid in dying. I authorize my
141 attending physician to contact a pharmacist to fill the prescription for
142 such medication, upon my request.
143
144 INITIAL ONE:
145
146 .... I have informed my family of my decision and taken family
147 opinions into consideration.
148
149 .... I have decided not to inform my family of my decision.
146
147 .... I have no family to inform of my decision.
147
148 I understand that I have the right to rescind this request at any time.
148
149 I understand the full import of this request and I expect to die if and
149 when I take the medication to be dispensed or prescribed. I further
150 understand that although most deaths occur within three hours, my
151 death may take longer and my attending physician has counseled me
152 about this possibility.
153
154 I make this request voluntarily and without reservation, and I
154 accept full responsibility for my decision to request aid in dying.
155
156 Signed: ....
156
157 Dated: ....
157
157 DECLARATION OF WITNESSES
158
159 By initialing and signing below on the date the person named above
159 signs, I declare that:
160
160 Witness 1 .... Witness 2 ....
Initials .... Initials ....

1. The person making and signing the request is personally known to me or has provided proof of identity;

2. The person making and signing the request signed this request in my presence on the date of the person's signature;

3. The person making the request appears to be of sound mind and not under duress, fraud or undue influence;

4. I am not the attending physician for the person making the request;

5. The person making the request is not my relative by blood, marriage or adoption;

6. I am not entitled to any portion of the estate of the person making the request upon such person's death under any will or by operation of law; and

7. I am not an owner, operator or employee of a health care facility where the person making the request is a resident or receiving medical treatment.

Printed Name of Witness 1 ....

Signature of Witness 1 .... Date ....

Printed Name of Witness 2 ....

Signature of Witness 2 .... Date ....

Sec. 5. (NEW) (Effective October 1, 2019) (a) A qualified patient may rescind his or her request for aid in dying at any time and in any manner without regard to his or her mental state.

(b) An attending physician shall offer a qualified patient an opportunity to rescind his or her request for aid in dying at the time...
such patient submits a second written request for aid in dying to the
attending physician.

(c) No attending physician shall dispense or prescribe medication
for aid in dying without the attending physician first offering the
qualified patient a second opportunity to rescind his or her request for
aid in dying.

Sec. 6. (NEW) (Effective October 1, 2019) When an attending
physician is presented with a patient's first written request for aid in
dying made pursuant to sections 2 to 4, inclusive, of this act, the
attending physician shall:

(1) Make a determination that the patient (A) is an adult, (B) has a
terminal illness, (C) is competent, and (D) has voluntarily requested
aid in dying. Such determination shall not be made solely on the basis
of age, disability or any specific illness;

(2) Require the patient to demonstrate residency in this state by
presenting: (A) A Connecticut driver's license; (B) a valid voter
registration record authorizing the patient to vote in this state; or (C)
any other government-issued document that the attending physician
reasonably believes demonstrates that the patient is a current resident
of this state;

(3) Ensure that the patient is making an informed decision by
informing the patient of: (A) The patient's medical diagnosis; (B) the
patient's prognosis; (C) the potential risks associated with self-
administering the medication to be dispensed or prescribed for aid in
dying; (D) the probable result of self-administering the medication to
be dispensed or prescribed for aid in dying; (E) the feasible alternatives
to aid in dying and health care treatment options including, but not
limited to, palliative care; and (F) the availability of counseling with a
psychologist, psychiatrist or licensed clinical social worker; and

(4) Refer the patient to a consulting physician for medical
confirmation of the attending physician's diagnosis of the patient's terminal illness, the patient's prognosis and for a determination that the patient is competent and acting voluntarily in requesting aid in dying.

Sec. 7. (NEW) (Effective October 1, 2019) In order for a patient to be found to be a qualified patient for the purposes of this section, sections 1 to 6, inclusive, of this act and sections 8 to 19, inclusive, of this act, a consulting physician shall: (1) Examine the patient and the patient's relevant medical records; (2) confirm, in writing, the attending physician's diagnosis that the patient has a terminal illness; (3) verify that the patient is competent, is acting voluntarily and has made an informed decision to request aid in dying; and (4) refer the patient for counseling, if required in accordance with section 8 of this act.

Sec. 8. (NEW) (Effective October 1, 2019) (a) If, in the medical opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological condition including, but not limited to, depression, that is causing impaired judgment, either the attending or consulting physician shall refer the patient for counseling to determine whether the patient is competent to request aid in dying.

(b) An attending physician shall not provide the patient aid in dying until the person providing such counseling determines that the patient is not suffering a psychiatric or psychological condition including, but not limited to, depression, that is causing impaired judgment.

Sec. 9. (NEW) (Effective October 1, 2019) (a) After an attending physician and a consulting physician determine that a patient is a qualified patient, in accordance with sections 6 to 8, inclusive, of this act and after such qualified patient submits a second request for aid in dying in accordance with sections 3 and 4 of this act, the attending physician shall:

(1) Recommend to the qualified patient that he or she notify his or
her next of kin of the qualified patient's request for aid in dying and inform the qualified patient that a failure to do so shall not be a basis for the denial of such request;

(2) Counsel the qualified patient concerning the importance of: (A) Having another person present when the qualified patient self-administers the medication dispensed or prescribed for aid in dying; and (B) not taking the medication in a public place;

(3) Inform the qualified patient that he or she may rescind his or her request for aid in dying at any time and in any manner;

(4) Verify, immediately before dispensing or prescribing medication for aid in dying, that the qualified patient is making an informed decision;

(5) Fulfill the medical record documentation requirements set forth in section 10 of this act; and

(6) (A) Dispense such medication, including ancillary medication intended to facilitate the desired effect to minimize the qualified patient's discomfort, if the attending physician is authorized to dispense such medication, to the qualified patient; or (B) upon the qualified patient's request and with the qualified patient's written consent (i) contact a pharmacist and inform the pharmacist of the prescription, and (ii) personally deliver the written prescription, by mail, facsimile or electronic transmission to the pharmacist, who shall dispense such medication directly to the qualified patient, the attending physician or an expressly identified agent of the qualified patient.

