South Dakota Elder Abuse Task Force

Final Report and Recommendations

December 2015
Introduction

The South Dakota Elder Abuse Task Force was the creation of Senate Bill 168, passed during the 2015 Legislative Session. The South Dakota Legislature vested the Task Force with a two-pronged mission: “to study the prevalence and impact of elder abuse in South Dakota and to make recommendations to the Legislature on policies and legislation to effectively address the issue.” To accomplish these ends, the Legislature allotted seventeen seats on the Task Force:

- Three members of the Senate chosen by the President Pro Tempore:
  - Sen. James Bradford
  - Sen. David Novstrup
  - Sen. Bruce Rampelberg

- Three members of the House of Representatives chosen by the Speaker of the House of Representatives:
  - Rep. Brian Gosch
  - Rep. Kris Langer
  - Rep. Lee Schoenbeck

- Three members chosen by the Governor “who have significant experience working with issues related to elder abuse”:
  - Sarah Dahlin Jennings (South Dakota State Director – AARP)
  - Jennifer Murray (Regional Manager, DSS – Adult Services & Aging)
  - Robert Kean (Attorney and Fmr. Exec. Director of South Dakota Advocacy Services)

- Seven members appointed by the Chief Justice of the Supreme Court, specifically “five members who have significant experience working with issues related to elder abuse and two members from the banking industry”:
  - Justice Steven L. Zinter (South Dakota Supreme Court)
  - Dr. Victoria Walker (Chief Medical & Quality Officer, The Evangelical Lutheran Good Samaritan Society)
  - Quentin Riggins (Attorney and Chair of the Real Property, Probate & Trust Law Section, State Bar of South Dakota)
  - Tim Neyhart (Executive Director, South Dakota Advocacy Services)
- Dr. David Brechtelsbauer (Physician, Geriatrician, and Clinical Faculty at the USD Sanford School of Medicine)
- Rick Rylance (Regional President, Dacotah Bank)
- Kristina Schaefer (Vice President – General Counsel & Dir. of Risk Management, Fishback Financial Corporation)

- One member “who has significant experience working with issues related to elder abuse” appointed by the Attorney General:
  - Paul Cremer (Assistant Attorney General & Division Director, Medicaid Fraud Control Unit)

The Legislature gave the Task Force six months to complete its task. In that time, the Task Force selected a Chair – Justice Steven Zinter – and formed four Committees to focus on specialized areas of interest on the broad topic of elder abuse: (1) Elder Abuse and Neglect, (2) Elder Financial Exploitation, (3) Education, and (4) Guardianships, Wills, and Powers of Attorney.

The Task Force met four times as a group. Public input was solicited and received at all meetings. In between the full group meetings, the Committees conducted numerous teleconferences in which they directed research, drafted proposed legislation, and prepared reports to the full Task Force. The following report reflects the recommendations of the Task Force as a whole. The appendices contain proposed legislation, policies, and commentary from the Task Force.
Summary of Findings

The Nature and Scope of Elder Abuse Generally:

Elder abuse, neglect, and exploitation has been described at various times as “hiding in plain sight,” a “hidden epidemic,” and a “silent crisis”—all despite the fact that “there are no official national statistics” on elder abuse. This has been attributed to a lack of uniform reporting systems in states, as well as a dearth of reporting by victims of such incidents and their caregivers.

In 2004, it was estimated that there were 381,430 reports of elder abuse to adult protective services in the United States, or 8.33 reports for every 1,000 elders. What makes this number striking is that two studies have found that only about one out of fourteen or one out of every 23 cases of elder abuse is actually reported to law enforcement or adult protective services. The “majority” of seniors so abused are those “who live in the community rather than in nursing homes or other senior living facilities;” indeed, approximately one in ten elders living in their homes experience abuse, neglect, or exploitation each year. These findings are consistent with another national study finding that approximately 90% of abusers were known perpetrators, and 66% were adult children or spouses.

As for elder financial exploitation, a study estimated that reporting occurred in only one out of every 25 incidents, amounting to at least five million financial abuse victims each year. According to a separate 2009 study, the loss attributed to these incidents amounted to $2.6 billion annually in the United States.

Beyond the financial costs of exploitation and obvious injuries caused by abuse and neglect, there are aggravating factors that make such acts against the elderly particularly harmful. It should be no surprise that elders’ relative physical and mental frailty makes them susceptible to long-term harm from abuse. Indeed,
studies confirm that elder abuse victims face a five times greater risk of premature death, suffer poorer health and functioning, and experience a three-to-four times higher discharge rate to a nursing home after a hospital stay.xiv

Given the aging profile of this country’s population, upward trends in elder abuse, neglect, and exploitation are likely to continue. South Dakota is no exception to this dynamic.

