XII. ESTADOS UNIDOS DE AMÉRICA

XII.1. LEGISLACIÓN

XII.1.1. LEYES FEDERALES

Assisted Suicide Funding Restriction Act of 1997 Federal Patient Self Determination Act 1990

[H.R. 1003: Public Law 105-12, 111 Stat. 23-28,et. seq.(4/30/97)]*

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **Short Title**: This Act may be cited as the '**Assisted Suicide Funding Restriction Act of 1997'**.

(b) **Table of Contents**: The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Findings and purpose.

Sec. 3. Restriction on use of Federal funds under health care programs.

Sec. 4. Restriction on use of Federal funds under certain grant programs under the Developmental Disabilities Assistance and Bill of Rights Act.

Sec. 5. Restriction on use of Federal funds by advocacy programs.

Sec. 6. Restriction on use of other Federal funds.

Sec. 7. Clarification with respect to advance directives.

Sec. 8. Application to District of Columbia.

Sec. 9. Conforming amendments.

Sec. 10. Relation to other laws.

Sec. 11. Effective date.

Sec. 12. Suicide prevention (including assisted suicide).

SEC. 2. FINDINGS AND PURPOSE.

(a) **Findings**: Congress finds the following:

(1) The Federal Government provides financial support for the provision of and payment for health care services, as well as for advocacy activities to protect the rights of individuals.

(2) Assisted suicide, euthanasia, and mercy killing have been criminal offenses throughout the United States and, under current law, it would be unlawful to provide services in support of such illegal activities.

(3) Because of recent legal developments, it may become lawful in areas of the United States to furnish services in support of such activities.

(4) Congress is not providing Federal financial assistance in support of assisted suicide, euthanasia, and mercy killing and intends that Federal funds not be used to promote such activities.

(b) **Purpose**: It is the principal purpose of this Act to continue current Federal policy by providing explicitly that Federal funds may not be used to pay for items and services (including assistance) the purpose of which is to cause (or assist in causing) the suicide, euthanasia, or mercy killing of any individual.

SEC. 3. RESTRICTION ON USE OF FEDERAL FUNDS UNDER HEALTH CARE PROGRAMS.

(a) **Restriction on Federal Funding of Health Care Services**: Subject to subsection (b), no funds appropriated by Congress for the purpose of paying (directly or indirectly) for the provision of health care services may be used—

(1) to provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing;

(2) to pay (directly, through payment of Federal financial participation or other matching payment, or otherwise) for such an item or service, including payment of expenses relating to such an item or service; or

(3) to pay (in whole or in part) for health benefit coverage that includes any coverage of such an item or service or of any expenses relating to such an item or service.

(b) **Construction and Treatment of Certain Services**: Nothing in subsection (a), or in any other provision of this Act (or in any amendment made by this Act), shall be construed to create *apply to or to affect* any limitation relating to—

(1) the withholding or withdrawing of medical treatment or medical care;

(2) the withholding or withdrawing of nutrition or hydration;

(3) abortion; or

(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(c) **Limitation on Federal Facilities and Employees**: Subject to subsection (b), with respect to health care items and services furnished—

(1) by or in a health care facility owned or operated by the Federal government, or

(2) by any physician or other individual employed by the Federal government to provide health care services within the scope of the physician's or individual's employment, no such item or service may be furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any

* Fuente: Legal Services Corporation.- https://www.oig.lsc.gov/legis/pl105-12.htm

individual, such as by assisted suicide, euthanasia, or mercy killing.

(d) **List of Programs to Which Restrictions Apply**:

(1) **Federal health care funding programs**: Subsection (a) applies to funds appropriated under or to carry out the following:

(A) **Medicare program**: Title XVIII of the Social Security Act.

(B) **Medicaid program**: Title XIX of the Social Security Act.

(C) **Title xx social services block grant**: Title XX of the Social Security Act.

(D) **Maternal and child health block grant program**: Title V of the Social Security Act.

(E) **Public health service act**: The Public Health Service Act.

(F) **Indian health care improvement act**: The Indian Health Care Improvement Act.

(G) **Federal employees health benefits program**: Chapter 89 of title 5, United States Code.

(H) **Military health care system (including tricare and champus programs)**: Chapter 55 of title 10, United States Code.

(I) **Veterans medical care**: Chapter 17 of title 38, United States Code.

(J) **Health services for peace corps volunteers**: Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(K) **Medical services for federal prisoners**: Section 4005(a) of title 18, United States Code.

(2) **Federal facilities and personnel**: The provisions of subsection (c) apply to facilities and personnel of the following:

(A) **Military health care system**: The Department of Defense operating under chapter 55 of title 10, United States Code.

(B) **Veterans medical care**: The Veterans Health Administration of the Department of Veterans Affairs.

(C) **Public health service**: The Public Health Service.

(3) **Nonexclusive list**: Nothing in this subsection shall be construed as limiting the application of subsection (a) to the programs specified in paragraph (1) or the application of subsection (c) to the facilities and personnel specified in paragraph (2).

SEC. 4. RESTRICTION ON USE OF FEDERAL FUNDS UNDER CERTAIN GRANT PROGRAMS UNDER THE DEVELOPMENTAL DISABILITIES ASSISTANCE AND BILL OF RIGHTS ACT.

Subject to section 3(b) (relating to construction and treatment of certain services), no funds appropriated by Congress to carry out part B, D, or E of the Developmental Disabilities Assistance and Bill of Rights Act may be used to support or fund any program or service which has a purpose of assisting in procuring any item, benefit, or service furnished for the purpose of causing, or the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

SEC. 5. RESTRICTION ON USE OF FEDERAL FUNDS BY ADVOCACY PROGRAMS.

