Appendix

Margaret Dore Memo

Reject Oregon Bill

HB 2217 A

as of

May 8, 2019

CURRICULUM VITAE

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ATTORNEY 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.
Law Clerk to Chief Justice Vernon R. Pearson. (August 1987 to August 1988).

The Washington State Court of Appeals, Tacoma, Washington USA.
Law Clerk to Judge John A. Petrich. (August 1986 to August 1987).

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.
- Washington State Bar Association, 1986-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.
- National Association of Elder Law Attorneys, 1996, 2001, present.
- Vision Awareness of Washington, President, 1993-2001.
- Washington State Trial Lawyers Association, 1996, other years.

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;

Margaret K. Dore, "Physician-Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice," *The Vermont Bar Journal*, Winter 2011;

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 K. Dore, "Aid in Dying: Not Legal in Idaho; Not About Choice," *The Advocate*, official publication of the Idaho State Bar, Vol. 52, No. 9, pages 18-20, September 2010;

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

Margaret K. Dore, "'Death with Dignity': What Do We Advise Our Clients?," King County Bar Association, *Bar Bulletin*, May 2009.

Guardianship, Elder Abuse and Family Law

Margaret K. Dore, Ten Reasons People Get Railroaded into Guardianship, 21 *American Journal of Family Law* 148, Winter 2008;

Margaret K. Dore, The Time is Now: Guardians Should be Licensed and Regulated Under the Executive Branch, Not the Courts, Washington State Bar Association, *Bar News*, March 2007;

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

Margaret K. Dore, The Case Against Court Certification of Guardians: The Case for Licensing and Regulation, National Academy of Elder Law Attorneys, *NAELA News*, Vol. 18, No. 1, February/March 2006;

Margaret K. Dore, The Stamm Case and Guardians ad Litem, King County Bar Association, *Bar Bulletin*, June 2005, Washington State Bar Association, *Elder Law Section Newsletter*, Winter 2004-2005, p. 3;

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, "Washington Rejects 'Friendly Parent' Presumption in Child Custody Cases," Washington State Bar Association, *Bar News*, August 2001;

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, "The Friendly Parent Concept (Access to Justice denied)," Washington State Trial Lawyers Association, *Trial News*, Volume 36, No. 9, May 2001;

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

Margaret K. Dore, "The Friendly Parent Concept--A Construct Fundamentally at Odds With The Parenting Act, RCW 26.09," Washington State Bar Association, *Family Law Section Newsletter*, Spring 1999.

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).

- Wendy N. Davis, "Family Values in Flux: Some Lawyers are growing hostile to the 'friendly parent' idea in custody fights," *ABA Journal*, Vol. 87, p. 26, October 2001 (featuring Margaret Dore after victory in Washington State).

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);

- *Kelly-Hansen v. Kelly-Hansen*, 87 Wn. App. 320, 941 P.2d 1108 (1997) (3-0 opinion re: post-dissolution dispute);

- *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.

Passed the C.P.A. examination in 1982.

THE OREGON DEATH WITH DIGNITY ACT

OREGON REVISED STATUTES

(General Provisions)

(Section 1)

Note: The division headings, subdivision headings and leadlines 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.

(2) One of the witnesses shall be a person who is not:

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

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

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

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

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

(Safeguards)

(Section 3)

127.815 §3.01. Attending physician responsibilities. (1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

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

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

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

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;

(i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of ORS 127.855;

(k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(L)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or

(B) With the patient's written consent:

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

(ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 §3.01; 1999 c.423 §3]

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

127.825 §3.03. Counseling referral. If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [1995 c.3 §3.03; 1999 c.423 §4]

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

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

127.840 §3.06. Written and oral requests. In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request. [1995 c.3 §3.06]

127.845 §3.07. Right to rescind request. A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request. [1995 c.3 §3.07]

127.850 §3.08. Waiting periods. No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897. [1995 c.3 §3.08]

127.855 §3.09. Medical record documentation requirements. The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

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

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

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

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

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

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

(1) Possession of an Oregon driver license;

(2) Registration to vote in Oregon;

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

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

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

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

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

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

127.870 §3.12. Effect on construction of wills, contracts and statutes. (1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 §3.12]

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

127.880 §3.14. Construction of Act. Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 §3.14]

(Immunities and Liabilities)

(Section 4)

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

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

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

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

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

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

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

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

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

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent

contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

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

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

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

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

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

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

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

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

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

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

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

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

127.890 §4.02. Liabilities. (1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897. [1995 c.3 §4.02]

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

(Severability)

(Section 5)

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

(Form of the Request)

(Section 6)

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

REQUEST FOR MEDICATION

TO END MY LIFE IN A HUMANE

AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

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

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

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

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

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

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

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

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

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Is not a patient for whom either of us is attending physician.

