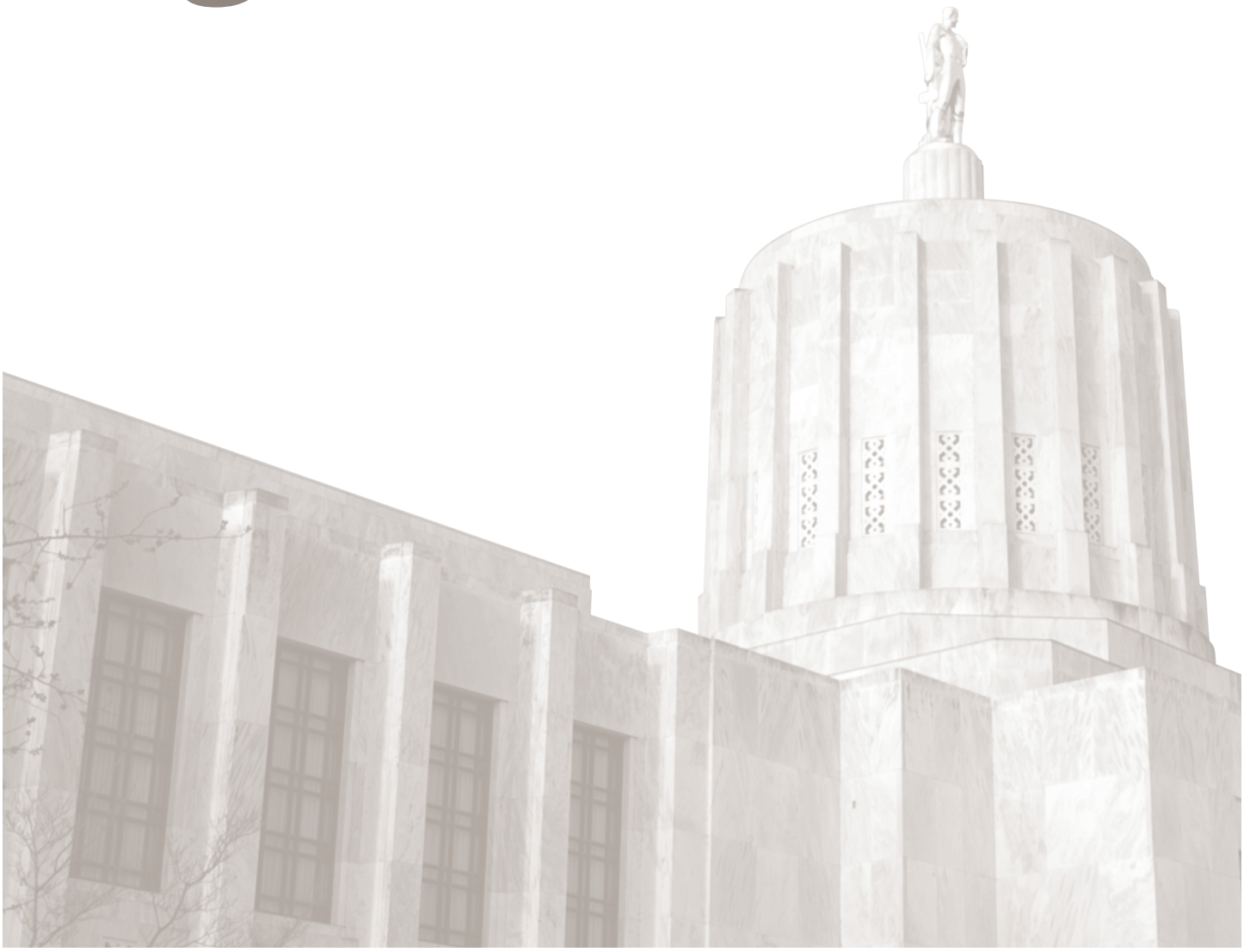
Death with Dignity
NATIONAL CENTER

Model Legislation



Death with Dignity
NATIONAL CENTER

520 SW 6th Avenue, Suite 1220
Portland, Oregon 97204

(503) 228-4415
info@deathwithdignity.org

DeathwithDignity.org
/DeathwithDignity
@DeathwDignity

It took well more than a year to write the Oregon Death with Dignity Act in 1993-1994, paving the way for passage of the world's first law approved by Oregon voters in 1994. Since then, the Act has served as the foundation for similar laws passed by legislatures or voters in nine jurisdictions, as well as legislation introduced by lawmakers in over 20 states.