(a) **In General**: Subject to section 3(b) (relating to construction and treatment of certain services), no funds appropriated by Congress may be used to assist in, to support, or to fund any activity or service which has a purpose of assisting in, or to bring suit or provide any other form of legal assistance for the purpose of—

(1) securing or funding any item, benefit, program, or service furnished for the purpose of causing, or the purpose of assisting in causing, the suicide, euthanasia, or mercy killing of any individual;

(2) compelling any person, institution, governmental entity to provide or fund any item, benefit, program, or service for such purpose; or

(3) asserting or advocating a legal right to cause, or to assist in causing, the suicide, euthanasia, or mercy killing of any individual.

(b) **List of Programs to Which Restrictions Apply**:

(1) **In general**: Subsection (a) applies to funds appropriated under or to carry out the following:

(A) **Protection and advocacy systems under the developmental disabilities assistance and bill of rights act**: Part C of the Developmental Disabilities Assistance and Bill of Rights Act.

(B) **Protection and advocacy systems under the protection and advocacy for mentally ill individuals act**: The Protection and Advocacy for Mentally Ill Individuals Act of 1986.

(C) **Protection and advocacy systems under the rehabilitation act of 1973**: Section 509 of the Rehabilitation Act of 1973 (29 U.S.C. 794e).

(D) **Ombudsman programs under the older americans act of 1965**: Ombudsman programs under the Older Americans Act of 1965.

(E) **Legal assistance**: Legal assistance programs under the Legal Services Corporation Act.

(2) **Nonexclusive list**: Nothing in this subsection shall be construed as limiting the application of subsection (a) to the programs specified in paragraph (1).

SEC. 6. RESTRICTION ON USE OF OTHER FEDERAL FUNDS.

(a) **In General**: Subject to section 3(b) (relating to construction and treatment of certain services) and subsection (b) of this section, no funds appropriated by the Congress shall be used to provide, procure, furnish, or fund any item, good, benefit, activity, or service, furnished or performed for the purpose of causing, or assisting in causing, the suicide, euthanasia, or mercy killing of any individual.

(b) **Nonduplication**: Subsection (a) shall not apply to funds to which section 3, 4, or 5 applies, except that subsection (a), rather than section 3, shall apply to funds appropriated to carry out title 10, United States Code (other than chapter 55), title 18, United States Code (other than section 4005(a)), and chapter 37 of title 28, United States Code.

SEC. 7. CLARIFICATION WITH RESPECT TO ADVANCE DIRECTIVES.

Subject to section 3(b) (relating to construction and treatment of certain services), sections 1866(f) and 1902(w) of the Social Security Act shall not be construed—

(1) to require any provider or organization, or any employee of such a provider or organization, to inform or counsel any individual regarding any right to obtain an item or service furnished for the purpose of causing, or the purpose of assisting in causing, the death of the individual, such as by assis-

ted suicide, euthanasia, or mercy killing; or

(2) to apply to or to affect any requirement with respect to a portion of an advance directive that directs the purposeful causing of, or the purposeful assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

SEC. 8. APPLICATION TO DISTRICT OF COLUMBIA.

For purposes of this Act, the term 'funds appropriated by Congress' includes funds appropriated to the District of Columbia pursuant to an authorization of appropriations under title V of the District of Columbia Self-Government and Governmental Reorganization Act and the term 'Federal government' includes the government of the District of Columbia.

SEC. 9. CONFORMING AMENDMENTS.

(a) **Medicare Program**:

(1) **Funding**: Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(A) by striking 'or' at the end of paragraph (14);

(B) by striking the period at the end of paragraph (15) and inserting '; or'; and

(C) by inserting after paragraph (15) the following new paragraph:

'(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997.'.

(2) **Advance directives**: Section 1866(f) of such Act (42 U.S.C. 1395cc(f)) is amended by adding at the end the following new paragraph:

'(4) For construction relating to this subsection, see section 7 of the Assisted Suicide Funding Restriction Act of 1997 (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).'.

(b) **Medicaid Program**:

(1) **Funding**: Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(A) by striking 'or' at the end of paragraph (14);

(B) by striking the period at the end of paragraph (15) and inserting '; or'; and

(C) by inserting after paragraph (15) the following new paragraph:

'(16) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.'.

(2) **Advance directives**: Section 1902(w) of such Act (42 U.S.C. 1396a(w)) is amended by adding at the end the following new paragraph:

'(5) For construction relating to this subsection, see section 7 of the Assisted Suicide Funding Restriction Act of 1997 (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).'.

(c) **Title XX Block Grant Program**: Section 2005(a) of the Social Security Act (42 U.S.C. 1397d(a)) is amended—

(1) by striking 'or' at the end of paragraph (8);

(2) by striking the period at the end of paragraph (9) and inserting '; or'; and

(3) by adding at the end the following:

'(10) in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997.'.

(d) **Maternal and Child Health Block Grant Program**: Section 501(a) of the Social Security Act (42 U.S.C. 701(a)) is amended by adding at the end the following:

'Funds appropriated under this section may only be used in a manner consistent with the Assisted Suicide Funding Restriction Act of 1997.'.

(e) **Public Health Service Act**: Title II of the Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end thereof the following new section:

'SEC. 246. RESTRICTION ON USE OF FUNDS FOR ASSISTED SUICIDE, EUTHANASIA, AND MERCY KILLING.