(b) The person signing the qualified patient's death certificate shall list the underlying terminal illness as the cause of death.

Sec. 10. (NEW) (Effective October 1, 2019) The attending physician shall ensure that the following items are documented or filed in a qualified patient's medical record:
(1) The basis for determining that a qualified patient is an adult and a resident of the state;

(2) All oral requests by a qualified patient for medication for aid in dying;

(3) All written requests by a qualified patient for medication for aid in dying;

(4) The attending physician's diagnosis of a qualified patient's terminal illness and prognosis, and a determination that a qualified patient is competent, is acting voluntarily and has made an informed decision to request aid in dying;

(5) The consulting physician's confirmation of a qualified patient's diagnosis and prognosis, confirmation that a qualified patient is competent, is acting voluntarily and has made an informed decision to request aid in dying;

(6) A report of the outcome and determinations made during counseling, if counseling was recommended and provided in accordance with section 8 of this act;

(7) Documentation of the attending physician's offer to a qualified patient to rescind his or her request for aid in dying at the time the attending physician dispenses or prescribes medication for aid in dying; and

(8) A statement by the attending physician indicating that (A) all requirements under this section and sections 1 to 9, inclusive, of this act have been met, and (B) the steps taken to carry out a qualified patient's request for aid in dying, including the medication dispensed or prescribed.

Sec. 11. (NEW) (Effective October 1, 2019) Any person, other than a qualified patient, in possession of medication dispensed or prescribed for aid in dying that has not been self-administered shall return such
medication to the attending physician or the Commissioner of Consumer Protection in accordance with section 21a-252 of the general statutes.

Sec. 12. (NEW) (Effective October 1, 2019) (a) Any provision of a contract, including, but not limited to, a contract related to an insurance policy or annuity, conditioned on or affected by the making or rescinding of a request for aid in dying shall not be valid.

(b) On and after October 1, 2019, the sale, procurement or issuance of any life, health or accident insurance or annuity policy or the rate charged for any such policy shall not be conditioned upon or affected by the making or rescinding of a request for aid in dying.

(c) A qualified patient's act of requesting aid in dying or self-administering medication dispensed or prescribed for aid in dying shall not constitute suicide for any purpose, including, but not limited to, a criminal prosecution under section 53a-56 of the general statutes.

Sec. 13. (NEW) (Effective October 1, 2019) (a) As used in this section, "participate in the provision of medication" means to perform the duties of an attending physician or consulting physician, a psychiatrist, psychologist or pharmacist in accordance with the provisions of sections 2 to 10, inclusive, of this act. "Participate in the provision of medication" does not include: (1) Making an initial diagnosis of a patient's terminal illness; (2) informing a patient of his or her medical diagnosis or prognosis; (3) informing a patient concerning the provisions of this section, sections 1 to 12, inclusive, of this act and sections 16 to 19, inclusive, of this act, upon the patient's request; or (4) referring a patient to another health care provider for aid in dying.

(b) Participation in any act described in sections 1 to 12, inclusive, of this act and sections 16 to 19, inclusive, of this act by a patient, health care provider or any other person shall be voluntary. Each health care provider shall individually and affirmatively determine whether to participate in the provision of medication to a qualified patient for aid.
in dying. A health care facility shall not require a health care provider to participate in the provision of medication to a qualified patient for aid in dying, but may prohibit such participation in accordance with subsection (d) of this section.

(c) If a health care provider or health care facility chooses not to participate in the provision of medication to a qualified patient for aid in dying, upon request of a qualified patient, such health care provider or health care facility shall transfer all relevant medical records to any health care provider or health care facility, as directed by a qualified patient.

(d) A health care facility may adopt written policies prohibiting a health care provider associated with such health care facility from participating in the provision of medication to a patient for aid in dying, provided such facility provides written notice of such policy and any sanctions for violation of such policy to such health care provider. Notwithstanding the provisions of this subsection or any policies adopted in accordance with this subsection, a health care provider may: (1) Diagnose a patient with a terminal illness; (2) inform a patient of his or her medical prognosis; (3) provide a patient with information concerning the provisions of this section, sections 1 to 12, inclusive, of this act and sections 16 to 19, inclusive, of this act, upon a patient's request; (4) refer a patient to another health care facility or health care provider; (5) transfer a patient's medical records to a health care provider or health care facility, as requested by a patient; or (6) participate in the provision of medication for aid in dying when such health care provider is acting outside the scope of his or her employment or contract with a health care facility that prohibits participation in the provision of such medication.

(e) Except as provided in a policy adopted in accordance with subsection (d) of this section, no health care facility may subject an employee or other person who provides services under contract with the health care facility to disciplinary action, loss of privileges, loss of
membership or any other penalty for participating, or refusing to
participate, in the provision of medication or related activities in good
faith compliance with the provisions of this section, sections 1 to 12,
inclusive, of this act and sections 16 to 19, inclusive, of this act.

Sec. 14. (NEW) (Effective October 1, 2019) (a) A person is guilty of
murder when such person, without authorization of a patient, wilfully
alters or forges a request for aid in dying, as described in sections 3
and 4 of this act, or conceals or destroys a rescission of such a request
for aid in dying with the intent or effect of causing the patient's death.