Scope of Challenges in South Dakota – A Matter of Demographics:

Because of reporting challenges, it was not possible to obtain a large amount of South Dakota-specific statistics on the prevalence of elder abuse. Some state statistics did, however, emerge. For instance, the Department of Social Services (DSS) reported receiving an annual average of 661 Adult Protective Service calls in the last five years. And according to the Unified Judicial System’s (UJS) criminal charging information, in the past ten years, there were eight charges of theft by exploitation under SDCL 22-46-3, and ninety-two charges of adult abuse or neglect under SDCL 22-46-2. Considering the number of elders in South Dakota, the Task Force felt this number was exceedingly low.

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Projections of South Dakota’s Elderly and Disabled Population (2000 – 2035)

2000 and 2005 data are actuals; 2010–2035 are projections.

- From Abt Associates, Evaluating Long-Term Care Options for South Dakota: Update, 2015
According to a 2015 study prepared by Abt Associates for DSS's Division of Adult Services and Aging (DSS-ASA), the number of South Dakota citizens age 65 and older will increase nearly 84% from 2010 to 2035, from “approximately 103,000 to 226,000.” Within this age cohort, the most vulnerable to elder abuse—disabled elders—will peak in 2030 at 85,000, increasing 71% from the 2010 Census total of about 33,000. Put in different terms:

By 2035, in all but 10 South Dakota counties elders will make up over 20 percent of the population. In 27 counties, elders will be over 40 percent of the local population. Even in the growing population centers, around Sioux Falls and Rapid City, elders will make up 29-30 percent of residents.

While the most substantial population growth in the elder age cohort will occur in high population areas, areas of the state not surrounding Sioux Falls and Rapid City will still see their elder populations increase by between 25,000 and 50,000. Resources in these rural areas, including specialized assistance from DSS-ASA, will be stretched even thinner. These resource concerns, coupled with national estimates and South Dakota's demographic outlook, indicate that elder abuse will have a profound impact on our state's future—an impact requiring a coordinated and planned response.

Input from Stakeholders:

The Task Force received phone calls, e-mails, and in-person comments from stakeholders as well as concerned citizens whose elder family members were impacted by abuse, neglect, and exploitation. Their input is provided below.

Concerned citizens often related that existing legal processes—including powers of attorney, court-appointed guardians/conservators, and joint accounts—had been manipulated to exploit elders. Financial exploitation was the predominant form of elder abuse cited by these sources. Some individuals also
asserted that their elder parents were being isolated and emotionally abused by a close family or friend caregiver. Certain members of the public opined that financial institutions needed to play a more active role in reporting signs of financial exploitation.

Case workers and home care providers for elders related concerns about elder capacity and the proper time to intervene, particularly in cases of neglect and self-neglect. A consensus among care providers reflected a need for closer and more effective partnerships with law enforcement, particularly in rural communities. Some cited problems of law enforcement failure to follow up on reports in rural areas and in Reservation communities; a lack of particularized training for police on the signs of adult abuse, neglect, and exploitation; and the lack of prosecutor training to handle these often technical, domestic cases. One social worker suggested joint training on elder abuse and neglect for local Adult Services & Aging staff and law enforcement. These care providers universally asserted that instances of elder abuse, neglect, and exploitation were underreported. Multiple care providers indicated that the issue of elder abuse, in terms of public perception and law enforcement response, is where domestic abuse was thirty years ago.

Elder law attorneys and law enforcement noted that, in their experience, elder financial exploitation was the most widespread concern. However, law enforcement indicated that elder abuse and neglect was substantially underreported. One law enforcement officer with expertise on elder abuse raised the concern of ambiguity in our criminal statutes regarding who is culpable for neglecting an elder. Another cited the need to create a mechanism to quickly separate an in-home abuser or neglecter from an elder or vulnerable adult, and the need for prosecution and investigative specialists for elder abuse, neglect, and exploitation cases. An attorney that specializes in this area raised a concern regarding the use of binding arbitration in long-term care service agreements that keep cases of institutional elder abuse out of the courts. Elder lawyers and law enforcement noted that the often domestic nature of elder crimes makes reporting difficult, but law enforcement offered that they would arrest if they had probable cause, even if an elder parent did not want their abusive child arrested. An elder law attorney and sheriff both cited the need for greater cooperation and reporting from financial institutions to assist with investigating elder exploitation. Law enforcement also saw a need for Department of Social Services to increase disclosure of prior substantiated reports of abuse and neglect.