'Appropriations for carrying out the purposes of this Act shall not be used in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997.'.

(f) **Indian Health Care Improvement Act**: Title II of the Indian Health Care Improvement Act (25 U.S.C. 1621 et seq.) is amended by adding at the end the following new section:

'**LIMITATION ON USE OF FUNDS**

'Sec. 225. Amounts appropriated to carry out this title may not be used in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997.'.

(g) **Federal Employees Health Benefit Program**: Section 8902 of title 5, United States Code, is amended by adding at the end the following:

'(o) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.'.

(h) **Military Health Care Program**: Section 1073 of title 10, United States Code, is amended by adding at the end the following: 'This chapter shall be administered consistent with the Assisted Suicide Funding Restriction Act of 1997.'.

(i) **Veterans' Medical Care Program**:

(1) **In general**: Subchapter I of chapter 17 of title 38, United States Code, is amended by adding at the end the following new section:

'1707. Restriction on use of funds for assisted suicide, euthanasia, or mercy killing

'Funds appropriated to carry out this chapter may not be used for purposes that are inconsistent with the Assisted Suicide Funding Restriction Act of 1997.'.

(2) **Clerical amendment**: The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1706 the following new item:

'1707. Restriction on use of funds for assisted suicide, euthanasia, or mercy killing.'.

(j) **Health Care Provided for Peace Corps Volunteers**: Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)) is amended by adding at the end the following: 'Health care may not be provided under this subsection in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997.'.

(k**) Medical Services for Federal Prisoners**: Section 4005(a) of title 18, United States Code, is amended by inserting 'and to the extent consistent with the Assisted Suicide

Funding Restriction Act of 1997' after 'Upon request of the Attorney General'.

(l) **Developmental Disabilities and Bill of Rights Act**:

(1) **State plans regarding developmental disabilities councils**: Section 122(c)(5)(A) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6022(c)(5)(A)) is amended—

(A) in clause (vi), by striking 'and' after the semicolon at the end;

(B) in clause (vii), by striking the period at the end and inserting '; and'; and

(C) by adding at the end the following clause:

'(viii) such funds will be used consistent with the section 4 of the Assisted Suicide Funding Restriction Act of 1997.'.

(2) **Legal actions by protection and advocacy systems**: Section 142(h) of such Act (42 U.S.C. 6042(h)) is amended by adding at the end the following new paragraph:

'(3) **Limitation**: The systems may only use assistance provided under this chapter consistent with section 5 of the Assisted Suicide Funding Restriction Act of 1997.'.

(3) **University affiliated programs**: Section 152(b)(5) of such Act (42 U.S.C. 6062(b)(5)) is amended by adding at the end the following: 'Such grants shall not be used in a manner inconsistent with section 4 of the Assisted Suicide Funding Restriction Act of 1997.'.

(4) **Grants of national significance**: Section 162(c) of such Act (42 U.S.C. 6082(c)) is amended—

(A) by striking 'and' at the end of paragraph (4),

(B) by striking the period at the end of paragraph (5) and inserting '; and', and

(C) by adding at the end the following new paragraph:

'(6) the applicant provides assurances that the grant will not be used in a manner inconsistent with section 4 of the Assisted Suicide Funding Restriction Act of 1997'.

(m) **Protection and Advocacy for Mentally Ill Individuals Act of** 1986: Section 105(a) of the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10805(a)) is amended—

(1) in paragraph (8), by striking 'and' at the end;

(2) in paragraph (9), by striking the period and inserting '; and'; and

(3) by adding at the end thereof the following new paragraph:

'(10) not use allotments provided to a system in a manner inconsistent with section 5 of the Assisted Suicide Funding Restriction Act of 1997.'.

(n) **Protection and Advocacy Systems Under the Rehabilitation Act of** 1973: Section 509(f) of the Rehabilitation Act of 1973 (29 U.S.C. 794e(f)) is amended—

(1) in paragraph (6), by striking 'and' after the semicolon at the end;

(2) in paragraph (7), by striking the period at the end and inserting '; and'; and

(3) by adding at the end the following paragraph:

'(8) not use allotments provided under this section in a manner inconsistent with section 5 of the Assisted Suicide Funding Restriction Act of 1997.'.

(o) **Older Americans Act of** 1965: Title VII of the Older Americans Act of 1965 is amended by adding at the end the following new section:

'SEC. 765. FUNDING LIMITATION.

'Funds provided under this title may not be used in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997.'.

(p) (o) **Legal Services Program**: Section 1007(b) of the Legal Services Corporation Act (42 U.S.C. 2996f(b)) is amended—

(1) by striking 'or' at the end of paragraph (9);

(2) by striking the period at the end of paragraph (10) and inserting '; or'; and

(3) by adding after paragraph (10) the following:

'(11) to provide legal assistance in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997.'.

(q) (p) **Construction on Conforming Amendments**: The fact that a law is not amended under this section shall not be construed as indicating that the provisions of this Act do not apply to such a law.

SEC. 10. RELATION TO OTHER LAWS.

The provisions of this Act supersede other Federal laws (including laws enacted after the date of the enactment of this Act) except to the extent such laws specifically supersede the provisions of this Act.

SEC. 11. EFFECTIVE DATE.

(a) **In General**: The provisions of this Act (and the amendments made by this Act) take effect upon its enactment and apply, subject to subsection (b), to Federal payments made pursuant to obligations incurred after the date of the enactment of this Act for items and services provided on or after such date.