(b) A person is guilty of murder when such person coerces or exerts
undue influence on a patient to complete a request for aid in dying, as
described in sections 3 and 4 of this act, or coerces or exerts undue
influence on a patient to destroy a rescission of such request with the
intent or effect of causing the patient's death.

Sec. 15. (NEW) (Effective October 1, 2019) (a) Nothing in sections 1 to
14, inclusive, of this act or sections 16 to 19, inclusive, of this act
authorizes a physician or any other person to end another person's life
by lethal injection, mercy killing, assisting a suicide or any other active
euthanasia.

(b) No action taken in accordance with sections 1 to 14, inclusive, of
this act or sections 16 to 19, inclusive, of this act shall constitute
causing or assisting another person to commit suicide in violation of
section 55a-54a or 55a-56 of the general statutes.

(c) No person shall be subject to civil or criminal liability or
professional disciplinary action, including, but not limited to,
revocation of such person's professional license, for (1) participating in
the provision of medication or related activities in good faith
compliance with the provisions of sections 1 to 14, inclusive, of this act
and sections 16 to 19, inclusive, of this act, or (2) being present at the
time a qualified patient self-administers medication dispensed or
prescribed for aid in dying.
(d) An attending physician's dispensing of, or issuance of a 
prescription for medication for aid in dying or a patient's request for 
aid in dying, in good faith compliance with the provisions of sections 1 
to 19, inclusive, of this act shall not constitute neglect for the purpose 
of any law or provide the sole basis for appointment of a guardian or 
conservator for such patient.

Sec. 16. (NEW) (Effective October 1, 2019) Sections 1 to 15, inclusive, 
of this act or sections 17 to 19, inclusive, of this act do not limit liability 
for civil damages resulting from negligent conduct or intentional 
misconduct by any person.

Sec. 17. (NEW) (Effective October 1, 2019) (a) Any person who 
knowingly possesses, sells or delivers medication dispensed or 
prescribed for aid in dying for any purpose other than delivering such 
medication to a qualified patient, or returning such medication in 
accordance with section 11 of this act, shall be guilty of a class D 
felony.

(b) Nothing in sections 1 to 16, inclusive, of this act or section 18 or 
19 of this act shall preclude criminal prosecution under any provision 
of law for conduct that is inconsistent with said sections.

Sec. 18. (NEW) (Effective October 1, 2019) Nothing in sections 1 to 17, 
inclusive, of this act or section 19 of this act shall limit the jurisdiction 
or authority of the nonprofit entity designated by the Governor to 
serve as the Connecticut protection and advocacy system under 
chapter 813 of the general statutes.

Sec. 19. (NEW) (Effective October 1, 2019) No person who serves as an 
attending physician, consulting physician or a witness as described in 
section 3 of this act, or otherwise participates in the provision of 
medication for aid in dying to a qualified patient, shall inherit or 
receive any part of the estate of such qualified patient, whether under 
the provisions of law relating to intestate succession or as a devisee or 
legatee, or otherwise under the will of such qualified patient, or receive

LCO No. 3338  
15 of 16
any property as beneficiary or survivor of such qualified patient after such qualified patient has self-administered medication dispensed or prescribed for aid in dying.

This act shall take effect as follows and shall amend the following sections:

<table>
<thead>
<tr>
<th>Section</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>October 1, 2019</td>
<td>New section</td>
</tr>
<tr>
<td>2</td>
<td>October 1, 2019</td>
<td>New section</td>
</tr>
<tr>
<td>3</td>
<td>October 1, 2019</td>
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<tr>
<td>4</td>
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<td>5</td>
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<td>7</td>
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<td>October 1, 2019</td>
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</tr>
<tr>
<td>10</td>
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</tr>
<tr>
<td>11</td>
<td>October 1, 2019</td>
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</tr>
<tr>
<td>12</td>
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<td>October 1, 2019</td>
<td>New section</td>
</tr>
<tr>
<td>18</td>
<td>October 1, 2019</td>
<td>New section</td>
</tr>
<tr>
<td>19</td>
<td>October 1, 2019</td>
<td>New section</td>
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</table>

Statement of Purpose:
To provide aid in dying to terminally ill patients.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: REP. STEINBERG, 136th Dist.; REP. GRESKO, 121st Dist.

H.B. 5898
CURRICULUM VITAE

MARGARET K. DORE, ESQ., M.B.A.
Law Offices of Margaret K. Dore, P.S.
Choice is an Illusion, a Nonprofit Corporation
1001 Fourth Avenue, Suite 4400
Seattle, Washington USA 98154
(206) 389-1754 main reception
(206) 389-1562 direct line
(206) 389-1530 (fax)
(206) 697-1217 (cell)
www.margaretdore.com
www.choiceillusion.org
margaretdore@margaretdore.com

ATTOYNEY EXPERIENCE:

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

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

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

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

JUDICIAL CLERKSHIPS:

The Washington State Supreme Court, Olympia, Washington USA.

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

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

PROFESSIONAL MEMBERSHIPS:

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

PUBLICATIONS:

Assisted Suicide and Euthanasia

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

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


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


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


Guardianship, Elder Abuse and Family Law


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


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


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


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

AWARDS/RECOGNITIONS:

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

PUBLISHED DECISIONS:

- In re Guardianship of Stamm, 121 Wn. App. 830, 91 P.3d 126 (2004) (3-0 opinion limiting the admissibility of guardian ad litem testimony);
- Lawrence v. Lawrence, 105 Wn. App.683, 20 P.3d 972 (2001) (3-0 opinion re: the “friendly parent” concept, that its use in a child custody determination would be an abuse of discretion);
- Jain v. State Farm, 130 Wn.2d 688, 926 P.2d 923 (1996), (7-2 opinion re: insurance coverage and retroactive application of decisional law); and
- In Re Alpine Group, Inc., 151 B.R. 931 (9th Cir. BAP 1993) (3-0 opinion re: attorney fees in bankruptcy).