In contacting tribal agencies, there was a consensus on the need for additional resources to investigate abuse and to support elder service providers on
Elder abuse is one of the most underreported social problems in our society today. It is estimated that at least 5 million seniors are victimized yearly. Sadly, nearly 84% of these incidents go unreported.

Impaired adults are often not able to protect themselves against incidents of abuse, neglect, or exploitation. Many do not know where to turn for assistance. Others are incapable of seeking help because they are physically dependent, unable to leave their home, or use a telephone. Many are simply too embarrassed or frightened to ask for help. They may be reluctant to press charges against the abuser, especially if the abuser is a family member. We must bring an end to their silent suffering.
<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>
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<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>At time of death</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
Table 3. Death with Dignity Act process for the participants who have died

<table>
<thead>
<tr>
<th></th>
<th>2016 Number</th>
<th>2016 %</th>
<th>2015 Number</th>
<th>2015 %</th>
<th>2014 Number</th>
<th>2014 %</th>
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<tbody>
<tr>
<td><strong>Family and Psychiatric/Psychological involvement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Referred for psychiatric/psychological evaluation²</td>
<td>11</td>
<td>5</td>
<td>8</td>
<td>4</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Patient informed family of decision³</td>
<td>221</td>
<td>94</td>
<td>170</td>
<td>94</td>
<td>146</td>
<td>88</td>
</tr>
<tr>
<td><strong>Medication⁴</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secobarbital</td>
<td>77</td>
<td>32</td>
<td>106</td>
<td>52</td>
<td>112</td>
<td>64</td>
</tr>
<tr>
<td>Pentobarbital</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Secobarbital/Pentobarbital Combination</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Phenobarbital</td>
<td>1</td>
<td>&lt;1</td>
<td>92</td>
<td>46</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Phenobarbital/Chloral Hydrate Combination</td>
<td>106</td>
<td>44</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chloral Hydrate</td>
<td>1</td>
<td>&lt;1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine sulfate</td>
<td>52</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>&lt;1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Duration of patient-physician relationship⁵</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25 weeks</td>
<td>125</td>
<td>53</td>
<td>100</td>
<td>51</td>
<td>62</td>
<td>43</td>
</tr>
<tr>
<td>25 weeks – 51 weeks</td>
<td>25</td>
<td>11</td>
<td>15</td>
<td>8</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>1 year or more</td>
<td>84</td>
<td>36</td>
<td>80</td>
<td>40</td>
<td>57</td>
<td>40</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Range (min – max)</td>
<td>&lt;1 wk – 31 yrs</td>
<td>&lt;1 wk – 2 yrs</td>
<td>&lt;1 wk – 23 yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration between first oral request and death²</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25 weeks</td>
<td>209</td>
<td>89</td>
<td>163</td>
<td>84</td>
<td>145</td>
<td>87</td>
</tr>
<tr>
<td>25 weeks or more</td>
<td>24</td>
<td>10</td>
<td>32</td>
<td>16</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Range (min – max)</td>
<td>2 wks – 112 wks</td>
<td>2 wks – 95 wks</td>
<td>2 wks – 57 wks</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:

¹ Data published in 2014 and 2015 reports

² Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 236 of the 240 participants in 2016 who died.

³ Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 234 of the 240 participants in 2016 who died.

⁴ Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 240 participants in 2016 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.

⁵ Data are collected from the After Death Reporting form. At the time of publication, data are available for 236 of the 240 participants in 2016 who died.
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.

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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.
127.865 s.3.11. Reporting requirements.

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

(b) The division 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 division.

(2) The Health Services 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 division shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 s.3.11; 1998 c.423 s.8]

127.870 s.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 s.3.12]

127.875 s.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 s.3.13]


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 s.3.14]

(Immunities and Liabilities)

(Section 4)

127.885 s.4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.

Except as provided in ORS 127.860:

(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 does 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. If 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;
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
November 3, 2010

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

Exhibit 1
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   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
OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

<table>
<thead>
<tr>
<th>Legal Name</th>
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<th>Middle</th>
<th>Last</th>
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<th>Death Date</th>
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<td>Male</td>
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<td>Informant's Name</td>
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<td>Donation and cremation</td>
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<td>Place of Disposition</td>
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<td>Date of Disposition</td>
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<td>Registrar's Signature</td>
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<td>Amendment</td>
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</table>

Was case referred to Medical Examiner? | No | Autopsy? | No | Were autopsy findings available to complete the cause of death? | |

IMMEDIATE CAUSE

ca

Other Causes Contributing to Death

Date of Injury | Place of Injury | Location of Injury | Describe how injury occurred | Did tobacco use contribute to death? | Injury at Work? |

Other Cause

If transportation injury, specify.