This Death with Dignity National Center model legislation takes what we believe is the best language and best approach to many of the issues facing patients, families, legislators and voters, culled from our many years of work in states across the country who have considered and passed this law.

We have included language from the California and Maine statutes and an amendment to the Oregon law passed by the Oregon State Legislature in 2019.

Additionally, this document includes annotations that provide context for how the legislation has evolved to address issues of patient access and provider participation while keeping in place the same critical safeguards that ensures control, safety and autonomy.

We hope this document serves as a resource for policymakers, providers, scholars, and activists seeking to familiarize themselves with death with dignity legislation.

Peg Sandeen, PhD, MSW
Executive Director | Death with Dignity National Center

DEATH WITH DIGNITY NATIONAL CENTER will provide a professional consultation should you need assistance crafting a bill for your legislature or have questions regarding this model legislation.

You may research and compare all currently enacted laws using our website research tool at this link: **https://www.deathwithdignity.org/state-statute-navigator/**

FOR MORE INFORMATION

Peg Sandeen, PhD, MSW
Executive Director
psandeen@deathwithdignity.org

Val Lovelace
Statewide Campaigns Director
vlovelace@deathwithdignity.org

Death with Dignity Model Legislation

§1.01. Short Title. This chapter may be known and cited as the [State] Death with Dignity Act.

§2.01. Definitions. The following words and phrases, whenever used in this statute, 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.[1]

(3) "Capable" means that in the opinion of the patient's attending physician or consulting physician, state-licensed psychiatrist or state-licensed psychologist, state-licensed clinical social worker, or state-licensed clinical professional counselor, 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[2].

(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[3].

(6) "Department" means the [State Department of Public Health / Health].[4]

(7) "Health care provider" means:

---

[1]As of August 2020, twenty-two states allow "full practice authority" for advanced-practice nurses (APRN) to provide independent healthcare services for patients. This was not the case when Oregon's law was first enacted. Restricting the medical practice of death with dignity only to physicians may lead to limited patient access and under-utilization of provider resources in some states. Full practice laws and restrictions vary state to state, so this is one area of language that should be tailored to each states' laws.

[2]Some Death with Dignity statutes (Washington, e.g.) use the word "competent" in place of "capable" with the same definition. Competency is determined by judges and the courts, while questions of capacity are decided by physicians and other psychiatric and/or mental health consultants. See Leo, R. J. (1999). Competency and the capacity to make treatment decisions: A primer for primary care physicians. *Primary Care Companion to the Journal of Clinical Psychiatry,1*(5), 131-141. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC181079/ for a broader discussion. We are recommending "capacity" as the chosen model language because the Death with Dignity Act refers to medical professionals making decisions, and not the courts.

[3]The model language draws distinctions between the "attending physician" and "consulting physician." The attending physician is meant to assume primary responsibility for the care of the patient's terminal disease, much like an oncologist would assume primary responsibility for someone with a cancer diagnosis or a hospice medical director would take over care for a patient admitted into hospice.

The consulting physician, in a second opinion role, must have training or experience qualifying him or her to provide both diagnosis and prognosis.

It is not the case that any licensed physician in the state can write a Death with Dignity prescription or be an attending or consulting physician. Both roles must fit the defined guidelines.

[4]The Death with Dignity Act is not implemented by any department of the Executive Branch, as it acts as guidance for provider practice. However, the bill sets out a data collection and reporting process which is overseen by state epidemiologists.

(a) A person licensed, certified or otherwise authorized or permitted by the law of [State] to administer health care services or dispense medication in the ordinary course of business or practice of a profession; or

(b) A health care facility as defined by [state statute defining healthcare facility].

(8) "Informed decision" means a decision by a qualified patient to request and obtain a prescription for medication that the qualified patient may self-administer to end the qualified 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 to taking the medication, including, but not limited to, palliative care and comfort care, hospice care, pain control, and disease-directed treatment options.

(9) "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.

(10) "Mental health specialist assessment" one or more consultations between a mental health specialist 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.

(11) "Mental health specialist" means a state-licensed psychiatrist, state-licensed psychologist, state-licensed clinical social worker, or state-licensed clinical professional counselor.[5]

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

(13) "Physician" means a Doctor of Medicine or Osteopathy licensed in [State] to practice medicine by the [State Boards of Licensing for Physicians and Osteopaths][6].

