IN THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

SCA Case No: 531/2015
GNP Case No: 27401/2015

In the matter between:

THE MINISTER OF JUSTICE AND CORRECTIONAL SERVICES
(First Appellant
First Respondent in the Court a quo)

THE MINISTER OF HEALTH
(Second Appellant
Second Respondent in the Court a quo)

THE NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS
(Third Appellant
Fourth Respondent in the Court a quo)

THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA
(Fourth Appellant
Third Respondent in the Court a quo)

and

ESTATE LATE STRANSHAM-FORD,
ROBERT JAMES
Respondent
(Applicant in the Court a quo)

EXPERT AFFIDAVIT: ATTORNEY MARGARET K. DORE

I, the undersigned,

MARGARET K. DORE, ESQ., MBA

do hereby make oath and state the following:
The facts contained herein are true and correct and within my personal knowledge unless otherwise stated.

QUALIFICATIONS AND EXPERIENCE

1. I am an attorney licensed to practice law in Washington State, USA since 1986, with my office situated at 1001 4th Avenue, Suite 4400, Seattle, Washington State, USA.

2. I am a member of the Washington State Bar Association.

3. I am also a member of the American Bar Association and the King County Bar Association.

4. I am a former Chair of the Elder Law Committee of the American Bar Association Family Law Section.

5. I am president of Choice is an Illusion, a non-profit corporation opposed to assisted suicide and euthanasia.

6. I have worked in opposition to assisted suicide and/or euthanasia in the United States and Canada, and with regard to Australia and other jurisdictions. My work has included: providing legal and policy analyses to legislators and courts; drafting and editing legislation; testifying before legislative committees; appearing in court; participating in formal debates; and writing scholarly articles. I have performed such work in the following.

7. In 2010, I wrote a legal/policy analysis in opposition to Canada's Bill C-384, which had sought to legalize assisted suicide and euthanasia throughout that country. The bill was defeated by the Canadian Parliament. In addition, I testified before a legislative committee in Quebec. I also participated at the trial level in Leblanc v. Canada, a Quebec case, which had sought to legalize assisted suicide and euthanasia throughout Canada. Pursuant to a trial court order, I wrote and submitted affidavits to the Attorney General of Canada, three of which were filed with the court by that office on behalf of the Canadian government. The case was dismissed after the plaintiff, Ms. Leblanc, died.

8. More recently, I presented to a five member legislative delegation from the State of Victoria, Australia, in Portland, Oregon USA on April 7, 2016. My topic was elder abuse, assisted suicide and euthanasia in Oregon and Washington State. I also addressed a draft euthanasia bill pending in the State of South Australia.
ATTACHMENTS

9. I attach true and correct copies of the following documents:

9.1 my curriculum vitae hereto marked as "MD1", which includes a list of my professional publications in opposition to assisted suicide and euthanasia.

9.2 a memorandum that I submitted to the Australian delegation, which attaches the Oregon and Washington "Death with Dignity Acts" and provides a detailed legal/policy analysis of these Acts. A true and correct conformed copy of the memo, together with its annexures, is hereto marked as "MD2".

9.3 the declaration of William Toffler, MD, which I provided to the Australian delegation and which explains why young adults with insulin dependent diabetes, who are likely to have decades to live, are "terminal" for the purpose of assisted suicide eligibility in Oregon. The declaration is hereto marked "MD3".

9.4 an article written by me and published by the King County Bar Association, titled "Death with Dignity: What Do We Advise Our Clients?" The article is hereto marked "MD4".
9.5 a declaration of testimony by Oregon attorney Isaac Jackson, dated September 18, 2012, describing the lack of transparency under Oregon's assisted suicide act. The declaration is hereto marked "MD5".

9.6 an e-mail from Alicia Parkman, Oregon Mortality Research Analyst, to me, dated January 4, 2012, confirming that law enforcement cannot get access to identifying information under Oregon's act. ("MD6")

9.7 an e-mail from Alicia Parkman, to me, dated January 4, 2012, confirming that "the identity of individual patients is not recorded in any manner . . . all source documentation is destroyed." ("MD7")

9.8 the "Confidentiality of Death Certificates" policy issued by the Oregon Department of Human Resources Health Division, December 12, 1997 (clarifying that failure to comply can result in immediate termination), as published in the Issues in Law & Medicine, Volume 14, Number 3, 1998. ("MD8")

9.9 Washington State (Release of Information Regarding the Death with Dignity Act), revised April 9, 2009. ("MD9")
EXPERT COMMENT

I have been asked to provide expert comment on

9.10 the law and practice of physician assisted suicide in Oregon and Washington State; and

9.11 the affidavits of Ann Jackson and Peter Reagan filed by the Centre for Applied Legal Studies in this appeal, which have been provided to me and I have read.

A TIME CONSTRAINT

10. I have pressing time commitments, including pending legislation, which is coming on for hearing next Monday in Ottawa, Ontario, Canada. For this reason, I am relying on my already prepared Australian memo and the other documents described above to provide my expert comment herein.

11. If so desired, I am happy to provide the Court with additional materials at another time.

The Oregon and Washington Acts

12. The Oregon and Washington "Death with Dignity Acts" legalize physician-assisted suicide and euthanasia as those terms are traditionally defined. See memo, pp. 2-3 (regarding definitions) at "MD2".
13. Oregon's act went into effect in 1997. Washington's act, which is modelled on Oregon's act, went into effect in 2009. Both acts were passed by ballot measures in which voters were promised that "only" the patient would be allowed to administer the lethal dose. There is, however, no such language in either act. See memo, pp. 10-12 at "MD2", and article at "MD4." Indeed, both acts allow someone else to administer the lethal dose to the patient, which is euthanasia. Id.

14. Under the Oregon and Washington acts, "eligible" patients can have years, even decades, to live. See: memo, pp. 5-7 and Dr. Toffler's declaration. ("MD2" and "MD3").

15. The Oregon and Washington acts are stacked against the patient. Reasons for this include the following: (a) a patient's heir, who will financially benefit from the patient's death, is allowed to actively participate in signing the patient up for the lethal dose; and (b) once the lethal dose is in the house, there is a complete lack of oversight over administration ("even if the patient struggled, who would know?") See memo, MD2 at pages 7 to 14.

16. Another example is the requirement that the death certificate report a natural death caused by a terminal disease. See memo, pp.15-16. (MD2) "The significance is a legal inability to prosecute criminal behaviour, for example, in the case of an outright murder for the money. The cause of death, as a matter of law, is a terminal disease." Id.
17. The falsification of the death certificate to reflect a terminal disease also contributes to a lack transparency, as do other Oregon and Washington practices. See MD2 through MD9.

The Jackson/Reagan Affidavits are Materially Misleading

With my time constraints, I provide just two examples:

18. Oregon's Act does not require "self-administration." Ms. Jackson's affidavit, p.8, paragraph 22 says that the patient "must be able to self-administer . . . the life-ending medication." Dr. Reagan's affidavit, p. 5, paragraph 14, makes this same claim. There is no such requirement in Oregon's act, which does not even use the term, "self-administer." See my memo, "MD2", at pp. 11-12.

19. Patients are not required to be "dying." Ms. Jackson's affidavit, p. 8, paragraph 23, says that the "option" (meaning assisted suicide) is "only available to dying patients." Consider also, Dr. Reagan's affidavit, p. 3, which refers to assisted suicide/euthanasia as "aid in dying," "medical aid in dying" and "physician assisted dying." (Emphasis added). As noted supra, there no requirement that patients be "dying." "Eligible" patients may have years, even decades, to live. See my memo, "MD2", at pp. 5-7 and Dr. Toffler's declaration, MD3".
20. If I have not dealt with any particular allegation in the Jackson/Reagan affidavits, such allegation is denied to the extent that it is inconsistent with what is contained in this affidavit and the annexures thereto".

CONCLUSION

21. It is my hope that the material that I have provided will be of assistance to the Supreme Court of Appeal in South Africa in its determination of the appeal. Please let me know if you would like me to provide additional information at another time.

MARGARET K. DORE, ESQ., MBA

I hereby certify that the deponent has acknowledged that she:

(a) knows and understands the contents of this affidavit;
(b) has no objection to taking the oath;
(c) considers the oath to be binding on her conscience.

THUS signed and sworn to before me, at Seattle, Washington on April 25, 2016, USA

Henry E. Lippek, Notary Public
COMMISSIONER OF OATHS
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/or court cases regarding assisted suicide and euthanasia. This work has occurred in the U.S., Canada, Australia and other jurisdictions. (October 1994 to present).

Lanz & Danielson, Seattle, Washington USA.

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.

JUDICIAL CLERKSHIPS:

The Washington State Supreme Court, Olympia, Washington USA.

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

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

PROFESSIONAL MEMBERSHIPS:

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

PUBLICATIONS:

**Assisted Suicide and Euthanasia**

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

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


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


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


**Guardianship, Elder Abuse and Family Law**


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


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


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

AWARDS/RECOGNITIONS:

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

PUBLISHED DECISIONS:

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

EDUCATION:

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

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

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

MEMORANDUM

TO: Hon Edward O’Donohue MLC (Chair), Ms Nina Springle MLC (Deputy Chair), Mr Cesar Melhem MLC, Ms Fiona Patten MLC and Ms Jaclyn Symes MLC

AND TO: Lilian Topic, Secretary Standing Committee on Legal and Social Issues

FROM: Margaret Dore, Esq., MBA

Choice is an Illusion, a nonprofit corporation

RE: Elder Abuse, Assisted Suicide and Euthanasia in Oregon and Washington State USA; A Comparison to the South Australia Euthanasia Bill (the Key Proposal)

MEETING: April 7, 2016 at 12:15 pm

MEMO

DATE: April 7, 2016

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I. INTRODUCTION

I am a lawyer in Washington State USA where assisted suicide and euthanasia are legal pursuant to a “Death with Dignity” Act. Our Act is modeled on a similar Act in Oregon. Both Acts are similar to proposals in Australia, for example, the draft euthanasia bill in South Australia (the Key proposal).

I was asked to provide you with an understanding of elder law in the context of Oregon’s Act. The short answer is that the Act trumps elder abuse protections. This is also true of Washington’s Act and the Key proposal: These laws are sold as assuring patient choice and control, but they are instead stacked against the patient and a recipe for elder abuse.

The inquiry uses the term, “physician assisted dying.” There is, however, no requirement in the Oregon and Washington Acts, or the Key proposal, that patients be dying. “Eligible” people may have years, even decades, to live. I urge you to oppose legalization. Don’t be fooled.

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1 I am an elder law attorney licensed to practice law in Washington State since 1986. I am also a former Law Clerk to the Washington State Supreme Court and a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. I am president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. See www.margaretdore.com and www.choiceillusion.org.

2 The Washington and Oregon Acts are attached hereto at A-1 and A-14, respectively.

3 The Key proposal is attached hereto, at A-27 to A-42.
II. FACTUAL AND LEGAL BACKGROUND

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

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

[A] physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.5

"Assisted suicide" is a general term in which the assisting person is not necessarily a physician. "Euthanasia," by contrast, is the direct administration of a lethal agent with the intent to cause another person’s death.6

B. Withholding or Withdrawing Treatment is Not Assisted Suicide or Euthanasia

Withholding or withdrawing treatment ("pulling the plug") is not assisted suicide or euthanasia if the purpose is to withhold or remove burdensome treatment -- as opposed to an intent to kill the patient. More importantly, the patient does not necessarily die. Consider this quote from an article in Washington state regarding a man removed from a ventilator:

6 The AMA Code of Medical Ethics, Opinion 2.211, attached at A-43.
5 Id.
6 Opinion 2.21, Euthanasia. (Attached hereto at A-44).
[I]nstead of dying as expected, [he] slowly began to get better.7

C. The AMA Rejects Assisted Suicide and Euthanasia

The AMA rejects assisted suicide and euthanasia, stating they are:

[F]undamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.8

D. Elder Abuse is a Pervasive Problem in the United States and Australia; it Includes the Neglect, Financial Exploitation and Murder of Older Adults

Elder abuse is a pervasive problem in both the United States and Australia.9 Elder abuse perpetrators are often family members who start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or to coercing victims to sign over deeds to their homes, to change their wills

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8 AMA Code of Medical Ethics, Opns 2.211 and 2.21, supra at A-43 and A-44.

or to liquidate their assets. Victims may even be murdered.\textsuperscript{11} Amy Mix, an elder law attorney in the United States, explains why older people are especially vulnerable:

The elderly are at an at-risk group for a lot of reasons, including, but not limited to diminished capacity, isolation from family and other caregivers, lack of sophistication when it comes to purchasing property, financing, or using computers . . . .

[D]efendants are family members, lots are friends, often people who befriend a senior through church . . . . We had a senior victim who had given her life savings away to some scammer who told her that she’d won the lottery and would have to pay the taxes ahead of time. . . . The scammer found the victim using information in her husband’s obituary.\textsuperscript{12}

E. Victims Do Not Report

In both the Australia and the United States, victims do not report abuse. For example, in Victoria, it is projected that there are more than 20,000 unreported cases of abuse, neglect and exploitation each year and approximately 100,000 nationwide.\textsuperscript{13} Meanwhile, in the United States, it’s estimated that only 1 in 14

cases ever comes to the attention of the authorities.\textsuperscript{14} In another study, it was 1 out of 25 cases.\textsuperscript{15} Reasons for the lack of reporting include:

Many who suffer from abuse . . . don’t want to report their own child as an abuser.\textsuperscript{16}

III. THE OREGON AND WASHINGTON ACTS

A. Patients May Have Years, Even Decades, to Live

The Oregon and Washington Acts apply to persons diagnosed with a “terminal disease.” Such persons may have years, even decades, to live. This is true for three reasons:

1. In Oregon, “terminal disease” is interpreted to include chronic conditions such as insulin dependent diabetes

The Oregon and Washington Acts define “terminal disease,” as follows:

“Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.\textsuperscript{17}

In Oregon, this definition is interpreted to include chronic conditions such as “chronic lower respiratory disease” and

\begin{itemize}
\item \textsuperscript{14} Nat’l Center on Elder Abuse, \url{http://www.ncea.aoa.gov/Library/Data/}
\item \textsuperscript{15} Id.
\item \textsuperscript{16} “Adult Abuse,” District of Columbia, Department of Human Services, as of April 5, 2016. (Attached hereto at A-50.) See also \url{http://dhs.dc.gov/service/adult-abuse}
\item \textsuperscript{17} Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-15; Rev. Code Wash. § 70.245.010(13), attached at A-2.
\end{itemize}
"diabetes mellitus" (diabetes). Oregon doctor William Toffler explains:

Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live.

In Oregon, persons with chronic conditions such as insulin dependent diabetes are "eligible" for assisted suicide and euthanasia. Dr. Toffler states:

Such persons, with treatment, could otherwise have years or even decades to live.

2. Doctor predictions of life expectancy can be wrong

Patients may also have years to live because doctor predictions of life expectancy can be wrong. This is due to misdiagnosis and the fact that predicting life expectancy is not an exact science. Consider John Norton, who was diagnosed with ALS (Lou Gehrig's disease) at age 18. He was told that he would get progressively worse (be paralyzed) and die in three to


19 Published Letter to the Editor, William Toffler MD, New Haven Register, February 24, 2014, ¶2. (My private copy is attached hereto at A-58. I verified the accuracy of the content with Dr. Toffler).

20 Id. See Dr. Toffler's declaration submitted herewith - "MD3"

21 See Jessica Firger, "12 million Americans misdiagnosed each year," CBS NEWS, 4/17/14 (attached at A-59); and Nina Shapiro, supra at footnote 7.

22 Affidavit of John Norton, ¶ 1 (Attached hereto at A-60).
five years. Instead, the disease progression stopped on its own. In a 2012 affidavit, at age 74, he states:

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

3. Treatment can lead to recovery

Patients may also have years to live because treatment can lead to recovery. Consider Oregon resident, Jeanette Hall, who was diagnosed with cancer in 2000 and made a settled decision to use Oregon's law. Her doctor convinced her to be treated instead. In a 2012 affidavit, she states:

This last July, it was 12 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.

B. How the Oregon and Washington Acts Work

Both Acts have an application process to obtain the lethal dose, which includes a written request form with two required witnesses. One of the witnesses is allowed to be the patient's heir.

23 Id., ¶ 1.
24 Id., ¶ 4.
25 Id., ¶ 5.
26 Affidavit of Kenneth Stevens, MD, attached at A-63 to A-69; Jeanette Hall discussed at A-70 to A-71.
27 Id.
28 Affidavit of Jeanette Hall, attached at A-70, quote at A-71. Jeanette is still alive today, 15 years later.
29 See Washington's lethal dose request form, allowing one of two required with witnesses to the patient's heir. (Attached hereto at A-72).
heir, who will benefit financially from the patient’s death.  

Once the lethal dose is issued by the pharmacy, there is no supervision over administration. The death is reported on the death certificate as a natural death. 

C. A Comparison to Probate Law

When signing a will, having an heir act as a witness can support a finding of improper conduct. Washington’s probate code, for example, states that when one of two witnesses is a taker under the will, there is a rebuttal presumption that the taker/witness:

procured the gift by duress, menace, fraud, or undue influence.

Australia has similar law. Consider, for example, the Victoria Law Reform Commission’s description of “suspicious circumstances,” which can lead to invalidation of a will:

A beneficiary is involved in the will-making process, for example, by witnessing the will, writing or preparing the will or taking the will-maker to a solicitor.

The Oregon and Washington Acts, which allow the patient’s

30 Id.
31 See the Washington and Oregon Acts, in their entirety, at A-1 through A-25.
32 See e.g., Washington State’s death certificate instruction attached hereto at A-80.
34 Victoria Law Reform Commission, “Knowledge and approval of suspicious circumstances,” §2.58, attached hereto at A-74.
heir to actively participate in obtaining the patient’s death, do not promote patient choice. They invite coercion and worse.

D. Someone Else is Allowed to Speak for the Patient

In Washington, patients signing the lethal dose request form are required to be "competent." In Oregon, patients are required to be "capable." Regardless of the term used, this is a relaxed standard in which someone else is allowed to speak for the patient. For example, Washington’s Act states:

"Competent” means . . . a patient has the ability to make and communicate an informed decision . . . , including communication through persons familiar with the patient’s manner of communicating . . . . (Emphasis added.)