Name and Address of Certifier | | | | | |
| Name and Title of Attending Physician | | | | | |
| Medical Certifier | | | | | |
| Title of Certifier | M.D. | | | | |
| License Number | | | | | |

This is a true and exact reproduction of the document officially registered at the office of the Registrar.

Exhibit 3

Date Issued: 2010

A-52
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 purpose 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>  Wed, Jan 4, 2012 at 7:57 AM
To: Margaret Dore <margaretdore@margaretdore.com>
Cc: BURKOVSKAIA Tamara V <tamara.v.burkovaia@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
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
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 physician 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.

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 practicing 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
accordance
(noun)
Definition of accordance by Merriam-Webster
https://www.merriam-webster.com/dictionary/accordance
Definition of accordance. 1: agreement, conformity in accordance with a rule. 2: the act of granting something the accordance of a privilege.

In Accordance With | Definition of In Accordance With by Merriam ...
https://www.merriam-webster.com/dictionary/in%20accordance%20with
accordance: agreement, conformity: the act of granting something.

Accordance | Define Accordance at Dictionary.com
www.dictionary.com/browse/accordance
Accordance definition, agreement; conformity; in accordance with the rules. See more.

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www.macmillandictionary.com/us/dictionary/american/accordance
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: bestowed: accordance of rights. Collins English Dictionary ...

In accordance with - Idioms by The Free Dictionary
idioms.thefreedictionary.com/in+accordance+with
https://www.google.com/search?q=Define+%22accordance%22&rlz=1C1RNVE_enUS557US557&oq=Define+%22accordance%22&aqs=chrome..69i57j05.80..
What's the meaning of "in the spirit of"? - English Language & Usage ...
https://english.stackexchange.com/questions/.../what%3Athe-meaning%3Ain%3Athe%3Aspirit%3Aof

the spirit of the law (phrase) definition and synonyms | Macmillan ...

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dictionary.reverso.net/english-synonyms/in%20the%20spirit%20of

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

in the spirit of - definition of in the spirit of - Dictionarist
www.dictionarist.com/in+the+spirit+of

spirit Definition in the Cambridge English Dictionary
dictionary.cambridge.org/us/dictionary/english/spirit

Spirit Definition and Meaning - Bible Dictionary - Bible Study Tools
www.biblestudytools.com/dictionary/spirit

Spirit | Define Spirit at Dictionary.com
www.dictionary.com/browse/spirit

spirit, the principle of conscious life; the vital principle in humans, animating the body or mediating between body and soul. See more.
ingest - Definition of ingest at Dictionary.com

- Dictionary Definitions
- Thesaurus Synonyms
- Sentence 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.

**Related Forms:**

- Ingestion *In-geS's-ten noun
- Ingestive *In-geS's-tive adjective

**Ingest (In-jest')**

*Transitive Verb* ing-es't-ed, In-ges't-ing, In-ges'ts

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:**

- Ingestible *In-geS-tî-ble adjective
- Ingestion *In-geS's-ten noun
- Ingestive *In-geS's-tive adjective

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http://www.yourdictionary.com/ingest
Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

B. Wagner, J. Müller, A. Maercker

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

ABSTRACT

Background: Despite continuing political, legal and moral debate on the subject, assisted suicide is permitted in only a few countries worldwide. However, few studies have examined the impact that witnessing assisted suicide has on the mental health of family members or close friends.

Methods: A cross-sectional survey of 85 family members or close friends who were present at an assisted suicide was conducted in December 2007. Full or partial Post-Traumatic Distress Disorder (PTSD; Impact of Event Scale-Revised); depression and anxiety symptoms (Brief Symptom Inventory) and complicated grief (Inventory of Complicated Grief) were assessed at 14 to 24 months post-loss.

Results: Of the 85 participants, 13% met the criteria for full PTSD (cut-off ≥ 35), 6.5% met the criteria for subthreshold PTSD (cut-off ≥ 25), and 4.9% met the criteria for complicated grief. The prevalence of depression was 16%; the prevalence of anxiety was 8%.

Conclusion: A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although there seemed to be no complications in the grief process, about 20% of respondents experienced full or subthreshold PTSD related to the loss of a close person through assisted suicide.