_____Witness 1/Date

_____Witness 2/Date

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

[1995 c.3 §6.01; 1999 c.423 §11]

PENALTIES

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

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

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

A-Engrossed
House Bill 2217

Ordered by the House April 16
Including House Amendments dated April 16

Sponsored by Representative GREENLICK, Senator STEINER HAYWARD; Representatives FAHEY, KENY-GUYER, MARSH, NOSSE, SALINAS, WILDE, Senators PROZANSKI, ROBLAN (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Prohibits anyone other than patient from administering medication to end patient's life in humane and dignified manner.
Defines "self-administer." [*to include ingestion or other delivery method.*]
Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to death with dignity; creating new provisions; amending ORS 127.800, 127.815, 127.875, 127.885 and 127.897; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2019 Act is added to and made a part of ORS 127.800 to 127.897.

SECTION 2. Medication prescribed under ORS 127.800 to 127.897 must be self-administered by the patient and may not be administered on behalf of the patient by any other person.

SECTION 3. ORS 127.800 is amended to read:

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 **licensed** 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 per-

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

mitted 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 **for medication** 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*] **self-administering** the medication to be prescribed;

(d) The probable result of [*taking*] **self-administering** 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 licensed to practice medicine under ORS 677.100 to 677.228.

(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) "Self-administer" means a qualified patient's affirmative, conscious and voluntary act to take into his or her body medication to end his or her life in a humane and dignified manner.

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

SECTION 4. ORS 127.815 is amended to read:

127.815. §3.01. Attending physician responsibilities. (1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with [*taking*] **self-administering** the medication to be prescribed;

(D) The probable result of [*taking*] **self-administering** the medication to be prescribed; and

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

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient [*takes*] **self-administers** the medication prescribed pursuant to ORS 127.800 to 127.897 and of not [*taking*] **self-administering** the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15-day waiting period pursuant to ORS 127.840;

(i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of ORS 127.855;

(k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(L)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Oregon Medical Board, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or

(B) With the patient's written consent:

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

(ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's report of death.

SECTION 5. ORS 127.875 is amended to read:

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

SECTION 6. ORS 127.885 is amended to read:

127.885. §4.01. Immunities. Except as provided in ORS 127.890:

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

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

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

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a

copy of the patient's relevant medical records to the new health care provider.

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

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

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

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

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

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

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

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

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

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

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

(ii) Providing information about [*the Oregon Death with Dignity Act*] **ORS 127.800 to 127.897** to

a patient upon the request of the patient;

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

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

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (3), (4), (5) or (6).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community.

SECTION 7. ORS 127.897 is amended to read:

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

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

I, _____, am an adult of sound mind.

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

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

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

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

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

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I [*take*] **self-administer** the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

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

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence; **and**

(d) Is not a patient for whom either of us is attending physician.

_____ Witness 1/Date

_____ Witness 2/Date

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

SECTION 8. This 2019 Act takes effect on the 91st day after the date on which the 2019 regular session of the Eightieth Legislative Assembly adjourns sine die.

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.

A-23

ETHICS

Euthanasia

Code of Medical Ethics Opinion 5.8

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

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

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

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

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

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

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

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

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

AMA Principles of Medical Ethics: I, IV

Read more opinions about this topic

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

Terminal Uncertainty

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

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

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

That was almost four years ago.

Prodded by a son who lives in Seattle, Clayton sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center. Too weak to endure the toxicity of chemotherapy, she started with radiation, which at first made her even weaker but eventually

built her strength. Given dodgy prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called 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."

KTVZ.COM
CENTRAL OREGON'S NEWS LEADER

Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

News sources
POSTED: 11:35 PM PDT September 7, 2011 UPDATED: 4:36 AM PDT July 14, 2011
BEND, Ore.-

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

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

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

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

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

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

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

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

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

Deschutes County Circuit Judge Alta Brady signed an arrest warrant with $50,000 bail last Thursday, two days after she was indicted on a first-degree criminal mistreatment charge that alleges she took custody of Thomas Middleton, ?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 $200,000, the documents show, and it was deposited into an account for one of Sawyer?s businesses, Starboard LLC, and $90,000 of that was transferred to two other Sawyer companies, Genesis Futures and Tami Sawyer PC.