[5]States that enacted Death with Dignity legislation many years ago limited mental health assessment providers to psychiatrists and psychologists only. States adopting the legislation more recently have expanded to include social workers and other trained, licensed mental health professionals. Because limited access to psychiatrists and psychologists can act as a barrier to access and because social workers and other mental health professionals may now have access to expanded training and specialty experience in determining capacity, we are recommending a more expansive list of mental health professionals be considered.

[6]As noted in Section 2, some states are expanding delivery of primary care to include advance nurse practitioners and physician assistants. If providers other than licensed medical and osteopathic doctors will be included, then its recommended to define "provider" versus "physician" in paragraph 13 of Section 2 and list each provider with their affiliated state board of licensure.

(14) "Qualified interpreter" means a person who meets the standards promulgated by the [State] Healthcare Interpreting Association or the National Council on Health Care or other standards deemed acceptable by the department for healthcare providers in [State][7].

(15) "Qualified patient" means a capable adult who is a resident of the [State] 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 qualified patient's life in a humane and dignified manner.

(16) "Self-administer" means a qualified individual performs an affirmative, conscious, voluntary act to self-ingest medication prescribed pursuant to this Act to bring about the qualified patient's peaceful death. Self-administration does not include administration by intravenous or other parenteral injection or infusion.

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

§3.01. Standard of Care

(1) Care that complies with the requirement of this Act meets the medical standard of care.

(2) Nothing in this Act exempts a provider or other medical personnel from meeting medical standards of care for the treatment of individuals with a terminal disease.

§4.01. Written Request for Medication.

(1) An adult who is capable, is a resident of [State], and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed the wish to die, may make a written request for medication that the adult may self-administer in accordance with this Act.

(2) No person shall qualify under the provisions of this Act solely because of age or disability.

§5.01. Form of the Written Request.

(1) A valid request for medication under this Act shall be in substantially the form described in Section 27 of this Act, signed and dated by the patient and witnessed by at least one individual who, in the presence of the patient, attests 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) The language of a written request for medication under this Act may be:

(a) the language in which any conversations or consultations or interpreted conversations or consultations between a patient and the patient's attending or consulting physician are held.

[7]Most states have a certification requirement for medical interpretation services. See https://rid.org/advocacy-overview/state-information-and-advocacy/ for a current overview of state-by-state medical interpretation laws. If your state does have a codified certification requirement, you may consider constructing a definition of "qualified interpreter" that is consistent with current statutory language and eliminate national certification bodies.

(3) The witness required under this section must 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.

(d) The patient's attending physician, consulting physician, or mental health specialist.

(e) The patient's qualified interpreter.

(4) The written request for medication to end life in a humane and dignified manner may be made only by the requesting individual and shall not be made by the individual's surrogate decision-maker, healthcare proxy, attorney in fact for healthcare, nor via advance healthcare directive.

(5) If the individual decides to transfer care to another provider, the former provider shall make timely transfer all relevant medical records including written documentation of the dates of the individual's request concerning obtaining a prescription to end life in a humane and dignified manner.

§6.01. 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 [State] residency pursuant to Section 14 of this Act;

(c) To ensure that the patient is making an informed decision, inform 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 to taking the medication, including, but not limited to, palliative care and comfort care, hospice care, pain control, and disease-directed treatment options;

(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) Confirm that the patient's request does not arise from coercion or undue influence by another individual by discussing with the patient, outside the presence of any other individual, except for an interpreter, whether the patient is feeling coerced or unduly influenced;

(f) Refer the patient for a mental health assessment if appropriate pursuant to Section 8 of this Act;

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

(h) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this Act, and counsel the patient about not taking the medication in a public place;

(i) Inform the patient that the patient has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the time the patient makes the patient's second oral request pursuant to Section 11 of this Act;

(j) Verify, immediately prior to writing the prescription for medication under this Act, that the patient is making an informed decision;

(k) Inform the individual that there is no obligation to fill the prescription nor an obligation to self-administer the medication, if it is obtained.

(l) Fulfill the medical record documentation requirements of Section 13 of this Act;

(m) Ensure that all appropriate steps are carried out in accordance with this Act prior to writing a prescription for medication to enable a qualified patient to end the qualified patient's life in a humane and dignified manner; and

(n)(A) Deliver the prescription personally, by mail, or through an authorized electronic transmission to a licensed pharmacist who will dispense the medication, including any ancillary medications, to the attending provider, to the qualified individual, or to an individual expressly designated by the qualified individual in person or with a signature required on delivery, by mail service or by messenger service, or

(B) If authorized by the Drug Enforcement Agency, dispense the prescribed medication, including any ancillary medications, to the qualified individual or an individual designated in person by the qualified individual.