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.
NEWS RELEASE

Date: Sept. 9, 2010

Christine Stone, Oregon Public Health Information Officer; 971-673-1282, desk;
Contact: 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 of 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 55 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 65 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.
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.
consent claim may be submitted to the jury. In concluding that it was unnecessary to address the question directly, we stated:

[W]e need not decide whether an informed consent case may be proven without expert testimony since [the doctor] *374 admitted on adverse examination that the standards of the medical practice in his community would require him to advise her of the ramifications of the removal of the pin.

Id. at 512 (footnote omitted).

[9] [10] A majority of jurisdictions that recognize a cause of action for negligent disclosure adhere to the so-called “professional rule,” which places the burden on the plaintiff to prove by a preponderance of the expert medical testimony that the reasonable medical practitioner would have made disclosure under the circumstances. See, e.g., Tant v. Women’s Clinic, 382 So.2d 1120 (Ala.1980); Fidler v. Starnes, 268 Ark. 476, 597 S.W.2d 88 (1980); Woolley v. Henderson, 418 A.2d 1123 (Me.1980); Llera v. Wisner, 171 Mont. 254, 557 P.2d 805 (1976); Winkler v. Herr, 277 N.W.2d 579 (N.D.1979); Roark v. Allen, 633 S.W.2d 804 (Tex.1982). See also 52 A.L.R.3d 1084 (1973). Consequently, the dimensions of the disclosure duty are delineated through the medium of expert medical testimony. Under this view, a physician can be found to have breached his duty to disclose only upon a showing that his conduct fell below the standard deemed acceptable by his peers in the medical profession.


The seminal decision championing rejection of the professional rule is Canterbury v. Spence, supra. In Canterbury, plaintiff alleged that the defendant physician failed to inform him of the risk of paralysis inherent in a laminectomy procedure. The trial court granted a directed verdict for the defendant, noting there was insufficient evidence to support plaintiff’s claim. The Court of Appeals for the District of Columbia reversed, stating:

We agree that the physician’s noncompliance with a professional custom to reveal, like any other departure from prevailing medical practice, may give rise to liability to the patient. We do not agree that the patient's cause of action is dependent upon the existence and nonperformance of a relevant professional tradition....

Nor can we ignore the fact that to bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.

464 F.2d at 783-84 (footnotes omitted).

[12] We agree that the right to know-to be informed-is a fundamental right personal to the patient and should not be subject to restriction by medical practices that may be at odds with the patient's informational needs. Accordingly, we adopt the Canterbury v. Spence rule that the standard measuring the performance of the physician's duty to disclose is conduct which is reasonable under the circumstances. Id. at 785.

*375 [13] [14] [15] Consistent with our decision in Cunningham v. Yankton Clinic, P.A., supra, we deem a reasonable disclosure to be one which apprises the patient of all known material or significant risks inherent in a prescribed medical procedure, as well as the availability of any reasonable alternative treatment or procedures. 262 N.W.2d at 511. Additionally, material risks incident to

[4] ¶ 9] SDCL 25-7-6.3 lists the sources of “monthly income” that may be used to determine child support obligations. The listed sources include compensation for personal services, self-employment income, periodic payments from pensions or retirement programs, gain from assets, and certain statutory benefits. A lump sum inheritance is not included. The statute provides:

The monthly net income of each parent shall be determined by the parent’s gross income less allowable deductions, as set forth in this chapter. The monthly gross income of each parent includes amounts received from the following sources:

1. Compensation paid to an employee for personal services, whether salary, wages, commissions, bonus, or otherwise designated;
2. Self-employment income including gain, profit, or loss from a business, farm, or profession;
3. Periodic payments from pensions or retirement programs, including social security or veteran’s benefits, disability payments, or insurance contracts;
4. Interest, dividends, rentals, royalties, or other gain derived from investment of capital assets;
5. Gain or loss from the sale, trade, or conversion of capital assets;
6. Unemployment insurance benefits;
7. Worker’s compensation benefits; and
8. Benefits in lieu of compensation including military pay allowances.

Overtime wages, commissions, and bonuses may be excluded if the compensation is not a regular and recurring source of income for the parent. Income derived from seasonal employment shall be annualized to determine a monthly average income.

SDCL 25–7–6.3.