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

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

SUPREME COURT OF QUEENSLAND

CITATION:	*R v Morant* [2018] QSC 251
PARTIES:	**R** **v** **GRAHAM ROBERT MORANT** (defendant)
FILE NO/S:	Indictment No 1424 of 2018
DIVISION:	Trial Division
PROCEEDING:	Trial
DELIVERED ON:	2 November 2018 (delivered *ex tempore*)
DELIVERED AT:	Brisbane
HEARING DATE:	17 to 21 September 2018; 24 to 28 September 2018; 2 October 2018; 26 October 2018; 2 November 2018
JUDGE:	Davis J
ORDER:	**Convictions recorded.** **On count 1, the defendant is sentenced to 10 years imprisonment.** **On count 2, the defendant is sentenced to 6 years imprisonment.** **The sentences are to be served concurrently.** **Pursuant to s 159A of the *Penalties and Sentences Act* 1992, it is declared that 32 days spent in pre-sentence custody between 2 October 2018 and 2 November 2018 be deemed time already served under the sentence**
CATCHWORDS:	CRIMINAL LAW – PARTICULAR OFFENCES – OFFENCES AGAINST THE PERSON – MISCELLANEOUS OFFENCES – OTHER MISCELLANEOUS OFFENCES AND MATTERS – where the defendant was charged with one count of counselling suicide and one count of aiding suicide pursuant to s 311 – where the defendant was convicted of both counts after trial – where no comparatives are available for the offence of counselling suicide CRIMINAL LAW – SENTENCE – SENTENCING PROCEDURE – FACTUAL BASIS FOR SENTENCE – PARTICULAR CASES – where the Crown pressed for sentencing on the basis that the defendant counselled and aided his wife to commit suicide motivated by financial

the fact that you paid the premiums on the policies and inconsistent with your involvement with Mr Macallan and Mrs Morant in July 2014 and November 2014.

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

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

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

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

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

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

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

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

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

The New York Times

Prosecutors Say Doctor Killed To Feel a Thrill

By CHARLIE LEDUFF SEPT. 7, 2000

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

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

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

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

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

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

what he identified as the text of "My Secret Life," Mr. Swango was inspired to copy: "I love it. Sweet, husky, close smell of an indoor homicide."

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

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

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

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

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

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

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

When Judge Mishler asked for an explanation of the death of Mr. Siano, Mr. Swango read from a prepared text. "I intentionally killed Mr. Siano, who was at the time a patient at the veterans' hospital in Northport," he read. "I did this by administering a toxic substance which I knew was likely to cause death. I knew it was

Not only did Mr. Swango administer the lethal injection to Mr. Siano, prosecutors said, he did it on his day off, a day when he was not even on call. Prosecutors said that a nurse saw Mr. Swango sitting on a radiator near Mr. Siano's bed watching the man die from the lethal dose.

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

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

Mary A. Dowling, director of the hospital in Northport, tried to answer the wider question of how a man with Mr. Swango's background could find employment there.

She said that he was hired by the State University of New York at Stony Brook, and rotated through Northport as part of his Stony Brook residency training.

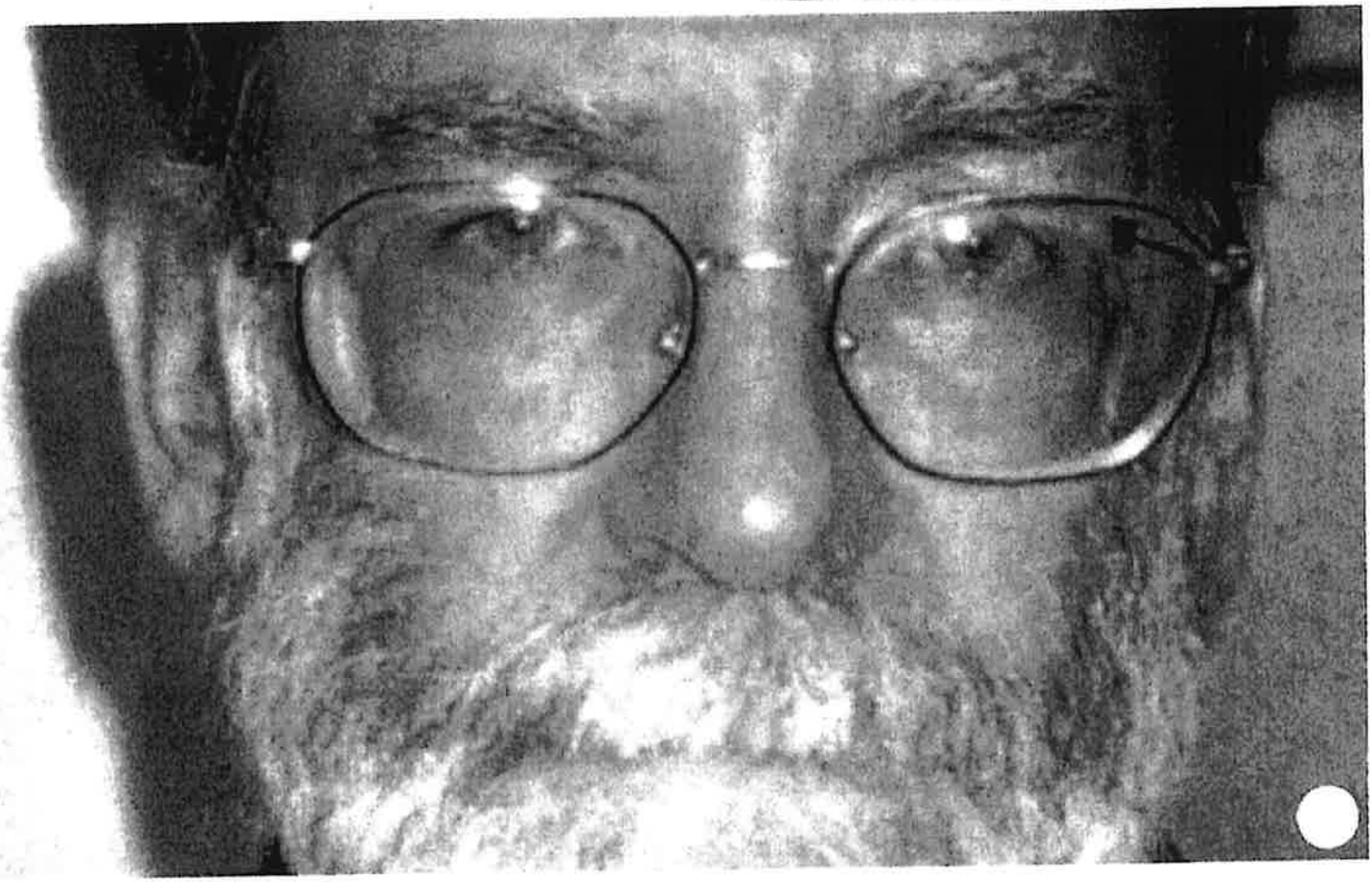
"Michael Swango failed to truthfully disclose the reason for a prior criminal conviction on his application," Ms. Dowling said, explaining that Mr. Swango had told administrators that his jail time had to do with a barroom brawl. "It was an offense he pled guilty to and for which he served three years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