EDUCATION:

University of Washington School of Law, Seattle, Washington USA.
Juris Doctorate, 1986.

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

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

Table 3. Death with Dignity Act process for the participants who have died

<table>
<thead>
<tr>
<th>Family and Psychiatric/Psychological involvement</th>
<th>2017</th>
<th>2016</th>
<th>2015¹</th>
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<tbody>
<tr>
<td>Referred for psychiatric/psychological evaluation²</td>
<td>4 2</td>
<td>11 5</td>
<td>8 4</td>
</tr>
<tr>
<td>Patient informed family of decision³</td>
<td>174 94</td>
<td>224 96</td>
<td>174 63</td>
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<tr>
<td><strong>Medication⁴</strong></td>
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<tr>
<td>Secobarbital</td>
<td>66 34</td>
<td>77 32</td>
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<td>Pentobarbital</td>
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<td>2 1</td>
<td>4 2</td>
</tr>
<tr>
<td>Secobarbital/Pentobarbital Combination</td>
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<td>0 0</td>
<td>0 0</td>
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<tr>
<td>Phenobarbital</td>
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<td>10 5</td>
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<tr>
<td>Phenobarbital/Chloral Hydrate Combination</td>
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<td>106 44</td>
<td>88 41</td>
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<tr>
<td>Chloral Hydrate</td>
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<tr>
<td>Morphine sulfate</td>
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<td>53 22</td>
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<tr>
<td>Other</td>
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**Timing**

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<tr>
<th>Duration of patient-physician relationship⁵</th>
<th>2017</th>
<th>2016</th>
<th>2015¹</th>
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<td>&lt;25 weeks</td>
<td>94 51</td>
<td>125 52</td>
<td>99 49</td>
</tr>
<tr>
<td>25 weeks – 51 weeks</td>
<td>21 11</td>
<td>25 10</td>
<td>18 9</td>
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<td>71 38</td>
<td>88 37</td>
<td>81 40</td>
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<td>2 1</td>
<td>4 2</td>
</tr>
<tr>
<td>Range (min – max)</td>
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<td>&lt;1 wk –</td>
<td>&lt;1 wk – 2 yrs</td>
</tr>
<tr>
<td></td>
<td>38 yrs</td>
<td>31 yrs</td>
<td>yrs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration between first oral request and death⁶</th>
<th>2017</th>
<th>2016</th>
<th>2015¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25 weeks</td>
<td>167 90</td>
<td>209 88</td>
<td>164 81</td>
</tr>
<tr>
<td>25 weeks or more</td>
<td>18 10</td>
<td>28 12</td>
<td>33 16</td>
</tr>
<tr>
<td>Unknown</td>
<td>0 0</td>
<td>0 0</td>
<td>5 2</td>
</tr>
<tr>
<td>Range (min – max)</td>
<td>2 wks –</td>
<td>2 wks –</td>
<td>0 wks –</td>
</tr>
<tr>
<td></td>
<td>81 wks</td>
<td>112 wks</td>
<td>95 wks</td>
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</tbody>
</table>

Notes:

2. Data are collected from the Attending Physician’s Compliance form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
3. Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 155 of the 196 participants in 2017 who died.
4. Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 196 participants in 2017 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.
5. Data are collected from the After Death Reporting form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
6. Data are collected from the After Death Reporting form and Attending physician Compliance Form. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.
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</thead>
<tbody>
<tr>
<td>Neurological disease (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amyotrophic lateral sclerosis (%)</td>
<td>15 (8.9)</td>
<td>117 (8.0)</td>
<td>10 (7.8)</td>
<td>16 (7.5)</td>
<td>23 (6.8)</td>
<td>53 (8.7)</td>
</tr>
<tr>
<td>Other neurological disease (%)</td>
<td>10 (6.0)</td>
<td>44 (3.0)</td>
<td>2 (1.6)</td>
<td>1 (0.5)</td>
<td>8 (2.4)</td>
<td>23 (3.8)</td>
</tr>
<tr>
<td>Respiratory disease [e.g., COPD] (%)</td>
<td>13 (7.7)</td>
<td>75 (5.1)</td>
<td>9 (7.0)</td>
<td>6 (2.8)</td>
<td>18 (5.3)</td>
<td>29 (4.8)</td>
</tr>
<tr>
<td>Heart/circulatory disease (%)</td>
<td>16 (9.5)</td>
<td>66 (4.5)</td>
<td>4 (3.1)</td>
<td>1 (0.5)</td>
<td>9 (2.6)</td>
<td>36 (5.9)</td>
</tr>
<tr>
<td>Infectious disease [e.g., HIV/AIDS] (%)</td>
<td>0 (0.0)</td>
<td>13 (0.9)</td>
<td>1 (0.8)</td>
<td>7 (3.3)</td>
<td>2 (0.6)</td>
<td>3 (0.5)</td>
</tr>
<tr>
<td>Gastrointestinal disease [e.g., liver disease] (%)</td>
<td>1 (0.6)</td>
<td>9 (0.6)</td>
<td>0 (0.0)</td>
<td>1 (0.5)</td>
<td>1 (0.3)</td>
<td>6 (1.0)</td>
</tr>
<tr>
<td>Endocrine/metabolic disease [e.g., diabetes] (%)</td>
<td>2 (1.2)</td>
<td>11 (0.8)</td>
<td>0 (0.0)</td>
<td>2 (0.9)</td>
<td>1 (0.3)</td>
<td>6 (1.0)</td>
</tr>
<tr>
<td>Other illnesses (%)</td>
<td>6 (3.6)</td>
<td>17 (1.2)</td>
<td>1 (0.8)</td>
<td>0 (0.0)</td>
<td>4 (1.2)</td>
<td>6 (1.0)</td>
</tr>
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</table>