With someone else allowed to speak for the patient, the patient’s choice and control is not guaranteed.


37 Wash. Rev. Code § 70.245.010(3), at A-2. Oregon’s Act has nearly identical language. See ORS 127.800 § 1.01(3), at A-14, which states:

"Capable” means . . . a patient has the ability to make and communicate an informed decision . . . , including communication through persons familiar with the patient’s manner of communicating . . . . (Emphasis added).
E. Someone Else is Allowed to Administer the Lethal Dose to the Patient

1. Generally accepted medical practice allows someone else to administer the lethal dose to the patient

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 include parents who administer drugs to their children and adult children who administer drugs to their parents.

The Washington and Oregon Acts imply that only the patient is allowed to administer the lethal dose to himself or herself. Washington’s Act says that a patient may “self-administer” the lethal dose. Both Acts have language describing the patient as taking the lethal dose himself or herself.

There is, however, no language stating that administration “must” be by self-administration, or that “only” the patient is allowed to take the lethal dose himself or herself. With self-administration and self-taking not mandatory, generally accepted medical practice prevails to allow someone else to administer the

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38 Declaration of Dr. Kenneth Stevens, MD, 01/06/16, at A-77, ¶¶ 9-10.
39 Id.
40 See e.g., Wash. Rev. Code § 70.245.010(7), attached hereto at A-2.
41 The lethal dose request form for both Acts states: “I expect to die when I take the medication to be prescribed.” See Washington’s Act, attached hereto at A-11, and Oregon’s Act, attached hereto at A-24.
42 See the Oregon and Washington Acts in their entirety, at A-1 to A-25.
lethal dose to the patient. Once again, the patient is not necessarily in control of his or her fate.

2. The term, "self-administer" allows someone else to administer the lethal dose to the patient

Oregon’s Act does not use the term, “self-administer.” In Washington state, “self-administer” is paradoxically defined to allow someone else to administer the lethal dose to the patient. Washington’s Act states:

“Self-administer” means a qualified patient’s act of ingesting medication to end his or her life . . . . (Emphasis added).

The Act does not define “ingest.” Dictionary definitions include:

[T]o take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing.” (Emphasis added).

With this definition, someone else putting the lethal dose in the patient’s mouth qualifies as proper administration because the patient will be “swallowing” the lethal dose, i.e., “ingesting” it. Someone else placing a medication patch on the patient’s arm will qualify because the patient will be “absorbing” the lethal dose, i.e., “ingesting” it. Gas administration, similarly, will qualify because the patient will be “inhaling” the lethal dose,

43 See Oregon Act in its entirety, at A-14 to A-25.


45 YourDictionary.com, attached hereto at A-78.
i.e., “ingesting” it. With self-administer defined as mere ingesting, someone else is allowed to administer the lethal dose to the patient.

F. Allowing Someone Else to Administer the Lethal Dose to the Patient is Euthanasia

Allowing someone else to administer the lethal dose to a patient is euthanasia under generally accepted medical terminology. The AMA Code of Ethics, Opinion 2.21, states:

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

G. The Acts Do Not Prohibit Euthanasia

The Oregon and Washington Acts seem to prohibit euthanasia, also known as “mercy killing.” For example, Oregon’s Act states:

Nothing in [this Act] 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.

This prohibition is, however, defined away in the next sentence. Oregon’s Act also states:

Actions taken in accordance with [this Act] shall not, for any purpose, constitute . . . mercy killing [another for word for

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46 Attached at A-44.


48 127.882 § 3.15, attached hereto at A-20.
euthanasia] . . . . (Emphasis added).49

H. Non-voluntary Euthanasia Appears to be Permissible

The Acts do not require patient “consent” to administration of the lethal dose.50 There is also no requirement that the patient be competent, capable, or even aware when the lethal dose is administered.51 There is no requirement that administration be voluntary.52 Without these requirements, non-voluntary euthanasia appears to be permissible.

I. There is No Oversight Over Administration of the Lethal Dose

If for the purpose of argument, the Oregon and Washington Acts do not allow euthanasia, voluntary or otherwise, patients are still at risk to the actions of other people. This is due to the complete lack of supervision at the death: Not even a

49 Id.


51 The Acts only address whether the patient is "competent" or "capable" in conjunction with the lethal dose request, not later at the time of administration. See Wash. Rev. Code §§ 70.245.010(3)(5)(11), 70.245.020(1), 70.245.030(1), 70.245.040(1)(a)(d), 70.245.050, 70.245.120(3)(4), 70.245.220 (regarding "sound mind"); Or. Rev. Stat. §§ 127.800 § 1.01(3)(5)(11), 127.805 § 2.01(1), 127.810 § 2.02(1), 127.815 § 3.01(1)(a)(d), 127.820 § 3.02, 127.855 § 3.09(3), 127.855 § 3.09(3), 127.897 § 6.01 (regarding "sound mind.")

52 The Acts contain provisions requiring that a determination be made as to whether a patient is acting "voluntarily" in conjunction with the lethal dose request, not later. See Wash. Rev. Code §§ 70.245.020(1), 70.245.030(1), 70.245.040(1)(a)(d), 70.245.050, 70.245.120(3)(4), 70.245.220; Or. Rev. Stat. §§ 127.805 § 2.01(1), 127.810 § 2.02(1), 127.815 § 3.01(1)(a)(d), 127.820 § 3.02, 127.855 § 3.09(3), 127.855 § 3.09(4), 127.897 § 6.01.
witness is required.\textsuperscript{53}

Without supervision, the opportunity is created for someone else to administer the lethal dose to the patient without his or her consent; the drugs used are water and alcohol soluble, such that they can be injected into a sleeping or restrained person.\textsuperscript{54} Even if the patient struggled, who would know? Alex Schadenberg, chair for the Euthanasia Prevention Coalition, International, elaborates:

With assisted suicide laws in Washington and Oregon, perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. \textit{Once the prescription is filled, there is no supervision over administration} . . . \textit{[I]f a patient struggled, "who would know?"} (Emphasis added.)\textsuperscript{55}

\textbf{J. Individual "Opt Outs" Are Not Allowed.}

The Washington and Oregon Acts do not allow an individual to opt out of their provisions. Consider, for example, an older woman with a house and a bank account, concerned that her unemployed son will push her to assisted-suicide or euthanasia. A possible deterrent is a will provision stating that he will be

\textsuperscript{53} See both Acts in their entirety, at A-1 through A-25.

\textsuperscript{54} The drugs used for assisted suicide in Oregon and Washington include Secobarbital and Pentobarbital (Nembutal). See "Secobarbital Sodium Capsules, Drugs.Com, at \url{http://www.drugs.com/pr/seconal-sodium.html} and \url{http://www.drugs.com/pr/nembutal.html} See also Oregon's government report, page 5, attached at A-56 (listing these drugs).


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disinherited if she dies under the Acts. Any such provision, however, is not valid. Washington’s Act states:

Any 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, is not valid. (Emphasis added).56

So much for personal choice and control.

K. The Death Certificate Is Required to Report a Natural Death Caused by a Terminal Disease

Both Acts are interpreted to require the death certificate to report a natural death caused by a terminal disease. Consider, for example, this Washington State death certificate instruction:

If you know the decedent used the Death with Dignity Act, you must comply with the strict requirements of the Act when completing the death record:

1. The underlying terminal disease must be listed as the cause of death.

2. The manner of death must be marked as “Natural.” (Emphasis added).57

The significance is a legal inability to prosecute criminal behavior, for example, in the case of an outright murder for the


money. The cause of death, as a matter of law, is a terminal disease.

I. The Felony for Undue Influence is Illusory and Unenforceable.

The Oregon and Washington Acts create a Class A felony for "undue influence."58 Neither Act, however, defines undue influence or provides elements of proof.59

Both Acts also allow conduct that would normally prove undue influence (allowing an heir to act as a witness on the lethal dose request form).60 How do you prove that undue influence occurred when the Act prohibiting undue influence allows conduct used to prove undue influence? It’s hard to say. The purported felony is, regardless, illusory and unenforceable.

IV. OTHER CONSIDERATIONS

A. Compassion & Choices’ Mission is to Promote Suicide, Assisted Suicide and Euthanasia

Passage of the Oregon and Washington Acts was spearheaded by the suicide advocacy group, Compassion & Choices.

Compassion & Choices was formed in 2004 as the result of a

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59 For example, Washington’s Act states:

A person who coerces or exerts undue influence on a patient to request medication to end the patient's life, or to destroy a rescission of a request, is guilty of a class A felony. (Emphasis added).


60 See “A Comparison to Probate Law,” supra at pages 8-9.

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merger/takeover of two other organizations. One of these organizations was the former Hemlock Society, originally formed by Derek Humphry.

In 2011, Humphry was the keynote speaker at Compassion & Choices' annual meeting here in Washington State. He was also in the news as a promoter of mail-order suicide kits. This was after a depressed 29 year old man used one of the kits to kill himself. compassion & choices' newsletter, promoting Humphry's presentation, references him as "the father of the modern movement for choice." Compassion & Choices' mission is to promote suicide, assisted suicide and euthanasia.

B. Any Study Claiming that Oregon's Law is Safe, is Invalid

In 2011, the lack of supervision over administration of the lethal dose in Oregon prompted Montana State Senator Jeff Essmann

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61 Ian Dowbiggin, A Concise History of Euthanasia 146 (2007) ("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices."). Accord. Compassion & Choices Newsletter attached at A-82 ("Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion in Dying to become Compassion & Choices").

62 Id.

63 Compassion & Choices Newsletter, regarding Humphry's October 22, 2011 speaking date. (Attached hereto at A-82.)

64 See Jack Moran, "Police kick in door in confusion over suicide kit," The Register-Guard, September 21, 2011 ("A spotlight was cast on the mail-order suicide kit business after a 29-year-old Eugene man committed suicide in December using a helium hood kit. The Register-Guard traced the $60 kit to [the company, which] has no website and does no advertising; clients find [the] address through the writings of Humphry.") (Emphasis added)

65 Id.

66 Compassion & Choices Newsletter, at A-82.
to observe that any studies claiming that Oregon’s law is safe are invalid. He stated:

[All] the protections end after the prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is [taken on a voluntary basis].

So frankly, any of the studies that come out of the state of Oregon’s experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.67

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

In 2012, a research study was released addressing trauma suffered by persons who had witnessed a legal assisted suicide in Switzerland.68 The study found that one out of five family members or friends present at an assisted suicide was traumatized. These people, experienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.69

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69 Id.
D. My Clients in Washington and Oregon.

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

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

E. The Oregon Health Plan Steers Patients to Suicide

Oregon’s Health Plan (Medicaid) steers patients to suicide via coverage incentives. See Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (attached at A-83); KATU TV Web Staff, "Letter noting assisted suicide raises questions," July 30, 2008 (attached at A-84); and Affidavit of Kenneth Stevens, MD (attached at A-64, ¶8 through A-69).
F. In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide; the Financial Cost Is "Enormous"

Government reports from Oregon show a positive statistical correlation between the legalization of physician-assisted suicide and an increase in other (conventional) suicides. This statistical correlation is consistent with a suicide contagion in which legalizing physician-assisted suicide encouraged other suicides. Please consider the following:

Oregon's assisted suicide act went into effect "in late 1997."71

By 2000, Oregon's conventional suicide rate was "increasing significantly."72

By 2007, Oregon's conventional suicide rate was 35% above the national average.73

By 2010, Oregon's conventional suicide rate was 41% above the national average.74

There is a significant financial cost associated with these other suicides. One reason is that people who attempt suicide (and fail) can injure themselves or become disabled by the attempt, to thereby require cure, rehabilitation and other

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72 See Oregon Health Authority News Release, 09/09/10. ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached at A-88)

73 Id.

support. A government report from Oregon states:

[T]he estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.\textsuperscript{75}

If Australia, with its larger population, legalizes assisted suicide and has the same experience as Oregon, the financial cost could be larger.\textsuperscript{76}

\section{A COMPARISON TO SOUTH AUSTRALIA (KEY PROPOSAL)}

The Key proposal, like the Oregon and Washington Acts, is not limited to people at the end of life. Indeed, there is not even a requirement of "terminality." (§ 4, at A-28).

The proposal also allows other people to speak for the patient. The death certificate is required to list a medical condition as the cause of death, hence preventing any recourse for criminal conduct such as murder. (§ 23, at A-39)

I had hoped to provide you with a detailed analysis of the proposal, to provide you with more meaningful information to take home, but I ran out of time. I would be happy to finish analyzing the proposal, or to analyze another bill at your request.

\section{CONCLUSION}

The Oregon and Washington Acts, and the Key proposal, are deceptively written legislation, which is stacked against the

\textsuperscript{75} See report at A-91.

\textsuperscript{76} Oregon's estimated population for 2015 is 4,028,971. United States Census Bureau at \url{http://www.census.gov/quickfacts/table/PST045215/00}. 

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patient. These laws are a recipe for abuse of the young and old, the rich and the poor, and those in between. They allow steerage to suicide and euthanasia. Patients and their families are traumatized. I urge you to say “No” to assisted suicide and euthanasia.

Respectfully Submitted,

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Australian Delegation

Portland, Oregon USA

April 7, 2016
Chapter 70.245 RCW

THE WASHINGTON DEATH WITH DIGNITY ACT

Chapter Listing

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70.245.190 Immunities—Basis for prohibiting health care provider from participation
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70.245.200 Willful alteration/forgery—Coercion or undue influence—Penalties—Civil damages
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70.245.210 Claims by governmental entity for costs incurred.
70.245.220 Form of the request.
70.245.901 Short title—2009 c 1 (Initiative Measure No. 1000).
70.245.902 Severability—2009 c 1 (Initiative Measure No. 1000).
70.245.903 Effective dates—2009 c 1 (Initiative Measure No. 1000).
70.245.904 Captions, part headings, and subpart headings not law—2009 c 1 (Initiative
Measure No. 1000).

70.245.010 Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires
otherwise.
(1) "Adult" means an individual who is eighteen 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) "Competent" 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 an informed decision 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 competent 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 law 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 that the qualified patient may self-administer 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 in the state of Washington.

(11) "Qualified patient" means a competent adult who is a resident of Washington state and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.

(12) "Self-administer" means a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner.

(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.

[2009 c 1 § 1 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.020
Written request for medication.

(1) An adult who is competent, is a resident of Washington state, 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 that the patient may self-administer to end his or her life in a humane and dignified manner in accordance [A-2]
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with this chapter.

(2) A person does not qualify under this chapter solely because of age or disability.

[2009 c 1 § 2 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.030 Form of the written request.

(1) A valid request for medication under this chapter shall be in substantially the form described in RCW 70.245.220, 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 competent, 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 health by rule.

[2009 c 1 § 3 (Initiative Measure No. 1000, approved November 4, 2008).]
(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this chapter 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 fifteen-day waiting period under RCW 70.245.090;

(i) Verify, immediately before writing the prescription for medication under this chapter, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of RCW 70.245.120;

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

(l)(i) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under statute and rule to dispense and has a current drug enforcement administration certificate; or

(ii) With the patient's written consent:

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

(B) Deliver the written prescription personally, by mail or facsimile to the pharmacist, who will dispense the medications directly to either the patient, the attending physician, or an expressly identified agent of the patient. Medications dispensed pursuant to this subsection shall not be dispensed by mail or other form of courier.

(2) The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death.

[2009 c 1 § 4 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.050 Consulting physician confirmation.

Before a patient is qualified under this chapter, 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 competent, is acting voluntarily, and has made an informed decision.

[2009 c 1 § 5 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.060 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. Medication to end a patient's life in a humane and dignified manner shall not be prescribed until the person performing the counseling determines

http://app.leg.wa.gov/rcw/default.aspx?cite=70.245&full=true
that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

[2009 c 1 § 6 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.070
Informed decision.

A person shall not 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. Immediately before writing a prescription for medication under this chapter, the attending physician shall verify that the qualified patient is making an informed decision.

[2009 c 1 § 7 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.080
Notification of next of kin.

The attending physician shall recommend that the patient notify the next of kin of his or her request for medication under this chapter. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

[2009 c 1 § 8 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.090
Written and oral requests.

To receive a prescription for medication that the qualified patient may self-administer 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 at least fifteen 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 qualified patient an opportunity to rescind the request.

[2009 c 1 § 9 (Initiative Measure No. 1000, approved November 4, 2008).]
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 this chapter may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

[2009 c 1 § 10 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.110
Waiting periods.

(1) At least fifteen days shall elapse between the patient's initial oral request and the writing of a prescription under this chapter.

(2) At least forty-eight hours shall elapse between the date the patient signs the written request and the writing of a prescription under this chapter.

[2009 c 1 § 11 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.120
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, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is competent, is 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 under RCW 70.245.090; and

(7) A note by the attending physician indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

[2009 c 1 § 12 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.130
Residency requirement.

Only requests made by Washington state residents under this chapter may be granted. Factors
demonstrating Washington state residency include but are not limited to:

(1) Possession of a Washington state driver's license;
(2) Registration to vote in Washington state; or
(3) Evidence that the person owns or leases property in Washington state.

[2009 c 1 § 13 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.140
Disposal of unused medications.

Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means.

[2009 c 1 § 14 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.150
Reporting of information to the department of health—Adoption of rules—Information collected not a public record—Annual statistical report.

(1)(a) The department of health shall annually review all records maintained under this chapter.
(b) The department of health shall require any health care provider upon writing a prescription or dispensing medication under this chapter to file a copy of the dispensing record and such other administratively required documentation with the department. All administratively required documentation shall be mailed or otherwise transmitted as allowed by department of health rule to the department no later than thirty calendar days after the writing of a prescription and dispensing of medication under this chapter, except that all documents required to be filed with the department by the prescribing physician after the death of the patient shall be mailed no later than thirty calendar days after the date of death of the patient. In the event that anyone required under this chapter to report information to the department of health provides an inadequate or incomplete report, the department shall contact the person to request a complete report.

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

(3) The department of health shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section.

[2009 c 1 § 15 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.160
Effect on construction of wills, contracts, and statutes.
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(1) Any 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, is not valid.

(2) Any obligation owing under any currently existing contract shall not 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.