[5] ¶ 10.] Although an inheritance is not a listed source of income, the list is non-exhaustive. See *Peterson v. Peterson*, 2000 S.D. 58, ¶ 21, 610 N.W.2d 69, 72 (re-stating our prior holding that “nothing in [the statute listing several sources of income for child support purposes] indicates that the listing of the general categories of income is exclusive. The use of the word ‘include’ suggests a legislative intent to encompass other, unlisted sources of income.”). “[W]here general words [in this case, “monthly ... income”] precede the enumeration of particular classes of things, the *ejusdem generis* [canon] of construction requires that the general words ... be construed as applying only to things of the same general kind as those enumerated.” *See DeHaven v. Hall*, 2008 S.D. 57, ¶ 51, 753 N.W.2d 429, 444–45. Therefore, the question is whether a lump sum inheritance is a thing of the same general kind as the listed sources of “income” in SDCL 25–7–6.3.5

The question whether a prospective inheritance is “income” for purposes of calculating child support was not answered in *Peterson v. Peterson*, 2000 S.D. 58, 610 N.W.2d 69, or *Gross v. Gross*, 355 N.W.2d 4 (S.D.1984). In Peterson, we acknowledged our decision in *Gross v. Gross*, 355 N.W.2d 4, ¶ 21, 610 N.W.2d at 72. We indicated that in *Gross*, “a pending inheritance award was included in the calculation of child support.” *Id.* However, *Peterson’s* statement of the holding in *Gross* was incorrect. In *Gross*, we only held that a pending inheritance could be considered in determining whether there was a change in circumstances justifying a modification of a prior child support order. 355 N.W.2d at 8–9. Further, *Gross* was decided before the enactment of the child support guidelines statutes. Therefore, *Gross* does not stand for the proposition that a pending inheritance is “monthly income” for purposes of calculating child support under SDCL 25–7–6.3.

[11] ¶ 11.] We conclude that Father’s lump sum inheritance is an asset or capital that is unlike the types of monthly income listed in SDCL 25–7–6.3. First, Father’s inheritance is not similar to compensation for services, income from self-employment, or periodic payments from pensions or retirement programs. See SDCL 25–7–6.3(1)–(3). Second, his inheritance is not similar to the gains derived from the investment or conversion of assets. See SDCL 25–7–6.3(4)–(5). Finally, his inheritance is not similar to worker’s compensation, unemployment insurance, or other benefits paid in lieu of compensation. See SDCL 25–7–6.3(6)–(8). Father’s lump sum inheritance is a gift of capital that is not captured by the statute.
that party ever sought the advice of the beneficiary. Because Lincoln argues that no confidential relationship existed, he contends that the court erred in applying the presumption of undue influence. 2

2 The presumption of undue influence is a mechanism that alters the burden of production. When the presumption arises, the burden of production shifts to the beneficiary to show he took no unfair advantage of the person who was allegedly unduly influenced. However, the ultimate burden of persuasion remains on the contestant to prove the elements of undue influence by a preponderance of the evidence. See SDCL 53-4-7. 3

Lincoln argues that the circuit court's alternative ruling is not independent of the court's confidential relationship determination because confidential relationship language appears in various conclusions of law discussing the alternative ruling. However, the court's findings of fact (that do not refer to a confidential relationship) clearly establish undue influence under the four alternative factors. We conclude that the circuit court's alternative ruling was independent of the ruling that a confidential relationship existed.

3 Undue influence occurs:
   (1) In the use, by one in whom a confidence is reposed by another, or who holds a real or apparent authority over him, of such confidence or authority for the purpose of obtaining an unfair advantage over him; or
   (2) In taking an unfair advantage of another's weakness of mind; or
   (3) In taking a grossly oppressive and unfair advantage of another's necessities or distress.

SDCL 53-4-7.

Susceptibility to Undue Influence

Lincoln argues that no evidence supported the court's finding that Pearl was susceptible to undue influence. He focuses on the absence of medical evidence regarding Pearl's mental functioning. Lincoln contends that in the absence of medical evidence of mental deficits, the court erred in finding that Pearl was susceptible to undue influence.

Concededly, "physical and mental weakness is always material upon the question of undue influence." Obviously, an aged and infirm person with impaired mental faculties would be more susceptible to influence than a mentally alert younger person in good health." In re Estate of Metz, 78 S.D. 212, 221, 100 N.W.2d 393, 398 (1960) (quoting Johnson v. Shaver, 41 S.D. 585, 172 N.W. 676, 678 (1919)). But this Court has not required medical evidence to prove susceptibility to undue influence. See, e.g., id. (finding susceptibility to undue influence solely through inconsistent testamentary statements and admissions that the party allegedly influenced was senile, childish, and incompetent to attend to his business affairs).

