<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2016 (N=133)</th>
<th>1998–2015 (N=994)</th>
<th>Total (N=1,127)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lethal medication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secobarbital (%)</td>
<td>86 (64.7)</td>
<td>582 (58.6)</td>
<td>668 (59.3)</td>
</tr>
<tr>
<td>Pentobarbital (%)</td>
<td>0 (0.0)</td>
<td>386 (38.8)</td>
<td>386 (34.3)</td>
</tr>
<tr>
<td>Phenobarbital (%)</td>
<td>39 (29.3)</td>
<td>17 (1.7)</td>
<td>56 (5.0)</td>
</tr>
<tr>
<td>Other (combination of above and/or morphine) (%)</td>
<td>8 (6.0)</td>
<td>9 (0.9)</td>
<td>17 (1.5)</td>
</tr>
<tr>
<td><strong>End of life concerns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Losing autonomy (%)</td>
<td>119 (89.5)</td>
<td>906 (91.6)</td>
<td>1,025 (91.4)</td>
</tr>
<tr>
<td>Less able to engage in activities making life enjoyable (%)</td>
<td>119 (89.5)</td>
<td>888 (89.7)</td>
<td>1,007 (89.7)</td>
</tr>
<tr>
<td>Loss of dignity (%)</td>
<td>87 (65.4)</td>
<td>680 (78.8)</td>
<td>767 (77.0)</td>
</tr>
<tr>
<td>Losing control of bodily functions (%)</td>
<td>49 (36.8)</td>
<td>475 (48.1)</td>
<td>524 (46.8)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>65 (48.9)</td>
<td>408 (41.3)</td>
<td>473 (42.2)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it (%)</td>
<td>47 (35.3)</td>
<td>249 (25.2)</td>
<td>296 (26.4)</td>
</tr>
<tr>
<td>Financial implications of treatment (%)</td>
<td>7 (5.3)</td>
<td>31 (3.1)</td>
<td>38 (3.4)</td>
</tr>
<tr>
<td><strong>Health-care provider present</strong> (collected since 2001)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When medication was ingested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician</td>
<td>14</td>
<td>149</td>
<td>163</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
<td>14</td>
<td>256</td>
<td>270</td>
</tr>
<tr>
<td>No provider</td>
<td>5</td>
<td>86</td>
<td>91</td>
</tr>
<tr>
<td>Unknown</td>
<td>100</td>
<td>433</td>
<td>533</td>
</tr>
<tr>
<td><strong>At time of death</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician (%)</td>
<td>13 (10.1)</td>
<td>136 (15.0)</td>
<td>149 (14.4)</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present (%)</td>
<td>14 (10.9)</td>
<td>281 (31.0)</td>
<td>295 (28.5)</td>
</tr>
<tr>
<td>No provider</td>
<td>102 (79.1)</td>
<td>489 (54.0)</td>
<td>591 (57.1)</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td><strong>Complications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty ingesting/regurgitated</td>
<td>3</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>None</td>
<td>24</td>
<td>530</td>
<td>554</td>
</tr>
<tr>
<td>Unknown</td>
<td>106</td>
<td>437</td>
<td>543</td>
</tr>
<tr>
<td><strong>Other outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regained consciousness after ingesting DWDA medications</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 1 | Oregon Death with Dignity Act
I, Kenneth Stevens, declare the following under penalty of perjury.

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

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

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

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

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

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

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

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

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

[Signature]
Kenneth Stevens, Jr., MD
Sherwood, Oregon
Mercy killing

n.
(Medicine) another term for euthanasia


eu·tha·na·sia (yu ˈthəˌnasē, ˌzi 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]

**ac·cord·ance**

/saˈkôrdns/ n.

**noun**

- In a manner conforming with;
  - "the product is disposed of in accordance with federal regulations";
  - "in agreement with, in conformity with, in line with, true to, in the spirit of, in accordance with union rules, in keeping with".

**Origin**

OLD FRENCH
- accord, accorder (to agree)

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

**Translate** accordance to

**Choose language**

**Use over time for: accordance**

**Map**

- 1800
- 1900
- 1950
- 2000
- 2010

**Accordance**

Definition of Accordance by Merriam-Webster

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

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

**In Accordance With**

Definition of In Accordance With by Merriam...