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

A version of this article appears in print on September 7, 2000, on Page B00001 of the National edition with the headline: Prosecutors Say Doctor Killed To Feel a Thrill.

A-33

The Guardian



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.

A-34

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 not 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. O''

suggest that he simply could not resist playing God, proving that he could take life as well as save it.

What is the scope of the inquiry?

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

What are its findings?

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

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

Could this happen again?

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

Characteristics	2017 (N=143)	1998–2016 (N=1,132)	Total (N=1,275)
Residence			
Metro counties (Clackamas, Multnomah, Washington) (%)	55 (38.5)	484 (43.1)	539 (42.6)
Coastal counties (%)	12 (8.4)	80 (7.1)	92 (7.3)
Other western counties (%)	65 (45.5)	471 (41.9)	536 (42.3)
East of the Cascades (%)	11 (7.7)	88 (7.8)	99 (7.8)
Unknown	*0*	*9*	*9*
End of life care			
Hospice			
Enrolled (%)	130 (90.9)	989 (90.1)	1119 (90.2)
Not enrolled (%)	13 (9.1)	109 (9.9)	122 (9.8)
Unknown	*0*	*34*	*34*
Insurance			
Private (%)	36 (31.3)	569 (53.8)	605 (51.6)
Medicare, Medicaid or other governmental (%)	78 (67.8)	474 (44.8)	552 (47.1)
None (%)	1 (0.9)	14 (1.3)	15 (1.3)
Unknown	28	75	103
Underlying illness			
Cancer (%)	**110 (76.9)**	**883 (78.0)**	**993 (77.9)**
Lung and bronchus (%)	23 (16.1)	193 (17.0)	216 (16.9)
Breast (%)	6 (4.2)	86 (7.6)	92 (7.2)
Colon (%)	6 (4.2)	73 (6.4)	79 (6.2)
Pancreas (%)	15 (10.5)	74 (6.5)	89 (7.0)
Prostate (%)	10 (7.0)	48 (4.2)	58 (4.5)
Ovary (%)	4 (2.8)	41 (3.6)	45 (3.5)
Other cancers (%)	46 (32.2)	368 (32.5)	414 (32.5)
Neurological disease (%)	**20 (14.0)**	**114 (10.1)**	**134 (10.5)**
Amyotrophic lateral sclerosis (%)	10 (7.0)	90 (8.0)	100 (7.8)
Other neurological disease (%)	10 (7.0)	24 (2.1)	34 (2.7)
Respiratory disease [e.g., COPD] (%)	**2 (1.4)**	**59 (5.2)**	**61 (4.8)**
Heart/circulatory disease (%)	**9 (6.3)**	**40 (3.5)**	**49 (3.8)**
Infectious disease [e.g., HIV/AIDS] (%))	**0 (0.0)**	**13 (1.1)**	**13 (1.0)**
Gastrointestinal disease [e.g., liver disease] (%)	**0 (0.0)**	**8 (0.7)**	**8 (0.6)**
Endocrine/metabolic disease [e.g., diabetes](%)	**1 (0.7)**	**7 (0.6)**	**8 (0.6)**
Other illnesses (%)[2]	**1 (0.7)**	**8 (0.7)**	**9 (0.7)**

Oregon 2017 Annual Report

IN THE STATE OF SOUTH DAKOTA

IN RE AN INITIATED MEASURE	**DECLARATION OF WILLIAM TOFFLER, MD**

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

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

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

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

Exhibit A, attached hereto.