**DWDA process**

| Referred for psychiatric evaluation (%)                                      | 3 (1.8)      | 65 (4.5)       | 28 (22.8)       | 8 (3.8)         | 6 (1.8)         | 20 (3.3)        |
| Patient informed family of decision (%)                                      | 156 (94.0)   | 1,292 (93.7)   | 55 (94.8)       | 198 (94.3)      | 317 (93.5)      | 566 (93.4)      |

**Patient died at**

| Home (patient, family or friend) (%)                                         | 147 (88.6)   | 1,342 (92.4)   | 121 (93.8)      | 198 (93.4)      | 326 (96.7)      | 550 (90.3)      |
| Assisted living or foster care facility (%)                                  | 12 (7.2)     | 72 (5.0)       | 4 (3.1)         | 11 (5.2)        | 10 (3.0)        | 35 (5.7)        |
| Nursing home (%)                                                             | 5 (3.0)      | 14 (1.0)       | 2 (1.6)         | 0 (0.0)         | 0 (0.0)         | 7 (1.1)         |
| Hospital (%)                                                                 | 0 (0.0)      | 4 (0.3)        | 1 (0.8)         | 0 (0.0)         | 0 (0.0)         | 3 (0.5)         |
| Hospice facility (%)                                                          | 0 (0.0)      | 2 (0.1)        | 0 (0.0)         | 0 (0.0)         | 0 (0.0)         | 2 (0.3)         |
| Other (%)                                                                     | 2 (1.2)      | 19 (1.3)       | 1 (0.8)         | 3 (1.4)         | 1 (0.3)         | 12 (2.0)        |
| Unknown                                                                       | 0            | 6              | 0               | 0               | 3              | 3               |

**Lethal medication**

| Secobarbital (%)                                                             | 92 (54.8)    | 846 (58.0)     | 86 (66.7)       | 91 (42.9)       | 223 (65.6)      | 354 (58.0)      |
| Pentobarbital (%)                                                            | 0 (0.0)      | 386 (26.5)     | 41 (31.8)       | 120 (56.6)      | 117 (34.4)      | 108 (17.7)      |
| DDMP1 (%)                                                                    | 10 (6.0)     | 67 (4.6)       | 0 (0.0)         | 0 (0.0)         | 0 (0.0)         | 57 (9.3)        |
| DDMP2 (%)                                                                    | 54 (32.1)    | 78 (5.3)       | 0 (0.0)         | 0 (0.0)         | 0 (0.0)         | 24 (3.9)        |
| Phenobarbital compound (%)                                                   | 2 (1.2)      | 65 (4.5)       | 0 (0.0)         | 0 (0.0)         | 0 (0.0)         | 63 (10.3)       |
| Other (%)                                                                    | 10 (6.0)     | 17 (1.2)       | 2 (1.6)         | 1 (0.5)         | 0 (0.0)         | 4 (0.7)         |
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.

https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide
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.

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

AMA Principles of Medical Ethics: I, IV

Read more opinions about this topic
Terminal Uncertainty

Washington's new "Death With Dignity" law allows doctors to help people commit suicide—once they've determined that the patient has only six months to live. But what if they're wrong?

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

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

That was almost four years ago. X

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 dod~ prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called pemetrexate.

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

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

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

Her experience underscores the difficulty doctors have in forecasting how long patients have to live—a difficulty that is about to become even more pertinent as the Washington Death With Dignity Act takes effect March 4. The law, passed by initiative last November and modeled closely on a 14-year-old law in Oregon, makes Washington the only other state in the country to allow terminally ill patients to obtain lethal medication. As in Oregon, the law is tightly linked to a prognosis: Two doctors must say a patient has six months or less to live before such medication can be prescribed.
Doctors also shade their prognoses according to their own biases and desires. Christakis' study found that the longer a doctor knew a patient, the more likely their prognosis was inaccurate, suggesting that doctors who get attached to their patients are reluctant to talk of their imminent demise. What's more, Christakis says, doctors see death "as a mark of failure."

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

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

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

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

"It was humbling," he says. "It was not amazing. That's the kind of thing in medicine that happens frequently."
Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

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

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

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

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

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

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

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

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

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

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

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

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

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than $300,000, 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 FC.

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

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

CITATION: R v Morant [2018] QSC 251

PARTIES: R
v
GRAHAM ROBERT MORANT (defendant)

FILE NO/S: Indictment No 1424 of 2018

DIVISION: Trial Division

PROCEEDING: Trial

DELIVERED ON: 2 November 2018 (delivered ex tempore)

DELIVERED AT: Brisbane

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

JUDGE: Davis J

ORDER: Convictions recorded.

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

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

The sentences are to be served concurrently.

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

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

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

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

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

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

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

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

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

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

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

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

By CHARLIE LUEDUFF  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 smelting death.

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

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

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

Another of Mr. Swango's favorite books, according to prosecutors, was "The Traveler," written by John Katzenbach. One passage that prosecutors contended offered a window into Mr. Swango's mind was: "when I kill someone, it's because I want to. It's the only way I have of reminding myself that I'm still alive."
what he identified as the text of "My Secret Life," Mr. Swango was inspired to copy: "I love it. Sweet, husky, close smell of an indoor homicide."