In this case, there was substantial non-medical evidence demonstrating Pearl's susceptibility to undue influence. Pearl had an eighth-grade education, and she lacked experience in business and personal transactions. When she signed the contract for deed, Pearl was almost eighty-four and hard of hearing. Pearl and Dennis testified that she had relied on her deceased husband to take care of all their business and legal matters during their marriage. This dependency continued after Harold's death. Pearl testified that, with the exception of her checking account and monthly expenses, she often asked her children for help with business and financial affairs, which she did not understand. Pearl's daughter Cheryl confirmed that Pearl's children had to explain such things as hospital bills, "documents," and Social Security because Pearl lacked experience with business matters. Further, Pearl, Dennis, and Cheryl testified that Pearl did not understand the contract for deed until they explained it to her after it had been executed. Susceptibility to undue influence
Section 1.

Terms used in this Act mean:

(1) "Attending physician," the physician who has primary responsibility for the care of the patient and treatment of the patient’s terminal disease;

(2) "Competency," in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient's ability to make and communicate an informed decision to healthcare providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available;

(3) "Consulting physician," a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease;

(4) "Counseling," 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;

(5) "Health care provider," 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;

(6) "Informed decision," a decision by a qualified patient, to request and obtain a prescription for medication that the qualified patient may self-administer to end the patient’s 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) The qualified patient's medical diagnosis;

(b) The qualified 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; and

(e) The feasible alternatives such as, comfort care, hospice care, and pain control;

(7) "Medically confirmed," the medical opinion of the attending physician that has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records;

(8) "Patient," a person who is under the care of a physician;

(9) "Physician," a doctor of medicine or a doctor of osteopathy licensed to practice medicine under chapter 36-4;
(10) "Qualified patient," a competent adult who is a resident of South Dakota and has satisfied the requirements of this Act in order to obtain a prescription for medication that the qualified patient may self-administer to end the patient's life in a humane and dignified manner;

(11) "Self-administer," a qualified patient's act of ingesting medication to end the patient's life in a humane and dignified manner; and

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

Section 2.

An adult patient who is competent, is a resident of South Dakota, and is determined by the attending physician and consulting physician to be suffering from a terminal disease, and who is voluntarily expressing a wish to die, may make a written request for medication that the patient may self-administer to end the patient's life in a humane and dignified manner in accordance with this Act; No person qualifies under this Act solely because of age or disability.

Section 3.

A valid request for medication under this Act shall be in substantially the form provided in this section, signed and dated by the patient and witnessed by at least two persons 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.

One of the witnesses shall be a person who is not:
(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; or
(3) An owner, operator, or employee of a healthcare facility where the qualified patient is receiving medical treatment or is a resident.

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

If the patient is a resident in a long-term care facility at the time the written request is made, one of the witnesses shall be a person designated by the
facility who meets the qualifications specified by the Department of Health in rules promulgated pursuant to chapter 1-26.

A request for medication as authorized by this Act 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 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:

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Section 4.

The attending physician shall:
(1) Make the initial determination of whether a patient has a terminal disease, is competent, and has made the request voluntarily;
(2) Require the patient to demonstrate South Dakota residency pursuant to section 13 of this Act;
(3) Ensure that the patient is making an informed decision by informing the patient of:
   (a) The patient's medical diagnosis;
   (b) The patient's prognosis;
   (c) The potential risks associated with taking the medication to be prescribed;
   (d) The probable result of taking the medication to be prescribed; and
   (e) The feasible alternatives such as comfort care, hospice care, and pain control;

NOTE: One witness may not be a relative by blood, marriage, or adoption of the person signing this request, may not be entitled to any portion of the person's estate upon death, and may 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 a person designated by the facility.
(4) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily;
(5) Refer the patient for counseling, if appropriate;
(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 under this Act and of not taking the medication in a public place;
(8) Inform the patient that the patient may 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;
(9) Verify, immediately before writing the prescription for medication under this Act, that the patient is making an informed decision;
(10) Fulfill the medical record documentation requirements;
(11) Ensure that all appropriate steps are carried out in accordance with this Act before writing a prescription for medication to enable a qualified patient to end the patient's life in a humane and dignified manner; and
(12) 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 or with the patient's written consent, the attending physician shall:
(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 may not be dispensed by mail or other form of courier.

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

Section 5.

Before a patient is qualified under this Act, 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 competent, is acting voluntarily, and has made an informed decision.
Section 6.

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 may not 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.

Section 7.