[2009 c 1 § 16 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.170
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 that the patient may self-administer to end his or her life in a humane and dignified manner. A qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner shall not have an effect upon a life, health, or accident insurance or annuity policy.

[2009 c 1 § 17 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.180
Authority of chapter—References to practices under this chapter—Applicable standard of care.

(1) Nothing in this chapter authorizes 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 this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide."
Consistent with RCW 70.245.010 (7), (11), and (12), 70.245.020(1), 70.245.040(1)(k), 70.245.060, 70.245.070, 70.245.090, 70.245.120 (1) and (2), 70.245.160 (1) and (2), 70.245.170, 70.245.190(1) (a) and (d), and 70.245.200(2), state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication.

(2) Nothing contained in this chapter shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist or psychologist, or other health care provider participating under this chapter.

[2009 c 1 § 18 (Initiative Measure No. 1000, approved November 4, 2008).]
Immunities—Basis for prohibiting health care provider from participation—Notification—Permissible sanctions.

(1) Except as provided in RCW 70.245.200 and subsection (2) of this section:
   (a) A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner;
   (b) A professional organization or association, or health care provider, may not 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 this chapter;
   (c) A patient's request for or provision by an attending physician of medication in good faith compliance with this chapter does not constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator; and
   (d) Only willing health care providers shall 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 this chapter, 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.

(2)(a) A health care provider may prohibit another health care provider from participating under chapter 1, Laws of 2009 on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under chapter 1, Laws of 2009. This subsection does not prevent a health care provider from providing health care services to a patient that do not constitute participation under chapter 1, Laws of 2009.

(b) A health care provider may subject another health care provider to the sanctions stated in this subsection if the sanctioning health care provider has notified the sanctioned provider before participation in chapter 1, Laws of 2009 that it prohibits participation in chapter 1, Laws of 2009:
   (i) Loss of privileges, loss of membership, or other sanctions provided under 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 chapter 1, Laws of 2009 while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a physician or other provider;
   (ii) Termination of a lease or other property contract or other nonmonetary remedies provided by a lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in chapter 1, Laws of 2009 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
   (iii) Termination of a contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in chapter 1, Laws of 2009 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 subsection (2)(b)(iii) prevents:
      (A) A health care provider from participating in chapter 1, Laws of 2009 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or
      (B) 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 under (b) of this subsection shall 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 the purposes of this subsection:

(i) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider before the provider's participation in chapter 1, Laws of 2009 of the sanctioning health care provider's policy about participation in activities covered by this chapter.

(ii) "Participate in chapter 1, Laws of 2009" means to perform the duties of an attending physician under RCW 70.245.040, the consulting physician function under RCW 70.245.050, or the counseling function under RCW 70.245.060. "Participate in chapter 1, Laws of 2009" does not include:

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

(B) Providing information about the Washington death with dignity act to a patient upon the request of the patient;

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

(D) 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.

3 Suspension or termination of staff membership or privileges under subsection (2) of this section is not reportable under RCW 18.130.070. Action taken under RCW 70.245.030, 70.245.040, 70.245.050, or 70.245.060 may not be the sole basis for a report of unprofessional conduct under RCW 18.130.180.

(4) References to "good faith" in subsection (1)(a), (b), and (c) of this section do not allow a lower standard of care for health care providers in the state of Washington.

[2009 c 1 § 19 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.200
Willful alteration/forgery—Coercion or undue influence—Penalties—Civil damages—Other penalties not precluded.

(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 is guilty of a class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication to end the patient's life, or to destroy a rescission of a request, is guilty of a class A felony.

(3) This chapter does not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct that is inconsistent with this chapter.

[2009 c 1 § 20 (Initiative Measure No. 1000, approved November 4, 2008).]
Claims by governmental entity for costs incurred.

Any governmental entity that incurs costs resulting from a person terminating his or her life under this chapter in a public place has a claim against the estate of the person to recover such costs and reasonable attorneys' fees related to enforcing the claim.

[2009 c 1 § 21 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.220
Form of the request.

A request for a medication as authorized by this chapter shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMAN [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 I may self-administer to end my life in a humane and dignified manner and to contact any pharmacist to fill the prescription.

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

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request:

Witness 1        Witness 2
Initials        Initials
......        ......        1. Is personally known to us or has provided proof of identity
......        ......        2. Signed this request in our presence on the date of the

http://app.leg.wa.gov/rcw/default.aspx?cite=70.245&full=true
person's signature;

3. Appears to be of sound mind and not under duress, fraud, or undue influence;

4. Is not a patient for whom either of us is the attending physician.

Printed Name of Witness 1: . . . .
Signature of Witness 1/Date: . . . .

Printed Name of Witness 2: . . . .
Signature of 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.

[2009 c 1 § 22 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.901
Short title—2009 c 1 (Initiative Measure No. 1000).

This act may be known and cited as the Washington death with dignity act.

[2009 c 1 § 26 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.902
Severability—2009 c 1 (Initiative Measure No. 1000).

If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

[2009 c 1 § 27 (Initiative Measure No. 1000, approved November 4, 2008).]

70.245.903
Effective dates—2009 c 1 (Initiative Measure No. 1000).

This act takes effect one hundred twenty days after the election at which it is approved [March 5, 2009], except for section 24 of this act which takes effect July 1, 2009.
70.245.904
Captions, part headings, and subpart headings not law—2009 c 1 (Initiative Measure No. 1000).

Captions, part headings, and subpart headings used in this act are not any part of the law.

[2009 c 1 § 30 (Initiative Measure No. 1000, approved November 4, 2008).]
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.
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]
South Australia

**Voluntary Euthanasia Bill 2015**

**A BILL FOR**

An Act to provide for choices at the end of life.

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The Parliament of South Australia enacts as follows:

Part 1—Preliminary

1—Short title

This Act may be cited as the Voluntary Euthanasia Act 2015.

2—Commencement

This Act will come into operation—

(a) on a day to be fixed by proclamation; or

(b) 6 months after the day on which it is assented to by the Governor, whichever is the sooner.

3—Interpretation

(1) In this Act—

eligible person—see section 10;
medical practitioner means a person registered under the Health Practitioner Regulation National Law in the medical profession (other than as a student);

psychiatrist means a person registered under the Health Practitioner Regulation National Law as a specialist in psychiatry;

request for voluntary euthanasia means a request for voluntary euthanasia to be administered made in accordance with this Act;

unbearable and hopeless suffering—see section 4;

voluntary euthanasia means the administration of drugs, in accordance with this Act, to bring about the death of a person who has made a request for voluntary euthanasia;

voluntary euthanasia request form means the voluntary euthanasia request form set out in Schedule 1.

(2) For the purposes of this Act, a reference to a consultation, examination or assessment of a person by a medical practitioner or psychiatrist will be taken to include a reference to a consultation, examination or assessment undertaken remotely by means of a system or scheme of a kind specified by the regulations.

4—Unbearable and hopeless suffering

(1) For the purposes of this Act, a person will be taken to be subject to unbearable and hopeless suffering if—

(a) the person is suffering from a medical condition (whether terminal or not); and

(b) the person is subject to mental or physical suffering or both attributable wholly or in part to the medical condition; and

(c) the suffering is unbearable to the person, determined in accordance with subsection (2); and

(d) the suffering is hopeless, determined in accordance with subsection (4).

(2) In determining whether a person's suffering is unbearable, the degree to which a person's suffering is unbearable or unbearable is to be determined subjectively, and need not meet an objective standard.

(3) The question of whether a person's suffering is bearable or unbearable cannot be challenged or questioned in any proceedings seeking to prevent or delay the administration of voluntary euthanasia to an eligible person.

(4) A person's suffering will be taken to be hopeless if there is no reasonably available medical treatment that would reduce or relieve the suffering to a level bearable to the person (and the nature, availability and potential effectiveness of such medical treatment is to be determined objectively).

5—Impaired decision making capacity

(1) For the purposes of this Act, a person will be taken to have an impaired decision making capacity in respect of a decision to make a request for voluntary euthanasia if the person is not capable of—

(a) understanding any information that may be relevant to the decision (including information relating to the consequences of making the decision); or
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(b) retaining such information; or
(c) using such information in the course of making the decision; or
(d) communicating his or her decision in any manner.

(2) For the purposes of this Act—

(a) a person will not be taken to be incapable of understanding information merely because the person is not able to understand matters of a technical or trivial nature; and
(b) a person will not be taken to be incapable of retaining information merely because the person can only retain the information for a limited time; and
(c) a person may fluctuate between having impaired decision making capacity and full decision making capacity.

6—Relationship to other Acts

(1) Unless the contrary intention expressly appears, this Act applies despite the provision of any other Act or law.

(2) Nothing in the Criminal Law Consolidation Act 1935, the Consent to Medical Treatment and Palliative Care Act 1995 or the Controlled Substances Act 1984 or any other Act or law prevents—

(a) a medical practitioner from prescribing or supplying, or a pharmacist or other person from selling, dispensing or supplying, a prescription drug or drug of dependence for a purpose relating to the administration of voluntary euthanasia in accordance with this Act; or
(b) a person from assisting (however described) in the administration of voluntary euthanasia in accordance with this Act.

(3) Nothing in this Act prevents a person from giving an advance care directive under the Advance Care Directives Act 2013 that makes provision for the future administration of voluntary euthanasia to the person (however, if a person who has given such an advance care directive also makes a request for voluntary euthanasia under this Act, then the request for voluntary euthanasia made under this Act will be taken to prevail).

(4) For the purposes of the Coroners Act 2003, the death of a person brought about by the administration of voluntary euthanasia is a reportable death (within the meaning of that Act).

(5) For the purposes of the Health Practitioner Regulation National Law (South Australia) Act 2010 and the Health Practitioner Regulation National Law, a failure by a medical practitioner to comply with this Act will be taken to constitute proper cause for disciplinary action against the medical practitioner.

(6) Nothing in this Act renders lawful voluntary euthanasia administered other than in accordance with this Act.
Part 2—Objects and principles

7—Object

The object of this Act is to reform the law—

(a) to allow adult persons of sound mind to formally request that their suffering be ended at the time of their choosing by the administration of voluntary euthanasia in accordance with this Act;

(b) to ensure that participation in the making of a request for voluntary euthanasia (including by gathering information), and the administration of voluntary euthanasia, in accordance with this Act does not amount to a criminal offence or cause a person to suffer any other discrimination or liability;

(c) to ensure that participation in the administration of voluntary euthanasia in accordance with this Act does not amount to a criminal offence or cause a person to suffer any other discrimination or liability;

(d) to ensure that the arrangements that a person may make under this Act to bring his or her suffering to an end are, and should be implemented as, a medical issue;

(e) to protect those persons who decline to be involved in the making of requests for, or the administration of, voluntary euthanasia by ensuring that those persons do not suffer any discrimination or liability.

8—Principles

The following principles must be taken into account in relation to the operation of this Act:

(a) subject to the laws of the State, every person has the right to choose how he or she should live his or her life;

(b) an adult person of sound mind is entitled—

   (i) to make lawful arrangements in respect of the end of his or her life should his or her suffering become unbearable and hopeless; and

   (ii) to bring about the end of his or her life should their suffering become unbearable and hopeless;

(c) medical practitioners and other persons should be able to provide assistance to persons wanting to make and implement lawful arrangements in respect of the end of their suffering without exposing themselves to civil or criminal liability or other detriment;

(d) the arrangements that a person may make under this Act to bring his or her suffering to an end are, and should be implemented as, a medical issue.
Part 3—Voluntary euthanasia

Division 1—No offence to provide medical information about voluntary euthanasia

9—No offence to provide medical information about voluntary euthanasia

Despite section 13A of the *Criminal Law Consolidation Act 1935*, or any other Act or law, a person incurs no criminal or civil liability by—

(a) providing medical information in relation to voluntary euthanasia; or

(b) selling or supplying medical equipment (not being a drug used in the administration of voluntary euthanasia) to be used for a purpose relating to the administration of voluntary euthanasia.

Note—

Section 13A of the *Criminal Law Consolidation Act 1935* makes it an offence to aid, abet or counsel the suicide or attempted suicide of another.

Division 2—Making a request for voluntary euthanasia

10—Who may make a request for voluntary euthanasia?

A person (an *eligible person*) may make a request for voluntary euthanasia if he or she—

(a) is a competent adult; and

(b) is subject to unbearable and hopeless suffering; and

(c) does not, at the time of the request, have an impaired decision making capacity in respect of a decision to make a request for voluntary euthanasia; and

Note—

See section 5 for the meaning of having an impaired decision making capacity.

(d) has lived in the State for a period of not less than 6 months immediately preceding the making of the request.

11—How to make a request for voluntary euthanasia

(1) An eligible person may make a request for voluntary euthanasia in accordance with this section.

(2) Before making a request for voluntary euthanasia, an eligible person—

(a) must be examined and assessed by a medical practitioner in accordance with section 12; and

(b) must be independently examined and assessed by a second medical practitioner in accordance with section 13; and

(c) must, if either medical practitioner so requires, be examined and assessed by a psychiatrist in accordance with section 14.
Subject to this section, the following requirements must be satisfied in respect of a request for voluntary euthanasia:

(a) the request must be made by the eligible person completing, as far as is appropriate, a voluntary euthanasia request form and presenting the form to the medical practitioner referred to in section 12;

(b) the request cannot be made until any report required under section 13 or 14 has been received by the medical practitioner referred to in section 12;

(c) in the case of a request referred to in subsection (4), the voluntary euthanasia request form must be accompanied by a certified copy of the audio-visual record and a copy of any certificate required under that subsection;

(d) the request must be witnessed in accordance with section 15;

(e) the request must comply with any other requirements set out in the regulations.

Despite subsection (3)(a), a request for voluntary euthanasia may, in the case of an eligible person who is unable to read or write or both, or who is not reasonably fluent in English, be made in accordance with the following provisions:

(a) the request must be made by the eligible person making an oral request to the medical practitioner referred in section 12 (whether with the assistance of an interpreter or otherwise);

(b) an audio-visual record of the making of the request for voluntary euthanasia must be made;

(c) in the case of an eligible person who is not reasonably fluent in English—any information required to be given to, or by, the eligible person under this Act must be given with the assistance of an interpreter in relation to a language in which the person is fluent;

(d) in the case of an eligible person whose ability to read or write or otherwise communicate is limited by an illness or disability—any information required to be given to, or by, the eligible person under this Act must be given with the assistance of a person (the person assisting) who is able to effectively communicate with the eligible person;

Note—

A person suffering from aphasia, for example, might be such a person.

(e) the interpreter, person assisting or the medical practitioner must—

(i) complete a voluntary euthanasia request form on behalf of the eligible person (and in such a case the form will be taken to be the eligible person's request for voluntary euthanasia); and

(ii) certify that the voluntary euthanasia request form accurately reproduces in English the information supplied by the eligible person in the course of making the request;

(f) the interpreter or person assisting must certify that the information required to be given to the person under this Act was given to, and appeared to be understood by, the eligible person;
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(g) the making of the request for voluntary euthanasia must otherwise comply with the requirements set out in subsection (3).

(5) On a request for voluntary euthanasia being made, the medical practitioner must, on the appropriate part of the voluntary euthanasia request form, certify that he or she is of the opinion that—

(a) any requirements under this Division have been satisfied in respect of the request for voluntary euthanasia; and

(b) the request for voluntary euthanasia appears to genuinely reflect the wishes of the eligible person; and

(c) the eligible person appeared to understand the nature and implications of the request for voluntary euthanasia; and

(d) the eligible person is the subject of unbearable and hopeless suffering; and

Note—

Section 4 sets out how this is to be determined.

(e) the eligible person was not acting under any form of duress, inducement or undue influence (including that due solely to a perception or mistake on the part of the person) in relation to his or her request for voluntary euthanasia.

12—Preliminary examination and assessment by medical practitioner

(1) For the purposes of section 11(2)(a), an examination and assessment of a person by a medical practitioner must comply with the following provisions:

(a) the examination and assessment must occur at a consultation initiated by or on behalf of the person;

(b) the medical practitioner must satisfy himself or herself that the person is the subject of unbearable and hopeless suffering;

(c) the medical practitioner must give to the person the following information in writing:

(i) a diagnosis and prognosis of his or her illness, injury or condition;

(ii) information explaining the forms of treatment that are reasonably available to treat his or her illness, injury or condition (if any) and the risks associated with such treatment;

(iii) information setting out the medical procedures that may be used to administer voluntary euthanasia and the risks associated with the procedures;

(iv) any other information required by the regulations for the purposes of this subsection.

(2) If the medical practitioner reasonably suspects that—

(a) the person is not of sound mind; or

(b) the decision making ability of the person is adversely affected by his or her state of mind; or
(c) the person is acting under any form of duress, inducement or undue influence (including that due solely to a perception or mistake on the part of the person) in relation to his or her wish to request voluntary euthanasia,

the medical practitioner must refer the person to a psychiatrist for examination and assessment in accordance with section 14.

(3) A person may be assisted in the course of an examination or assessment under this section by an interpreter or other person.

13—Examination and assessment by second medical practitioner

(1) For the purposes of section 11(2)(b), an examination and assessment of a person by a second medical practitioner must comply with the following provisions:

(a) the medical practitioner must be independent of both the medical practitioner referred to in section 12 and the person;

(b) the medical practitioner must examine the person;

(c) the medical practitioner must satisfy himself or herself that—

(i) the person is the subject of unbearable and hopeless suffering; and

(ii) the medical practitioner referred to in section 12 has complied with the provisions of section 12(1)(c);

(d) the medical practitioner must give to the person the following information in writing:

(i) his or her diagnosis and prognosis of the person's illness, injury or condition;

(ii) information explaining the forms of treatment that are reasonably available to treat the person's illness, injury or condition (if any) and the risks associated with such treatment.

(2) As soon as is reasonably practicable after an examination and assessment, the second medical practitioner must provide to the medical practitioner referred to in section 12 a written report setting out whether or not, in his or her opinion—

(a) the person is of sound mind; or

(b) the decision making ability of the person is adversely affected by his or her state of mind; or

(c) the person is acting under any form of duress, inducement or undue influence (including that due solely to a perception or mistake on the part of the person) in relation to his or her wish to request voluntary euthanasia.

