End of Life Choices: LWVAZ White Paper

Considering End of Life Choices - The Oregon Model

League of Women Voters of Arizona
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Informational White Paper for background
and educational use on issue of
End of Life Choices

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White Paper

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1. INTRODUCTION

At the bi-annual convention of the League of Women Voters of Arizona on May 19, 2013, it was decided to develop a White Paper on end of life choices and related legislation as it pertains to the League of Women Voters' Health Care position.[1] In considering the allocation of health care resources, the position of LWVUS emphasizes *quality of life* and the *wishes of the patient*, two factors that figure heavily in end of life issues.

End of life issues encompass many concerns, including advance directives, hospice care, palliative care, right-to-know, and do-not-resuscitate orders, among others. Specifically, this paper focuses on the **pros and cons of laws that permit a terminally ill, mentally competent adult to obtain prescription medication to hasten death.** This focus is chosen both for its high level of interest with many League members and a sudden wave of legislative activity across the country.

This paper is intended for league units and others around the state (or nation) as a basis for discussion if they choose to use it. Discussion may or may not lead to more formal action.

2. BACKGROUND

Approximately 16 years ago, Oregon enacted the first such law that is the subject of this paper. Now widely known as “the Oregon model,” it has been largely copied by other states that have enacted or proposed the same or similar laws. Four (4) states currently have such laws.

The laws in Oregon and Washington came into effect by ballot initiative. Montana's law came into being through a state Supreme Court decision and, most recently, Vermont's law was enacted by its legislature. In 2012, an Oregon style ballot initiative in Massachusetts failed 49% to 51%. By early 2013 at least seven other states had Oregon model bills pending in their legislatures. In Arizona, a similar legislative effort was tried but failed to gain support, although not recently.

3. WHAT THE MODEL LAW PROVIDES

A. First and foremost, the Oregon model is not euthanasia. With euthanasia, one person, such as Dr. Kevorkian, brings about the death of another. By contrast, the Oregon model requires that *only the patient himself may administer the medication*.[2] While this avoids a host of issues, it also eliminates some groups of the terminally ill from using the law. For example, late stage ALS patients who are perfectly competent mentally may want to use the law, but because they cannot swallow and can no longer use their arms they cannot administer the medication, and therefore cannot qualify. Similarly, patients with late stage Alzheimer's disease, who may have wanted to use the law at an earlier time when they were mentally competent, cannot later do so.

B. Two physicians must certify that the patient is terminally ill, that is, likely to die within six months. These two doctors may not be related to each other or part of the same medical practice. If either of them decides that the patient is depressed, the patient must be referred for counseling and be found to be competent, that is, able to make a rational choice.

C. The patient's decision must be witnessed and there must be a suitable time delay to ensure that the decision is not made in haste, without careful consideration.

D. The patient must be informed of alternatives, such as hospice care and adjustments to pain medication.[3]

E. Numerous other protections must be met. [4]

4. COMMON ARGUMENTS AGAINST THE OREGON MODEL

A. It is up to God when and how a person dies and is therefore not our right to tinker with this awesome event. This religious based view is deeply held by many [5] and, as such, should be and is fully respected and protected by our laws and public policies. However, it is not a religious view shared by all. Some religions specifically permit an Oregon style death.[6] Others are mixed.[7] Additionally, many atheists do not share this opposition view. Therefore, it can be argued that a law which bars an Oregon style death interferes with the right of some to exercise their First Amendment free exercise of religion. At the same time, many of our laws prohibit conduct that some religions permit, such as polygamy.

B. A physician's duty is to heal, not kill. Responses to this argument depend on interpretation of the physician's oath to "do no harm." At least some medical societies interpret the oath to preclude writing a prescription that the physician knows or has reason to know, the patient intends to use to end his life. However, a physician's duty also includes alleviation of suffering. The positions of a range of medical and public health organizations illustrate a widespread divergence of views within the medical community.[8] Since doctors differ on the issue of abortion and other medical procedures, they may be expected to differ on this issue.