No person may receive a prescription for medication to end the person's life in a humane and dignified manner unless the person has made an informed decision. Immediately before writing a prescription for medication under this Act, the attending physician shall verify that the qualified patient is making an informed decision.

Section 8.

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

Section 9.

To receive a prescription for medication that the qualified patient may self-administer to end the patient's life in a humane and dignified manner, a qualified patient shall make an oral request and a written request, and reiterate the oral request to the qualified patient's attending physician at least fifteen days after making the initial oral request. At the time the qualified patient makes a second oral request, the attending physician shall offer the qualified patient an opportunity to rescind the request.
Section 10.

A patient may rescind a request at any time and in any manner without regard to the patient’s mental state. No prescription for medication under this Act may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

Section 11.

At least fifteen days shall elapse between the patient’s initial oral request and the writing of a prescription under this Act. At least forty-eight hours shall elapse between the date the patient signs the written request and the writing of a prescription under this Act.

Section 12.

The following shall be documented or filed in the patient’s medical record:
(1) Any oral request by a patient for medication to end the patient’s life in a humane and dignified manner;
(2) Any written request 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, 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 the request at the time of the patient’s second oral request; and
(7) A note by the attending physician indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

Section 13.

Only requests made by South Dakota residents under this Act may be granted. A patient may demonstrate residency by any of the following:
(1) Possession of a South Dakota driver’s license;
(2) Registration to vote in South Dakota; or
(3) Evidence that the person owns or leases property in South Dakota.
Section 14.

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

Section 15.

The Department of Health shall annually review all records maintained under this Act. The department shall require any health care provider upon writing a prescription or dispensing medication under this Act to file a copy of the dispensing record and any other required documentation with the department. All required documentation shall be mailed or otherwise transmitted as allowed by the department no later than thirty calendar days after the writing of a prescription and dispensing of medication under this Act, 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.

The Department of Health shall promulgate rules pursuant to Chapter 1-26 outlining the documentation required pursuant to this section and how the documentation may be transmitted to the department. Notwithstanding any other provision of law, the information collected is not a public record and may not be made available for inspection by the public.

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

Section 16.

No provision in any 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 the person’s life in a humane and dignified manner, is valid.

No obligation 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 the person’s life in a humane and dignified manner.
Section 17.

No sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy may be conditioned upon or affected by the making or rescinding of a request, by a patient, for medication that the patient may self-administer to end the person's [sic] in a humane and dignified manner. A qualified patient's act of ingesting medication to end the patient's life in a humane and dignified manner does not have an effect upon any life, health, or accident insurance or annuity policy.

Section 18.

Nothing in this Act authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Any action taken in accordance with this Act does not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. No state report may refer to any practice under this Act as suicide or assisted suicide. Any state report shall refer to practice under this Act as obtaining and self-administering life-ending medication.

Nothing in this Act may 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 Act.

Section 19.

No person may be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act. This includes being present when a qualified patient takes the prescribed medication to end the patient's life in a humane and dignified manner.

Section 20.

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 this Act.
Section 21.

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.

Section 22.

Only willing health care providers may participate in the provision to a qualified patient of medication to end the patient's 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 Act, and the patient transfers the patient's 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.

Section 23.

A health care provider may prohibit another health care provider from participating under this Act 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. If a health care provider has provided the notice required pursuant to this section, the health care provider may subject another health care provider to the following sanctions:

(1) 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 under this Act while on the health care facility premises of the sanctioning health care provider, excluding the private medical office of a physician or other provider;
(2) 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 under this Act 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
(3) Termination of a contract or other nonmonetary remedies provided by contract if the sanctioned provider participates under this Act 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 section prevents a health care provider from participating under this Act while acting outside the course and scope of the provider’s capacity as an employee or independent contractor or a patient from contracting with the patient’s 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.

A health care provider that imposes sanctions under this action 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. No sanction imposed under this section may be the sole basis for a report of unprofessional conduct.

For the purposes of this section the notice required shall be in writing to the health care provider specifically informing the health care provider before the provider’s participation under this Act of the sanctioning health care provider's policy about participation in activities covered under this Act. Participating under this Act does not include making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis, providing information about this Act to a patient upon the request of the patient, or providing a patient, upon the request of the patient, with a referral to another physician.

Section 24.

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.

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.

This Act does not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person. The penalties in this section do not preclude criminal penalties applicable under other law for conduct that is inconsistent with this Act.
Section 25.

Any governmental entity that incurs costs resulting from a person terminating the person's life under this Act 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.

Section 26.

The effective date of this Act is April 1, 2019.

Be it enacted by the people of South Dakota.