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

4. Attached hereto, as Exhibits B-1 & B-2, are excerpts from

the most recent government statistical report regarding our law. The excerpts list chronic lower respiratory disease and diabetes mellitus as "underlying illnesses" sufficient to justify assisted suicide. The full report can be read at this link: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf

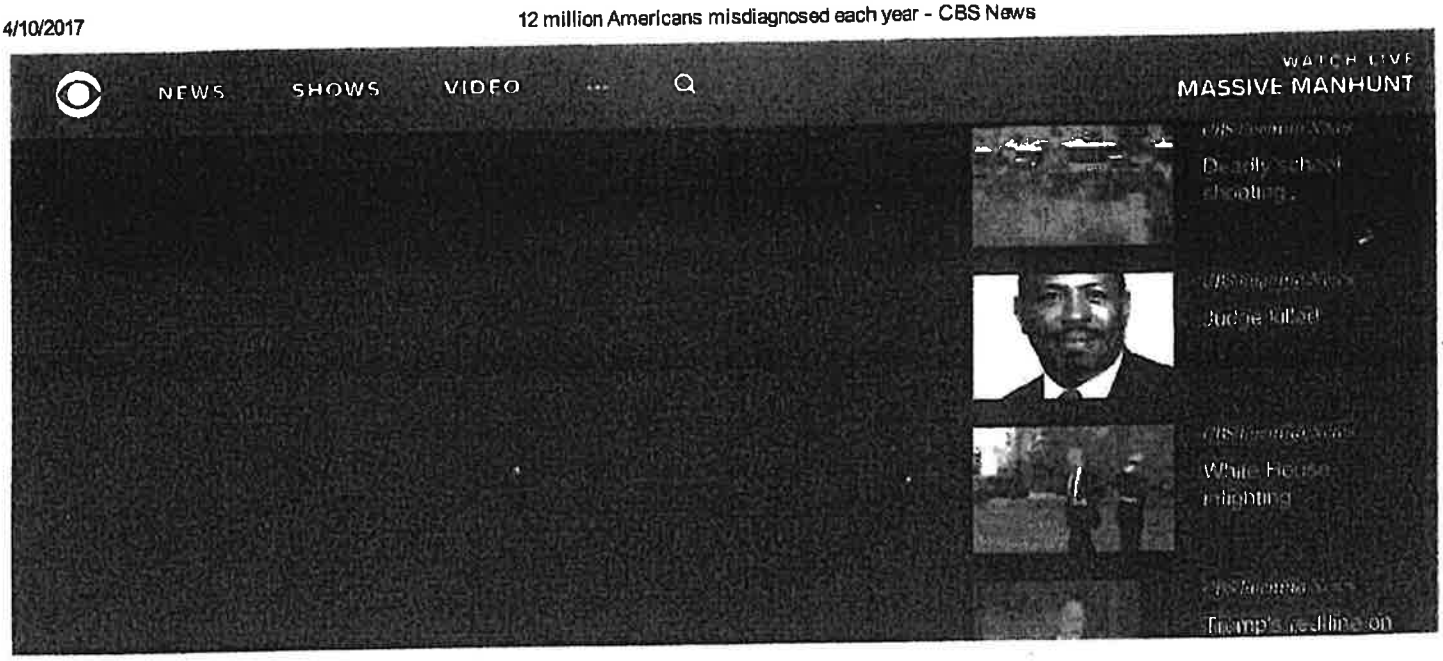
5. In Oregon, people with chronic conditions are "terminal," if without their medications, they have less than six months to live. This is significant when you consider that a typical insulin-dependent 20 year-old will live less than a month without insulin.

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

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

William L Toffler MD

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



By JESSICA FIRGER CBS NEWS *April 17, 2014, 5:00 AM*

12 million Americans misdiagnosed each year

17 Comments Share Tweet Stumble Email

Each year in the U.S., approximately 12 million adults who seek outpatient medical care are misdiagnosed, according to a new study published in the journal BMJ Quality & Safety. This figure amounts to 1 out of 20 adult patients, and researchers say in half of those cases, the misdiagnosis has the potential to result in severe harm.

Previous studies examining the rates of medical misdiagnosis have focused primarily on patients in hospital settings. But this paper suggests a vast number of patients are being misdiagnosed in outpatient clinics and doctors' offices.

"It's very serious," says CBS News chief medical correspondent Dr. Jon LaPook. "When you have numbers like 12 million Americans, it sounds like a lot -- and it is a lot. It represents about 5 percent of the outpatient encounters."

Getting 95 percent right be good on a school history test, he notes, "but it's not good enough for medicine, especially when lives are at stake."