C. No matter how well intentioned initially this will start us down a slippery slope that will expand to include forced prescriptions for the elderly, the infirm and disabled, the uninsured and possibly others who are not terminally ill. This is a concern of an organization that frequently lobbies against Oregon style laws, Not Dead Yet (NDY).[9] Sections of the Oregon bill and others based on it are replete with protections intended to prevent the bill from ever being used for anyone other than the persons for whom the bill was intended. Specifically, one section bars the prescription from being written for anyone solely because of age or disability.[10]

Have these protections worked? In the 16 years that the Oregon law has been tracked, both by the state health department and by independent peer review groups,[11] not a single instance of abuse has been identified. This is not proof that such abuses are absent. Further, the law provides that forging a request for the prescription or exerting undue influence to cause a patient to ask for it is a felony. This, too, does not prove such coercion or forgeries have been absent. [12]

D. There is no way to completely police this type of law so it is inevitable that there will be abuses. This argument can be used to oppose any and all such laws. The public must assess this risk in each case and balance it against perceived benefits.

E. Some elderly will feel they should end their lives before they want to because they will feel a duty to preserve the funds their relatives will inherit or to save relatives the chore of extended care. This may be happening in the states that have the Oregon model. On the other hand, it may also be happening in states with no Oregon model law. To date, there is no study known to the undersigned committee that indicates a connection between the activity feared and the existence of an Oregon type law.

F. Requests for the prescription medication are really about pain and if the pain were managed properly, there would be no need for the law. Sometimes, the side effects of medication are horrific. Further, the Oregon data show that about 97% of patients who obtained the medication were in hospice care, generally believed to be the best providers of pain management.[13] However, not all pain is responsive to even the best known pain medication. [14] Furthermore, not all pain at end of life is physical.

G. Requests for the prescription medication are really a cry for help. The Oregon model has many layers of protection to identify patients who do not really want the prescription but are reaching out for something else.[15] There is no proof, however, that those protections work in every case.

H. A diagnosis of terminal illness can be wrong. More than one physician must find that the patient is terminally ill. This, by itself, still does not guarantee that the diagnosis is correct. There are countless instances where the six month estimate is dramatically off, with such patients living for *years* after a diagnosis of terminal illness. However, it can be argued that *any* medical diagnosis carries the risk of error. The public must balance perceived risks with perceived benefits.

5. COMMON ARGUMENTS IN FAVOR OF THE OREGON MODEL

A. Each person owns his/her own body. Therefore, a patient has the right to terminate life when faced with the final stages of a terminal illness that will diminish quality of life and render it no longer worth living. While there is a strong tradition of individual liberty in the United States, the law does not give individuals unlimited and unfettered control over their own bodies. Abortion laws restrict the procedure after a certain number of weeks of pregnancy, as an example. Individuals are not permitted to take certain drugs, like heroin. Individuals are not permitted to cross the street against a traffic light no matter how hurried they are and there are countless other restrictions on a person's use of his own body.

B. My religion permits me to do this under these circumstances (a terminal illness) so therefore, I am exercising my First Amendment right to free exercise of religion. However, legislatures enact a wide range of statutes that counter religious views such as laws against polygamy, child marriage and so forth.

C. Humans should have the same humane treatment as terminally ill pets, which we do not allow to suffer needlessly. Comparing humans with animals goes only so far. We put suffering animals "to sleep" without their permission. This is <u>not</u> the Oregon Model.

D. Each of us has a right of privacy in our relationship with our physician and no one outside that relationship should know about it or interfere with it. This right of privacy extends to our physicians. This right to privacy was part of the underlying Montana State Supreme Court decision[16] that confirmed the right to die in that state. This concept was also put forth in a legal opinion by the State Attorney General of Georgia.[17] While the Georgia legislature subsequently overturned this position, other legislatures may find the argument more compelling.

