

Kenneth Norton
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Tilton, NH 03276

Honorable Chairman Robert Lynn
House Judiciary Committee
33 North State St.
Concord, New Hampshire 03301

January 28, 2025

Dear Chairman Lynn and House Judiciary Committee Members,

My name is Kenneth Norton and I live in Tilton and I am writing in strong support of HB 254. By way of background, I am a New Hampshire Licensed Independent Social Worker (LICSW) and for over 40 years my career has focused on mental health and suicide prevention. I have served as a subject matter expert on suicide prevention for the US Department of Defense, the Veteran's Administration, the Substance Abuse and Mental Health Services Administration (SAMHSA) and served for over a decade on the Steering Committee for the National Suicide Prevention Lifeline (988). Closer to home, I drafted the 2008 legislation that established NH's Suicide Prevention Council, served on the council for over a decade, and have been involved in numerous commissions, committees and legislative efforts in NH, and nationally to promote suicide prevention and improved access to mental health services.

As you are well aware, suicide is a significant public health challenge. Despite claims to the contrary, there is no legitimate research which indicates medical aid in dying increases or decreases suicide rates among the elderly, teens or other vulnerable populations. While medical aid in dying may meet the technical dictionary definition of suicide, there are important and significant differences between the two, which I have highlighted in the attached Op-ed which I wrote. It is important to note in 20+ years there have been less than 9,000 (not a typo) medical aid in dying deaths, combined for the 10 US states where it is legal, compared with over 49,300 US suicides in 2025. Simply stated there is no evidence medical aid in dying causes, or contributes to suicide deaths; we should focus our collective efforts on improving suicide prevention efforts.

For over 15 years, I have served as a member of the medical ethics committee at my local hospital. I have also presented nationally and internationally on "*Ethical Issues Regarding End of Life and Aid in Dying.*" Over the years, our medical ethics committee has reviewed difficult cases where palliative and hospice care are not sufficient to end the pain and suffering for patients at the end of their life. These tragic situations not only take a toll on the patient, but also emotionally on their family members and loved ones, and sometimes on the patient's treatment providers as well.

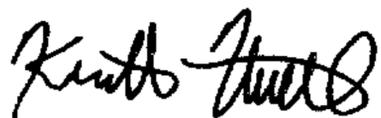
During my career, I also served two terms on the Board of Directors of the Disability Rights Center, and also received an award from the Governor's Commission on Disability for my advocacy efforts. For several reasons, I believe the concerns of some of my disability colleagues, who oppose HB 1283, are misplaced. A survey completed by the UNH survey center in October 2023 indicates that 74% of NH residents, who identify as disabled, support legislation to legalize medical aid in dying. In April of 2023, a

number of individuals and national disability groups filed a Federal law suit against California's End of Life Option's Act (EOLOA). Their claims largely followed the arguments put forward by the National Council on Disability in their 2019 report opposing aid in dying, saying people with disabilities were discriminated against because they lacked access to comprehensive health care, and hence were more vulnerable to coercion, and would be encouraged to seek death as an option under the bill. On March 27, 2024 US District Court Judge Aenelle-Rocha dismissed their case and claims. His order clearly rebuffs the arguments they put forth by stating claims vulnerable people will be subject to coercion are "implausible" given the laws safeguards and the voluntary process; claims that people are discriminated against and lack access to full array of health and behavioral health services "fail as a matter of law" given requirement of informed options such as hospice and palliative care, and plaintiffs' interpretation of the statute is inconsistent with the plain text of the EOLOA.

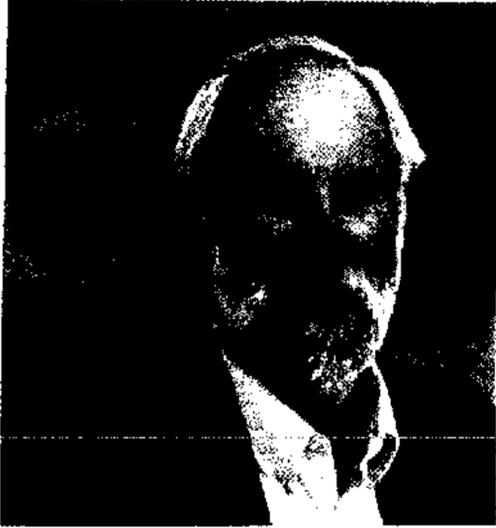
While all of these considerations are important, the most important for me is that my father was not afforded the peaceful death he prayed for, and he literally begged to end his suffering near the end of his life.