§7.01. Consulting Physician Confirmation.

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 capable, is acting voluntarily and has made an informed decision.

§8.01. Mental Health Specialist Assessment.

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, the physician shall refer the patient for an assessment[8] by a mental health

[8]Some statutes use the term "counseling" to refer to the process of a mental health professional evaluating a patient's capacity for making an informed decision. "Counseling" implies, in mental health professions, a potential to work through capacity impairment and/or recover to a state wherein the patient may eventually be able to qualify under the Act. "Evaluation" (or "Assessment") is a process of determining whether there are factors involved in a patient's decision-making capacity that may or may not be resolvable (e.g. a patient who is severely

specialist. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the assessment determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

§9.01. Informed Decision.

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

§10.01. Notification of Next of Kin.

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

§11.01. Written and Oral Requests.

(1) To receive a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterated the oral request to the individual's attending physician no less than 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 qualified patient an opportunity to rescind the request.

(2) Notwithstanding paragraph (1) of this section, if the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to the qualified patient's attending physician at any time after making the initial oral request[9].

§12.01. Right to Rescind Request.

A patient may rescind the 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.

---

dehydrated may experience a return of capacity upon treating the condition of dehydration, whereas a patient whose capacity has been diminished by progress of a dementia-related disease may be evaluated as permanently impaired, and therefore ineligible qualification under the Act).

[9]The elimination of waiting periods for qualified patients who are imminently dying was made in Oregon after 21 years of experience with the law demonstrated many patients waited too long after their diagnosis of a terminal disease to start the process for becoming a qualified patient. Some patients reach a point where they are actively dying and forcing them to wait through the codified waiting periods is not consistent with the object of achieving a dignified and humane death. Refer to SB 579, 2019 Regular Session of the Oregon Legislature (https://olis.leg.state.or.us/liz/2019R1/Measures/Overview/SB579)

§13.01. Medical Record Documentation Requirements.

The following shall be documented in the patient's medical record:

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

(2) All written requests be a patient for medication to end that patient's life in a humane and dignified manner;

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

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

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

(6) The attending physician's offer to the patient to rescind the patient's request at the time of the patient's second oral request pursuant to Section 12 of this Act; and

(7) A note by the attending physician indicating that all requirements pursuant to Section 6 of this Act have been met and indicating the steps taken to carry out the request, including notation of the medication prescribed.

§14.01. Residency Requirement.

Only requests made by [State] residents under this Act shall be granted. Factors demonstrating [State] residency include[10] but are not limited to:

(1) Possession of a [State] driver license;

(2) Registration to vote in the [State];

(3) Evidence that the person owns or leases property in [State]; or

(4) Filing of a [State] tax return for the most recent tax year.

§15.01. Disposal of Medication.

A person who has custody of or control over any unused medications prescribed pursuant to this Act after the death of the qualified patient shall personally deliver the unused medications to the nearest facility qualified to dispose of controlled substances or dispose of the unused medications by any lawful means, in accordance with the [State] Board of Pharmacy or a Federal Drug Administration approved take-back program.

[10]This is a list of items typically used to demonstrate residency. Your state may have a previously codified list of items demonstrating residency which may be more specific to your state. If so, your state's previously codified list is preferable to the one used in this model language document.

§16.01. Reporting Requirements.

The Department shall:

(1) Annually review all records maintained pursuant to this Act.

(2) Require any health care provider upon writing a prescription or dispensing medication pursuant to this Act to file a copy of the prescription or dispensing record, and other documentation required under Section 13 of this Act associated with writing the prescription or dispensing the medication, with the Department.

(a) Documentation required to be filed under this section must be mailed or otherwise transmitted as allowed by rules of the Department no later than 30 calendar days after writing of the prescription or the dispensing of medication pursuant to this Act, except that all documents required to be filed with the Department by the attending physician after the death of the qualified patient must be submitted no later than 30 calendar days after the date of the death of the qualified patient.

(b) In the event that a person required under this Act to report information to the Department provides an inadequate or incomplete report, the Department shall contact the person to request an adequate or complete report.

(3) The Department shall make rules to facilitate the collection of information regarding compliance with this Act. Except as otherwise required by law, the information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient's family, and any medical provider or pharmacist involved with the patient under the provisions of this Act. The information shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding. It shall not be a public record and may not be made available for inspection by the public.