E. On average more than half of a person's medical care expenditures over his/her lifetime is spent in the last few months of life. **The coming crisis in Medicare mandates that we permit the Oregon model everywhere to help save Medicare.** This argument indeed has a slippery slope in which any procedure could be encouraged or denied dependent upon its cost, rather than urgency or even likelihood of success. The LWVUS Health Care position includes as a primary consideration *the patient's wishes*. Therefore, it could be argued that the patient's decision should determine whether the prescription is provided, not financial considerations. The fact that approximately 30% of Oregon patients who obtain the prescription *never use it* [18] should likewise not affect whether it is provided since the patients wanted it, presumably find comfort in having it, and so comports with League's position that his or her wishes should prevail.

F. Terminally ill patients frequently end their lives before they really want to (and do so violently) for fear that they will not be physically able to do so at a later stage of their illness. The trauma suffered by the surviving loved one carries dreadful memories which neither that person nor the deceased would want. An Oregon style law enables a terminally ill person to live longer knowing he can end suffering even when mobility is limited. This argument is anecdotal. There is no research to support it.

ENDNOTES

[1] LWVUS Impact on Issues: A Guide to Public Policy Positions, "Health Care," April 1993; updated September 2011.

[2] Oregon Revised Statutes, Chapter 127.815s.3.01 (1) (g). (See appendix.)

[3] Oregon Revised Statues, Chapter 127. 815s.3.01 (1) (c) (E). (See appendix.)

[4] Oregon Revised Statues, Chapter 127.

[5] Catholic Catechism, Sec. 2277 for example, "An act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God...this murderous act must always be forbidden and excluded."

[6] Unitarian: "The Right to Die With Dignity," 1988 General Resolution.

[7] Jewish: Although the Jewish community overwhelmingly supports an Oregon-style law, there is no specific written position. The Talmud provides that nothing should be done to either prolong the life of a terminally ill person or to shorten it. The Reform Jewish movement has a formal 1991 Responsa (literally 'queries and replies') titled "Health Care Decisions on Dying" that resolves to "reaffirm that in accordance with Jewish tradition each individual has the ethical, moral and legal right to make his own or her own health care decisions, and that such right survives incompetency;" it further resolves to "promote and support the enactment of national, state and provincial legislation...to facilitate the decision making process."

[8] Medical Groups in Favor of Physician Assisted Dying: American Medical Student Association, American Medical Women's Association, American College of Legal Medicine, American Public Health Association.
Medical Groups Against: American Medical Association, American Nurses Association, Christian Medical and Dental Associations. Patient's Rights Council.

[9] Not Dead Yet (**www.notdeadyet.org**).

[10] Oregon Revised Statutes, Chapter 127. 805s2.01 (2).

[11] Journal of Medical Ethics "Legal Physician Assisted Dying in Oregon and the Netherlands; Evidence Concerning the Impact on Patients in Vulnerable Groups." J Med Ethics, 2007, 33: 591-597. Report to the Vermont Legislature: "Oregon's Death with Dignity Law and Euthanasia in the Netherlands: Factual Disputes." Montpelier, Vermont, Legislative Council 2004:30. Annual report of the Oregon Public Health Division – the most recent is "Oregon's Death with Dignity Act –2012":
http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx

[12] Oregon Revised Statutes, Chapter 127. 890s4.02(1)(2)

[13] Oregon's Public Health Division, Death with Dignity Act—2012 Annual Report. (See appendix B.)

[14] Nevertheless, the U.S. Supreme Court has recognized that "…palliative care, however, cannot alleviate all pain and suffering." Vacco v. Quill, 521 U.S. 793 (1997).

[15] Oregon Revised Statutes, Chapter 127.

[16] Baxter v. State, 2009 Mt 449. In 2009, the Montana Supreme Court ruled that physicians may assist patients in ending their lives by prescribing lethal medications (to be self-administered by the patient), citing the state's Rights of the Terminally Ill Act. Information on the Montana Supreme Court decision can be found at
http://searchcourts.mt.gov/getDocument?vid={88A87FE0-2501-438A-AC31-CCE62D37C894} .