(3) If the report provided by the second medical practitioner sets out that he or she is of the opinion—

(a) the person is not, or may not be, of sound mind; or

(b) the decision making ability of the person is, or may be, adversely affected by his or her state of mind; or

(c) the person is, or may be, acting under any form of duress, inducement or undue influence,
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the medical practitioner referred to in section 12 must refer the person to a psychiatrist for examination and assessment in accordance with section 14.

(4) A person may be assisted in the course of an examination or assessment under this section by an interpreter or other person.

14—Examination and assessment by psychiatrist

(1) For the purposes of this Part, an examination and assessment of a person by a psychiatrist must comply with the following provisions:

(a) the psychiatrist must examine the person;

(b) the psychiatrist must assess whether or not—

(i) the person is of sound mind; and

(ii) the decision making ability of the person is adversely affected by his or her state of mind; and

(iii) the person is acting under any form of duress, inducement or undue influence (including that due solely to a perception or mistake on the part of the person) in relation to his or her wish to request voluntary euthanasia; and

(iv) whether the person genuinely appears to understand the nature and implications of a request for voluntary euthanasia; and

(v) whether or not the person genuinely wishes voluntary euthanasia to be administered to him or her.

(2) As soon as is reasonably practicable after an examination and assessment, the psychiatrist must provide to the medical practitioner referred to in section 12 a written report in respect of the matters referred to in subsection (1).

(3) The validity and legality of a certification of a psychiatrist under this section cannot be challenged or questioned in any proceedings seeking to prevent or delay the administration of voluntary euthanasia to an eligible person.

(4) A person may be assisted in the course of an examination or assessment under this section by an interpreter or other person.

15—Requirements for witnessing request for voluntary euthanasia

(1) Subject to this section, a request for voluntary euthanasia may be witnessed by any competent adult person (whether or not the witness is related to, or known by, the eligible person to whom the request relates).

(2) The following persons cannot witness a particular eligible person's request for voluntary euthanasia:

(a) a medical practitioner or psychiatrist who examines or assesses the eligible person under this Division;

(b) a person who is a direct beneficiary of, or who otherwise has a direct interest in, the estate of the eligible person;

(c) a person who is the owner or operator (however described) of a hospital, hospice, nursing home or other institution for the care of the sick or infirm in which the eligible person resides, or an employee or agent of such a facility;
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(d) any other person declared by the regulations to be included in the ambit of this subsection.

(3) A request for voluntary euthanasia must be witnessed in accordance with the following provisions:

(a) the request for voluntary euthanasia must be made in the presence of the witness;

(b) the witness must, on the appropriate part of the voluntary euthanasia request form and in the presence of the medical practitioner referred to in section 12, certify that—

(i) he or she witnessed the making of the request for voluntary euthanasia; and

(ii) that he or she is not a person who cannot witness the eligible person's request for voluntary euthanasia; and

(iii) the request for voluntary euthanasia appears to genuinely reflect the wishes of the eligible person; and

(iv) the eligible person appeared to understand the nature and implications of the request for voluntary euthanasia; and

(v) that the witness is of the opinion that the eligible person was not acting under any form of duress, inducement or undue influence (including that due solely to a perception or mistake on the part of the eligible person) in relation to his or her request for voluntary euthanasia;

(c) the witnessing of the request must comply with any other provisions set out in the regulations.

(4) A person witnessing a request for voluntary euthanasia may be assisted by an interpreter or other person.

16—Revocation of request for voluntary euthanasia

(1) A person who has made a request for voluntary euthanasia may revoke the request at any time.

(2) A written, oral or any other indication of the revocation of, or of a person's wish to revoke, a request for voluntary euthanasia is sufficient to revoke the request (whether or not the person is mentally competent when the indication is given).

17—Duration of request for voluntary euthanasia

A request for voluntary euthanasia—

(a) has effect from the time the request practitioner completes the certification required under section 11(5); and

(b) remains in force until it is revoked in accordance with this Act.
Division 3—Administration of voluntary euthanasia

18—Authorised methods of administering voluntary euthanasia

(1) This Act authorises the administration of voluntary euthanasia to a person by the following means:

(a) by a medical practitioner administering drugs in concentrations likely to end the eligible person's life;

(b) by the person self-administering drugs in concentrations likely to end his or her life.

(2) For the purposes of this or any other Act or law, a person's request for voluntary euthanasia will, in the absence of evidence to the contrary, be taken to constitute any consent necessary for the administration of voluntary euthanasia to the person.

19—Administration of voluntary euthanasia by medical practitioner

(1) A medical practitioner (whether or not he or she is the medical practitioner referred to in section 12 in respect of a particular request for voluntary euthanasia) may administer voluntary euthanasia to a person if—

(a) the person—

(i) is competent; and

(ii) has lived in the State for a period of not less than 6 months immediately preceding the administration of voluntary euthanasia; and

(iii) is capable of communicating his or her decisions; and

(b) the person has made a request for voluntary euthanasia that is in force; and

(c) the person confirms that he or she wishes voluntary euthanasia to be administered; and

(d) more than 48 hours have passed since the person made the request for voluntary euthanasia.

(2) A medical practitioner may be assisted in relation to the administration of voluntary euthanasia by an interpreter or such other persons as he or she thinks fit.

20—Self-administration of voluntary euthanasia

(1) A person may self-administer voluntary euthanasia if—

(a) he or she is competent; and

(b) he or she has lived in the State for a period of not less than 6 months immediately preceding the administration of voluntary euthanasia; and

(c) he or she has made a request for voluntary euthanasia that is in force; and

(d) more than 48 hours have passed since he or she made the request for voluntary euthanasia.

(2) A person self-administering voluntary euthanasia may be assisted by such other persons as he or she thinks fit.
21—Person etc may decline to administer or assist in administration of voluntary euthanasia

(1) A medical practitioner may decline to administer voluntary euthanasia on any grounds without prejudice to the medical practitioner's employment or any other form of discrimination.

(2) A person may decline to assist in the administration of voluntary euthanasia on any grounds without prejudice to the person's employment or any other form of discrimination.

(3) The administering authority of a hospital, hospice, nursing home or other institution for the care of the sick or infirm may refuse to permit the administration of voluntary euthanasia within the institution but, if it does so—
   (a) must take steps to ensure that the refusal is brought to the attention of any person prior to being admitted to, or entering, the institution; and
   (b) if a person has been admitted to, or entered, the institution without having been made aware of the refusal—must, if the person so requests, arrange for the transfer of the person to an institution that permits the administration of voluntary euthanasia.

22—Protection from liability

(1) If a medical practitioner or other person—
   (a) takes part in, or is otherwise involved in relation to, the making of a request or purported request for voluntary euthanasia in accordance with this Act; or
   (b) takes part in, or is otherwise involved in relation to, the administration of voluntary euthanasia in accordance with this Act,

   the medical practitioner or person—
   (c) incurs no criminal liability (other than in proceedings for an offence against this Act) for an act or omission in so doing; and
   (d) incurs no civil liability for an act or omission in so doing, provided that the act or omission was done or made in good faith and without negligence.

(2) A medical practitioner or other person who (whether voluntarily or pursuant to a requirement under this Act) advises another person of a reasonable suspicion that a person has revoked a request for voluntary euthanasia—
   (a) cannot, by virtue of doing so, be held to have breached any code of professional etiquette or ethics, or to have departed from any accepted form of professional conduct; and
   (b) insofar as he or she has acted in good faith, incurs no civil or criminal liability in respect of the advice.

(3) For the purposes of this section, a reference to the civil liability of a person includes a reference to liability arising under disciplinary proceedings or similar proceedings.

(4) For the purposes of this section, a reference to the administration of voluntary euthanasia includes a reference to the attempted administration of voluntary euthanasia.
23—Cause of death— must be a medical condition

(1) For the purposes of the law of the State the cause of death of a person resulting from the administration of voluntary euthanasia—
   (a) will be taken to have been caused by the medical condition primarily responsible for the person's unbearable and hopeless suffering; and
   (b) will be taken not to be suicide or homicide.

(2) To avoid doubt, this section applies in relation to a finding under section 29 of the Coroners Act 2003.

24—Report to State Coroner

(1) A medical practitioner who administers voluntary euthanasia to a person must make a report to the State Coroner within 48 hours after the person's death.
   Maximum penalty: $5 000.

(2) A medical practitioner to whom a request for voluntary euthanasia is made must, as soon as is reasonably practicable after becoming aware that the person who made the request has self-administered voluntary euthanasia pursuant to the request, make a report to the State Coroner.
   Maximum penalty: $5 000.

(3) A report under this section must be in the prescribed form and must be accompanied by—
   (a) a copy of the voluntary euthanasia request form; and
   (b) a copy of any report or other document required to accompany the voluntary euthanasia request form under this Act; and
   (c) any other information required by the regulations.

Part 4—Offences etc

25—Undue influence etc not defined

A person who, by dishonesty or undue influence, induces another to make a request for voluntary euthanasia is guilty of an offence.
   Maximum penalty: Imprisonment for 10 years.

26—False or misleading statements

(1) A person who makes a false or misleading statement in, or in relation to, a request for voluntary euthanasia is guilty of an offence.
   Maximum penalty: Imprisonment for 10 years.

(2) For the purposes of this section, a reference to a request for voluntary euthanasia includes a reference to a request that has been revoked.
27—Certain persons to forfeit interest in estate

If a court finds a person guilty of an offence against section 25 or 26, the court may, on the application of the prosecution, order that the person forfeits any interest that the person might otherwise have had in the estate of the person who made the relevant request for voluntary euthanasia.

Part 5—Miscellaneous

28—Insurance

(1) An insurer is not entitled to refuse to make a payment that is payable under a life insurance policy on the death of the insured on the ground that the death resulted from the administration of voluntary euthanasia.

(2) A person is not obliged to disclose a request for voluntary euthanasia to an insurer.

(3) An insurer must not ask a person to disclose whether the person has made a request for voluntary euthanasia.

Maximum penalty: $10,000.

(4) This section applies despite an agreement between a person and an insurer to the contrary.

29—Victimisation

(1) A person commits an act of victimisation against another person (the victim) if he or she causes detriment to the victim on the ground, or substantially on the ground, that the victim—

(a) takes part in, or is otherwise involved in relation to, the making of a request, or purported request, for voluntary euthanasia in accordance with this Act; or

(b) takes part in, or is otherwise involved in relation to, the administration of voluntary euthanasia in accordance with this Act; or

(c) refuses to take part in the making of a request for, or administration of, voluntary euthanasia in accordance with this Act.

(2) An act of victimisation under this Act may be dealt with—

(a) as a tort; or

(b) as if it were an act of victimisation under the Equal Opportunity Act 1984, but, if the victim commences proceedings in a court seeking a remedy in tort, he or she cannot subsequently lodge a complaint under the Equal Opportunity Act 1984 and, conversely, if the victim lodges a complaint under that Act, he or she cannot subsequently commence proceedings in a court seeking a remedy in tort.

(3) If a complaint alleging an act of victimisation under this Act has been lodged with the Commissioner for Equal Opportunity and the Commissioner is of the opinion that the subject matter of the complaint has already been adequately dealt with by a competent authority, the Commissioner may decline to act on the complaint or to proceed further with action on the complaint.
(4) In this section—

_detriment_ includes—

(a) injury, damage or loss; or

(b) intimidation or harassment; or

(c) discrimination, disadvantage or adverse treatment in relation to the victim's employment or business; or

(d) threats of reprisal.

### 30—Confidentiality

(1) A person engaged or formerly engaged in the administration of this Act must not divulge or communicate personal information obtained (whether by that person or otherwise) in the course of official duties except—

(a) as required or authorised by or under this Act or any other Act or law; or

(b) with the consent of the person to whom the information relates; or

(c) in connection with the administration of this Act; or

(d) to an authority responsible under the law of a place outside this State, where the information is required for the proper administration of that law; or

(e) to an agency or instrumentality of this State, the Commonwealth or another State or a Territory of the Commonwealth for the purposes of the proper performance of its functions.

Maximum penalty: $10,000.

(2) Subsection (1) does not prevent disclosure of statistical or other data that could not reasonably be expected to lead to the identification of any person to whom it relates.

(3) Information that has been disclosed under subsection (1) for a particular purpose must not be used for any other purpose by—

(a) the person to whom the information was disclosed; or

(b) any other person who gains access to the information (whether properly or improperly and whether directly or indirectly) as a result of that disclosure.

Maximum penalty: $10,000.

### 31—Annual report on operation of Act

(1) The Minister must, on or before 30 September in each year, cause a report to be prepared on the operation of this Act during the previous financial year.

(2) The Minister must cause a copy of the report prepared under subsection (1) to be laid before both Houses of Parliament within 12 sitting days after receiving the report.

### 32—Regulations

The Governor may make such regulations as are contemplated by, or necessary or expedient for the purposes of, this Act.

### Schedule 1—Voluntary Euthanasia Request Form
Schedule 2—Related amendments and transitional provisions

Part 1—Preliminary

1—Amendment provisions

In this Act, a provision under a heading referring to the amendment of a specified Act amends the Act so specified.

Part 2—Amendment of Advance Care Directives Act 2013

2—Amendment of section 12—Provisions that cannot be included in advance care directives

(1) Section 12(1)(a)(i) and (ii)—delete subparagraphs (i) and (ii) and substitute:

(i) that is unlawful, or that would require an unlawful act to be performed; or

(2) Section 12—after subsection (1) insert:

(1a) An advance care directive cannot constitute a request for the administration of voluntary euthanasia to a person (however nothing in this subsection prevents a person from expressing his or her preferences or wishes in relation to voluntary euthanasia in an advance care directive).

Part 3—Amendment of Consent to Medical Treatment and Palliative Care Act 1995

3—Insertion of section 5

After section 4B insert:

5—Application of Act in respect of voluntary euthanasia

This Act does not apply in relation to medical treatment consisting of, or given in the course of, the administration of voluntary euthanasia to a person in accordance with the Voluntary Euthanasia Act 2015.
Opinion 2.211 - Physician-Assisted Suicide

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, allowing physicians to participate in assisted suicide would 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 participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

Opinion 2.21 - Euthanasia

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.

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. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Facts on Elder Abuse - Australia

Incidents of Abuse

- In comparing population numbers from around the world, it is projected that there are over 20,000 unreported cases of abuse, neglect, and exploitation in Victoria per year and approximately 100,000 throughout Australia per year. Other estimates include 20,000 for NSW and 25,000 for Queensland.
- Almost four times as many new incidents of abuse, neglect, and exploitation are not reported as those that were reported to and substantiated by adult protective services agencies and/or ombudsman entities. These predictions are also accurate for Australia. Thus 20,000 become 80,000. 100,000 become 400,000.

Lack of Reporting Mechanisms

- There are no mandatory reporting requirements in any State or Territory throughout Australia for elder abuse that is occurring in the community setting.
- Effective 1 July 2007, there will be mandatory reporting for all residential care facility staff for only incidents of serious physical assault and criminal sexual assault.
- There is no central database in any State or Territory recording incidents of abuse, neglect, and/or exploitation of vulnerable adults from the community sector.
- There is a state of continuous confusion throughout Australia about where to go for assistance. Currently there are no adequate response systems for those who need to report.

Concerns for the Federal Government

- By 2025 it is estimated that elder abuse will be costing the health system over $350 million dollars per year.
- There were 3947 cases probed nationally by aged-care watchdog the Office of Aged Care Quality and Compliance from July to December 31 in 2007- an increase from the 2005-06 financial year, when there were 1260 complaints under the former model. 1447 of them were in Victoria.
- Victoria is also responsible for more than half of all elderly care inquiries, aged-care standards and external agencies referred to police and the coroner. The report shows seven Victorian cases were referred to the coroner in the last six months of last year, six to police and 324 to the Aged Care Standards and Accreditation Agency.
- Cases investigated include allegations of serious physical assault, medical mismanagement and failed personal care.
- The Office of Aged Care Quality and Compliance says in NSW there were 929 breaches in aged care homes.
- There were 418 sexual and physical assaults on elderly people - 138 occurring in NSW nursing homes.
- There were 332 reports of medication management issues where elderly residents were administered an overdose, not given enough pain relief or given incorrect medication.
- Police investigated 23 incidents in aged care homes last year, with seven cases referred to the coroner, two to the Nurses Board and 101 to the Aged Care Standards and Accreditation Agency (ACSAA).
- Minister for Ageing Justine Elliot said the Government would introduce increased police checks on all staff employed at nursing homes and aged care facilities. As well, government inspections would increase by a third to 7000 a year.
- More than 1400 assault allegations were made by nursing-home residents in the past financial year 2008-2009. This is a record and a 52 per cent rise on the previous year's figures.
- Only 13 people have been convicted of nursing-home violence since compulsory reporting began in 2007.
- The Report on the Operation of the Aged Care Act reveals 1121 aged care facilities reported "alleged unreasonable use of force" on residents in 2008-09.
- Another 272 incidents involved residents who had been sexually assaulted; 18 incidents out of this total reported the residents were the victims of violence and sexual assault.
- Complaints against nursing homes jumped to more than 12,500.
- 367 police reports were made over missing residents.
- In 2009-2010, there were 1488 assaults on residents with 80% being physical assaults and/or unreasonable use of force, 19% being sexual assaults, and 1% being both.
- 745 residents went missing during this same period but there is no overall recording of what happened in these circumstances.

Causative Factors within Residential Care Facilities

- Since 1997, there have been no minimum staffing requirements with the Aged Care Act which merely states that a nursing home maintain an "adequate number of appropriately skilled" staff.
- There have been changes to state and federal laws that mean facilities no longer have to employ a minimum number of qualified nurses.
- May 2005 Report from Aged Care Association Australia represented only 93 responses or 3% of the 2,963 facilities at the time. The facilities comfortable with their competence in complaints handling were the majority of those completing the survey – resulting in 97% of the facilities not feeling competent about their complaints handling.
- Failure to provide a level of staffing is often a causative factor for residents to be at a critical risk of such serious problems as infections, bedsores, weight loss, functional decline and avoidable hospitalizations – placing the residents in serious jeopardy.
- Some facilities owned and operated by For Profit Corporations care more about the bottom line than overall quality of resident care and treatment. They do not provide the salaries and incentives that would attract enough qualified doctors, nurses, and aides to properly care for residents.
- 75% of the residents in residential care facilities do not receive regular visits by relatives, are visited infrequently or not at all - thus these residents are not well represented in complaints.
- In the Aged Care Association Australia 2005 study, respondents stated that focussed training on complaints handling and its processes is minimal or absent in about a third of all facilities. As to accountability, staff are not always clear about procedures and what to do when they encounter a complaint. The response "fall through the cracks" represented 20% of the answers given by the facilities questioned.
- One third of the facilities stated they handled complaints "informally".
- "We lose good staff because we do not prepare and support them properly to handle complaints" featured in 12% of the answers by respondents for their facility.