More from Morning Rounds with Dr. LaPook

For the paper, the researchers analyzed data from three prior studies related to diagnosis and follow-up visits. One of the studies examined the rates of misdiagnosis in primary care settings, while two of the studies looked at the rates of colorectal and lung cancer screenings and subsequent diagnoses.

To estimate the annual frequency of misdiagnosis, the authors used a mathematical formula and applied the proportion of diagnostic errors detected in the data to the number of all outpatients in the U.S. adult population. They calculated the overall annual rate of misdiagnoses to be 5.08 percent.

"Although it is unknown how many patients will be harmed from diagnostic errors, our previous work suggests that about one-half of diagnostic errors have the potential to lead to severe harm," write the authors in their study. "While this

From 60 Minutes


New Kid on the Street


Japan's Babe Ruth


Chief of Chobani


Brain Hacking

CANADA **C O U R S U P É R I E U R E**

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

GINETTE LEBLANC,
demanderesse
c.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur
et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO ASSISTED SUICIDE AND EUTHANASIA

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

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

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

3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the

time. By then, I had twitching in both hands, which were also getting weaker. At some point, I lost the ability to grip in my hands. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor's prescription and support, I would have taken that opportunity.

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

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

SWORN BEFORE ME at
MASSACHUSETTS, USA
on, August 1st, 2012

JOHN NORTON

NAME: Heidi Pruzynski
Heidi P

A notary in and for the
State of ~~Washington~~ MASSACHUSETTS

ADDRESS: 85 Main St
Florence MA 01062

EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

BEFORE THE LEGISLATURE OF THE STATE OF NEW YORK

IN RE NEW YORK BILLS	**DECLARATION OF KENNETH STEVENS, MD**

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

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

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

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

cancer. I understand that he had referred her to me.

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

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

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

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

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

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

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

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

Kenneth Stevens Jr. MD

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

Jeanette Hall

\\Server\dox\ASE 2016 +\New Zealand\Jeanette Hall Declaration.wpd

Before the
State of Rhode Island General Assembly

In Re H 5555	DECLARATION OF CHARLES BENTZ, MD

I, Charles Bentz, MD, declare the following under penalty of perjury.

1. I am a primary care physician at the Fanno Creek Clinic in Portland Oregon and Board Certified by the American Board of Internal Medicine. I have been asked to comment on how deaths via Oregon's Death with Dignity Act (assisted suicide/euthanasia) are reported on the death certificate.

2. Oregon's law was enacted by a ballot measure, which went into effect in 1997. My experience with the law includes one of my patients, an older gentleman that I had referred to another doctor for specialized treatment. The doctor instead provided him with a lethal dose pursuant to our law, which killed him.

3. The gentleman's death certificate listed the cause of death as a type of cancer, not the actual cause, a lethal dose.

4. More recently, I made inquiry with the Oregon Health

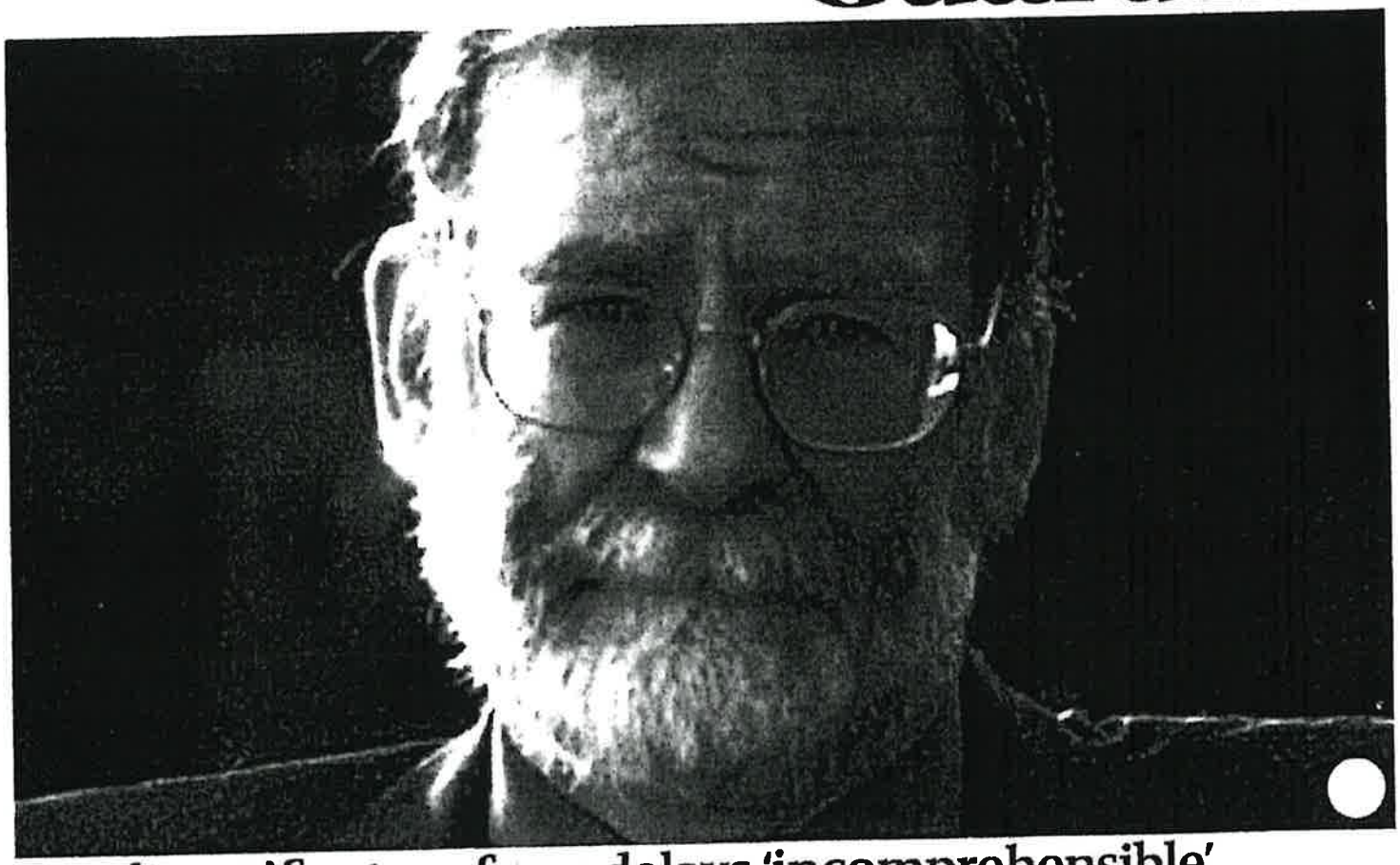
Authority, which is the agency overseeing our law. My query concerned the proper way to report a death on the death certificate. Below please find the answer from Craig New, Research Analyst, which he provided on May 17, 2018:

> There is not a clear, direct statement in the [Oregon] law regarding how the death certificate should be completed for a qualified DWDA [Death with Dignity Act] death. We rely on ORS 127.880 s.3.14 which states that actions taken in accordance with the DWDA law do not constitute suicide or assisted suicide. Therefore, it goes against the statute to list such terms as the cause of death on the patient's death certificate.
>
> 127.880 s.3.14. Construction of Act.
>
> Nothing in [Oregon's law] ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 s.3.14]

Signed under penalty of perjury, this 26th day of March 2019

Charles Bentz, MD
Portland Oregon

The Guardian



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."

Characteristics	2017 (N=143)	1998–2016 (N=1,132)	Total (N=1,275)
DWDA process			
Referred for psychiatric evaluation (%)	5 (3.5)	57 (5.1)	62 (4.9)
Patient informed family of decision (%)[3]	139 (97.9)	982 (93.1)	1,121 (93.7)
Patient died at			
Home (patient, family or friend) (%)	129 (90.2)	1,052 (93.4)	1,181 (93.1)
Long term care, assisted living or foster care facility (%)	13 (9.1)	55 (4.9)	68 (5.4)
Hospital (%)	0 (0.0)	4 (0.4)	4 (0.3)
Other (%)	1 (0.7)	15 (1.3)	16 (1.3)
Unknown	*0*	*6*	*6*
Lethal medication			
Secobarbital (%)	71 (49.7)	676 (59.7)	747 (58.6)
Pentobarbital (%)	0 (0.0)	386 (34.1)	386 (30.3)
Phenobarbital (%)	6 (4.2)	57 (5.0)	63 (4.9)
Morphine sulfate (%)	66 (46.2)	6 (0.5)	72 (5.6)
Other (%)	0 (0.0)	7 (0.6)	7 (0.5)
End of life concerns[4]	**(N=143)**	**(N=1,132)**	**(N=1,275)**
Losing autonomy (%)	125 (87.4)	1,029 (91.4)	1,154 (90.9)
Less able to engage in activities making life enjoyable (%)	126 (88.1)	1,011 (89.7)	1,137 (89.5)
Loss of dignity (%)[5]	96 (67.1)	769 (76.9)	865 (75.7)
Losing control of bodily functions (%)	53 (37.1)	526 (46.8)	579 (45.7)
Burden on family, friends/caregivers (%)	79 (55.2)	475 (42.2)	554 (43.7)
Inadequate pain control or concern about it (%)	30 (21.0)	297 (26.4)	327 (25.8)
Financial implications of treatment (%)	8 (5.6)	39 (3.5)	47 (3.7)
Health-care provider present (collected since 2001)	**(N=143)**	**(N=1,062)**	**(N=1,205)**
When medication was ingested[6]			
Prescribing physician	24	163	187
Other provider, prescribing physician not present	24	270	294
No provider	6	91	97
Unknown	*89*	*538*	*627*
At time of death			
Prescribing physician (%)	23 (16.1)	149 (14.3)	172 (14.6)
Other provider, prescribing physician not present (%)	19 (13.3)	295 (28.4)	314 (26.6)
No provider (%)	101 (70.6)	595 (57.3)	696 (58.9)
Unknown	*0*	*23*	*23*
Complications[6]	**(N=143)**	**(N=1,121)**	**(N=1,264)**
Difficulty ingesting/regurgitated	1	24	25
Seizures	2	0	2
Other	1	6	7
None	38	554	592
Unknown	*101*	*537*	*638*