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

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

**Accordance**

Define Accordance at Dictionary.com

www.dictionary.com/browse/accordance

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

accordance (noun) definition and synonyms | Macmillan Dictionary

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

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

**Accordance**

- definition of accordance by The Free Dictionary

www.thefreedictionary.com/accordance

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

**In accordance with**

- Idioms by The Free Dictionary

https://www.google.com/search?q=Define+%22accordance%22&rlz=1C1RNE_EnUS557US557&oq=Define+%22accordance%22&aqs=chrome..69i57j0i580i67k1.1577j0j7...

A-42
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.\(^1\) 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.
O.R.S. § 127.865

127.865. § 3.11. Reporting requirements

Currentness

(1)(a) The Oregon Health Authority shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The authority 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 authority.

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

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

Credits

Footnotes
1 Section title supplied by initiative petition.
O. R. S. § 127.865, OR ST § 127.865
Current with emergency legislation through Ch. 9 of the 2017 Reg. Sess., pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.
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@irjlaw.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:vdc/Justice# 2345752
CC: Katrina Hedberg, M.D., DHS
November 29, 2010

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

Re:

Dear Mr. Jackson:

The Oregon Medical Board has received your letter regarding [NAME], 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,

[Signature]
Randy H. Day
Complaint Resource Officer
Investigations/Compliance Unit

Exhibit Z
**Certification of Vital Record**

**Oregon Department of Human Services Center for Health Statistics**

**Certificate of Death**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Name</td>
<td>First</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
</tr>
<tr>
<td>Residence</td>
<td>Birthplace</td>
</tr>
<tr>
<td>Marital Status at Time of Death</td>
<td>Spouse's Name Prior to First Marriage</td>
</tr>
<tr>
<td>Father's Name</td>
<td>Informant's Name</td>
</tr>
<tr>
<td>Place of Death</td>
<td>Decedent's Residence</td>
</tr>
<tr>
<td>Method of Disposition</td>
<td>Donation and Cremation</td>
</tr>
<tr>
<td>Date of Disposition</td>
<td>TBD</td>
</tr>
<tr>
<td>Register's Signature</td>
<td>Funeral Director's Signature</td>
</tr>
<tr>
<td>Amendment</td>
<td>Was case referred to Medical Examiner?</td>
</tr>
<tr>
<td>Cause of Death</td>
<td>Immediate Cause</td>
</tr>
<tr>
<td>Due to (or as a consequence of)</td>
<td>Approximate Interval of Great to Death</td>
</tr>
<tr>
<td>Other significant conditions contributing to death</td>
<td>years</td>
</tr>
<tr>
<td>Manner of Death</td>
<td>Natural</td>
</tr>
<tr>
<td>Date of Injury</td>
<td>If Female</td>
</tr>
<tr>
<td>Location of Injury</td>
<td>Time of Injury</td>
</tr>
<tr>
<td>Describe how injury occurred</td>
<td></td>
</tr>
<tr>
<td>Name and Address of Certifier</td>
<td>Name and Title of Attending Physician [II Other than Certifier]</td>
</tr>
<tr>
<td>Medical Certifier</td>
<td>Title of Certifier</td>
</tr>
</tbody>
</table>

**Exhibit 3**

Karen S. Millette

A-49
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.
RE: Death with Dignity Act

2 messages

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

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
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

Margaret Dore <margaretdore@margaretdore.com>  
Draft To: Parkman Alicia A <alicia.a.parkman@state.or.us>  

Tue, Sep 11, 2012 at 4:49 AM

[Quoted text hidden]
There is no state "program" for participation in the Act. People do not "make application" to the State of Oregon or the Oregon Health Authority. It is up to qualified patients and licensed physicians to implement the Act on an individual basis. The Act requires the Oregon Health Authority to collect information about patients who participate each year and to issue an annual report.

Q: Are there any other states that have similar legislation?
A: Yes. The Death with Dignity National Center, which advocates for the passage of death with dignity laws, tracks the status of these laws around the country (see: https://www.deathwithdignity.org/take-action).

Q: Who can participate in the Act?
A: The law states that, in order to participate, a patient must be: 1) 18 years of age or older, 2) a resident of Oregon, 3) capable of making and communicating health care decisions for him/herself, and 4) diagnosed with a terminal illness that will lead to death within six (6) months. It is up to the attending physician to determine whether these criteria have been met.

Q: Can someone who doesn't live in Oregon participate in the Act?
A: No. Only patients who establish that they are residents of Oregon can participate if they meet certain criteria.