(4) The Department shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this Section[11].

§17.01. 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 the person's 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 the person's life in a humane and dignified manner.

§18.01. Insurance or Annuity Policies.

(1) 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

[11]No state has enacted a sunset on the reporting requirements; however, year after year of reporting requirements demonstrate little changes to usage and trends. It seems feasible for a state legislature to set an end date for the reporting process 10 years after implementation, or at some point when trends stabilize.

making or rescinding of a request, by a person, for medication to that the person may self-administer to end the person's life in a humane and dignified manner. Neither shall a qualified patient's act of self-administering medication to end the qualified patient's life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. A qualified patient whose life is insured under a life insurance policy issued under the provisions of [Applicable State Statute] and the beneficiaries of the policy may not be denied benefits on the basis of self-administration of medication by the qualified patient pursuant to this Act.

(2) The sale, procurement or issuance of any medical professional liability insurance policy issued under the provisions of [Applicable State Statute] or the rate charged by the insurer for the policy shall not be conditioned upon or affected by the participation of the health care provider in the provision of medication to a qualified patient in pursuant to this Act.

(3) An insurance carrier shall not provide any information in communications made to an individual about the availability of life-ending medication absent a request by the individual or the individual's attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of life-ending medication coverages. For purposes of this section, "insurance carrier" means a health care service plan as defined in [Applicable State Statute].

§19.01. Death Certificate.

(1) Unless otherwise prohibited by law, the attending physician or hospice medical director may sign the death certificate of a qualified individual who obtained and self-administered a prescription for medication pursuant to this Act.

(2) When a death occurrs in accordance with this Act, the death shall be attributed to the underlying terminal disease.

(a) Death following self-administering medication under this Act alone does not constitute grounds for post-mortem inquiry.

(b) Death in accordance with this Act shall not be designated suicide or homicide.

(3) A qualified individual's act of self-administering medication prescribed pursuant to this Act shall not be indicated on the death certificate.

(4) The Coroner may conduct a preliminary investigation to determine whether an individual received a prescription for medication under this Act.

§20.01. Construction of Act.

This Act does not authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken pursuant to this Act do not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide under the law. State reports may not refer to acts committed under this Act as "suicide" or "assisted suicide." Consistent with the provisions of this Act, state reports, other than death certificates, must

refer to acts committed under this Act as obtaining and self-administering life-ending medication.

§21.01. Immunities.

Except as provided in Section 22 of this Act:

(1) Notwithstanding any other law, a person shall not be subject to civil or criminal liability solely because the person was present when the qualified patient self-administered the prescribed medication to end the qualified patient's life in a humane and dignified manner. A person who is present may, without civil or criminal liability, assist the qualified individual by preparing the medication prescribed pursuant to this Act so long as the person does not assist the qualified person in ingesting the medication prescribed to end the qualified patient's life in a humane and dignified manner.

(2) No professional organization or association, state licensing board, 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.

(3) Notwithstanding any other law, a health care provider shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for participating in this Act, including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the Act, providing information to an individual regarding this Act, and providing a referral to a physician who participates in this Act. Nothing in this subdivision shall be construed to limit the application of, or provide immunity from Section 23 or Section 24 of this Act.

(4)(a) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this Act shall provide the sole basis for the appointment of a guardian or conservator.

(b) No actions taken in compliance with the provision of this Act shall constitute or provide the basis for any claim of neglect or elder abuse for any purpose of law.

§22.01. Voluntary Participation.

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 the qualified 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.

§23.01. Basis for Prohibiting Health Care Provider from Participation; Notification/Permissible Sanctions.

(1) (a) Notwithstanding any other provision of law, a health care provider may prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under this Act while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

(b) A health care provider that elects to prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating in activities under this Act, as described in paragraph (a) of this subsection, shall first give notice of the policy prohibiting participation under this Act to the individual or entity. A health care provider that fails to provide notice to an individual or entity in compliance with this subdivision shall not be entitled to enforce such a policy against that individual or entity.

(c) Subject to compliance with paragraph (b) of this subsection, the prohibiting health care provider may take action, including, but not limited to, the following, as applicable, against any individual or entity that violates this policy:

(A) Loss of privileges, loss of membership or other action authorized by the bylaws or rules and regulations of the medical staff.

(B) Suspension, loss of employment, or other action authorized by the policies and practices of the prohibiting health care provider.