Legal Issues

- There are no special statutes to cover neglect, mistreatment, or psychological abuse in any State or Territory.
- Elder abuse is not taught in the law school curriculum.
- Elder abuse is not a specially area of law with most elder lawyers dealing with wills and estate matters.
- Elder Abuse cases are extremely difficult to prosecute in court due to lack of specific elder abuse laws as well as due to unduly influenced and/or incapacitated victims.

Victimisation Facts

- Persons, aged 80 years and older, suffer abuse and neglect two to three times their proportion of the older population.
- Among known perpetrators of abuse and neglect, the perpetrator is a family member in 90 percent of the cases.
- Two-thirds of the perpetrators are adult children or spouses.
- The offender is most commonly a close relative, especially a grown child, spouse, or sibling.
- Less often, the abuser is a son-, or daughter-in-law, grandchild, niece, nephew, or friend and neighbour.
- The typical target is a frail, ailing woman more than 70 years old.
- In most cases, the victim and the abuser live in the same household in social isolation from friends, neighbours, and kin who might otherwise informally deter the wrongdoing.
- When homebound parents are physically beaten or financially exploited, sons are the most likely culprits.
- When daughters and daughters-in-law are abusive, their maltreatment usually takes the form of emotional and physical neglect.
- Mistreatment by home health aides and nursing home staff members is also suspected to be commonplace (Pagelow, 1989).
- Older persons who are mistreated can suffer from severe emotional distress, especially depression, and are likely to die more quickly.

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Reporting Abuse

Many who suffer from abuse may feel ashamed and embarrassed and suffer from low self esteem. Some don’t want to report their own child as an abuser. Often the abused simply fears more abuse if they report it. Others are too feeble to think clearly, or they may not realize that help is available.

You Can Help

It’s up to you to break the silence. Certain people are required by law to report abusers. They are conservators and guardians, court-appointed mental retardation advocates, police officers, licensed health professionals, health care administrators and social workers. Others such as neighbors, church members, relatives, and friends may report voluntarily. Persons reporting voluntarily need not identify themselves.

Who to Call

Call the hotline at (202) 541-3950. More victims are helped by callers outside the family than in it. When you call the hotline, a social worker will assist you. The social worker will take information about your concerns and will conduct an investigation to determine if abuse, neglect, or exploitation is occurring. Sometimes medical or psychiatric care helps resolve the problem. In other cases, services can be provided to victims in their homes or they can be removed from danger.

If the investigation indicates that a person is in need of protection, a variety of services may be made available to them. Social workers may arrange for counseling, legal services, emergency placement, and/or medical services.

Remember, the person you are worried about can refuse intervention. The merely eccentric will be left in peace. And your identity will be protected, because reports are confidential.

Contact TTY: 711
Introduction
Oregon’s Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. Data presented in this summary, including the number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of the medications (DWDA deaths), are based on required reporting forms and death certificates received by the Oregon Public Health Division as of January 27, 2016. More information on the reporting process, required forms, and annual reports is available at: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2015

Participation Summary and Trends
During 2015, 218 people received prescriptions for lethal medications under the provisions of the Oregon DWDA, compared to 155 during 2014 (Figure 1, above). As of January 27, 2016, the Oregon Public Health Division had received reports of 132 people who had died during 2015 from ingesting the medications prescribed under DWDA.

Since the law was passed in 1997, a total of 1,545 people have had prescriptions written under the DWDA, and 991 patients have died from ingesting the medications. From 1998 through 2013, the number of prescriptions written annually increased at an average of 12.1%; however, during 2014 and

2015, the number of prescriptions written increased by an average of 24.4%. During 2015, the rate of DWDA deaths was 38.6 per 10,000 total deaths.\(^1\)

A summary of DWDA prescriptions written and medications ingested are shown in Figure 2. Of the 218 patients for whom prescriptions were written during 2015, 125 (57.3%) ingested the medication; all 125 patients died from ingesting the medication without regaining consciousness. Fifty of the 218 patients who received DWDA prescriptions during 2015 did not take the medications and subsequently died of other causes.

Ingestion status is unknown for 43 patients prescribed DWDA medications in 2015. Five of these patients died, but they were lost to follow-up or the follow-up questionnaires have not yet been received. For the remaining 38 patients, both death and ingestion status are pending (Figure 2).

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\(^1\) Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2014 (34,160), the most recent year for which final death data are available.

**Patient Characteristics**

Of the 132 DWDA deaths during 2015, most patients (78.0%) were aged 65 years or older. The median age at death was 73 years. As in previous years, decedents were commonly white (93.1%) and well-educated (43.1% had a least a baccalaureate degree).

While most patients had cancer, the percent of patients with cancer in 2015 was slightly lower than in previous years (72.0% and 77.9%, respectively). The percent of patients with amyotrophic lateral sclerosis (ALS) was also lower (6.1% in 2015, compared to 8.3% in previous years). Heart disease increased from 2.0% in prior years to 6.8% in 2015.

Most (90.1%) patients died at home, and most (92.2%) were enrolled in hospice care. Excluding unknown cases, most (99.2%) had some form of health care insurance, although the percent of patients who had private insurance (36.7%) was lower in 2015 than in previous years (60.2%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (62.5% compared to 38.3%).

Similar to previous years, the three most frequently mentioned end-of-life concerns were: decreasing ability to participate in activities that made life enjoyable (96.2%), loss of autonomy (92.4%), and loss of dignity (75.4%).

**DWDA Process**

A total of 106 physicians wrote 218 prescriptions during 2015 (1-27 prescriptions per physician). During 2015, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements. During 2015, five patients were referred for psychological/psychiatric evaluation.

A procedure revision was made in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. For 27 patients, either the prescribing physician or another healthcare provider was present at the time of death. Prescribing physicians were present at time of death for 14 patients (10.8%) during 2015 compared to 15.7% in previous years; 13 additional cases had other health care providers present (e.g., hospice nurse). Data on time from ingestion to death is available for only 25 DWDA deaths during 2015. Among those 25 patients, time from ingestion until death ranged from five minutes to 34 hours. For the remaining two patients, the length of time between ingestion and death was unknown.
Table 1. Characteristics and end-of-life care of 991 DWDA patients who have died from ingesting DWDA medications, by year, Oregon, 1998-2015

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (%)</td>
<td>56 (42.4)</td>
<td>453 (52.7)</td>
<td>509 (51.4)</td>
</tr>
<tr>
<td>Female (%)</td>
<td>76 (57.6)</td>
<td>406 (47.3)</td>
<td>482 (48.6)</td>
</tr>
<tr>
<td><strong>Age at death (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-34 (%)</td>
<td>1 (0.8)</td>
<td>7 (0.8)</td>
<td>8 (0.8)</td>
</tr>
<tr>
<td>35-44 (%)</td>
<td>5 (3.8)</td>
<td>18 (2.1)</td>
<td>23 (2.3)</td>
</tr>
<tr>
<td>45-54 (%)</td>
<td>2 (1.5)</td>
<td>61 (7.1)</td>
<td>63 (6.4)</td>
</tr>
<tr>
<td>55-64 (%)</td>
<td>21 (15.9)</td>
<td>184 (21.4)</td>
<td>205 (20.7)</td>
</tr>
<tr>
<td>65-74 (%)</td>
<td>41 (31.1)</td>
<td>247 (28.8)</td>
<td>288 (29.1)</td>
</tr>
<tr>
<td>75-84 (%)</td>
<td>30 (22.7)</td>
<td>229 (26.7)</td>
<td>259 (26.1)</td>
</tr>
<tr>
<td>85+ (%)</td>
<td>32 (24.2)</td>
<td>113 (13.2)</td>
<td>145 (14.6)</td>
</tr>
<tr>
<td>Median years (range)</td>
<td>73 (30-102)</td>
<td>71 (25-96)</td>
<td>71 (25-102)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (%)</td>
<td>122 (93.1)</td>
<td>831 (97.1)</td>
<td>953 (96.6)</td>
</tr>
<tr>
<td>African American (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>American Indian (%)</td>
<td>0 (0.0)</td>
<td>2 (0.2)</td>
<td>2 (0.2)</td>
</tr>
<tr>
<td>Asian (%)</td>
<td>4 (3.1)</td>
<td>9 (1.1)</td>
<td>13 (1.3)</td>
</tr>
<tr>
<td>Pacific Islander (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>0 (0.0)</td>
<td>3 (0.4)</td>
<td>3 (0.3)</td>
</tr>
<tr>
<td>Two or more races (%)</td>
<td>1 (0.8)</td>
<td>3 (0.4)</td>
<td>4 (0.4)</td>
</tr>
<tr>
<td>Hispanic (%)</td>
<td>4 (3.1)</td>
<td>6 (0.7)</td>
<td>10 (1.0)</td>
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<tr>
<td>Unknown</td>
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<td>3</td>
<td>4</td>
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<tr>
<td><strong>Marital status</strong></td>
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<td></td>
</tr>
<tr>
<td>Married (Including Registered Domestic Partner) (%)</td>
<td>52 (39.7)</td>
<td>395 (46.1)</td>
<td>447 (45.3)</td>
</tr>
<tr>
<td>Widowed (%)</td>
<td>34 (26.0)</td>
<td>198 (23.1)</td>
<td>232 (23.5)</td>
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<tr>
<td>Never married (%)</td>
<td>9 (6.9)</td>
<td>69 (8.1)</td>
<td>78 (7.9)</td>
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<tr>
<td>Divorced (%)</td>
<td>36 (27.5)</td>
<td>194 (22.7)</td>
<td>230 (23.3)</td>
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<td>Unknown</td>
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<tr>
<td><strong>Education</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school (%)</td>
<td>7 (5.4)</td>
<td>51 (6.0)</td>
<td>58 (5.9)</td>
</tr>
<tr>
<td>High school graduate (%)</td>
<td>31 (23.8)</td>
<td>187 (21.9)</td>
<td>218 (22.2)</td>
</tr>
<tr>
<td>Some college (%)</td>
<td>36 (27.7)</td>
<td>224 (26.2)</td>
<td>260 (26.4)</td>
</tr>
<tr>
<td>Baccalaureate or higher (%)</td>
<td>56 (43.1)</td>
<td>392 (45.9)</td>
<td>448 (45.5)</td>
</tr>
<tr>
<td>Unknown</td>
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<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro counties (Clackamas, Multnomah, Washington) (%)</td>
<td>64 (49.2)</td>
<td>361 (42.3)</td>
<td>425 (43.2)</td>
</tr>
<tr>
<td>Coastal counties (%)</td>
<td>7 (5.4)</td>
<td>63 (7.4)</td>
<td>70 (7.1)</td>
</tr>
<tr>
<td>Other western counties (%)</td>
<td>48 (36.9)</td>
<td>365 (42.7)</td>
<td>413 (42.0)</td>
</tr>
<tr>
<td>East of the Cascades (%)</td>
<td>11 (8.5)</td>
<td>65 (7.6)</td>
<td>76 (7.7)</td>
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<tr>
<td>Unknown</td>
<td>2</td>
<td>5</td>
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</tr>
<tr>
<td><strong>End of life care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>118 (92.2)</td>
<td>747 (89.2)</td>
<td>865 (89.0)</td>
</tr>
<tr>
<td>Not enrolled (%)</td>
<td>10 (7.8)</td>
<td>81 (9.8)</td>
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<tr>
<td>Unknown</td>
<td>4</td>
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<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Private (alone or in combination) (%)</td>
<td>44 (36.7)</td>
<td>489 (60.2)</td>
<td>533 (57.2)</td>
</tr>
<tr>
<td>Medicare, Medicaid or other governmental (%)</td>
<td>75 (62.5)</td>
<td>311 (38.3)</td>
<td>386 (41.4)</td>
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<tr>
<td>None (%)</td>
<td>1 (0.8)</td>
<td>12 (1.5)</td>
<td>13 (1.4)</td>
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<td>Unknown</td>
<td>12</td>
<td>47</td>
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### Characteristics

#### Underlying Illness

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<th>Illness</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
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<tbody>
<tr>
<td>Malignant neoplasms (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung and bronchus (%)</td>
<td>95 (72.0)</td>
<td>667 (77.9)</td>
<td>762 (77.1)</td>
</tr>
<tr>
<td>Breast (%)</td>
<td>23 (17.4)</td>
<td>154 (18.0)</td>
<td>177 (17.9)</td>
</tr>
<tr>
<td>Colon (%)</td>
<td>9 (6.8)</td>
<td>64 (7.5)</td>
<td>73 (7.4)</td>
</tr>
<tr>
<td>Pancreas (%)</td>
<td>7 (5.3)</td>
<td>54 (6.3)</td>
<td>61 (6.2)</td>
</tr>
<tr>
<td>Prostate (%)</td>
<td>7 (5.3)</td>
<td>56 (6.5)</td>
<td>63 (6.4)</td>
</tr>
<tr>
<td>Ovary (%)</td>
<td>5 (3.8)</td>
<td>35 (4.1)</td>
<td>40 (4.0)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>3 (2.3)</td>
<td>33 (3.9)</td>
<td>36 (3.6)</td>
</tr>
<tr>
<td>Amyotrophic lateral sclerosis (%)</td>
<td>4 (3.1)</td>
<td>27 (3.1)</td>
<td>31 (3.1)</td>
</tr>
<tr>
<td>Chronic lower respiratory disease (%)</td>
<td>8 (6.1)</td>
<td>71 (8.3)</td>
<td>79 (8.0)</td>
</tr>
<tr>
<td>Heart disease (%)</td>
<td>6 (4.5)</td>
<td>38 (4.4)</td>
<td>44 (4.4)</td>
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<tr>
<td>HIV/AIDS (%)</td>
<td>0 (0.0)</td>
<td>9 (1.1)</td>
<td>9 (0.9)</td>
</tr>
<tr>
<td>Other illnesses (%)</td>
<td>14 (10.6)</td>
<td>54 (6.3)</td>
<td>68 (6.9)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>132</strong></td>
<td><strong>859</strong></td>
<td><strong>991</strong></td>
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#### End of life concerns

<table>
<thead>
<tr>
<th>Concern</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less able to engage in activities making life enjoyable (%)</td>
<td>127 (96.2)</td>
<td>758 (88.7)</td>
<td>885 (89.7)</td>
</tr>
<tr>
<td>Losing autonomy (%)</td>
<td>121 (92.4)</td>
<td>782 (91.5)</td>
<td>903 (91.6)</td>
</tr>
<tr>
<td>Loss of dignity (%)</td>
<td>98 (75.4)</td>
<td>579 (67.3)</td>
<td>677 (78.7)</td>
</tr>
<tr>
<td>Losing control of bodily functions (%)</td>
<td>46 (35.7)</td>
<td>428 (50.1)</td>
<td>474 (48.2)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>63 (48.1)</td>
<td>342 (40.0)</td>
<td>405 (41.1)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it (%)</td>
<td>37 (28.7)</td>
<td>211 (24.7)</td>
<td>248 (25.2)</td>
</tr>
<tr>
<td>Financial implications of treatment (%)</td>
<td>3 (2.3)</td>
<td>27 (3.2)</td>
<td>30 (3.1)</td>
</tr>
</tbody>
</table>

#### Health care provider present (collected 2001-present)

<table>
<thead>
<tr>
<th>When medication was ingested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing physician</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
</tr>
<tr>
<td>No provider</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At time of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing physician (%)</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present (%)</td>
</tr>
<tr>
<td>No provider (%)</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>
### Characteristics

<table>
<thead>
<tr>
<th>Complications</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regurgitated</td>
<td>2</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>None</td>
<td>23</td>
<td>506</td>
<td>529</td>
</tr>
<tr>
<td>Unknown</td>
<td>105</td>
<td>330</td>
<td>435</td>
</tr>
</tbody>
</table>

### Other outcomes

| Regained consciousness after ingesting DWDA medications | 0 | 6 | 6 |

### Timing of DWDA event

<table>
<thead>
<tr>
<th>Duration (weeks) of patient-physician relationship</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>9</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Range</td>
<td>1-1004</td>
<td>0-1905</td>
<td>0-1905</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>132</td>
<td>857</td>
<td>989</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration (days) between 1st request and death</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>45</td>
<td>47</td>
<td>46</td>
</tr>
<tr>
<td>Range</td>
<td>15-517</td>
<td>15-1009</td>
<td>15-1009</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>131</td>
<td>859</td>
<td>990</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minutes between ingestion and unconsciousness⁶</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Range</td>
<td>2-15</td>
<td>1-38</td>
<td>1-38</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>25</td>
<td>506</td>
<td>531</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>107</td>
<td>353</td>
<td>460</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minutes between ingestion and death⁶</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Range (minutes - hours)</td>
<td>5mins-34hrs</td>
<td>1min-104hrs</td>
<td>1min-104hrs</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>25</td>
<td>511</td>
<td>536</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>107</td>
<td>348</td>
<td>455</td>
</tr>
</tbody>
</table>

1. Unknowns are excluded when calculating percentages.
2. Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.
3. First recorded beginning in 2001. Since then, 40 patients (4.4%) have chosen not to inform their families, and 19 patients (2.1%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.
4. Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.
6. A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.
7. Six patients have regained consciousness after ingesting prescribed medications, and are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.
Letter to editor, New Haven Register
1 message

William Toffler <toffler@ohsu.edu>  Sun, Feb 23, 2014 at 7:23 PM
To: "letters@nhregister.com" <letters@nhregister.com>

Dear Editor,

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 assisted suicide, which is legal in Oregon, and which has been proposed for legalization in Connecticut. (Raised Bill No. 5326)

Our law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions such as "chronic lower respiratory disease" and "diabetes". Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live. They are unlikely die in less than six months unless they don't receive their medications. Such persons, with treatment, could otherwise have years or even decades to live.