Q: How does a patient demonstrate residency?
A: A patient must provide adequate documentation to the attending physician to verify that s/he is a current resident of Oregon. Factors demonstrating residency include, but are not limited to: an Oregon Driver License, a lease agreement or property ownership document showing that the patient rents or owns property in Oregon, an Oregon voter registration, a recent Oregon tax return, etc. It is up to the attending physician to determine whether or not the patient has adequately established residency.

Q: How long does someone have to be a resident of Oregon to participate in the Act?
A: There is no minimum residency requirement. A patient must be able to establish that s/he is currently a resident of Oregon.

Q: Can a non-resident move to Oregon in order to participate in the Act?
A: There is nothing in the law that prevents someone from doing this. However, the patient must be able to prove to the attending doctor that s/he is currently a resident of Oregon.

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 Oregon Health Authority 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 publicaion of the Annual Report, all source documentation is destroyed.

Q: Who can give a patient a prescription under the Act?
A: Patients who meet certain criteria can request a prescription for lethal medication from a licensed Oregon physician. The physician must be a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) licensed to practice medicine by the Board of Medical Examiners for the State of Oregon. The physician must also be willing to participate in the Act. Physicians are not required to provide prescriptions to patients and participation is voluntary. Additionally, some health care systems (for example, a Catholic hospital or the Veterans Administration) have prohibitions against participating in the Act that physicians must abide by as terms of their employment.

Q: If a patient's doctor does not participate in the Act, how can s/he get a prescription?
A: The patient must find another M.D. or D.O. licensed to practice medicine in Oregon who is willing to participate. The Oregon Health Authority does not recommend doctors, nor can we provide the names of participating physicians or patients due to the need to protect confidentiality.

Q: If a patient's primary care doctor is located in another state, can that doctor write a prescription for the patient?
A: No. Only M.D.s or D.O.s licensed to practice medicine by the Board of Medical Examiners for the State of Oregon can write a valid prescription for lethal medication under the Act.

Q: How does a patient get a prescription from a participating physician?
A: The patient must meet certain criteria to be able to request to participate in the Act. Then, the following steps must be fulfilled:

1. The patient must make two oral requests to the attending physician, separated by at least 15 days;
2. The patient must provide a written request to the attending physician, signed in the presence of two witnesses, at least one of whom is not related to the patient;
3. The attending physician and a consulting physician must confirm the patient's diagnosis and prognosis;
4. The attending physician and a consulting physician must determine whether the patient is capable of making and communicating health care decisions for him/herself;
5. If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder (such as depression), the patient must be referred for a psychological examination;
6. The attending physician must inform the patient of feasible alternatives to the Act including comfort care, hospice care, and pain control;
7. The attending physician must request, but may not require, the patient to notify their next-of-kin of the prescription request. A patient can rescind a request at any time and in any manner. The attending physician...
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, Senckenbergstr. 10, 04103 Leipzig, Germany
b Department of Psychiatry, University Hospital Zurich, Ulmistrasse 8, 8091 Zurich, Switzerland
c Department of Psychopathology and Clinical Intervention, University of Zurich, Nenndorferstr. 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 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 50,000 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.
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

>>> "Margaret Dore" <margaretdore@margaretdore.com> 6/25/2011 11:04 AM >>>
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
Law Offices of Margaret K. Dore, P.S.
www.margaretdore.com
1001 4th Avenue, 44th Floor
Seattle, WA 98154
206 389 1754
**NEWS RELEASE**

Date: Sept. 9, 2010

Christine Stone, Oregon Public Health Information Officer; 971-673-1282, desk; 503-602-8027, cell; christine.l.stone@state.or.us.

**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.

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.
Suicides in Oregon
Trends and Risk Factors

Oregon Violent Death Reporting System
Injury and Violence Prevention Program
Office of Disease Prevention and Epidemiology


Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the leading cause of injury death - there are more deaths due to suicide in Oregon than due to car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all Oregonians. 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 2007 and 2003 to 2007 data of Oregon Violent Death Reporting System (ORVDRS). This report presents main findings of suicide trends and risk factors in Oregon.

Key Findings

In 2007, the age-adjusted suicide rate among Oregonians was 15.2 per 100,000 was 35 percent higher than the national average:

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among women ages 45-64 rose 35 percent from 8.2 per 100,000 in 2000 to 12.8 per 100,000 in 2007.

Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (78.4 per 100,000). White males had the highest suicide rate among all races/ethnicity (25.6 per 100,000). Firearms were the dominant mechanism of suicide among men (62%).

Approximately 27 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (45.7 vs. 27.4 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.

Over 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 just about half of female victims were receiving treatment for mental health problems at the time of death.

Investigators suspect that 30 percent of suicide victims had used alcohol in the hours preceding their death.

The number of suicides in each month varies. But there was not a clear seasonal pattern.
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

Note to Readers:
Data collected through 2010
Report Excerpts attached hereto
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 43 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 25 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.
Executive Summary

Suicide is one of Oregon’s most persistent public health problems. Suicide is the second leading cause of death among Oregonians aged 15 to 34 years, and the eighth leading cause of death among all Oregonians in 2012. 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. We analyzed mortality data from 1981 to 2012 and Oregon Violent Death Reporting System (ORVDRS) data from 2003 to 2012. This report presents findings of suicide trends and associated factors in Oregon. These data can inform prevention programs, policy, and planning.

Key Findings

In 2012, the age-adjusted suicide rate among Oregonians was 17.7 per 100,000, 42 percent higher than the national average.

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among adolescents aged 10 through 17 years has increased since 2011 after decreasing from 1990 to 2010.

Suicide rates among adults aged 45 to 64 years rose more than 50 percent from 18.1 per 100,000 in 2000 to 28.7 per 100,000 in 2012; the rate increased more among females than among males.

Suicide rates among males aged 65 years and older decreased approximately 18 percent from nearly 50 per 100,000 in 2000 to 42 per 100,000 in 2012.

From 2003 to 2012:

Males were 3.6 times more likely to die by suicide than females. The highest suicide rate occurred among males aged 85 years and older (72.4 per 100,000). Non-Hispanic white males had the highest suicide rate among all racial/ethnic groups (27.1 per 100,000).

Approximately 25 percent of suicides occurred among veterans. Male veterans had almost twice the suicide rate than non-veteran males (45.5 vs. 29.0 per 100,000). 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, fewer than one third of male victims, and fewer than 60 percent of female victims, were receiving treatment for mental health problems at the time of death.
**Ingest Definition**

**In-gest** (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.

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

---

**In-gest** (in-jëst')

*transitive verb* In-gest-ed, In-gest-ing, In-gests

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 Keesuk Yoon).

Origin: Latin *ingerere*, inges- : in-, in; see in- 2 + gerere, to carry.

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

---

*Webster's New World College Dictionary* Copyright © 2010 by Wiley Publishing, Inc., Cleveland, Ohio. Used by arrangement with John Wiley & Sons, Inc.

define in the spirit of

Google

About 63,100,000 results (0.65 seconds)

in (or in the) spirit
phrase of spirit

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

Translations, word origin, and more definitions

What's the meaning of "in the spirit of"? - English Language & Usage ...
https://english.stackexchange.com/questions/.../what-s-the-meaning-of-in-the-spirit-of
Apr 22, 2014 - ... in the spirit of full disclosure, the test in question turned out to be my actor at Seaon.
... Source: http://mgty.com/?q=in+the+spirit+of+definition...

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

enter / get into the spirit of something (phrase) definition and ...
www.macaillandictionary.com/us/dictionair/...enter-get-into-the-spirit-of-something ▶
Define enter / get into the spirit of something (phrase) and get synonyms. What is enter / get into the spirit of something (phrase)? enter / get into the spirit of ...

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

in the spirit of synonym | English synonyms dictionary | Reverso
dictionary.reverso.net/english-synonyms/in%20the%20spirit%20of ▶
in the spirit of synonyms, antonyms, English dictionary. English language, definition, see also 'spirit','spirited','spiritual','spirit', Reverso dictionary, English ...

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

in the spirit of - definition of in the spirit of - Dictionaryist
www.dictionaryist.com/in+the+spirit+of ▶
Definition of in the spirit of. What is the meaning of in the spirit of in various languages. Translation of in the spirit of in the dictionary.

spirit Definition in the Cambridge English Dictionary
dictionary.cambridge.org/us/dictionary/english/spirit ▶
spirit definition, meaning, what is spirit: a particular way of thinking, feeling, or behaving, especially a way that is typical of a... Learn more.