(b) **Application to Contracts**: Such provisions shall apply with respect to contracts entered into, renewed, or extended after the date of the enactment of this Act and shall also apply to a contract entered into before such date to the extent permitted under such contract.

SEC. 12. SUICIDE PREVENTION (INCLUDING ASSISTED SUICIDE).

(a) **Purpose**: The purpose of this section is to reduce the rate of suicide (including assisted suicide) among persons with disabilities or terminal or chronic illness by furthering knowledge and practice of pain management, depression identification and treatment, and issues related to palliative care and suicide prevention.

(b) **Research and Demonstration Projects**: Section 781 of the Public Health Service Act (42 U.S.C. 295) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection:

'(e) **Research and Demonstration Projects on Suicide Prevention (Including Assisted Suicide)**:

'(1) **Research**: The Secretary may make grants to and enter into contracts with public and private entities for conducting research intended to reduce the rate of suicide (including assisted suicide) among persons with disabilities or terminal or chronic illness. The Secretary shall give preference to research that aims—

'(A) to assess the quality of care received by patients with disabilities or terminal or chronic illness by measuring and reporting specific outcomes;

'(B) to compare coordinated health care (which may include coordinated rehabilitation services, symptom control, psychological support, and community-based support services) to traditional health care delivery systems; or

'(C) to advance biomedical knowledge of pain management.

'(2) **Training**: The Secretary may make grants and enter into contracts to assist public and private entities, schools, academic health science centers, and hospitals in meeting the costs of projects intended to reduce the rate of suicide (including assisted suicide) among persons with disabilities or terminal or chronic illness. The Secretary shall give preference to qualified projects that will—

'(A) train health care practitioners in pain management, depression identification and treatment, and issues related to palliative care and suicide prevention;

'(B) train the faculty of health professions schools in pain management, depression identification and treatment, and issues related to palliative care and suicide prevention; or

'(C) develop and implement curricula regarding disability issues, including living with disabilities, living with chronic or terminal illness, attendant and personal care, assistive technology, and social support services.

'(3) **Demonstration projects**: The Secretary may make grants to and enter into contracts with public and nonprofit private entities for the purpose of conducting demonstration projects that will—

'(A) reduce restrictions on access to hospice programs; or

'(B) fund home health care services, community living arrangements, and attendant care services.

'(4) **Palliative medicine**: The Secretary shall emphasize palliative medicine among its funding and research priorities.'.

(c) **Report by General Accounting Office**: Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Congress a report providing an assessment of programs under subsection (e) of section 781 of the Public Health Service Act (as added by subsection (b) of this section) to conduct research, provide training, and develop curricula and of the curricula offered and used by schools of medicine and osteopathic medicine in pain management, depression identification and treatment, and issues related to palliative care and suicide prevention. The purpose of the assessment shall be to determine the extent to which such programs have furthered knowledge and practice of pain management, depression identification and treatment, and issues related to palliative care and suicide prevention.

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42 U.S.C. 1395 cc (a)

Subpart E – Miscellaneous

SEC. 4751. REQUIREMENTS FOR ADVANCED DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE.

(a) **IN GENERAL**. – Section 1902 (42 U.S.C. 1396a(a)), as amended by sections 4401(a)(2), 4601(d), 4701(a), 4711(a), and 4722 of this title, is amended

(1) in subsection (a)—

(A) by striking «and» at the end of paragraph (55),

(B) by striking the period at the end of paragraph (56) and inserting «; and:, and

(C) by inserting after paragraph (56) the following new paragraphs;

«(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or health maintenance organization (as defined in section 1903(m)(1)(A)) receiving funds under the plan shall comply with the requirements of subsection (w);

«(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w).»; and

(2) by adding at the end of the following new subsection:

«(w)(1) For purposes of subsection (a)(57) and sections 1903(m)(1)(A) and 1919(c)(2)(E), the requirements of this subsection is that a provider or organization (as the case may be) maintained written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

«(A) to provide written information to each such individual concerning—

«(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

«(ii) the provider's or organization's written policies respecting the implementation of such rights;

«(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

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«(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

«(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

«(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

«(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

«(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

«(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

«(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

«(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

«(E) in the case of a health maintenance organization, at the time of enrollment of the individual with the organization.

«(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.»

«(4) In this subsection, the term 'advance directive' means a written instruction, such as a living will or durable power of

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* Fuente: http://www.fha.org/acrobat/Patient%20Self%20Determination%20Act%201990.pdf

attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(a) CONFORMING AMENDMENTS.—

(1) Section 1903(m)(1)(A)(42 U.S.C. 1396b(m)(1)(A)) is amended—

(A) by inserting «meets the requirement of section 1902(w)» after «which» the first place it appears, and

(B) by inserting «meets the requirement of section 1902(a) and» after «which» the second place it appears.

(2) Section 1919(c)(2) of such Act (42 U.S.C. 139r(c)(2)) is amended by adding at the end the following new subparagraph:

«(E) INFORMATION RESPECTING ADVANCE DIRECTIVES.—A nursing facility must comply with the requirements of section 1902(w) (relating to maintaining written policies and procedures respecting advance directives).»

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act.

(d) PUBLIC EDUCATION CAMPAIGN.—

(1) IN GENERAL.— The Secretary, no later than 6 months after the date of enactment of this section, shall develop and implement a national campaign to inform the public of the option to execute advance directives and of a patient's right to participate and direct health care decisions.