This illustrates a great problem with our law--it encourages people with years to live, to throw away their lives. I am also concerned, that by starting to label people with chronic conditions "terminal," there will be an excuse to deny such persons appropriate medical treatment to allow them to continue to live healthy and productive lives.

These factors are something for your legislators to consider. Do you want this to happen to you or your family?

Furthermore, in my practice I have had many patients ask about assisted-suicide. In each case, I have offered care and treatment but declined to provide assisted suicide. In one case, the man's response was "Thank you."

To read a commentary on the most recent Oregon government assisted-suicide report, which lists chronic conditions as the "underlying illness" justifying assisted suicide, please go here: http://www.noassistedsuicideconnecticut.org/2014/02/oregons-new-assisted-suicide-report.html

To read about some of my cases in Oregon, please go here: http://www.choiceillusion.org/p/what-people-mean_25.html

I hope that Connecticut does not repeat Oregon's mistake.

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
503-494-5322
503-494-8573 (patient care)
503-494-4496 (fax)
toffler@ohsu.edu
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."

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.
AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO
ASSISTED SUICIDE AND EUTHANASIA

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

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

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

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

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

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

NAME: HEIDI PRUZYN

A notary in and for the
State of MASSACHUSETTS

ADDRESS: 95 MAIN ST
Florence, MA 01062

EXPIRY OF COMMISSION: June 22, 2015

PLACE SEAL HERE:

Heidi Pruzyn
Notary Public

MASSACHUSETTS

A-62
AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

1. I am a doctor in Oregon USA 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 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 for the court 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 twelve years.

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

8. Today, for patients under the Oregon Health Plan (Medicaid), there is also a financial incentive to commit suicide: The Plan covers the cost. The Plan’s “Statements of Intent for the April 1, 2012 Prioritized List of Health Services,” states:

   It is the intent of the [Oregon Health Services] Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services.

Attached hereto at page SI-1.

Affidavit of Kenneth Stevens, Jr., MD - page 2
F:\ASE Files\leblanc\Kenneth Stevens MD Affidavit.wpd
9. Under the Oregon Health Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient’s treatment. For example, patients with cancer are denied treatment if they have a “less than 24 months median survival with treatment” and fit other criteria. This is the Plan’s “Guideline Note 12.” (Attached hereto at page GN-4).

10. The term, “less than 24 months median survival with treatment,” means that statistically half the patients receiving treatment will live less than 24 months (two years) and the other half will live longer than two years.

11. Some of the patients living longer than two years will likely live far longer than two years, as much as five, ten or twenty years depending on the type of cancer. This is because there are always some people who beat the odds.

12. All such persons who fit within “Guideline Note 12” will nonetheless be denied treatment. Their suicides under Oregon’s assisted suicide act will be covered.

13. 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.
14. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Canada, your government health plan could follow a similar pattern. If so, the plan will pay for a patient to die, but not to live.
STATEMENT OF INTENT 1: PALLIATIVE CARE

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the goals for medical treatment and with services available according to the patient's expected length of life (see examples below).

Palliative care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services that should be available to patients with a life-threatening limiting illness,

A) without regard to a patient’s expected length of life:
   - Inpatient palliative care consultation; and,
   - Outpatient palliative care consultation, office visits.
B) with an expected median survival of less than one year, as supported by the best available published evidence:
   - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.
C) with an expected median survival of six months or less, as supported by peer-reviewed literature:
   - Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

It is the intent of the Commission that certain palliative care treatments be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Some examples of covered palliative care treatments include:

A) Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.
B) Surgical decompression for malignant bowel obstruction.
C) Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.
D) Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.
E) Acupuncture with intent to relieve nausea.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. See Guideline Note 12: TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE.

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

It is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.
GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

b) Suspected Crohn's disease: upper and lower endoscopy, small bowel follow through
2) Radiological evidence of lack of stricture
3) Only covered once during any episode of illness
4) FDA approved devices must be used
5) Patency capsule should not be used prior to procedure

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Central serous retinopathy (362.41) is included on this line only for treatment when the condition has been present for 3 months or longer. Pars planitis (363.21) should only be treated in patients with 20/40 or worse vision.

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES


A) CSF are not indicated for primary prophylaxis of febrile neutropenia unless the primary chemotherapeutic regimen is known to produce febrile neutropenia at least 20% of the time. CSF should be considered when the primary chemotherapeutic regimen is known to produce febrile neutropenia 10-20% of the time; however, if the risk is due to the chemotherapeutic regimen, other alternatives such as the use of less myelosuppressive chemotherapeutic or dose reduction should be explored in this situation.

B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.

C) CSF are not indicated in patients who are acutely neutropenic but afebrile.

D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic fligrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <1000/mcl, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.

E) CSF are not indicated to increase chemotherapy dose-intensity or schedule, except in cases where improved outcome from such increased intensity has been documented in a clinical trial.

F) CSF (other than pegfligastim) are indicated in the setting of autologous progenitor cell transplantation, to mobilize peripheral blood progenitor cells, and after their infusion.

G) CSF are NOT indicated in patients receiving concomitant chemotherapy and radiation therapy.

H) There is no evidence of clinical benefit in the routine, continuous use of CSF in myelodysplastic syndromes. CSF may be indicated for some patients with severe neutropenia and recurrent infections, but should be used only if significant response is documented.

I) CSF is indicated for treatment of cyclic, congenital and idiopathic neutropenia.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE


This guideline only applies to patients with advanced cancer who have less than 24 months median survival with treatment.

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:
- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.

Unpublished evidence may be taken into consideration in the case of rare cancers which are universally fatal within six months without treatment.

The Health Evidence Review Commission is reluctant to place a strict $/QALY (quality adjusted life-year) or $/LYS (life-year saved) requirement on end-of-life treatments, as such measurements are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend $100,000 in public resources to increase an individual’s expected survival by three months when hundreds of thousands of Oregonians are without any form of health insurance.

4-16-2012
GUIDELINE NOTES FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE (CONT'D)

Treatment with the goal to palliate is addressed in Statement of Intent 1, Palliative Care.

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76, 195

Minimally invasive coronary artery bypass surgery indicated only for single vessel disease.

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

Lines 79, 103, 105, 125, 131, 156, 170, 198, 206, 231, 280, 314

Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89, 384

Radiation treatment is indicated only in those at high risk of heterotopic bone formation: those with a history of prior heterotopic bone formation, ankylosing spondylitis or hypertrophic osteoarthritis.

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1, 3, 4

Cystic fibrosis carrier testing is covered for 1) non-pregnant adults if indicated in the genetic testing algorithm or 2) pregnant women.

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

Dental cleaning and fluoride treatments are limited to once per 12 months for adults and twice per 12 months for children up to age 19 (D1110, D1120, D1203, D1204, D1206). More frequent dental cleanings and/or fluoride treatments may be required for certain higher risk populations.

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108, 279

Ventricular assist devices are covered only in the following circumstances:

A) as a bridge to cardiac transplant;
B) as treatment for pulmonary hypertension when pulmonary hypertension is the only contraindication to cardiac transplant and the anticipated outcome is cardiac transplant; or,
C) as a bridge to recovery.

Ventricular assist devices are not covered for destination therapy.

Ventricular assist devices are covered for cardiomyopathy only when the intention is bridge to cardiac transplant.

GUIDELINE NOTE 19, PET SCAN GUIDELINES

Lines 125, 144, 165, 166, 170, 182, 207, 208, 220, 221, 243, 276, 278, 292, 312, 339

PET Scans are covered for diagnosis of the following cancers only:
- Solitary pulmonary nodules and non-small cell lung cancer
- Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

PET scans are covered for the initial staging of the following cancers:
- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal

4-16-2012
AFFIDAVIT OF JEANETTE HALL
OPPOSING ASSISTED SUICIDE

THE UNDERSIGNED, being first duly sworn under oath, states:

1. I live in Oregon where physician-assisted suicide is legal. Our law was enacted in 1997 via a ballot initiative 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, Ken 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!

Affidavit of Jeanette Hall - Page 1
E:\ASE Files\Leblanc\Jeanette Hall Affidavit.wpd
4. This July, it was 12 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 17th day of August 2012

Jeanette Hall

SWORN BEFORE ME at
OREGON, USA
on, August 17, 2012

NAME: Jeanette Hall

A notary in and for the
State of Oregon

ADDRESS: 1567 Smith Ave

EXPIRY OF COMMISSION: September 28, 2015

PLACE SEAL HERE:
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 an incurable, irreversible terminal disease that will result in death within six months 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 feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and dispense or to contact a pharmacist to dispense the prescription.

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 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. I further declare that I am of sound mind and not acting under duress, fraud, or undue influence.

Signature: ____________ County of Residence: ____________ Date: ____________

DECLARATION OF WITNESSES

By initialing and signing below in the presence of the person named above signs, we declare that the person making and signing the above request:

Witness 1

[ ] Personally known to us or has provided proof of identity;

[ ] Signed this request in our presence on the date following the person's signature;

[ ] Appears to be of sound mind and not under duress, fraud, or undue influence;

[ ] Is not a patient for whom either of us is the attending physician.

Witness 2

Printed Name: ____________ Signature: ____________ Date: ____________

Printed Name: ____________ Signature: ____________ Date: ____________

NOTE: Only one of two witnesses may be a relative by blood, marriage, or adoption of the person signing this request, or be entitled to any portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident. The patient's attending physician at the time of the request is not eligible to be a witness. If the patient is an inpatient at a long-term health care facility, one of the witnesses shall be an individual designated by the facility.

DOH 422-063/CHS 601 (REV 07/01/2009)
C
WEST'S REVISED CODE OF WASHINGTON ANNOTATED
TITLE 11. PROBATE AND TRUST LAW
CHAPTER 11.12. WILLS
→ 11.12.160. Interested witness—Effect on will

(1) An interested witness to a will is one who would receive a gift under the will.

(2) A will or any of its provisions is not invalid because it is signed by an interested witness. Unless there are at least two other subscribing witnesses to the will who are not interested witnesses, the fact that the will makes a gift to a subscribing witness creates a rebuttable presumption that the witness procured the gift by duress, menace, fraud, or undue influence.

(3) If the presumption established under subsection (2) of this section applies and the interested witness fails to rebut it, the interested witness shall take so much of the gift as does not exceed the share of the estate that would be distributed to the witness if the will were not established.

(4) The presumption established under subsection (2) of this section has no effect other than that stated in subsection (3) of this section.

Current with 2008 Legislation effective through September 30, 2008

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END OF DOCUMENT

With 2 witnesses, one of whom is interested, the presumption of undue influence, etc., is created.

Knowledge and approval and suspicious circumstances

2.56 In order for a will to be valid, it is necessary for the person seeking a grant of probate to establish that the will-maker had knowledge of, and approved, its contents. Complying with the formal requirements of validity (for example, the witnessing requirements) and having proof of testamentary capacity is usually enough to establish knowledge and approval. 86

2.57 However, where a suspicious circumstance exists, the person seeking to uphold the will must prove that there was knowledge and approval. 87 The onus of proof is on that person, not the person challenging the will. 88 Lack of knowledge and approval is raised more frequently in Australian probate matters than undue influence because it avoids difficult problems of proof. 89

2.58 What may constitute a suspicious circumstance has not been limited by the courts or legislation. 70 Circumstances that have been held to be suspicious and require further investigation include the following:

- A beneficiary is involved in the will-making process, for example by witnessing the will, writing or preparing the will or taking the will-maker to a solicitor. 71
- The will-maker is ‘blind, illiterate, or mentally or physically enfeebled’. 72
- The will has not been read to the will-maker or by the will-maker prior to execution. 73
- The will changes a pattern of previous wills by cutting out ‘natural’ beneficiaries and replacing them with recent acquaintances. 75

2.59 The degree of suspicion will depend on the facts of the case. If suspicion is not removed, probate may not be granted. An previous valid will may be upheld, or the deceased person’s property may be distributed according to the intestacy rules as if no will had been made.

Question

W9 Are any changes to the law relating to knowledge and approval and suspicious circumstances necessary to improve protection for older and vulnerable will-makers?

FOOTNOTES

66 Nock v Austin (1918) 25 CLR 519, 528.
69 Burns, above n 17, 157, 163.
70 Tyrell v Peintan (1894) 151, 157; Bool v Bool (1941) St R Qd. 28, 39.
72 Nock v Austin (1918) 25 CLR 519; Re Emanuel [1981] VR 113; Able Australia Services v Yannas [2010] VSC 237 (3 June 2010) [97]; Roebuck v Snoke [2000] WASC 312 (20 December 2000) [94]; Barry v Butlin (1838) 2 Moore 460, 481; 12 ER 1089; Tyrell v Peintan (1894) P 151 (where the beneficiary’s son wrote and executed the will).

BEFORE THE LEGISLATURE OF THE
STATE OF NEW YORK

IN RE NEW YORK BILLS

DECLARATION OF KENNETH
STEVEN, 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
Sherwood, Oregon
Ingest (In jést)

transitive verb

To take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing.
Origin: < L ingestus, pp. of ingerere, to carry, put into < in-, into + gerere, to carry.

Related Forms:
- Ingestion In-ges'-tion noun
- Ingestive In-ges'-tive adjective

Ingest (In-jěst')

transitive verb In-gest-ed, In-gest-ing, In-gest-s

1. To take into the body by the mouth for digestion or absorption. See Synonyms at eat.
2. To take in and absorb as food: "Marine ciliates ... can be observed ... ingesting other single-celled creatures and harvesting their chloroplasts" (Carol Kaesuk Yoon).

Origin: Latin ingerere, ingest- : in-, in; see In-² + gerere, to carry.

Related Forms:
- In-gest'i-ble adjective
- Ingestion In-ges'-tion noun
- Ingestive In-ges'-tive adjective

Dictionary Home » Dictionary Definitions » Ingest
- Dictionary Definitions
- Thesaurus Synonyms
- Sentences Examples

Ingest definition

ingest (In jest')

transitive verb

to take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing.
Origin: < L ingestus, pp. of ingerere, to carry, put into < in-, into + gerere, to carry.

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Mercy killing - definition of mercy killing by The Free Dictionary

http://www.thefreedictionary.com/mercy+killing

mercgy killing
Also found in: Thesaurus, Medical, Legal, Acronyms, Encyclopedia, Wikipedia.

n.
Euthanasia.


mercgy killing

n.
(Medicine) another term for euthanasia


euthanasia (,yu əˈner ə, -ʒi ə, -zi ə)

n.
Also called mercy killing, the act of putting to death painlessly or allowing to die, as by withholding medical measures from a person or animal suffering from an incurable, esp. a painful, disease or condition.

[1640–50; < New Latin < Greek euthanasia easy death]

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Thesaurus

Legend: Synonyms —— Related Words ≠ Antonyms

Switch to new thesaurus

Noun 1. mercy killing - the act of killing someone painlessly (especially someone suffering from an incurable illness)

≡ euthanasia

← kill, putting to death, killing - the act of terminating a life

Based on WordNet 3.0, Farlex clipart collection. © 2003-2012 Princeton University, Farlex Inc.
Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys:
Compliance with the Death with Dignity Act

Washington’s Death with Dignity Act (RCW 70.245) states that “...the patient’s death certificate...shall list the underlying terminal disease as the cause of death.” The act also states that, “Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law.”

If you know the decedent used the Death with Dignity Act, you must comply with the strict requirements of the law when completing the death record:

1. The underlying terminal disease must be listed as the cause of death.
2. The manner of death must be marked as “Natural.”
3. The cause of death section may not contain any language that indicates that the Death with Dignity Act was used, such as:
   a. Suicide
   b. Assisted suicide
   c. Physician-assisted suicide
   d. Death with Dignity
   e. I-1000
   f. Mercy killing
   g. Euthanasia
   h. Secobarbital or Seconal
   i. Pentobarbital or Nembutal

The Washington State Registrar will reject any death certificate that does not properly adhere to the requirements of the Death with Dignity Act. If a death certificate contains any reference to actions that might indicate use of the act, the Local Registrar and Funeral Director will be instructed, under RCW 70.58.030, to obtain a correction from the medical certifier before a permit to proceed with disposition will be issued.

Call the Department of Health’s Center for Health Statistics (360-236-4307) for guidance on how to proceed if you have any questions regarding compliance with cause of death reporting under the Death with Dignity Act.

---

1 Under state law, the State Registrar of Vital Statistics “shall prepare and issue such detailed instruction as may be required to secure the uniform observance of its provisions and the maintenance of a perfect system of registration... The State Registrar shall carefully examine the certificates received monthly from the local registrars, county auditors, and clerks of the court and, if any are incomplete or unsatisfactory, the State Registrar shall require such further information to be furnished as may be necessary to make the record complete and satisfactory.” RCW 43.70.160.
Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

BEND, Ore. - Former Bend real estate broker Tami Sawyer was arraigned Thursday on state charges of criminal misappropriation 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 misappropriation 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 misappropriation 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 from Mexico 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 misappropriation charge that alleges she took custody of Thomas Middleton, 7a dependent or elderly person, for the purpose of fraud.

The first-degree aggravated theft charge alleges that in October 2009, 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 2006, 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 $80,000 of that was transferred to two other Sawyer companies, Genesis Fuluree and Tami Sawyer PC.

Sawyer and her husband, a former Bend police captain, face trial scheduled for December in Eugene.
Derek Humphry to be Keynote Speaker at 2011 Annual Meeting

This year our keynote speaker will be Derek Humphry, the author of *Final Exit* and the founder of the Hemlock Society USA in 1980. Derek is generally considered to be the father of the modern movement for choice at the end of life in America.

Derek is a British journalist and author who has lived in the United States since 1978, the same year he published the book *Jean's Way* describing his first wife's final years of suffering from cancer and his part in helping her to die peacefully. The public response to the book caused him to start the Hemlock Society USA in 1980 from his garage in Santa Monica. Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion In Dying to become Compassion & Choices.

In 1991 he published *Final Exit*. Much to his surprise, it became the national #1 bestseller within six months. Since then it has been translated into 12 languages and is now in its fourth edition.