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

	2017		2016		2015[1]	
	Number	%	Number	%	Number	%
Family and Psychiatric/Psychological involvement						
Referred for psychiatric/psychological evaluation[2]	4	2	11	5	8	4
Patient informed family of decision[3]	174	94	224	95	174	93
Medication[4]						
Secobarbital	66	34	77	32	109	51
Pentobarbital	0	0	2	1	4	2
Secobarbital/Pentobarbital Combination	0	0	0	0	0	0
Phenobarbital	0	0	2	<1	10	5
Phenobarbital/Chloral Hydrate Combination	0	0	106	44	88	41
Chloral Hydrate	0	0	1	<1		
Morphine sulfate	130	66	53	22	4	2
Other	0	0	1	<1	0	0
Timing						
Duration of patient-physician relationship[5]						
<25 weeks	94	51	125	52	99	49
25 weeks – 51 weeks	21	11	25	10	18	9
1 year or more	71	38	88	37	81	40
Unknown	0	0	2	1	4	2
Range (min – max)	<1 wk – 38 yrs		<1 wk – 31 yrs		<1 wk – 2 yrs	
Duration between first oral request and death[6]						
<25 weeks	167	90	209	88	164	81
25 weeks or more	18	10	28	12	33	16
Unknown	0	0	0	0	5	2
Range (min – max)	2 wks – 81 wks		2 wks – 112 wks		0 wks – 95 wks	

Notes:

1. Data published in 2016 report: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.
2. Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
3. Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.
4. Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 196 participants in 2017 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.
5. Data are collected from the After Death Reporting form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
6. Data are collected from the After Death Reporting form and Attending physician Compliance Form. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.

Washington State

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands

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February 24, 2000
N Engl J Med 2000; 342:551-556
DOI: 10.1056/NEJM200002243420805

27 References
69 Citing Articles

Abstract

BACKGROUND AND METHODS

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

RESULTS

In 114 cases, the physician's intention was to provide assistance with suicide, and in 535, the intention was to perform euthanasia. Problems of any type were more frequent in cases of assisted suicide than in cases of euthanasia. Complications occurred in 7 percent of cases of assisted suicide, and problems with completion (a longer-than-expected time to death, failure to induce coma, or induction of coma followed by awakening of the patient) occurred in 16 percent of the cases; complications and problems with completion occurred in 3 percent and 6 percent of cases of euthanasia, respectively. The physician decided to administer a lethal medication in 21 of the cases of assisted suicide (18 percent), which thus became

cases of euthanasia. The reasons for this decision included problems with completion (in 12 cases) and the inability of the patient to take all the medications (in 5).

CONCLUSIONS

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

Introduction

ALTHOUGH EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE ARE ILLEGAL IN MOST countries, they are performed in several parts of the world.[1-9] Oregon has made physician-assisted suicide legal under specified conditions.[10] In the Netherlands, a physician who performs euthanasia or provides assistance with suicide will not be prosecuted if the act has been carried out under strict conditions, which have been formulated by the courts and the medical profession.[11] One of these conditions is that euthanasia or assistance with suicide must be carried out in a professionally responsible way. In 1987, the Royal Dutch Association of Pharmacy issued guidelines on the use and preparation of drugs for euthanasia. The guidelines were revised on the basis of doctors' experiences in 1994 and 1998.[12,13]

The incidence of physician-assisted suicide and euthanasia and attitudes toward these practices have been studied extensively, but the few reports on the clinical aspects of these practices are based on limited data or small numbers of cases.[14-18] We performed a study to determine whether there are problems with the clinical aspects of euthanasia and physician-assisted suicide as reported by the physicians involved, including complications and problems with completion, such as a prolonged interval between the administration of medications and the patient's death.

Methods

STUDY DESIGN

In 1990 and 1991 and in 1995 and 1996, we performed two studies of euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands. Detailed information about the design of these studies has been reported elsewhere.[1,19,20] In three parts of the studies, detailed information on the clinical aspects of euthanasia and physician-assisted suicide was collected.

In 1990 and 1991, we interviewed a stratified random sample of 405 physicians that included 152 general practitioners, 50 nursing home physicians, and 203 physicians in the specialties of cardiology, surgery, internal medicine, pulmonology, and neurology. Nine percent of eligible physicians declined to take part in