(2) DEVELOPMENT AND DISTIBUTION OF INFORMATION.— The Secretary shall develop or approve nationwide informational materials that would be distributed by providers under the requirements of this section, to inform the public and the medical and legal profession of each person's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

(3) PROVIDING ASSISTANCE TO STATES.— The Secretary shall assist appropriate State agencies, associations, or other private entities in developing the State-specific documents that would be distributed by providers under the requirements of this section. The Secretary shall further assist appropriate State agencies, associations, or other private entities in ensuring that providers are provided a copy of the documents that are to be distributed under the requirements of the section.

(4) DUTIES OF SECRETARY.— The Secretary shall mail information to Social Security recipients, add a page to the medicare handbook with respect to the provisions of this section.

XII.1.2. LEYES DE LOS ESTADOS*

Alabama

Advance Directive Law. Sections 22-8A-1 through 22-8A-13, Code of Alabama 1975.- Chapter 8A Termination of life-support procedures.- http://www.alaha.org/resources.aspx?id=33#law

Natural Death Act [1981], Ala. Code §§ 22-8A-1 to -10(1990).

Alaska

Statute Chapter 13.52. Health care decisions Act. Sec. 13.52.010. Advance health care directives.- http://www.nrc-pad.org/images/stories/PDFs/alaska_statute.pdf

Rights of Terminally Ill Act [1986], Alaska Stat. §§ 18.12.010 to -.100 (1986). Alaska Statutory Form Power of Attorney Act [1988], Alaska Stat. §§ 13.26.332 to 13.26.353 (1990)

Arizona

Medical Treatment Decisions Act [1985,1991), Ariz. Rev.Stat. Ann. §§ 36-3201 to -3210

(1986, 1991). http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/36/03201.htm&Title=36&DocType=ARS

Arizona Powers of Attorney Act [1974], Ariz. Rev. Stat. Ann. §§ 14-5501 to -5502

(1975). http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/14/05501.htm&Title=14&DocType=ARS

Arkansas

Rights of the Terminally ill or Permanently Uncon-scious Act [1987], Ark. Stat. Ann. §§ 20-17-201 to -218 (Supp. 1987).

California

Effective July 1, 2000, the Natural Death Act and the laws governing Durable Powers of Attorney for Health Care was replaced by the new Health Care Decisions Law (AB 891—Chapter 658). This new, greatly improved, law should improve the value and acceptance of advance directives. http://www.leginfo.ca.gov/pub/99-00/bill/asm/ab_0851-0900/ab_891_bill_19991010_chaptered.html

Colorado

Medical Treatment Decision Act [1985,1989], Colo. Rev. Stat. §§ 15-18-101 to -113 (1987 & Supp. 1990). http://www.michie.com/colorado/lpext.dll?f=templates&fn=main-h.htm&cp=

Colorado Powers of Attorney Act [1963], Colo. Rev. Stat. §§ 15.14-501 to -502 (1987).

http://www.michie.com/colorado/lpext.dll?f=templates&fn=main-h.htm&cp=

Connecticut

Removal of Life Support Systems Act [1985, 1991], Conn. Gen. Stat. §§ 19a-570 to -575 (Supp. 1991). http://www.cga.ct.gov/2007/pub/Chap368w.htm

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By Pat Milmoe McCarrick.- http://bioethics.georgetown.edu/publications/scopenotes/sn2.pdf

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Oregon
THE OREGON DEATH WITH DIGNITY ACT (1997) OREGON REVISED STATUTES

(General Provisions)
(Section 1)

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 §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 §1.01; 1999 c.423 §1]

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

(Section 2)

127.805 §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 §2.01; 1999 c.423 §2]

127.810 §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 Department of Human Services by rule. [1995 c.3 §2.02]

(Safeguards)

(Section 3)

127.815 §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 §3.01; 1999 c.423 §3]

127.820 §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 §3.02]

127.825 §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 §3.03; 1999 c.423 §4]

127.830 §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 §3.04]

127.835 §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 §3.05; 1999 c.423 §6]

127.840 §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 §3.06]

127.845 §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 §3.07]

127.850 §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 §3.08]

127.855 §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 §3.09]

127.860 §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 §3.10; 1999 c.423 §8]

127.865 §3.11. Reporting requirements. (1)(a) The Department of Human Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The department 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 department.

(2) The department 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 department shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 §3.11; 1999 c.423 §9; 2001 c.104 §40]

127.870 §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 §3.12]

127.875 §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 §3.13]

127.880 §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 §3.14]

(Immunities and Liabilities)

(Section 4)

127.885 §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 §4.01; 1999 c.423 §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 §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 §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 §5a]

(Severability)

(Section 5)

127.895 §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 §5.01]

(Form of the Request)

(Section 6)

127.897 §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 §6.01; 1999 c.423 §11]

PENALTIES

127.990: [Formerly part of 97.990; repealed by 1993 c.767 §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]

West Virginia Health Care Decisions Act*
(Including 2002 Amendments)

§16-30-1. Short title.
This article may be cited as the «West Virginia Health Care Decisions Act.»

§16-30-2. Legislative findings and purpose.
a. *Purpose.* — The purpose of this article is to ensure that a patient's right to self-determination in health care decisions be communicated and protected; and to set forth a process for private health care decision making for incapacitated adults,

* Fuente: West Virginia University .-http://www.hsc.wvu.edu/chel/ad_forms/wvhcda3.htm

including the use of advance directives, which reduces the need for judicial involvement and defines the circumstances under which immunity shall be available for health care providers and surrogate decision makers who make health care decisions.