[17] Georgia Code 16-5-5(b) only prohibits publically advertising, offering or holding oneself out as offering to intentionally and actively assist another in the commission of suicide. In a brief submitted to the Supreme Court of Georgia in 2011 the state's Attorney General found that Georgia law permits a physician to write a prescription for life ending medication to a terminally ill, mentally competent adult. That position was subsequently overridden by state legislation.

[18] Ibid 13. (Oregon's Public Health Division, Death with Dignity Act – 2012 Annual Report. See Appendix B.)

APPENDICES -- A & B

Appendix A – Oregon Death with Dignity Act

Oregon Revised Statute

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

127.800 s.1.01. Definitions.
The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

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

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

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

(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

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

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

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

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

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

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.
(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 s.2.01; 1999 c.423 s.2]

127.810 s.2.02. Form of the written request.
(1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

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

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

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

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

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

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

(Safeguards)

(Section 3)

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

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

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

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

(A) His or her medical diagnosis;

(B) His or her prognosis;

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

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

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

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

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

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

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

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

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

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

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

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

(B) With the patient's written consent:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Possession of an Oregon driver license;

(2) Registration to vote in Oregon;

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

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

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; 1999 c.423 s.9]

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]

127.880 s.3.14. Construction of Act.
Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 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 127.890:

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

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

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

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

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

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the

sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

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

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

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

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

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

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

(d) For purposes of this subsection:

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

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

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

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

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

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

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

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

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

127.890 s.4.02. Liabilities.

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

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

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

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

127.892 Claims by governmental entity for costs incurred.

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

(Severability)

(Section 5)

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

(Form of the Request)

(Section 6)

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

REQUEST FOR MEDICATION

TO END MY LIFE IN A HUMANE

AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

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

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

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

INITIAL ONE:

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

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

_____ I have no family to inform of my decision.

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

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

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

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

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

(b) Signed this request in our presence;

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

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

_____ Witness 1/Date

_____ Witness 2/Date

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

[1995 c.3 s.6.01; 1999 c.423 s.11]

PENALTIES

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

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

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

Appendix B –From Oregon Public Health Division.

Image of report on following pages. For obtain a crisper copy for printing, see document at:

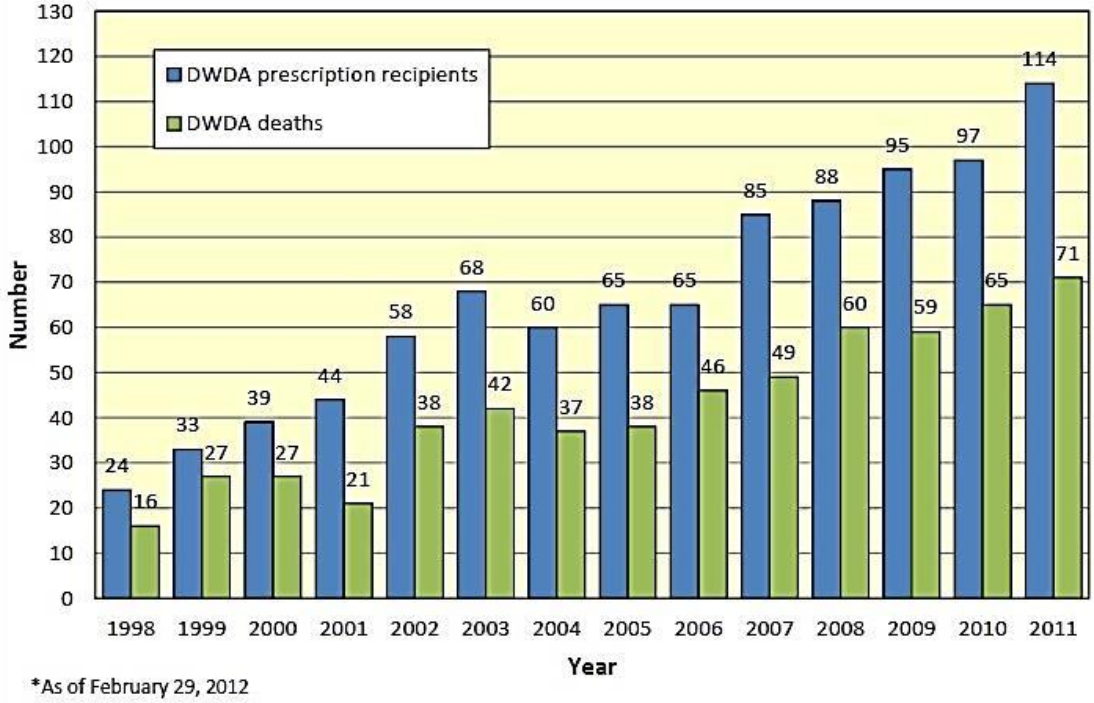
http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx

Oregon Public Health Division

Oregon's Death with Dignity Act--2011

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2011 are listed below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and deaths that occurred as a result of ingesting prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of February 29, 2012. For more detail, please view the figures and tables on our web site at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2011



*As of February 29, 2012

- As of February 29, 2012, prescriptions for lethal medications were written for 114 people during 2011 under the provisions of the DWDA, compared to 97[1] during 2010 (Figure 1). At the time of this

[1] The Oregon Public Health Division's 2010 Report lists 96 prescriptions because the report listed data as of January 7, 2011. Information on one additional prescription written in 2010 was received following the date of the report.

report, there were 71 known DWDA deaths during 2011. This corresponds to 22.5 DWDA deaths per 10,000 total deaths.[2]

- Since the law was passed in 1997, a total of 935 people have had DWDA prescriptions written and 596 patients have died from ingesting medications prescribed under the DWDA.

- Of the 114 patients for whom DWDA prescriptions were written during 2011, 64 (56.1%) ingested the medication; 63 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness approximately 14 hours following ingestion and died about 38 hours later. Incomplete ingestion was reported for the patient.

- Nine patients with prescriptions written in previous years ingested the medication during 2011; eight of these patients died from ingesting the medication, and one ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient briefly regained consciousness following ingestion and died approximately 30 hours later. Possible medication tolerance was reported for the patient. Thus, two patients ingesting lethal medication in 2011 awoke and ultimately died of their underlying illness. One patient received their prescription in 2011 and the other received their prescription in 2010.

- Twenty-five (25) of the 114 patients who received DWDA prescriptions during 2011 did not take the medications and died of their underlying illness.

- Ingestion status is unknown for 25 patients for whom DWDA prescriptions were written during 2011. Three of these patients died and follow-up questionnaires were received, but ingestion status could not be determined. For the remaining 22 patients, both death and ingestion status are pending (Figure 2).

- Of the 71 DWDA deaths during 2011, most (69.0%) were aged 65 years or older; the median age was 70 years. As in previous years, most were white (95.6%), well-educated (48.5% had a least a baccalaureate degree), and had cancer (82.4%).