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

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

https://www.google.com/search?q=define+in+the+spirit+of&rlz=1C1RNE_E_enUS557US557&oq=define+%22in+the+sp&aqs=chrome.1.69i57j0i55j0i43j0i137.96894j0j7&sourceid=chrome-企业管理面面(1) 1/2...
HOUSE BILL NO. 160

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO END OF LIFE OPTIONS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 16 of the Delaware Code by adding a new Chapter by making deletions as shown by strike through and insertions as shown by underline as follows and redesignating accordingly:

CHAPTER 25B. END OF LIFE OPTIONS.

§ 2501B. Definitions.

As used in this chapter:

(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, and who routinely provides medical care to patients with advanced and terminal illnesses in the normal course of their medical practice. Such practice may not be primarily or solely comprised of persons requesting medication to end their life in a humane and dignified manner.

(2) "Capable" means that in the opinion of an individual's attending physician and consulting physician, or licensed medical professional if an opinion is requested by the attending or consulting physician, the individual has the ability to make and communicate an informed medical decision to healthcare providers, including communication through a person familiar with the individual's manner of communicating if that person is 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 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 terminally ill patient to request and obtain a prescription that the individual may self-administer to end their 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 all of the following:
   a. The patient's medical diagnosis.
   b. The patient's prognosis.
   c. The potential risks associated with taking the medication to be prescribed.
   d. The probable result of taking the medication to be prescribed.
   e. The feasible alternatives, including 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 Licensure and Discipline for the State of Delaware.

(11) "Qualified patient" means a capable adult who is a resident of Delaware and has satisfied the requirements of this chapter in order to obtain a prescription for medication to end their life in a humane and dignified manner.

(12) "Self-administer" means any affirmative, voluntary and final physical act by a qualified patient to take the medication to bring about their own peaceful death.

(13) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within 6 months.

§ 2502B. Who may initiate a written request for medication.
   (a) An adult who is capable, is a resident of Delaware, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed a wish to die, may make a written request for medication for the purpose of ending their life in a humane and dignified manner in accordance with this chapter.

   (b) No person can qualify under the provisions of this chapter solely because of age or disability.

§ 2503B. Form of the written request.
(a) A valid request for medication under this chapter must be in substantially the form described herein, 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.

(b) No more than one person who is any of the following may serve as a witness under subsection (a) of this section:

   (1) A relative of the patient by blood, marriage, or adoption.

   (2) 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.

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

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

§ 2504B, Attending physician responsibilities.

(a) The attending physician shall do all of the following:

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

   (2) Request that the patient demonstrate Delaware residency under § 2513B of this chapter.

   (3) Ensure that the patient is making an informed decision, including informing the patient of the following:

       a. The patient's medical diagnosis.

       b. The patient's prognosis.

       c. The potential risks associated with taking the medication to be prescribed.

       d. The probable result of taking the medication to be prescribed.

       e. The feasible alternatives, including comfort care, hospice care and pain control.

   (4) Refer the patient to a consulting physician for medical confirmation of the terminal disease diagnosis and for a confirmation that the patient is capable and acting voluntarily.

   (5) Refer the patient for counseling, if appropriate, pursuant to § 2506B of this chapter.

   (6) Recommend that the patient notify next of kin.

   (7) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to this chapter and of not taking the medication in a public place.
(8) 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 § 2511B of this chapter.

(9) Verify, immediately prior to writing the prescription for medication under this chapter, that the patient is making an informed decision.

(10) Fulfill the medical record documentation requirements of § 2512B of this chapter.

(11) Ensure that all appropriate steps are carried out in accordance with the provisions of this chapter prior to writing a prescription for medication to enable a qualified patient to end their life in a humane and dignified manner.

(12)a. Subject to the 72-hour limitation in § 4739A of this title, dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient’s discomfort, but only if the attending physician is registered as a dispensing physician with the Board of Medical Licensure and Discipline, has a current Drug Enforcement Administration certificate, and complies with any applicable administrative rule or regulation; or

b. Contact a pharmacist, inform the pharmacist of the prescription, and deliver the written prescription to the pharmacist personally, by mail, or other method acceptable to the pharmacist, who will dispense the medications only to the patient, the attending physician, or an agent expressly identified in writing by both the patient and the attending physician.

(b) The attending physician may sign the qualified patient’s death certificate. The death certificate must list the underlying terminal illness as the cause of death.

§ 2505B. Consulting physician confirmation.

Before a patient becomes qualified under this chapter, a consulting physician shall examine the patient and the patient’s 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.