The intent of the Legislature is to establish an effective method for private health care decision making for incapacitated adults, and to provide that the courts should not be the usual venue for making decisions. It is not the intent of the Legislature to legalize, condone, authorize or approve mercy killing or assisted suicide.

b. *Findings.* — The Legislature hereby finds that:

Common law tradition and the medical profession in general have traditionally recognized the right of a capable adult to accept or reject medical or surgical intervention affecting one's own medical condition;

The application of recent advances in medical science and technology increasingly involves patients who are unconscious or otherwise unable to accept or reject medical or surgical treatment affecting their medical conditions;

Such advances have also made it possible to prolong the dying process artificially through the use of intervening treatments or procedures which, in some cases, offer no hope of medical benefit;

Capable adults should be encouraged to issue advance directives designating their health care representatives so that in the event any such adult becomes unconscious or otherwise incapable of making health care decisions, decisions may be made by others who are aware of such person's own wishes and values; and

The right to make medical treatment decisions extends to a person who is incapacitated at the moment of decision. An incapacitated person who has not made his or her wishes known in advance through an applicable living will, medical power of attorney or through some other means has the right to have health care decisions made on his or her behalf by a person who will act in accordance with the incapacitated person's expressed values and wishes, or, if those values and wishes are unknown, in the incapacitated person's best interests.

§16-30-3. Definitions.

For the purposes of this article:

a. «Actual knowledge» means the possession of information of the person's wishes communicated to the health care provider orally or in writing by the person, the person's medical power of attorney representative, the person's health care surrogate or other individuals resulting in the health care provider's personal cognizance of these wishes. Constructive notice and other forms of imputed knowledge are not actual knowledge.

b. «Adult» means a person who is eighteen years of age or older, an emancipated minor who has been established as such pursuant to the provisions of section twenty-seven, article seven, chapter forty-nine of this code or a mature minor.

c. «Advanced nurse practitioner» means a registered nurse with substantial theoretical knowledge in a specialized area of nursing practice and proficient clinical utilization of the knowledge in implementing the nursing process, and who has met the further requirements of title 19, legislative rules for West Virginia board of examiners for registered professional nurses, series 7 , who has a mutually agreed upon association in writing with a physician and has been selected by or assigned to the person and has primary responsibility for treatment and care of the person.

d. «Attending physician» means the physician selected by or assigned to the person who has primary responsibility for treatment and care of the person and who is a licensed physician. If more than one physician shares that responsibility, any of those physicians may act as the attending physician under this article.

e. «Capable adult» means an adult who is physically and mentally capable of making health care decisions and who is not considered a protected person pursuant to the provisions of chapter forty-four-a of this code.

f. «Close friend» means any adult who has exhibited significant care and concern for an incapacitated person who is willing and able to become involved in the incapacitated person's health care and who has maintained regular contact with the incapacitated person so as to be familiar with his or her activities, health and religious and moral beliefs.

g. «Death» means a finding made in accordance with accepted medical standards of either: (1) The irreversible cessation of circulatory and respiratory functions; or (2) the irreversible cessation of all functions of the entire brain, including the brain stem.

h. «Guardian» means a person appointed by a court pursuant to the provisions of chapter forty-four-a of this code who is responsible for the personal affairs of a protected person and includes a limited guardian or a temporary guardian.

i. «Health care decision» means a decision to give, withhold or withdraw informed consent to any type of health care, including, but not limited to, medical and surgical treatments, including life-prolonging interventions, psychiatric treatment, nursing care, hospitalization, treatment in a nursing home or other facility, home health care and organ or tissue donation.

j. «Health care facility» means a facility commonly known by a wide variety of titles, including, but not limited to, hospital, psychiatric hospital, medical center, ambulatory health care facility, physicians' office and clinic, extended care facility operated in connection with a hospital, nursing home, a hospital extended care facility operated in connection with a rehabilitation center, hospice, home health care and other facility established to administer health care in its ordinary course of business or practice.

k. «Health care provider» means any licensed physician, dentist, nurse, physician's assistant, paramedic, psychologist or other person providing medical, dental, nursing, psychological or other health care services of any kind.

l. «Incapacity» means the inability because of physical or mental impairment to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented and to communicate that choice in an unambiguous manner.

m. «Life-prolonging intervention» means any medical procedure or intervention that, when applied to a person, would serve to artificially prolong the dying process or to maintain the person in a persistent vegetative state. Life-prolonging intervention includes, among other things, nutrition and hydration administered intravenously or through a feeding tube. The term «life-prolonging intervention» does not include the administration of medication or the performance of any other medical procedure considered necessary to provide comfort or to alleviate pain.

n. «Living will» means a written, witnessed advance directive governing the withholding or withdrawing of life-prolonging intervention, voluntarily executed by a person in accordance with the requirements of section four of this article.

o. «Mature minor» means a person less than eighteen years of age who has been determined by a qualified physician, a qualified psychologist or an advanced nurse practitioner to have the capacity to make health care decisions.

p. «Medical information» or «medical records» means and includes without restriction any information recorded in any form of medium that is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse that relates to the past, present or future physical or mental health of the person, the provision of health care

to the person, or the past, present or future payment for the provision of health care to the person.

q. «Medical power of attorney representative» or «representative» means a person eighteen years of age or older appointed by another person to make health care decisions pursuant to the provisions of section six of this article or similar act of another state and recognized as valid under the laws of this state.