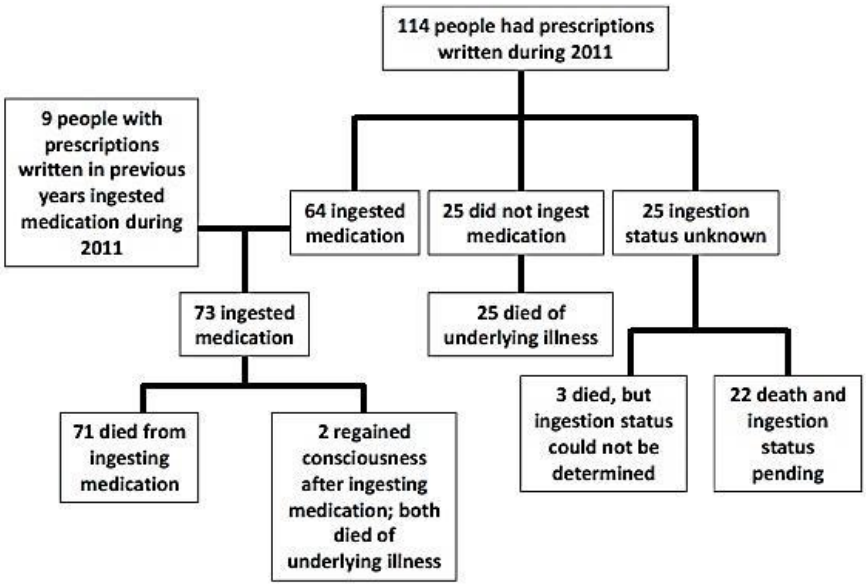
- Most (94.1%) patients died at home; and most (96.7%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Most (96.7%) had some form of health care insurance, although the number of patients who had private insurance (50.8%) was lower in 2011 than in previous years (68.0%), and the number of patients who had only Medicare or Medicaid insurance was higher than in previous years (45.9% compared to 30.4%).

- As in previous years, the three most frequently mentioned end-of-life concerns were: decreasing ability to participate in activities that made life enjoyable (90.1%), loss of autonomy (88.7%), and loss of dignity (74.6%).

[2] Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2009 (31,547), the most recent year for which final death data is available.

- One of the 71 DWDA patients who died during 2011 was referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for six patients (8.5%) during 2011 compared to 18.7% in previous years.
- A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for eight of the 71 DWDA deaths during 2011. Among those eight patients, time from ingestion until death ranged from 15 minutes to 1.5 hours.
- Sixty-two (62) physicians wrote the 114 prescriptions provided during 2011 (range 1-14 prescriptions per physician).
- During 2011, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2011, as of February 29, 2012



http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf

Table 1. Characteristics and end-of-life care of 596 DWDA patients who have died from ingesting a lethal dose of medication as of February 29, 2012, by year, Oregon, 1998-2011

Characteristics	2011 (N=71)	1998-2010 (N=525)	Total (N=596)
Sex	N (%)[1]	N (%)[1]	N (%)[1]
Male (%)	26 (36.6)	282 (53.7)	308 (51.7)
Female (%)	45 (63.4)	243 (46.3)	288 (48.3)
Age			
18-34 (%)	0 (0.0)	6 (1.1)	6 (1.0)
35-44 (%)	1 (1.4)	13 (2.5)	14 (2.3)
45-54 (%)	5 (7.0)	39 (7.4)	44 (7.4)
55-64 (%)	16 (22.5)	107 (20.4)	123 (20.6)
65-74 (%)	23 (32.4)	147 (28.0)	170 (28.5)
75-84 (%)	18 (25.4)	150 (28.6)	168 (28.2)
85+ (%)	8 (11.3)	63 (12.0)	71 (11.9)
Median years (range)	70 (41-96)	71 (25-96)	71 (25-96)
Race			
White (%)	65 (95.6)	514 (97.9)	579 (97.6)
African American (%)	0 (0.0)	1 (0.2)	1 (0.2)
American Indian (%)	0 (0.0)	1 (0.2)	1 (0.2)
Asian (%)	0 (0.0)	7 (1.3)	7 (1.2)
Pacific Islander (%)	1 (1.5)	0 (0.0)	1 (0.2)
Other (%)	0 (0.0)	0 (0.0)	0 (0.0)
Two or more races (%)	0 (0.0)	0 (0.0)	0 (0.0)
Hispanic (%)	2 (2.9)	2 (0.4)	4 (0.7)
Unknown	*3*	*0*	*3*
Marital Status			
Married (%)	26 (38.2)	245 (46.7)	271 (45.7)
Widowed (%)	19 (27.9)	115 (21.9)	134 (22.6)
Never married (%)	7 (10.3)	42 (8.0)	49 (8.3)
Divorced (%)	16 (23.5)	123 (23.4)	139 (23.4)
Unknown	*3*	*0*	*3*
Education			
Less than high school (%)	3 (4.4)	37 (7.1)	40 (6.8)
High school graduate (%)	9 (13.2)	130 (24.9)	139 (23.5)
Some college (%)	23 (33.8)	125 (23.9)	148 (25.0)
Baccalaureate or higher (%)	33 (48.5)	231 (44.2)	264 (44.7)
Unknown	*3*	*2*	*5*
Residence			
Metro counties (%)[2]	27 (39.7)	226 (43.0)	253 (42.7)
Coastal counties (%)	6 (8.8)	41 (7.8)	47 (7.9)
Other western counties (%)	31 (45.6)	219 (41.7)	250 (42.2)
East of the Cascades (%)	4 (5.9)	39 (7.4)	43 (7.3)
Unknown	*3*	*0*	*3*
End of life care			
Hospice			
Enrolled (%)[3]	59 (96.7)	463 (88.9)	522 (89.7)
Not enrolled (%)	2 (3.3)	58 (11.1)	60 (10.3)
Unknown	*10*	*4*	*14*
Insurance			
Private (%)[4]	31 (50.8)	351 (68.0)	382 (66.2)
Medicare, Medicaid or Other Governmental (%)	28 (45.9)	157 (30.4)	185 (32.1)
None (%)	2 (3.3)	8 (1.6)	10 (1.7)
Unknown	*10*	*9*	*19*