Although not affiliated with – and sometimes even at odds with – Compassion & Choices, Derek is still actively involved in the movement. Always interesting and sometimes controversial, Derek will provide our supporters and their guests with his perspective about the evolution of the movement for choice at the end of life in America.

Save the Date!
Sat., October 22, 2011, 1-3 p.m.
University Unitarian Church
6556 35th Ave NE
Seattle, WA 98115-7393

Derek Humphry
Death Drugs Cause Uproar in Oregon

By SUSAN DONALDSON JAMES  •  Aug. 6, 2008

The news from Barbara Wagner's doctor was bad, but the rejection letter from her insurance company was crushing.

The 64-year-old Oregon woman, whose lung cancer had been in remission, learned the disease had returned and would likely kill her.

Her last hope was a $4,000-a-month drug that her doctor prescribed for her, but the insurance company refused to pay.

What the Oregon Health Plan did agree to cover, however, were drugs for a physician-assisted death. Those drugs would cost about $50.

"It was horrible," Wagner told ABCNews.com. "I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won't give you the medication to live."

Critics of Oregon's decade-old Death With Dignity Law -- the only one of its kind in the nation -- have been up in arms over the indignity of her unsigned rejection letter. Even those who support Oregon's liberal law were upset.

The incident has spilled over the state border into Washington, where advocacy groups are pushing for enactment of Initiative 1000 in November, legalizing a similar assisted-death law.

Opponents say the law presents all involved with an "unacceptable conflict" and the impression that insurance companies see dying as a cost-saving measure. They say it steers those with limited finances toward assisted death.
"News of patient denial is tough enough for a truly ill person to bear," said Steve Hopcraft, a spokesman for Compassion and Choices, a group that supports coverage of physician-assisted death.

Letter's Impact 'Devastating'

"Imagine if the recipient had pinned his hope for survival on an unproven treatment, or if this were the first time he understood the disease had entered the terminal phase. The impact of such a letter would be devastating," he told ABCNews.com.

Wagner, who had worked as a home health care worker, a waitress and a school bus driver, is divorced and lives in a low-income apartment. She said she could not afford to pay for the medication herself.

"I'm not too good today," said Wagner, a Springfield great-grandmother. "But I'm opposed to the [assisted suicide] law. I haven't considered it, even at my lowest point."

A lifelong smoker, she was diagnosed with lung cancer in 2005 and quit. The state-run Oregon Health Plan generously paid for thousands of dollars worth of chemotherapy, radiation, a special bed and a wheelchair, according to Wagner.

The cancer went into remission, but in May, Wagner found it had returned. Her oncologist prescribed the drug Tarceva to slow its growth, giving her another four to six months to live.

But under the insurance plan, she can only receive "palliative" or comfort care, because the drug does not meet the "five-year, 5 percent rule" -- that is, a 5 percent survival rate after five years.

A 2005 New England Journal of Medicine study found the drug erlotinib, marketed as Tarceva, does marginally improve survival for patients with advanced non-small cell lung cancer who had completed standard chemotherapy.

The median survival among patients who took erlotinib was 6.7 months compared to 4.7 months for those on placebo. At one year, 31 percent of the patients taking erlotinib were still alive compared to 22 percent of those taking the placebo.

"It's been tough," said her daughter, Susie May, who burst into tears.
while talkin'...- ABCNews.com.

"I was the first person my mom called when she got the letter," said May, 42. "While I was telling her, 'Mom, it will be ok,' I was crying, but trying to stay brave for her."

"I've talked to so many people who have gone through the same problems with the Oregon Health Plan," she said.

Indeed, Randy Stroup, a 53-year-old Dexter resident with terminal prostate cancer, learned recently that his doctor's request for the drug mitoxantrone had been rejected. The treatment, while not a cure, could ease Stroup's pain and extend his life by six months.

Playing With 'My Life'

"What is six months of life worth?" he asked in a report in the Eugene Register-Guard. "To me it's worth a lot. This is my life they're playing with."

The Oregon Health Plan was established in 1994 and the physician-assisted suicide law was passed in 1997. The health plan, recently hailed as one of the nation's top

The health plan, for those whose incomes fall under the poverty level, prioritizes coverage -- from prevention first, to chronic disease management, treatment of mental health, heart and cancer treatment.

"It's challenging because health care is very expensive, but that's not the real essence of our priority list," said Dr. Jeanene Smith, administrator for the Office of for Oregon's Health Policy and Research staff.

"We need evidence to say it is a good use of taxpayer's dollars," she said. "It may be expensive, but if it does wonders, we cover it."

The state also regularly evaluates and updates approvals for cancer treatments. "We look as exhaustively as we can with good peer review evidence," she said.

The health plan takes "no position" on the physician-assisted suicide law, according to spokesman Jim Sellers.
Barbara Wagner has one wish - for more time.

"I'm not ready, I'm not ready to die," the Springfield woman said. "I've got things I'd still like to do."

Her doctor offered hope in the new chemotherapy drug Tarceva, but the Oregon Health Plan sent her a letter telling her the cancer treatment was not approved.

Instead, the letter said, the plan would pay for comfort care, including "physician aid in dying," better known as assisted suicide.

"I told them, I said, 'Who do you guys think you are? You know, to say that you'll pay for my dying, but you won't pay to help me possibly live longer?' " Wagner said.

An unfortunate interpretation?

Dr. Som Saha, chairman of the commission that sets policy for the Oregon Health Plan, said Wagner is making an "unfortunate interpretation" of the letter and that no one is telling her the health plan will only pay for her to die.

But one critic of assisted suicide calls the message disturbing nonetheless.

"People deserve relief of their suffering, not giving them an overdose," said Dr. William Toffler.

He said the state has a financial incentive to offer death instead of life: Chemotherapy drugs such as Tarceva cost $4,000 a month while drugs for assisted suicide cost less than $100.
Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

B. Wagner a,⁎, J. Müller b, A. Maercker c

a University Clinic for Psychotherapy and Psychosomatic Medicine, University Hospital Leipzig, Semmelweisstr. 10, 04103 Leipzig, Germany
b Department of Psychiatry, University Hospital Zurich, Carlistra. 8, 8091 Zurich, Switzerland
c Department of Psychopathology and Clinical Intervention, University of Zurich, Binzmühlenstr. 14/17, 8050 Zurich, Switzerland

1. Introduction

Assisted suicide and euthanasia for terminally ill patients are punishable by law almost everywhere except Switzerland, the Netherlands, Belgium and the U.S. states of Oregon and Washington. Assisted suicide is generally defined as the prescribing or supplying of drugs with the explicit intention of enabling the patient to end his or her own life. In euthanasia, in contrast, it is the physician who administers the lethal drug. In the Netherlands and Belgium, physician-assisted euthanasia is legally permitted, meaning that physicians are allowed to administer drugs to end a patient's life at his or her request. In Switzerland, in contrast, euthanasia is punishable by imprisonment (Article 114 of the Swiss penal code). It is only in the absence of self-serving motives that assisting another person's suicide is permissible. Physicians in Switzerland are therefore allowed to prescribe or supply a lethal dose of barbiturates with the explicit intention of enabling a patient they have examined to end his or her own life. However, most assisted suicides in Switzerland are conducted with the assistance of non-profit organisations [23]. These right-to-die organisations offer personal guidance to members suffering diseases with "poor outcome" or experiencing "unbearable suffering" who wish to die.

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient's home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient's home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.
Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

Oregon’s suicide rate is 35 percent higher than the national average. The rate is 15.2 suicides per 100,000 people compared to the national rate of 11.3 per 100,000. (For 2007)

After decreasing in the 1990s, suicide rates have been increasing significantly since 2000, according to a new report, "Suicides in Oregon: Trends and Risk Factors," from Oregon Public Health. The report also details recommendations to prevent the number of suicides in Oregon.

"Suicide is one of the most persistent yet preventable public health problems. It is the leading cause of death from injuries — more than even from car crashes. Each year 550 people in Oregon die from suicide and 1,800 people are hospitalized for non-fatal attempts," said Lisa Millet, MPH, principal investigator, and manager of the Injury Prevention and Epidemiology Section, Oregon Public Health.

There are likely many reasons for the state’s rising suicide rate, according to Millet. The single most identifiable risk factor associated with suicide is depression. Many people can manage their depression; however, stress and crisis can overwhelm their ability to cope successfully.

Stresses such as from job loss, loss of home, loss of family and friends, life transitions and also the stress veterans can experience returning home from deployment — all increase the likelihood of suicide among those who are already at risk.

"Many people often keep their depression a secret for fear of discrimination. Unfortunately, families, communities, businesses, schools and other institutions often discriminate against people with depression or other mental illness. These people will continue to die needlessly unless they have support and effective community-based mental health care," said Millet.

The report also included the following findings:

- There was a marked increase in suicides among middle-aged women. The number of women between 45 and 64 years of age who died from suicide rose 55 percent between 2000 and 2006 — from 8.2 per 100,000 to 12.8 per 100,000 respectively.

Oregon Health Authority
Suicides in Oregon: Trends and Risk Factors
-2012 Report-

Oregon Violent Death Reporting System
Injury and Violence Prevention Program
Center for Prevention and Health Promotion
Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all Oregonians in 2010. The financial and emotional impacts of suicide on family members and the broader community are devastating and long lasting. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data of the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Key Findings

- In 2010, the age-adjusted suicide rate among Oregonians of 17.1 per 100,000 was 41 percent higher than the national average.
- The rate of suicide among Oregonians has been increasing since 2000.
- Suicide rates among adults ages 45-64 rose approximately 50 percent from 18.1 per 100,000 in 2000 to 27.1 per 100,000 in 2010. The rate increased more among women ages 45-64 than among men of the same age during the past 10 years.
- Suicide rates among men ages 65 and older decreased approximately 15 percent from nearly 50 per 100,000 in 2000 to 45 per 100,000 in 2010.
- Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (76.1 per 100,000). Non-Hispanic white males had the highest suicide rate among all races/ethnicity (27.1 per 100,000). Firearms were the dominant mechanism of injury among men who died by suicide (62%).
- Approximately 26 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (44.6 vs. 31.5 per 100,000). Significantly higher suicide rates were identified among male veterans ages 18-24, 35-44 and 45-54 when compared to non-veteran males. Veteran suicide victims were reported to have more physical health problems than non-veteran males.
- Psychological, behavioral, and health problems co-occur and are known to increase suicide risk. Approximately 70 percent of suicide victims had a diagnosed mental disorder, alcohol and/or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, less than one third of male victims and about 60 percent of female victims were receiving treatment for mental health problems at the time of death.
- Eviction/loss of home was a factor associated with 75 deaths by suicide in 2009-2010.
Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts. Suicide is the second leading cause of death among Oregonians ages 15-54, and the 6th leading cause of death among all ages in Oregon. The cost of suicide is enormous: In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars. The loss to families and communities broadens the impact of each death.

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors." This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

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IN THE STATE OF COLORADO

IN RE PROPOSED INITIATIVE #124

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 Colorado.

2. Oregon's law applies to "terminal" patients who are predicted to have less than six months to live. Our law defines terminal as follow:

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

5. I am concerned that by labelling people with chronic conditions "terminal," there will be an excuse to deny such persons medical treatment so that they can continue to live healthy and productive lives. Oregon's Medicaid program is already denying treatment to some patients based on a statistical prognosis.

6. To read the most recent Oregon government report on our law, listing chronic conditions as an "underlying illness" to justify assisted-suicide, please see Exhibit B attached hereto.

Signed under penalty of perjury, this 11th day of April 2016

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

Chapter 127

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

Please browse this page or download the statute for printing - (or read the statute at https://www.oregonlegislature.gov)

127.800 s.1.01. Definitions.

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

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

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal 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 s.1.01; 1999 c.423 s.1]

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

(Section 2)

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

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and
### Oregon Public Health Division

#### Characteristics

<table>
<thead>
<tr>
<th>Underlying Illness</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Malignant neoplasms (%)</strong></td>
<td>72 (68.6)</td>
<td>596 (79.4)</td>
<td>668 (78.0)</td>
</tr>
<tr>
<td>Lung and bronchus (%)</td>
<td>16 (15.2)</td>
<td>139 (18.5)</td>
<td>155 (18.1)</td>
</tr>
<tr>
<td>Breast (%)</td>
<td>7 (6.7)</td>
<td>57 (7.6)</td>
<td>64 (7.5)</td>
</tr>
<tr>
<td>Colon (%)</td>
<td>5 (4.8)</td>
<td>49 (6.5)</td>
<td>54 (6.3)</td>
</tr>
<tr>
<td>Pancreas (%)</td>
<td>9 (8.6)</td>
<td>47 (6.3)</td>
<td>56 (6.5)</td>
</tr>
<tr>
<td>Prostate (%)</td>
<td>2 (1.9)</td>
<td>33 (4.4)</td>
<td>35 (4.1)</td>
</tr>
<tr>
<td>Ovary (%)</td>
<td>5 (4.8)</td>
<td>28 (3.7)</td>
<td>33 (3.9)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>28 (26.7)</td>
<td>243 (32.4)</td>
<td>271 (31.7)</td>
</tr>
<tr>
<td><strong>Amyotrophic lateral sclerosis (%)</strong></td>
<td>17 (16.2)</td>
<td>54 (7.2)</td>
<td>71 (8.3)</td>
</tr>
<tr>
<td><strong>Chronic lower respiratory disease (%)</strong></td>
<td>4 (3.8)</td>
<td>34 (4.5)</td>
<td>38 (4.4)</td>
</tr>
<tr>
<td>Heart Disease (%)</td>
<td>3 (2.9)</td>
<td>14 (1.9)</td>
<td>17 (2.0)</td>
</tr>
<tr>
<td>HIV/AIDS (%)</td>
<td>0 (0.0)</td>
<td>9 (1.2)</td>
<td>9 (1.1)</td>
</tr>
<tr>
<td><strong>Other illnesses</strong></td>
<td>9 (8.6)</td>
<td>44 (5.9)</td>
<td>53 (6.2)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

#### DWDA process

| Patient informed family of decision (%) | 95 (90.5) | 634 (93.6) | 729 (93.2) |
| Patient died at | 3 (2.9) | 44 (5.9) | 47 (5.5) |
| Home (patient, family or friend) (%) | 94 (89.5) | 716 (95.3) | 810 (94.6) |
| Long term care, assisted living or foster care facility (%) | 8 (7.6) | 29 (3.9) | 37 (4.3) |
| Hospital (%) | 0 (0.0) | 1 (0.1) | 1 (0.1) |
| Other (%) | 3 (2.9) | 5 (0.7) | 8 (0.9) |
| **Unknown** | 0 | 3 | 3 |
| Lethal medication | 63 (60.0) | 403 (53.4) | 466 (54.2) |
| Secobarbital (%) | 41 (39.0) | 344 (45.6) | 385 (44.8) |
| Pentobarbital (%) | 1 (1.0) | 7 (0.9) | 8 (0.9) |
| Other (%) | 0 | 3 | 3 |

#### End of life concerns

| Losing autonomy (%) | 96 (91.4) | 686 (91.5) | 782 (91.5) |
| Losing ability to engage in activities making life enjoyable (%) | 91 (86.7) | 667 (88.9) | 758 (88.7) |
| Loss of dignity (%) | 75 (71.4) | 504 (68.0) | 579 (79.3) |
| Losing control of bodily functions (%) | 52 (49.5) | 376 (50.1) | 428 (50.1) |
| Burden on family, friends/caregivers (%) | 42 (40.0) | 300 (40.0) | 342 (40.0) |
| Inadequate pain control or concern about it (%) | 33 (31.4) | 178 (23.7) | 211 (24.7) |
| Financial implications of treatment (%) | 5 (4.8) | 22 (2.9) | 27 (3.2) |

#### Health-care provider present

| When medication was ingested | 14 | 119 | 133 |
| Prescribing physician | 6 | 238 | 244 |
| Other provider, prescribing physician not present | 4 | 76 | 80 |
| No provider | 81 | 251 | 332 |
| At time of death | 14 (13.9) | 107 (15.9) | 121 (15.7) |
| Prescribing physician (%) | 6 (5.9) | 263 (35.2) | 269 (34.8) |
| Other provider, prescribing physician not present (%) | 81 (80.2) | 301 (44.9) | 382 (49.5) |
| No provider (%) | 4 | 13 | 17 |

#### Complications

| Regurgitated | 0 | 22 | 22 |
| Seizures | 0 | 0 | 0 |
| Other | 0 | 1 | 1 |
| None | 20 | 487 | 507 |
| Unknown | 85 | 244 | 329 |

#### Other outcomes

| Regained consciousness after ingesting DWDA medications (%) | 0 | 6 | 6 |

For more information, visit [Oregon Public Health Division](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf)
### Characteristics

<table>
<thead>
<tr>
<th>Timing of DWDA event</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration (weeks) of patient-physician relationship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>19</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Range</td>
<td>1-1312</td>
<td>0-1905</td>
<td>0-1905</td>
</tr>
<tr>
<td><strong>Number of patients with information available</strong></td>
<td>105</td>
<td>754</td>
<td>857</td>
</tr>
<tr>
<td><strong>Number of patients with information unknown</strong></td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Duration (days) between 1st request and death</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>43</td>
<td>48</td>
<td>47</td>
</tr>
<tr>
<td>Range</td>
<td>15-439</td>
<td>15-1009</td>
<td>15-1009</td>
</tr>
<tr>
<td><strong>Minutes between ingestion and unconsciousness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Range</td>
<td>2-15</td>
<td>1-38</td>
<td>1-38</td>
</tr>
<tr>
<td><strong>Number of patients with information available</strong></td>
<td>20</td>
<td>487</td>
<td>507</td>
</tr>
<tr>
<td><strong>Number of patients with information unknown</strong></td>
<td>85</td>
<td>267</td>
<td>352</td>
</tr>
<tr>
<td><strong>Minutes between ingestion and death</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>27</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Range (minutes - hours)</td>
<td>11mins-1hr</td>
<td>1min-104hrs</td>
<td>1min-104hrs</td>
</tr>
<tr>
<td><strong>Number of patients with information available</strong></td>
<td>20</td>
<td>492</td>
<td>512</td>
</tr>
<tr>
<td><strong>Number of patients with information unknown</strong></td>
<td>85</td>
<td>262</td>
<td>347</td>
</tr>
</tbody>
</table>

1. Unknowns are excluded when calculating percentages.
2. Includes Oregon Registered Domestic Partnerships.
4. Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.
5. Private insurance category includes those with private insurance alone or in combination with other insurance.
6. Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson’s disease and Huntington’s disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.
7. First recorded beginning in 2001. Since then, 37 patients (4.7%) have chosen not to inform their families, and 16 patients (2.0%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.
8. Other Includes combinations of seconobarbital, pentobarbital, phenobarbital, and/or morphine.
9. Affirmative answers only ("Don’t know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.
11. The data shown are for 2001-2014 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.
12. A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.
13. There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths), and 2012 (1 death). Please refer to the appropriate years’ annual reports on our website (http://www.oregonhealth.org/dwd) for more detail on these deaths.
14. Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.