r. «Parent» means a person who is another person's natural or adoptive mother or father or who has been granted parental rights by valid court order and whose parental rights have not been terminated by a court of law.

s. «Persistent vegetative state» means an irreversible state as diagnosed by the attending physician or a qualified physician in which the person has intact brain stem function but no higher cortical function and has neither self-awareness or awareness of the surroundings in a learned manner.

t. «Person» means an individual, a corporation, a business trust, a trust, a partnership, an association, a government, a governmental subdivision or agency or any other legal entity.

u. «Physician orders for scope of treatment (POST) form» means a standardized form containing orders by a qualified physician that details a person's life-sustaining wishes as provided by section twenty-five of this article.

v. «Principal» means a person who has executed a living will or medical power of attorney.

w. «Protected person» means an adult who, pursuant to the provisions of chapter forty-four-a of this code, has been found by a court, because of mental impairment, to be unable to receive and evaluate information effectively or to respond to people, events and environments to an extent that the individual lacks the capacity to: (1) Meet the essential requirements for his or her health, care, safety, habilitation or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs to provide for his or her support or for the support of legal dependents without the assistance or protection of a conservator.

x. «Qualified physician» means a physician licensed to practice medicine who has personally examined the person.

y. «Qualified psychologist» means a psychologist licensed to practice psychology who has personally examined the person.

z. «Surrogate decisionmaker» or «surrogate» means an individual eighteen years of age or older who is reasonably available, is willing to make health care decisions on behalf of an incapacitated person, possesses the capacity to make health care decisions and is identified or selected by the attending physician or advanced nurse practitioner in accordance with the provisions of this article as the person who is to make those decisions in accordance with the provisions of this article.

aa. «Terminal condition» means an incurable or irreversible condition as diagnosed by the attending physician or a qualified physician for which the administration of life-prolonging intervention will serve only to prolong the dying process.

§16-30-4. Executing a living will or medical power of attorney.

a. Any competent adult may execute at any time a living will or medical power of attorney. A living will or medical power of attorney made pursuant to this article shall be:

1. In writing;

2. executed by the principal or by another person in the principal's presence at the principal's express direction if the principal is physically unable to do so;

3. dated;

4. signed in the presence of two or more witnesses at least eighteen years of age; and

5. signed and attested by such witnesses whose signatures and attestations shall be acknowledged before a notary public as provided in subsection (d) of this section

b. In addition, a witness may not be:

1. The person who signed the living will or medical power of attorney on behalf of and at the direction of the principal;

2. Related to the principal by blood or marriage;

3. Entitled to any portion of the estate of the principal under any will of the principal or codicil thereto: Provided, That the validity of the living will or medical power of attorney shall not be affected when a witness at the time of witnessing such living will or medical power of attorney was unaware of being a named beneficiary of the principal's will;

4. Directly financially responsible for principal's medical care;

5.The attending physician; or

6. The principal's medical power of attorney representative or successor medical power of attorney representative.

c. The following persons may not serve as a medical power of attorney representative or successor medical power of attorney representative:

1. A treating health care provider of the principal;

2. an employee of a treating health care provider not related to the principal;

3. an operator of a health care facility serving the principal; or

4. any person who is an employee of an operator of a health care facility serving the principal and who is not related to the principal.

d. It shall be the responsibility of the principal or his or her representative to provide for notification to his or her attending physician and other health care providers of the existence of the living will or medical power of attorney or a revocation of the living will or medical power of attorney. An attending physician or other health care provider, when presented with the living will or medical power of attorney, or the revocation of a living will or medical power of attorney, shall make the living will, medical power of attorney or a copy of either or a revocation of either a part of the principal's medical records.

e. At the time of admission to any health care facility, each person shall be advised of the existence and availability of living will and medical power of attorney forms and shall be given assistance in completing such forms if the person desires: Provided, That under no circumstances may admission to a health care facility be predicated upon a person having completed either a medical power of attorney or living will.

f. The provision of living will or medical power of attorney forms substantially in compliance with this article by health care providers, medical practitioners, social workers, social service agencies, senior citizens centers, hospitals, nursing homes, personal care homes, community care facilities or any other similar person or group, without separate compensation, does not constitute the unauthorized practice of law.

g. The living will may, but need not, be in the following form and may include other specific directions not inconsistent with other provisions of this article. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the living will which can be given effect without the invalid direction and to this end the directions in the living will are severable.

STATE OF WEST VIRGINIA LIVING WILL

The kind of Medical Treatment I Want and Don't Want

If I Have a Terminal Condition or Am In a Persistent Vegetative State

Living will made this _________day of_______(month,year).
I,____,
being of sound mind, willfully and voluntarily declare that I

want my wishes to be respected if I am very sick and not able to communicate my wishes for myself. In the absence of my ability to give directions regarding the use of life-prolonging medical intervention, it is my desire that my dying shall not be prolonged under the following circumstances:

If I am very sick and not able to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition or to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others), I direct that life-prolonging medical intervention that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain.

(Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis and mental health treatment may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.) I give the following SPECIAL DIRECTIVES OR LIMITATIONS:

____
____
____

It is my intention that this living will be honored as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences resulting from such refusal.

I understand the full import of this living will.

____
Signed
____

____
Address

I did not sign the principal's signature above for or at the direction of the principal. I am at least eighteen years of age and am not related to the principal by blood or marriage, entitled to any portion of the estate of the principal to the best of my knowledge under any will of principal or codicil thereto, or directly financially responsible for principal's medical care. I am not the principal's attending physician or the principal's medical power of attorney representative or successor medical power of attorney representative under a medical power of attorney.