Characteristics	2011 (N=71)	1998-2010 (N=525)	Total (N=596)
Underlying illness			
Malignant neoplasms (%)	**56 (82.4)**	**424 (80.8)**	**480 (80.9)**
Lung and bronchus (%)	16 (23.5)	96 (18.3)	112 (18.9)
Breast (%)	11 (16.2)	41 (7.8)	52 (8.8)
Colon (%)	2 (2.9)	34 (6.5)	36 (6.1)
Pancreas (%)	4 (5.9)	38 (7.2)	42 (7.1)
Prostate (%)	1 (1.5)	25 (4.8)	26 (4.4)
Ovary (%)	3 (4.4)	22 (4.2)	25 (4.2)
Other (%)	19 (27.9)	168 (32.0)	187 (31.5)
Amyotrophic lateral sclerosis (%)	**2 (2.9)**	**42 (8.0)**	**44 (7.4)**
Chronic lower respiratory disease (%)	**5 (7.4)**	**20 (3.8)**	**25 (4.2)**
Heart Disease (%)	**1 (1.5)**	**9 (1.7)**	**10 (1.7)**
HIV/AIDS (%)	**0 (0.0)**	**8 (1.5)**	**8 (1.3)**
Other illnesses (%)[5]	**4 (5.9)**	**22 (4.2)**	**26 (4.4)**
Unknown	***3***	***0***	***3***
DWDA process			
Referred for psychiatric evaluation (%)	1 (1.4)	39 (7.4)	40 (6.7)
Patient informed family of decision (%)[6]	70 (98.6)	423 (93.8)	493 (94.4)
Patient died at			
Home (patient, family or friend) (%)	64 (94.1)	498 (94.9)	562 (94.8)
Long term care, assisted living or foster care facility (%)	4 (5.9)	21 (4.0)	25 (4.2)
Hospital (%)	0 (0.0)	1 (0.2)	1 (0.2)
Other (%)	0 (0.0)	5 (1.0)	5 (0.8)
Unknown	*3*	*0*	*3*
Lethal medication			
Secobarbital (%)	56 (78.9)	318 (60.6)	374 (62.8)
Pentobarbital (%)	15 (21.1)	200 (38.1)	215 (36.1)
Other (%)[7]	0 (0.0)	7 (1.3)	7 (1.2)
End of life concerns[8]	**(N=71)**	**(N=521)**	**(N=592)**
Losing autonomy (%)	63 (88.7)	475 (91.2)	538 (90.9)
Less able to engage in activities making life enjoyable (%)	64 (90.1)	459 (88.1)	523 (88.3)
Loss of dignity (%)[9]	53 (74.6)	333 (84.1)	386 (82.7)
Losing control of bodily functions (%)	24 (33.8)	294 (56.4)	318 (53.7)
Burden on family, friends/caregivers (%)	30 (42.3)	184 (35.3)	214 (36.1)
Inadequate pain control or concern about it (%)	23 (32.4)	111 (21.3)	134 (22.6)
Financial implications of treatment (%)	2 (2.8)	13 (2.5)	15 (2.5)
Health-care provider present[10]	**(N=71)**	**(N=455)**	**(N=526)**
When medication was ingested[11]			
Prescribing physician	6	94	100
Other provider, prescribing physician not present	3	228	231
No provider	5	67	72
Unknown	*57*	*66*	*123*
At time of death			
Prescribing physician (%)	6 (8.5)	83 (18.7)	89 (17.3)
Other provider, prescribing physician not present (%)	2 (2.8)	252 (56.9)	254 (49.4)
No provider (%)	63 (88.7)	108 (24.4)	171 (33.3)
Unknown	*0*	*12*	*12*
Complications[11]	**(N=71)**	**(N=525)**	**(N=596)**
Regurgitated	1	21	22
Seizures	0	0	0
None	11	456	467
Unknown	*59*	*48*	*107*
Other outcomes			
Regained consciousness after ingesting DWDA medications[12]	2	3	5