§ 2506B. 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, that physician shall refer the patient for counseling. No medication to end a patient’s life in a humane and dignified manner may 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 and reports the determination to the referring physician.

§ 2507B. Informed decision.
No person may receive a prescription for medication to end their life in a humane and dignified manner unless they have made an informed decision as defined in this chapter. Immediately prior to writing a prescription for medication under this chapter, the attending physician shall verify that the patient is making an informed decision.

§ 2508B. Family notification.

The attending physician shall recommend that the patient notify the next of kin of the patient’s request for medication pursuant to this chapter. A patient who declines or is unable to notify next of kin will not be denied their request for medication for that reason.

§ 2509B. Written and oral requests.

In order for a patient to receive a prescription for medication to end the patient’s life in a humane and dignified manner, a patient must have made two oral requests and one written request. The second oral request must be made no less than 15 days after making the initial oral request to the patient’s attending physician. At the time the patient makes a second oral request, the attending physician shall offer the patient an additional opportunity to rescind the request.

§ 2510B. Right to rescind request.

A patient may rescind the request for medication at any time and in any manner without regard to the patient’s 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.

§ 2511B. Waiting and expiration periods.

(a) No less than 15 days may elapse between the patient’s initial oral request and the writing of a prescription under this chapter. No less than 48 hours may elapse between the patient’s written request and the writing of a prescription under this chapter.

(b) The patient’s initial oral request automatically expires after 1 year if a prescription is not written pursuant to the provisions of this chapter during that time. If the initial oral request has expired, a prescription may not be written based on that initial oral request. However, the patient may make a subsequent initial oral request.

§ 2512B. Medical record documentation requirements.

The following must be documented or filed in the patient’s medical record:

(1) All oral requests by a patient for medication to end the patient’s life in a humane and dignified manner.

(2) All written requests by a patient for medication to end the patient’s life in a humane and dignified manner.

(3) The attending physician’s diagnosis and prognosis, determinations that the patient is capable, is acting voluntarily, and has made an informed decision.
(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, 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 the patient's request at the time of the patient's second oral request pursuant to § 2509B of this chapter.

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

§ 2513B. Residency requirement.

(a) Only requests made by Delaware residents under this chapter may be granted.

(b) Factors demonstrating Delaware residency include:

(1) Possession of a Delaware driver license.

(2) Registration to vote in Delaware.

(3) Evidence that the person owns or leases property in Delaware.

(4) The filing of a Delaware tax return for the most recent tax year.

§ 2514B. Reporting requirements and comprehensive guidelines.

(a) The Department may annually review a sample of records maintained pursuant to § 2501B through § 2518B of this chapter.

(b) The Department shall require any health care provider upon dispensing medication pursuant to § 2501B through § 2518B of this chapter to file a copy of the dispensing record with the Department.

(c) The Department shall make rules and regulations 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.

(d) The Department shall generate and make available to the public an annual statistical report of information collected under this section.

(e) The Department shall develop comprehensive guidelines designed to be a resource for health care professionals and institutions implementing the provisions of this chapter.

§ 2515B. Effect on construction of wills, contracts, and statutes.

(a) Any provision in a will, contract, 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 their life in a humane and dignified manner, is void and unenforceable.
(b) No obligation owing under any currently existing contract may be conditioned or affected by the making or rescinding of a request, by a person, for medication to end their life in a humane and dignified manner.

§ 2516B. Insurance or annuity policies.

(a) Any provision in an insurance policy, an annuity, a contract, or any other agreement, issued or made on or after the effective date of this chapter is not valid to the extent that the provision would attach consequences to or otherwise restrict or influence an individual's decision to make or rescind a request for medication to end their life in a humane and dignified manner pursuant to this chapter.

(b) Any obligation under a contract existing on the effective date of this chapter may not be conditioned on or affected by the making or rescinding of a request for medication, by a person, to end their life in a humane and dignified manner pursuant to this chapter.

(c) The sale, procurement, or issuance of a life, a health, or an accident insurance or annuity policy or the rate charged for a life, a health, or an accident insurance or annuity policy may not be conditioned on or affected by the making or rescinding of a request for medication, by a person, to end their life in a humane and dignified manner pursuant to this chapter.

(d) A qualified patient's act of ingesting medication to end their life in a humane and dignified manner pursuant to this chapter may not have an effect under a life, a health, or an accident insurance or annuity policy that differs from the effect under the policy of the patient's death from natural causes.

§ 2517B. Construction of Act.