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

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

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

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

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

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

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

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

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

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

Mary A. Dowling, director of the hospital in Northport, tried to answer the wider question of how a man with Mr. Swango's background could find employment there. She said that he was hired by the State University of New York at Stony Brook, and rotated through Northport as part of his Stony Brook residency training.

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

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

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A version of this article appears in print on September 7, 2000, on Page 200301 of the National edition with the headline: Prosecutors Say Doctor Killed To Feel a Thrill.
Q&A: Harold Shipman

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

David Batty
Thu 25 Aug 2005 10.19 EDT

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

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

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

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

Why did he kill his patients?
Various theories have been put forward to explain why Shipman turned to murder. Some suggest that he was avenging the death of his mother, who died when he was 17. The more charitable view is that he injected old ladies with morphine as a way of easing the burdens on the NHS. Others
suggest that he simply could and resist playing God, proving that he could take life as well as save it.

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

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

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

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

**Since you're here...**
... we have a small favour to ask. More people are reading and supporting our independent, investigative reporting than ever before. And unlike many news organisations, we have chosen an approach that allows us to keep our journalism accessible to all, regardless of where they live or what they can afford.

This is The Guardian’s model for open, independent journalism: available to everyone, funded by our readers. Readers’ support powers our work, giving our reporting impact and safeguarding our essential editorial independence. This means the responsibility of protecting independent journalism is shared, enabling us all to feel empowered to bring about real change in the world. Your support gives Guardian journalists the time, space and freedom to report with tenacity and rigor, to shed light where others won't. It emboldens us to challenge authority and question the status quo. And by keeping all of our journalism free and open to all, we can foster inclusivity.
THE OREGON DEATH WITH DIGNITY ACT
OREGON REVISED STATUTES

(General Provisions)

(Section 1)

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.

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.
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 Connecticut.

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, ORS 127.800 s.1.01(12), attached hereto.

3. In practice, this definition is interpreted to include people with chronic conditions such as diabetes mellitus, better known as "diabetes."
4. Attached hereto, as Exhibit B, is an excerpt from the most recent Oregon government statistical report regarding our law. The excerpt lists "diabetes" as an "underlying illness" sufficient for assisted suicide.

5. In Oregon, chronic conditions such as diabetes are insufficient for assisted suicide, if, without treatment such as insulin, the patient has less than six months to live. This is significant when you consider that, without insulin, a typical insulin-dependent 20 year old will live less than a month.

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.

7. I have also been provided with an excerpt of the proposed Connecticut bill, which states:

   "Terminal illness" means the final stage of an incurable and irreversible medical condition that an attending physician anticipates, within reasonable medical judgment, will produce a patient's death within six months.

Exhibit C, HE 5417, Sec. 1(19), attached hereto.

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

DECLARATION OF WILLIAM TOFFLER - PAGE 2
9. In short, if Connecticut follows Oregon practice to determine eligibility without treatment, the proposed bill will apply to people with chronic conditions such as insulin dependent diabetes. Such persons, with treatment, can have years or decades to live happy, healthy and productive lives.

Signed under penalty of perjury this 17th day of March 2018, at Portland Oregon.

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
Chapter 127

Note: The division headings, subdivision headings and headlines for 127.600 to 127.697 were enacted as part of Ballot Measure 93 (1994) and were not provided by Legislative Counsel.

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

127.600 s.1.01. Definitions.

The following words and phrases, whenever used in ORS 127.600 to 127.697, 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 127.600 to 127.697 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

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

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

(Specialty 2)