I regret that a family matter prevents me from personally testifying in support of HB 254. I recognize and respect that this is a difficult issue with many factors to weigh. My hope is that rather than focus on the fears and "what if" scenarios presented by those opposing the bill, you will focus on the specifics of this bill and the many safeguards included in the bill and you will vote HB 254 as Ought to Pass. Thank you for your consideration.

Respectfully,



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Op-Ed*: Let's Stop Calling Medical Aid In Dying Suicide

By KENNETH NORTON LICSW February 6, 2024

**Appeared in Concord Monitor, In Depth NH; and Seacoast on Line*

The New Hampshire legislature is considering a bill to join our Maine and Vermont neighbors to allow New Hampshire residents with a terminal illness, in consultation with two medical providers, the option of ending their suffering and having a peaceful death. As a Licensed Independent Clinical Social Worker who has spent over four decades working to prevent suicide at the local, state, national and international level, I think it is time to look closely at the differences between the two, and stop referring to medical aid in dying as suicide.

Legally, in the 10 states and Washington D.C. where medical aid in dying is allowed, the death is not counted as a suicide death. Medical Examiners and Coroners list the underlying terminal illness, which the person was diagnosed with as the cause of death on the death certificate of patients who utilize medical aid in dying.

People who die by suicide, for whatever reason, no longer wish to live and feel that they have no other option than death. The person who chooses medical aid in dying *wants* to live yet has been diagnosed with a terminal illness that will end their life, and may cause intense suffering before they die. They are fully informed of other options including palliative care, hospice, and comfort measures. This is not a decision they are allowed to take lightly or at the spur of the moment. It requires thoughtful controls and two medical opinions in support of specific terminal illness.

A high correlation exists between suicide and mental illness. The person who dies by suicide may or may not be rational, or even competent in that moment. Research shows that many suicide deaths are impulsive. Although the person may have contemplated suicide for some time, it may only be a matter of minutes between making the decision to die and then taking their life. By contrast, in medical aid in dying, people go through a formal process with two medical professionals that includes: an assessment of their mental capability, a determination about their terminal illness, an informed consent process including a review of available options, and a mandatory waiting period.

People who die by suicide die alone, and often die by violent means. In New Hampshire over 75% of suicides involve firearms or hanging. Nationally, over 75% of suicide deaths occur in a home or primary residence. These violent deaths result in trauma for their loved ones who return home to find their loved one dead. The scene, shock, and aftermath are so distressing that many people are no longer able to continue to live in their homes. Suicide deaths can also be traumatizing and contribute to PTSD in first responders who are called to the scene.

Family, friends, and loved ones of a person who dies by suicide can experience intense emotions including shock, guilt, anger, shame, regret, and despair as they try to come to terms with the suddenness of the death, and make sense of the often-unanswerable question: “*why?*” People who are bereaved by suicide may experience suicidal thoughts and are statistically at higher risk themselves for suicide. Suicide deaths are often devastating and life altering for family and friends resulting in a long and complicated grief process that may last years. It is said *the person who dies by suicide dies a single death, but their family/friends are left to die a thousand deaths.*

By contrast, the person who goes through the medical aid in dying process, frequently includes loved ones in their decision. Most die in their home, surrounded by their family and friends. The death is planned, and peaceful. Family and friends are left at peace knowing that this was their choice and their suffering is over. To be clear, this does not stop those close people from grieving the death, but it eliminates the “whys” and “what ifs” as well as the trauma from a sudden suicide.

Despite our best efforts, there is still considerable shame and stigma associated with, and experienced by family and friends after a suicide. We should be careful not to contribute to that stigma by extending it to medical aid in dying. Whether you support or are opposed to medical aid in dying, we should acknowledge there are significant differences between the two, and we should stop labeling medical aid in dying as suicide.

Kenneth Norton LICSW lives in Tilton and is the former Executive Director of NAMI NH – The National Alliance of Mental Illness (opinions expressed here are his own)