

PHYSICIAN-ASSISTED SUICIDE

UNLESS YOU HAVE BEEN living on the moon, you know that Oregon voters reaffirmed the Death with Dignity Act in last week's election. Notwithstanding objections raised by federal legislators and the Drug Enforcement Agency, this issue of the *CD Summary* covers bureaucratic details of physician-assisted suicide (PAS)--under the presumption that the Death with Dignity Act is law in Oregon. The Act requires that the Oregon Health Division (OHD) collect information pertaining to compliance and make available to the public an annual statistical report. The OHD is required to "make rules to facilitate the collection of information regarding compliance with this Act" and to "annually review a sample of records maintained pursuant to this Act." These reporting requirements are needed to determine the extent to which the Act is being used by physicians and patients, and to assure that the safeguards built into the Act are being followed. After the statute first passed in 1994, the OHD convened a task force to assist in writing emergency administrative rules. These rules were filed with the Secretary of State's office on November 6, 1997. The OHD has six months in which to write permanent administrative rules, a process that requires public notification and a hearing.

Because Oregon is the first state in the U.S. to legalize PAS, much attention will be focused on the effects of the legislation. How many prescriptions are being written? Of the patients who get a prescription filled, how many are actually taking them? These questions can only be answered if physicians provide accurate data as required by the Act.

REQUIREMENTS OF THE ACT

The Death with Dignity Act allows terminally ill Oregonians to obtain a physician's prescription for lethal drugs, to be self-administered. The law

requires that the patient: 1) be an adult; 2) be "capable"; 3) be an Oregon resident; 4) have a terminal illness with less than six months to live; and 5) voluntarily request a prescription for lethal drugs. The form of the request must be in writing, signed and dated by the patient and witnessed by a least two individuals (not to include the attending physician) who attest that the patient is capable and acting voluntarily. At least one of the individuals must be neither a relative nor heir of the patient, or an owner, operator or employee of a health care facility where the patient is receiving medical care.

PHYSICIAN RESPONSIBILITIES

Under the Act, the attending physician has the following responsibilities: 1) to determine whether the patient has a terminal illness, is capable, and has made the request voluntarily; 2) to inform the patient of his/her diagnosis and prognosis, the risks and probable result of taking the prescribed medication, and the feasible alternatives, including comfort care, hospice care and pain control; 3) to refer the patient to a consulting physician for confirmation of the diagnosis and determination that the patient is capable and acting voluntarily; 4) to refer the patient for counseling if, in the opinion of either the attending physician or the consulting physician the patient may be suffering from any mental disorder, including depression, causing impaired judgment; 5) to request that the patient notify next of kin (the patient does not have to comply); and 6) to offer the patient the opportunity to rescind the request at any time. In order to receive a prescription under the Death with Dignity Act, a qualifying patient must make both an oral and a written request, and reiterate the oral request at least 15 days after making the initial request. In addition, at the time the prescription is written for

a patient, the attending physician must send the following documentation to the State Registrar for Vital Records: 1) a copy of the written request for medication to end life as outlined in Section 6 of the Act; and 2) either a form developed by the OHD that is fully and accurately completed (see information below on how to get the forms), or a notation that relevant portions of the patient's medical record are available for the OHD to review. Physicians are encouraged to make patients aware of the requirement that the OHD have access to data regarding implementation of the Act.

MEDICAL RECORD DOCUMENTATION

The following must be documented in the patient's medical record: 1) all oral and written requests by the patient for medication prescribed under the Death with Dignity Act; 2) the attending and consulting physicians' evaluations, including diagnosis, prognosis and determination that the patient is capable, acting voluntarily and has made an informed decision; 3) the report of the counseling evaluation, if performed; 4) the attending physician's offer to the patient to rescind the request at the time of the second oral request; and 5) a note by the attending physician that the patient has met all the requirements of the Act, including a notation of the medication prescribed.

DEATH CERTIFICATE

At the time of death, if contacted by the patient (beforehand) or the family, the medical certification of the death should be completed and signed by the attending physician per standard practice. (*Note: at press time, the role of the medical examiner vis a vis the attending physician in these situations is under discussion. We'll let you know if these instructions change.*) We recommend that physicians completing the death certificates following PAS note for "immediate cause," "Drug overdose, legally

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prescribed" or the equivalent, and specify the patient's underlying terminal disease on the following line as an underlying cause. The manner of death should be marked as "other." (Do not mark "legal intervention," which is restricted to capital punishment or incidents involving police actions.) Any certificate wherein the manner of death is marked "other" that does not specify "Drug overdose, legally prescribed" will be queried to determine whether or not the death was a result of taking the prescribed drugs. Additional clarifying information collected during the query will not be used to amend the death certificate.

When a death certificate from a patient who has received a prescription for lethal drugs is received by the OHD, a form that captures information about the physician's knowledge of events surrounding the patient's death may be sent to the physician. The form is to be completed and returned directly to the OHD within ten working days. Information supplied on this form will not be used to amend the official copy of the death certificate. In addition to the authority specifically outlined in the Act, the OHD has a blanket authority to conduct "special morbidity and mortality" studies. For auditing purposes, the OHD will on occasion select a sample of death certificates from patients for whom a written request for medication to end life was sent to the OHD and survey those physicians as to the circumstances surrounding the patient's illness and/or death.

Death certificates are confidential. OAR 333-11-096 (1) states that the OHD "shall not permit inspection of, or disclose information contained in ... death records, or issue a copy of ... any such record unless ... satisfied that the applicant has a direct and tangible interest in such record." During the 1997 legislative session, the Vital Records Statute was amended to allow for a two-part death certificate. One is the "public" part needed to settle the estate; this is the one that will routinely be given out and does not include medical information. The other part has the cause of death and factors related to the death that are important for public health purposes. Access to this part of the death certificate will be strictly limited to close relatives and others who demonstrate a specific medical or other need for the information (e.g. a rare genetic condition in a relative).

OTHER CONCERNS

Confidentiality is important to ensure compliance with the Act. The Act ensures that "information collected shall not be a public record and may not be made available for inspection by the public." Thus, information provided to the OHD in compliance with the Act regarding the identity of patients, health care providers, and health care facilities shall be confidential. Summary information released in Health Division reports will be in summary form only to prevent identification of individuals, physicians or health care providers complying with this Act.

The Act does not assign enforcement authority to OHD and is silent on what we should do when non-compliance is encountered. When problems with documentation or reporting from physicians are encountered, we will query those providers for clarification. If we encounter an egregious violation with the provisions of the Act, the individual committing the violation shall be reported to the appropriate licensing board.

Copies of the rules are available from the Oregon Health Division, Office of the Administrator at (503) 731-4000 and the reporting forms are available from Virginia Davis in the Center for Health Statistics, PO Box 14050, Portland OR 97293-0050; phone (503) 731-4027. The *CD Summary*, and the emergency rules and forms can be found on our web site (<http://www.ohd.hr.state.or.us/cdpe/>).

Parturient Plague

NATIONALLY, lab-confirmed influenza has been reported from 10 states with type A in nine states and type B in one. Influenza type A(H3N2) has been reported from California, Hawaii and New York; type A(not subtyped) has been reported from Arizona, Alaska, Michigan, Nevada, Texas, and Washington; and influenza type B has been isolated in West Virginia. WHO labs tested 3,494 specimens for respiratory viruses and 18 (0.5%) were positive for influenza. Here in Oregon, we have yet to identify an influenza isolate.