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

TOFFLER EXHIBIT A
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2017 (N=143)</th>
<th>1998–2016 (N=1,132)</th>
<th>Total (N=1,275)</th>
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<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro counties (Clackamas, Multnomah, Washington) (%)</td>
<td>55 (38.5)</td>
<td>484 (43.1)</td>
<td>539 (42.6)</td>
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<tr>
<td>Coastal counties (%)</td>
<td>12 (8.4)</td>
<td>80 (7.1)</td>
<td>92 (7.3)</td>
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<td>Other western counties (%)</td>
<td>65 (45.5)</td>
<td>471 (41.9)</td>
<td>536 (42.3)</td>
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<td>East of the Cascades (%)</td>
<td>11 (7.7)</td>
<td>88 (7.8)</td>
<td>99 (7.8)</td>
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<tr>
<td>Unknown</td>
<td>0</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td><strong>End of life care</strong></td>
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<td></td>
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<tr>
<td>Hospice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled (%)</td>
<td>130 (90.9)</td>
<td>989 (90.1)</td>
<td>1119 (90.2)</td>
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<tr>
<td>Not enrolled (%)</td>
<td>13 (9.1)</td>
<td>109 (9.9)</td>
<td>122 (9.8)</td>
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<tr>
<td>Unknown</td>
<td>0</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
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<td></td>
</tr>
<tr>
<td>Private (%)</td>
<td>36 (31.3)</td>
<td>569 (53.8)</td>
<td>605 (51.6)</td>
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<tr>
<td>Medicare, Medicaid or other governmental (%)</td>
<td>78 (67.8)</td>
<td>474 (44.8)</td>
<td>552 (47.1)</td>
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<td>None (%)</td>
<td>1 (0.9)</td>
<td>14 (1.3)</td>
<td>15 (1.3)</td>
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<td>Unknown</td>
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<td>75</td>
<td>103</td>
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<td><strong>Underlying illness</strong></td>
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</tr>
<tr>
<td>Cancer (%)</td>
<td>110 (76.9)</td>
<td>883 (78.0)</td>
<td>993 (77.9)</td>
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<td>Lung and bronchus (%)</td>
<td>23 (16.1)</td>
<td>163 (17.0)</td>
<td>216 (16.9)</td>
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<tr>
<td>Breast (%)</td>
<td>6 (4.2)</td>
<td>86 (7.6)</td>
<td>92 (7.2)</td>
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<tr>
<td>Colon (%)</td>
<td>6 (4.2)</td>
<td>73 (6.4)</td>
<td>79 (6.2)</td>
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<tr>
<td>Pancreas (%)</td>
<td>15 (10.5)</td>
<td>74 (6.5)</td>
<td>89 (7.0)</td>
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<tr>
<td>Prostate (%)</td>
<td>10 (7.0)</td>
<td>48 (4.2)</td>
<td>58 (4.5)</td>
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<td>Ovary (%)</td>
<td>4 (2.8)</td>
<td>41 (3.6)</td>
<td>45 (3.5)</td>
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<tr>
<td>Other cancers (%)</td>
<td>46 (32.2)</td>
<td>368 (32.5)</td>
<td>414 (32.5)</td>
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<tr>
<td>Neurological disease (%)</td>
<td>20 (14.0)</td>
<td>114 (10.1)</td>
<td>134 (10.5)</td>
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<td>Amyotrophic lateral sclerosis (%)</td>
<td>10 (7.0)</td>
<td>90 (8.0)</td>
<td>100 (7.8)</td>
</tr>
<tr>
<td>Other neurological disease (%)</td>
<td>10 (7.0)</td>
<td>24 (2.1)</td>
<td>34 (2.7)</td>
</tr>
<tr>
<td>Respiratory disease [e.g., COPD] (%)</td>
<td>2 (1.4)</td>
<td>59 (5.2)</td>
<td>61 (4.8)</td>
</tr>
<tr>
<td>Heart/circulatory disease (%)</td>
<td>9 (6.3)</td>
<td>40 (3.5)</td>
<td>49 (3.8)</td>
</tr>
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<td>Infectious disease [e.g., HIV/AIDS] (%)</td>
<td>0 (0.0)</td>
<td>13 (1.1)</td>
<td>13 (1.0)</td>
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<tr>
<td>Gastrointestinal disease [e.g., liver disease] (%)</td>
<td>0 (0.0)</td>
<td>8 (0.7)</td>
<td>8 (0.6)</td>
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<td>Endocrine/metabolic disease [e.g., diabetes] (%)</td>
<td>1 (0.7)</td>
<td>7 (0.6)</td>
<td>8 (0.6)</td>
</tr>
<tr>
<td>Other illnesses (%)</td>
<td>1 (0.7)</td>
<td>8 (0.7)</td>
<td>9 (0.7)</td>
</tr>
</tbody>
</table>
(17) "Qualified patient" means a competent adult who is a resident of this state, has a terminal illness and has satisfied the requirements of this section and sections 2 to 9, inclusive, of this act, in order to obtain aid in dying;

(18) "Self-administer" means a qualified patient’s act of ingesting medication; and

(19) "Terminal illness" means the final stage of an incurable and irreversible medical condition that an attending physician anticipates, within reasonable medical judgment, will produce a patient’s death within six months.

Sec. 2. (NEW) (Effective October 1, 2018) (a) A patient who (1) is an adult, (2) is competent, (3) is a resident of this state, (4) has been determined by such patient’s attending physician to have a terminal illness, and (5) has voluntarily expressed his or her wish to receive aid in dying, may request aid in dying by making two written requests to such patient’s attending physician pursuant to sections 3 and 4 of this act.

(b) No person, including, but not limited to, an agent under a living will, an attorney-in-fact under a durable power of attorney, a guardian, or a conservator, may act on behalf of a patient for purposes of this section, section 1 or sections 3 to 19, inclusive, of this act.

Sec. 3. (NEW) (Effective October 1, 2018) (a) A patient wishing to receive aid in dying shall submit two written requests to such patient’s attending physician in substantially the form set forth in section 4 of this act. A patient’s second written request for aid in dying shall be submitted not earlier than fifteen days after the date on which a patient submits the first request. A valid written request for aid in dying under sections 1 and 2 of this act and sections 4 to 19, inclusive, of this act shall be signed and dated by the patient. Each request shall be witnessed by at least two persons in the presence of the patient. Each person serving as a witness shall attest, in writing, that to the best of his or her knowledge and belief (1) the patient appears to be of sound mind, (2) the patient is acting voluntarily and not being coerced to sign the request, and (3) the witness is not: (A) A relative of the patient by blood, marriage or adoption, (B) entitled to any portion of the estate of the patient upon the patient’s death, under any will or by operation of law, and (C) an owner, operator or employee of a health care facility where the patient is a resident or receiving medical treatment.

(b) No person serving as a witness to a patient’s request to receive aid in dying shall be: (1) A relative of such patient by blood, marriage or adoption; (2) at the time the request is signed, entitled to any portion of the estate of the patient upon the patient’s death, under any will or by operation of law; (3) an owner, operator or employee of a health care facility where the patient is a resident or receiving medical treatment; or (4) such patient’s attending physician at the time the request is signed.

(c) Any patient’s act of requesting aid in dying or a qualified patient’s self-administration of medication prescribed for aid in dying shall not provide the sole basis for appointment of a conservator or guardian for such patient or qualified patient.