Characteristics	2011 (N=71)	1998-2010 (N=525)	Total (N=596)
Timing of DWDA event			
Duration (weeks) of patient-physician relationship[13]			
Median	12	12	12
Range	1-1379	0-1905	0-1905
Number of patients with information available	*71*	*523*	*594*
Number of patients with information unknown	*0*	*2*	*2*
Duration (days) between 1st request and death			
Median	47	46	46
Range	15-872	15-1009	15-1009
Number of patients with information available	*71*	*525*	*596*
Number of patients with information unknown	*0*	*0*	*0*
Minutes between ingestion and unconsciousness[11]			
Median	5	5	5
Range	2-10	1-38	1-38
Number of patients with information available	*8*	*454*	*462*
Number of patients with information unknown	*63*	*71*	*134*
Minutes between ingestion and death[11]			
Median	27	25	25
Range (minutes - hours)	15min-1.5hrs	1min-104hrs	1min-104hrs
Number of patients with information available	*8*	*459*	*467*
Number of patients with information unknown	*63*	*66*	*129*

1 Unknowns are excluded when calculating percentages.

2 Clackamas, Multnomah, and Washington counties.

3 Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.

4 Private insurance category includes those with private insurance alone or in combination with other insurance.

5 Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.

6 First recorded beginning in 2001. Since then, 21 patients (4.0%) have chosen not to inform their families, and 8 patients (1.5%) have had no family to inform. There was one unknown case in 2002, two in 2005, and one in 2009.

7 Other includes combinations of secobarbital, pentobarbital, and/or morphine.

8 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

9 First asked in 2003. Data available for 71 patients in 2011, 396 patients between 1998-2010, and 467 patients for all years.

10 The data shown are for 2001-2011 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.

11 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

12 Patients who regained consciousness after ingesting prescribed medications are not included in the total number of DWDA deaths. In 2005, one patient regained consciousness 65 hours after ingesting the medication, subsequently dying from underlying illness 14 days after awakening. In 2010, two patients regained consciousness after ingesting medications. One patient regained consciousness 88 hours after ingesting the medication, subsequently dying from underlying illness three months later. The other patient regained consciousness within 24 hours, subsequently dying from underlying illness five days following ingestion. In 2011, two patients regained consciousness after ingesting the medication. One of the patients very briefly regained consciousness after ingesting the prescribed medication and died from underlying illness about 30 hours later. The other patient regained consciousness approximately 14 hours after ingesting the medication and died from underlying illness about 38 hours later.

13 Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.

-- End of Appendices.

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