(C) Termination of lease or other contract between the prohibiting health care provider and the individual or entity that violates the policy.

(D) Imposition of any other nonmonetary remedy provided for in any lease or contract between the prohibiting health care provider and the individual or entity in violation of the policy.

(d) Nothing in this section shall be construed to prevent, or to allow a prohibiting health care provider to prohibit any other health care provider, employee, independent contractor, or other person or entity from any of the following:

(A) Participating or entering into an agreement to participate, in activities under this subsection, while on premises that are not owned or under the management or direct control of the prohibiting provider or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the prohibiting health care provider.

(B) Participating, or entering into an agreement to participate, in activities under this subsection as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the prohibiting provide.

(e) In taking actions pursuant to paragraph (c) of this subsection, a health care provider shall comply with all procedures required by law, its own policies or procedures, and any other contract with the individual or entity in violation of the policy, as applicable:

(f) For purposes of this section:

(A) "Notice" means a separate statement in writing advising of the prohibiting health care provider policy with respect to participating in activities under this part.

(B) "Participating, or entering into an agreement to participate, in activities under this section" means doing or entering into an agreement to do any one or more of the following:

(i) Performing the duties of an attending physician as specified in Section 6.

(ii) Performing the duties of a consulting physician as specified in Section 7.

(iii) Performing the duties of a mental health specialist, in the circumstance that a referral to one is made.

(iv) Delivering the prescription for, dispensing, or delivering the dispensed drug to end life in a humane and dignified manner pursuant to paragraph (1)(n) of Section 6.

(v) Being present when the qualified individual takes the medication prescribed pursuant to this Act.

(C) "Participating, or entering into an agreement to participate, in activities under this part" does not include doing, or entering into an agreement to do, any of the following:

(i) Diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, or determining whether a patient has the capacity to make decisions.

(ii) Providing information to a patient about this Act.

(iii) Providing a patient, upon the patient's request, with a referral to another health care provider for the purposes of participating in the activities authorized by this Act.

(g) Any action taken by a prohibiting provider pursuant to this Act shall not be reportable under [include all relevant state licensing boards for all professions included in the bill]. The fact that a health care provider participates in activities under this part shall not be the sole basis for a complaint or report by another health care provider of unprofessional or dishonorable conduct under [include all relevant state licensing boards for all professionals included in the bill].

(h) Nothing in this part shall prevent a health care provider from providing an individual with health care services that do not constitute participation in this Act.

(7) No provision of the Act shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community.

§24.01. Willful Alteration or Forgery; Coercion or Undue Influence; Penalties; Civil Damages; Other Penalties Not Precluded.

The following provisions govern criminal and other penalties for certain violations of the Act:[12]

(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) The attending physician, consulting physician, mental health specialist, or interpreter may not be related to the patient by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual's estate upon death[13].

(4) Nothing in the Act limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(5) The penalties in this Act do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this Act.

§25.01. Claims by Governmental Entity for Costs Incurred.

Any governmental entity that incurs costs resulting from a qualified patient terminating the qualified patient's life pursuant to the provisions of this Act 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.

§26.01. Severability.

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

---

[12]It is recommended for bill sponsors to consult with their State Attorney General office, Judiciary, or other legal advisors to determine whether existing criminal code is sufficiently able to address potential abuse of the Act.

[13]The American Medical Association Code of Medical Ethics Opinion E-1.2.1 provides the following guidance on treating family members: "In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems."

AMA Code of Medical Ethics Opinion 1.2.1, *Treating Self or Family*, accessed 08/25/2020, https://www.ama-assn.org/delivering-care/ethics/treating-self-or-family

§27.01. Form of the Request.

A request for a 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 palliative and comfort care, hospice care, pain control and disease-directed treatment options.

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 WITNESS

I declare that the person signing this request:

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

(b) Signed this request in my presence;

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

(d) Is not a patient for whom I am attending physician, consulting physician, mental health specialist, or interpreter.

_____Witness/Date

NOTE: The 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.

Death with Dignity
NATIONAL CENTER

520 SW 6th Avenue, Suite 1220
Portland, Oregon 97204

(503) 228-4415
info@deathwithdignity.org

DeathwithDignity.org
/DeathwithDignity
@DeathwDignity

FOR MORE INFORMATION

Peg Sandeen, PhD, MSW
Executive Director
psandeen@deathwithdignity.org

Val Lovelace
Statewide Campaigns Director
vlovelace@deathwithdignity.org