Sec. 4. (NEW) (Effective October 1, 2018) A request for aid in dying as authorized by this section, sections 1 to 3, inclusive, of this act and sections 5 to 19, inclusive, of this act shall be in substantially the following form:

REQUEST FOR MEDICATION TO AID IN DYING

I, ...., am an adult of sound mind.
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.
AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO ASSISTED SUICIDE AND EUTHANASIA

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

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

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

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

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

5. I will be 75 years old this coming September. If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come. I hope that Canada does not legalize these practices.
SWORN BEFORE ME at
MASSACHUSETTS, USA
on, AUGUST 15TH, 2012

NAME: HENRI PRZYBYLSKI

A notary in and for the
State of Washington, MASSACHUSETTS

ADDRESS: 35 MAIN ST
Florence, MA 01062

EXPIRY OF COMMISSION: JUNE 22, 2018

PLACE SEAL HERE:

[Notary Seal]

AFFIDAVIT OF JOHN NORTON- Page 3

[Signature and Seal]

A-49
I, Kenneth Stevens, declare the following under penalty of perjury.

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

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

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

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

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

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

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

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

Affidavit of Kenneth Stevens, Jr., MD - page 2

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9. Finally, I have been asked to comment on generally accepted medical practice regarding the administration of prescription drugs to a patient.

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

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

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

DECLARATION OF JEANETTE HALL

I, JEANETTE HALL, declare as follows:

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

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

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

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

Dated this 28th day of NOVEMBER 2018

Jeanette Hall
ac•cord•ance (ə-kör′dəns/ ə-h) noun: accordance

noun: accordance

In a manner conforming with.
"the product is designed in accordance with federal regulations" synonyms: in agreement with, in conformity with, in line with, true to, in the spirit of, observing, following, adhering to; "he is held in accordance with union rules"

Origin

OLD FRENCH OLD FRENCH
accorder accordance
accorder accordance

ENGLISH
accord
accord

Middle English; from Old French accordance; from accorder "bring to an agreement" (see accord).

Translate accordance to Choose language

Use over time for: accordance

1664 1750 1792 1846 1946

Show less

Accordance | Definition of Accordance by Merriam-Webster
https://www.merriam-webster.com/dictionary/accordance

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

In Accordance With | Definition of In Accordance With by Merriam ...
https://www.merriam-webster.com/dictionary/in%20accordance%20with

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

Accordance | Define Accordance at Dictionary.com
www.dictionary.com/browse/accordance

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

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

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Accordance - definition of accordance by The Free Dictionary
www.thefreedictionary.com/accordance

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

In accordance with - Idioms by The Free Dictionary
idioms.thefreedictionary.com/in-accordance-with

Feedback
in (or in the) spirit

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

Translations, word origin, and more definitions

What's the meaning of "in the spirit of"? - English Language & Usage...
https://english.stackexchange.com/questions/.../what-is-the-meaning-of-in-the-spirit-of...
Apr 22, 2014 - In the spirit of full disclosure, the texts in question turned out to be my editor at Salon...
Source: http://longly.com/?q=in%3a%20the%20spirit%20of%3a%20definition...

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

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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 "spirits","spiritual","wraith","soul", Reverso dictionary, English...

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

in the spirit of - definition of in the spirit of - DictionaryNet
www.dictionary.com/in-the-spirit-of
Definition of in the spirit of. What is the meaning of in the spirit of? in various languages. Translation of in the spirit of in the dictionary.

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

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

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

https://www.oxford dictionaries.com/definition/english/spirit
Death certificate reform delays ‘incomprehensible’

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

Press Association
Wed 21 Jan 2015 05.09 EST

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

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

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

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

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

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

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

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

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

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

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

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

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

$190,823 contributed
$1,000,000
our goal
In these critical times ...
... help us protect independent journalism at a time when factual, trustworthy reporting is under threat by making a year-end gift to support The Guardian. We’re asking our US readers to help us raise one million dollars by the new year so that we can report on the stories that matter in 2019. Small or big, every contribution you give will help us reach our goal.

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In 2018, The Guardian broke the story of Cambridge Analytica’s Facebook data recorded the human fallout from family separations; we charted the rise in gun violence on Americans’ lives.
2011 Connecticut Code
Title 53a Penal Code
Chapter 952 Penal Code: Offenses
Sec. 53a-54a. Murder.

Sec. 53a-54a. Murder. (a) A person is guilty of murder when, with intent to cause the death of another person, he causes the death of such person or of a third person or causes a suicide by force, duress or deception; except that in any prosecution under this subsection, it shall be an affirmative defense that the defendant committed the proscribed act or acts under the influence of extreme emotional disturbance for which there was a reasonable explanation or excuse, the reasonableness of which is to be determined from the viewpoint of a person in the defendant's situation under the circumstances as the defendant believed them to be, provided nothing contained in this subsection shall constitute a defense to a prosecution for, or preclude a conviction of, manslaughter in the first degree or any other crime.

(b) Evidence that the defendant suffered from a mental disease, mental defect or other mental abnormality is admissible, in a prosecution under subsection (a) of this section, on the question of whether the defendant acted with intent to cause the death of another person.

(c) Murder is punishable as a class A felony in accordance with subdivision (2) of section 53a-35a unless it is a capital felony or murder under section 53a-54d.

(P.A. 73-137, S. 2; P.A. 80-442, S. 15, 28; P.A. 83-486, S. 4; P.A. 92-260, S. 26.)

History: P.A. 80-442 amended Subsec. (c) to specify punishment in accordance with Sec. 53a-35a(2), deleting reference to death penalty imposed as provided by Sec. 53a-46a for capital felony, effective July 1, 1981; P.A. 83-486 amended Subsec. (a) by replacing

Sec. 53a-56. Manslaughter in the second degree: Class C felony. (a) A person is guilty of manslaughter in the second degree when: (1) He recklessly causes the death of another person; or (2) he intentionally causes or aids another person, other than by force, duress or deception, to commit suicide.

(b) Manslaughter in the second degree is a class C felony.

(1969, P.A. 828, S. 57.)


Subsec. (a):