(a) 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.

(b) Nothing in this chapter should be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community.

§ 2518B. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.

Except as provided in this chapter:

(1) No person is subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with the provisions of this chapter. This includes being present when a qualified patient takes the prescribed medication to end their 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 the provisions of this chapter.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this chapter constitutes abuse or neglect for any purpose of law or provide the sole basis for the appointment of a guardian or involuntary commitment.

(4) No health care provider will 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 their 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 their 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. A health care provider may prohibit another health care provider from participating in any activities pursuant to this chapter on the premises of the prohibiting health care provider if the prohibiting health care provider has notified in advance all health care providers with privileges to practice on the premises and the general public of the prohibiting health care provider's policy regarding participating in activities covered by this chapter. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in activities covered by this chapter.

b. Except as provided in paragraphs (1) through (4) of this section, a health care provider may subject another health care provider to any of the sanctions stated in this paragraph if the sanctioning health care provider has notified the health care provider prior to participation in activities covered by this chapter, by a separate statement in writing specifically informing the health care provider of the sanctioning health care provider's policy, that it prohibits such participation:

1. 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 health care provider is a member of the sanctioning health care provider's medical staff and participates in activities covered by this chapter while on the premises of the sanctioning health care provider, but not including the private medical office of the sanctioned health care provider.

2. Termination of lease or other property contract or other non-monetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned health care provider participates in activities covered by this chapter 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.

3. Termination of contract or other non-monetary remedies provided by contract if the sanctioned
health care provider participates in activities covered by this chapter while acting in the course and scope of
the sanctioned health care provider's capacity as an employee or independent contractor of the sanctioning
health care provider. Nothing in this paragraph may be construed to prevent:

A. A health care provider from participating in activities covered by this chapter while acting
outside the course and scope of the health care provider's capacity as an employee or independent
contractor.

B. A patient from contracting with the patient's attending physician and consulting physician to
act outside the course and scope of the health care 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 (5)b. of this section must follow all
due process and other procedures the sanctioning health care provider has that are related to the imposition of
sanctions on a health care provider.

d. Participation in activities covered by this chapter means to perform the duties of an attending physician
in § 2504B of this chapter, the consulting physician function in § 2505B of this chapter, or the counseling function
in § 2506B of this chapter. Participation in activities covered by this chapter does not include the following:

1. Making an initial determination that a patient has a terminal disease and informing the patient of
the medical prognosis.

2. Providing information about the Delaware End of Life Options Act to a patient upon the request of
the patient.

3. Providing a patient, upon the request of the patient, with a referral to another physician.

4. A patient contracting with their 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 paragraph (5)b. of this section is not
reportable under this chapter. Action taken pursuant to § 2504B, § 2505B, or § 2506B of this chapter may not be the
sole basis for a report of unprofessional or dishonorable conduct.

§ 2519B. Claims by governmental entity for costs incurred.
Any governmental entity that incurs costs resulting from a person terminating their life pursuant to the provisions of this chapter 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.

§ 2520B. Form of the request.

A request for a medication as authorized by the provisions of this chapter must 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 to not 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 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: No more than one of the witnesses may be 1) a relative (by blood, marriage or adoption) of the person signing this request, 2) entitled to any portion of the person's estate upon death, or 3) an owner, operator, or employee at a health care facility where the person is a patient or resident.

Section 2. Any section of this Act being held invalid as to any person or circumstance does not affect the application of any other section of this Act which can be given full effect without the invalid section or application.

Section 3. This Act shall take effect 6 months after its enactment into law.

Section 4. This Act shall be known and may be cited as the “Delaware End of Life Options Act.”

SYNOPSIS

The Delaware End of Life Options Act provides an additional option which terminally ill adults nearing their death can decide to select, to lessen their pain and suffering. The bill clarifies the procedures necessary for making the request, including 1) the presentation of all end of life options which include comfort care, hospice care, and pain control, 2) a physician's evaluation, 3) medical confirmation by a second physician, 4) psychiatric/psychological counseling when indicated, 5) the passage of two waiting periods, and 6) the completion of a formally witnessed request for prescribed medication. The bill provides many safeguards to ensure the patient is making an informed decision, the right to rescind any request for medication, and immunity for persons participating in good faith compliance with the procedures. When the process is followed with its safeguards, the terminally ill patient is provided the right to receive medication to peacefully end the patient's life in a humane and dignified manner.