A client wants to know about the new Death with Dignity Act, which legalizes physician-assisted suicide in Washington. Do you take the politically correct path and agree that it's the best thing since sliced bread? Or do you do your job as a lawyer and tell him that the Act has problems and that he may want to take steps to protect himself?

Patient "Control" is an Illusion

The new act was passed by the voters as Initiative 1000 and has now been codified as Chapter 70.245 RCW.

During the election, proponents touted it as providing "choice" for end-of-life decisions. A glossy brochure declared, "Only the patient — and no one else — may administer the [lethal dose]." The Act, however, does not say this anywhere. The Act also contains coercive provisions. For example, it allows an heir who will benefit from the patient's death to help the patient sign up for the lethal dose.

How the Act Works

The Act requires an application process to obtain the lethal dose, which includes a written request form with two required witnesses. The Act allows one of these witnesses to be the patient's heir. The Act also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient's heir. This does not promote patient choice; it invites coercion.

Interested witness

By comparison, when a will is signed, having an heir as one of witnesses creates a presumption of undue influence. The probate statute provides that when one of the two required witnesses is a taker under the will, there is a
rebuttable presumption that the taker/witness "procured the gift by duress,
menace, fraud, or undue influence."  

Once the lethal dose is issued by the pharmacy, there is no oversight. The
death is not required to be witnessed by disinterested persons. Indeed, no one
is required to be present. The Act does not state that "only" the patient may
administer the lethal dose; it provides that the patient "self-administer" the
dose.

"Self-administer"

In an Orwellian twist, the term "self-administer" does not mean that
administration will necessarily be by the patient. "Self-administer" is instead
defined as the act of ingesting. The Act states, "Self-administer means a
qualified patient's act of ingesting medication to end his or her life."  

In other words, someone else putting the lethal dose in the patient's mouth
qualifies as "self-administration." Someone else putting the lethal dose in a
feeding tube or IV nutrition bag also would qualify. "Self-administer" means
that someone else can administer the lethal dose to the patient.

No witnesses at the death

If, for the purpose of argument, "self-administer" means that only the patient
can administer the lethal dose himself, the patient still is vulnerable to the
actions of other people, due to the lack of required witnesses at the death.

With no witnesses present, someone else can administer the lethal dose
without the patient's consent. Indeed, someone could use an alternate
method, such as suffocation. Even if the patient struggled, who would know?
The lethal dose request would provide an alibi.

This situation is especially significant for patients with money. A California
case states, "Financial reasons [are] an all too common motivation for killing
someone."  

Without disinterested witnesses, the patient's control over the
"time, place and manner" of his death, is not guaranteed.

If one of your clients is considering a "Death with Dignity" decision, it is
prudent to be sure that they are aware of the Act's gaps.

What to Tell Clients

1. Signing the form will lead to a loss of control

By signing the form, the client is taking an official position that if he dies
suddenly, no questions should be asked. The client will be unprotected against
others in the event he changes his mind after the lethal prescription is filled
and decides that he wants to live. This would seem especially important for
clients with money. There is, regardless, a loss of control.

2. Reality check

The Act applies to adults determined by an "attending physician" and a
"consulting physician" to have a disease expected to produce death within six
months. But what if the doctors are wrong? This is the point of a recent article
in The Seattle Weekly: Even patients with cancer can live years beyond
expectations. The article states:

Since the day [the patient] was given two to four months to live,
[she] has gone with her children on a series of vacations...
"We almost lost her because she was having too much fun, not from cancer," [her son chuckles].

Conclusion

As lawyers, we often advise our clients of worst-case scenarios. This is our obligation regardless of whether it is politically correct to do so. The Death with Dignity Act is not necessarily about dignity or choice. It also can enable people to pressure others to an early death or even cause it. The Act also may encourage patients with years to live to give up hope. We should advise our clients accordingly.

Margaret Dore is a Seattle attorney admitted to practice in 1986. She is the immediate past chair of the Elder Law Committee of the ABA Family Law Section. She is a former chair of what is now the King County Bar Association Guardianship and Elder Law Section. For more information, visit her website at [www.margaretdore.com](http://www.margaretdore.com).

1 The Act was passed by the voters in November as Initiative 1000 and has now been codified as RCW chapter 70.245.

2 I-1000 color pamphlet, “Paid for by Yes! on 1000.”

3 RCW 70.245.030 and .220 state that one of two required witnesses to the lethal-dose request form cannot be the patient’s heir or other person who will benefit from the patient’s death; the other may be.

4 id.

5 RCW 70.245.010(3) allows someone else to talk for the patient during the lethal-dose request process; for example, there is no prohibition against this person being the patient’s heir or other person who will benefit from the patient’s death. The only requirement is that the person doing the talking be “familiar with the patient’s manner of communicating.”

6 RCW 11.88.160(2).

7 RCW 70.245.010(12).

8 People v. Stuart, 67 Cal. Rptr. 3rd 129, 143 (2007).

9 RCW 70.245.010(11) & (13).


11 id.

Go Back
DECLARATION OF TESTIMONY

I, Isaac Jackson, declare under penalty of perjury the following:

1. I am a lawyer licensed to practice law in the State of Oregon, USA. I am in private practice with my own law firm specializing in injury claims, including wrongful death cases. I previously served as a Law Clerk to Judge Charles Carlson of the Lane County Circuit Court. I was also an associate lawyer with a firm that specializes in insurance defense and civil litigation.

2. I write to inform the court regarding a lack of transparency under Oregon’s assisted suicide act. Even law enforcement is denied access to information collected by the State of Oregon. Moreover, according to the current Oregon State website, this lack of access is official Oregon State Policy.

3. In 2010, I was retained by a client whose father had apparently died under Oregon’s law. The client wanted to know whether that was true. I therefore made inquiry on his behalf. However and unlike other deaths I have investigated, it was difficult to get information.

4. I wrote Dr. Hedberg, the State epidemiologist. Attached hereto as Exhibit 1 is a true and correct copy of a letter I received back from the Office of the Attorney General of Oregon dated November 3, 2010. The letter describes that the Oregon Health Authority is only allowed to release annual statistical information about assisted suicide deaths. The letter states:

   ORS [Oregon Revised Statutes] 127.865 prevents OHA [Oregon Health Authority] from releasing any information to you or your client. OHA may only make public annual statistical information.

5. I also wrote the Oregon Medical Board. Attached hereto as Exhibit 2 is a true and correct redacted copy of a letter I received back, dated November 29, 2010, which states in part:

   While sympathetic to [your client’s] concerns about the circumstances of his father’s death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Health collects these documents for their purposes. Further, if the Board did have the documents as a part of an investigation, the Board would be prevented from releasing them by ORS 676.175. See Exhibit 2.

6. I also received a copy of the decedent’s death certificate, which is the official death record in Oregon. A true and correct, but redacted copy, is attached hereto as Exhibit 3. The “immediate cause of death” is listed as “cancer.” The “manner of death” is listed as “Natural.”

///
7. Per my request, a police officer was assigned to the case. Per the officer's confidential report, he did not interview my client, but he did interview people who had witnessed the decedent's death.

8. The officer’s report describes how he determined that the death was under Oregon’s assisted suicide law act due to records other than from the State of Oregon. The officer’s report also describes that he was unable to get this information from the Oregon Health Authority, which was not willing to confirm or deny whether the deceased had used the act. The officer closed the case.

9. Attached hereto as Exhibit 4 is a true and correct copy of the Oregon Health Authority's data release policy, as of September 18, 2012, which states in part:

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

The Oregon Health Authority's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation. Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.

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

Pursuant to Oregon Rules of Civil Procedure 1E, I hereby declare that the above statement is true to the best of my knowledge and belief, and that I understand it is made for use as evidence in court and is subject to penalty for perjury.

Dated Sept. 18 2012

Isaac Jackson, OSB 055494
Jackson Law Office, LLC
Post Office Box 41240
Eugene, OR 97404
541.225.5061
Jackson@ijrjlaw.com
Isaac Jackson  
Jackson Law Office, LLC  
P.O. Box 279  
Eugene, OR 97440  

Re: Death with Dignity Act Records Request  

Dear Mr. Jackson:  

Dr. Hedberg, the state epidemiologist, received your letter dated October 27, 2010, requesting certain Death with Dignity Act records that may have been filed under OAR 333-009-0010. If records cannot be provided, you also ask Dr. Hedberg to investigate the existence of the documents and report findings to you, or lastly, to at least verify whether the Oregon Health Authority (OHA) has any record of contact with your client's deceased father. In sum, your client would like any information that might shed light on his father's death.

While Dr. Hedberg understands the difficult time your client must be going through, ORS 127.865 prevents OHA from releasing any information to you or your client. OHA may only make public annual statistical information. Please be assured that if irregularities are found on paperwork submitted to the OHA under OAR 333-009-0010, OHA can and has reported information to the Oregon Medical Board who can then investigate the matter.

I understand that you are in the process of getting the death certificate for your client's father and that may shed some light on the matter for your client. If your client believes that some nefarious actions have taken place he certainly could contact law enforcement.

Please contact me if you have additional questions.

Sincerely,

Shannon K. O'Fallon  
Senior Assistant Attorney General  
Health and Human Services Section

SKO:vdo:Justice# 2345752  
cc: Katrina Hedberg, M.D, DHS
November 29, 2010

Issac Jackson
Jackson Law Office
PO Box 279
Eugene, OR 97440

Dear Mr. Jackson:

The Oregon Medical Board has received your letter regarding and his death, apparently under the Oregon Death with Dignity Act. In order for the Board to proceed with a formal investigation, a medical and/or legal basis must exist to support an allegation that a physician licensed by the Board may have violated Oregon law. In our review of the information that you presented we did not find a physician identified nor was there a specific allegation of misconduct on the part of a physician. As such, the board is not able to initiate a formal investigation.

While sympathetic to concerns about the circumstances of his father's death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Human Services collects these documents for their purposes. Further, if the Board did have the documents as a part of an investigation, the Board would be prevented from releasing them by ORS 676.175.

Thank you for bringing your concerns to the attention of the Oregon Medical Board. If you have any further questions regarding this matter, you may contact me at 971-673-2702.

Sincerely,

Randy H. Day
Complaint Resource Officer
Investigations/Compliance Unit
Data Release Policy | Death with Dignity Act

Release of Information Regarding the Death with Dignity Act

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

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

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

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

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

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

Frequently Asked Questions Related to Additional Data Requests

http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignity... 9/19/2012
RE: Death with Dignity Act

2 messages

Parkman Alicia A <alicia.a.parkman@state.or.us>       Wed, Jan 4, 2012 at 7:57 AM
To: Margaret Dore <margaretdore@margaretdore.com>
Cc: BURKOVSKAIA Tamara V <tamara.v.burkovskai@state.or.us>

Thank you for your email regarding Oregon's Death with Dignity Act. For all of your questions, the answer is no. Since our office is charged with maintaining absolute confidentiality, our policy is to never release identifying information. We can neither confirm nor deny participation of any individual patient or physician. We have been contacted by law enforcement and legal representatives in the past, but have not provided identifying information of any type. To ensure confidentiality, our office does not maintain source documentation on participants.

Please let me know if you have further questions.

Thank you,

Alicia

Alicia Parkman
Mortality Research Analyst
Center for Health Statistics
Oregon Health Authority
Ph: 971-673-1150
Fax: 971-673-1201

From: Margaret Dore [mailto:margaretdore@margaretdore.com]
Sent: Monday, January 02, 2012 5:48 PM
To: alicia.a.parkman@state.or.us
Subject: Death with Dignity Act

My questions are...
Thank you for answering my prior questions about Oregon's death with dignity act.

I have these follow up questions:

1. Would your office release copies of completed reporting forms, e.g., a doctor's completed "Oregon Death with Dignity Act Attending Physician Follow-up Form," in response to a civil subpoena?

2. Would your office release copies of completed reporting forms in answer to a request by law enforcement?

3. Would your office confirm to law enforcement whether a person had in fact died under Oregon's Death with Dignity Act?

Margaret Dore
Law Offices of Margaret K. Dore, P.S.
www.margaretdore.com
1001 4th Avenue, 44th Floor
Seattle, WA 98154
206 389 1754
Re: Record Retention Policy

1 message

DWDA INFO <dwda.info@state.or.us>          Mon, Jun 27, 2011 at 4:18 PM
To: Margaret Dore <margaretdore@margaretdore.com>

Hello Ms. Dore,

Thank you for your email regarding Oregon's Death with Dignity Act (DWDA). To answer your question, no, we would not have that information on file. Because the DWDA forms and data are not public records, they do not fall under the retention schedule. We (the Public Health Division) compile the data we need for our reports and then destroy all source documentation after one year.


The FAQ does contain a question specific to how data are collected, used and maintained by the agency:

Q: Are participating patients reported to the State of Oregon by name?

A: The State does collect the names of patients in order to cross-check death certificates. However, the law guarantees the confidentiality of all participating patients (as well as physicians) and the Department of Human Services does not release this information to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed.

Please let me know if you have further questions.

Thank you,

Alicia

Alicia Parkman
Mortality Research Analyst
Center for Health Statistics
Oregon Health Authority
971-673-1150
alicia.a.parkman@state.or.us
Hi. I am an attorney in Washington State.

I would like to know what is Oregon's document retention policy regarding DWDA reporting.

For example, if there were a question about a death occurring five years ago, would the original doctor after-death report still be on file with your office?

Thanks.

Margaret Dore
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CONFIDENTIALITY OF
DEATH CERTIFICATES

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION

(503) 731-4412 Center for Health Statistics
FAX (503) 731-4084 P.O. Box 14050
TDD-Nonvoice (503) 731-4031 Portland, OR 97293-0050

December 12, 1997

TO: County Vital Records Registrars and Deputies
FROM: Sharon Rice, Manager, Registration Unit Center for Health Statistics

SUBJECT: CONFIDENTIALITY—DEATH WITH DIGNITY

This memo is to insure your continued support of the Vital Records strict code of confidentiality on all birth and death certificates.

You received a memo dated November 18, 1997 from Edward Johnson, II, State Registrar. In this memo he discussed the necessity of protecting the privacy of all parties when a death occurs by means of Oregon's death with dignity law.

I have received several calls from different counties asking for more information. After discussing these concerns with the Registrar and physicians within the Health Division the following rules will apply to all physician assisted deaths.

You will neither confirm nor deny if a death has occurred in your county. If this question is asked by employees within your own Health Department, those calls should be referred to Edward Johnson, II, State Registrar (503) 731-4109 or Katrina Hedberg, M.D. (503) 731-4024. If you are asked for information from any other source on this specific topic, those callers will be referred to Katrina Hedberg, M.D., Oregon Health Division, (503) 731-4024. Do not refer callers to me as I am not at liberty to discuss this topic, and I would only have to refer the caller again.

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We will begin asking funeral directors to direct report all physicians assisted death certificates to this office thus eliminating the registration through the county office. This will assist in maintaining the confidentiality in your office. Only limited staff in records will be aware of this type of death, as these records will not be handled through regular channels. We will also be controlling the issuance of certified copies making sure the family is aware of the new abbreviated copies and recommending they receive this type of certified copy.

If the funeral home chooses to forward the death record to your office, you may forward it to this office for registration. You should not maintain a white copy of the death record for six months nor should you issue certified copies.

If you do register the death locally then you may not maintain a six-month copy of the death record. Before issuing any certified copies of the death record you will need to contact this office for special permission to do so. There are three people in this office that can grant that permission:

Edward Johnson, II—State Registrar (503) 731-4109
Carol Sanders, Manager, Certification Unit 731-4416
Sharon Rice, Manager, Registration Unit 731-4412

Since we do not anticipate a large number of these cases, the different rules for the handling, these deaths should not adversely affect your work. You may never have this type of death occur within your county.

If you haven't by now determined the seriousness of this, let me add one additional statement so you will know how seriously this matter is being taken by the State Health Division. Any staff within the Center for Health Statistics that reveals any information they are not authorized to release, will immediately be terminated. Any county vital records staff, releasing information will have their registrar-deputy registrar commissions immediately revoked, thus eliminating you from having any contact with vital records within your county.

Remember if you are asked if any physician assisted deaths have occurred in your county you may neither confirm nor deny their occurrence. This may put you in a difficult position if you are being asked from Personnel within your own health department. Again, you will need to explain that you have been told you are not to discuss this topic with anyone, and refer the caller as mentioned earlier in this memo.
Release of Information Regarding the Death with Dignity Act

The Death with Dignity Act requires the Washington State Department of Health to collect information and make an annual statistical report available to the public. RCW 70.245.150.

The law also states "The department of health shall adopt rules to facilitate the collection of information regarding compliance with this chapter. Except as otherwise required by law, the information collected is not a public record and may not be made available for inspection by the public." RCW 70.245.150(2). Consistent with that statutory mandate, the Department of Health will not:

- Disclose information that identifies patients, physicians, witnesses, or other participants, in activities covered by the Act; or

- Release a report when the first death occurs.

The Department of Health will publish the types and quantities of forms received under the Death with Dignity Act on the web at www.doh.wa.gov/dwda. This information will be updated weekly.

The Department of Health will also publish an annual report which will include at least information on how many prescriptions are written under this Act and how many people ingest the prescribed medication. The specificity of released data will depend on whether there are adequate numbers in a reporting field to ensure confidentiality.

The first annual report will include data from March 5, 2009 through December 31, 2009. Statistical reports will be completed annually thereafter.

Revised April 9, 2009