Witness____________________DATE_____________________

Witness____________________DATE_____________________

STATE OF___________________

COUNTY OF________________________

I, ___________________, a Notary Public of said County, do certify that_____________,

as principal, and ______________________, and______________________, as witnesses,

whose names are signed to the writing above bearing date on the _______ day of _____________________, 20____, have this day acknowledged the same before me.

Given under my hand this _______ day of ____________________, 20_____.

My commission expires: _______________________________

____
Signature of Notary Public

h. A medical power of attorney may, but need not, be in the following form, and may include other specific directions not inconsistent with other provisions of this article. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the medical power of attorney are severable.

STATE OF WEST VIRGINIA
MEDICAL POWER OF ATTORNEY

The Person I Want to Make Health Care Decisions
For Me When I Can't Make Them for Myself

Dated: ______________________________ , 20______
I,____, hereby
(Insert your name and address)
appoint my representative to act on my behalf to give, withhold or withdraw informed consent to health care decisions in the event that I am not able to do so myself.
The person I choose as my representative is:
____
(Insert the name, address, area code and telephone number of the person you wish to designate as your representative)

The person I choose as my successor representative is:

If my representative is unable, unwilling or disqualified to serve, then I appoint:
____
(Insert the name, address, area code and telephone number of the person you wish to designate as your successor representative)

This appointment shall extend to, but not be limited to, health care decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home health care. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, or autopsy if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment or procedures. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions.

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician and all legal authorities be bound by the decisions that are made by the representative appointed by this document and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated below.

I am giving the following SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, funeral arrangements, autopsy and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.)

____
____

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

____
Signature of the Principal

I did not sign the principal's signature above. I am at least eighteen years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, or legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

Witness________________ DATE______________________

Witness________________ DATE______________________

STATE OF___________________

COUNTY OF________________________

I, ____________, a Notary Public of said County, do certify that____________,

as principal, and ______________________, and_____________________, as witnesses,

whose names are signed to the writing above bearing date on the _______ day of

_____________________, 20____, have this day acknowledged the same before me.

Given under my hand this ______________________ day of ____________________, 20_____.

My commission expires: _______________________________.
____
Notary Public

§16-30-5. Applicability and resolving actual conflict between advance directives.

a. The provisions of this article which directly conflict with the written directives contained in a living will or medical power of attorney executed prior to the effective date of this statute shall not apply. An expressed directive contained in a living will or medical power of attorney or by any other means the health care provider determines to be reliable shall be followed.

b. If there is a conflict between the person's expressed directives, the physician orders for scope of treatment form and the decisions of the medical power of attorney representative or surrogate, the person's expressed directives shall be followed.

c. In the event there is a conflict between two advance directives executed by the person, the one most recently completed takes precedence only to the extent needed to resolve the inconsistency.

d. If there is a conflict between the decisions of the medical power of attorney representative or surrogate and the person's best interests as determined by the attending physician when the person's wishes are unknown, the attending physician shall attempt to resolve the conflict by consultation with a qualified physician, an ethics committee or by some other means. If the attending physician cannot resolve the conflict with the medical power of attorney representative, the attending physician may transfer the care of the person pursuant to subsection (b), section twelve of this article.

§16-30-6. Private decision-making process; authority of living will, medical power of attorney representative and surrogate.

a. Any capable adult may make his or her own health care decisions without regard to guidelines contained in this article.

b. Health care providers and health care facilities may rely upon health care decisions made on behalf of an incapacitated person without resort to the courts or legal process, if the decisions are made in accordance with the provisions of this article.

c. The medical power of attorney representative or surrogate shall have the authority to release or authorize the release of an incapacitated person's medical records to third parties and make any and all health care decisions on behalf of an incapacitated person, except to the extent that a medical power of attorney representative's authority is clearly limited in the medical power of attorney.

d. The medical power of attorney representative or surrogate's authority shall commence upon a determination, made pursuant to section seven of this article, of the incapacity of the adult. In the event the person no longer is incapacitated or the medical power of attorney representative or surrogate is unwilling or unable to serve, the medical power of attorney representative or surrogate's authority shall cease. However, the authority of the medical power of attorney representative or surrogate may recommence if the person subsequently becomes incapacitated as determined pursuant to section seven of this article unless during the intervening period of capacity the person executes an advance directive which makes a surrogate unnecessary or expressly rejects the previously appointed surrogate as his or her surrogate. A medical power of attorney representative or surrogate's authority terminates upon the death of the incapacitated person except with respect to decisions regarding autopsy, funeral arrangements or cremation and organ and tissue donation: Provided, That the medical power of attorney representative or surrogate has no authority after the death of the incapacitated person to invalidate or revoke a preneed funeral contract executed by the incapacitated person in accordance with the provisions of article fourteen, chapter forty-seven of this code prior to the onset of the incapacity and either paid in full before the death of the incapacitated person or collectible from the proceeds of a life insurance policy specifically designated for that purpose.

e. The medical power of attorney representative or surrogate shall seek medical information necessary to make health care decisions for an incapacitated person. For the sole purpose of making health care decisions for the incapacitated person, the medical power of attorney representative or surrogate shall have the same right of access to the incapacitated

person's medical information and the same right to discuss that information with the incapacitated person's health care providers that the incapacitated person would have if he or she was not incapacitated.

f. If an incapacitated person previously expressed his or her wishes regarding autopsy, funeral arrangements or cremation, organ or tissue donation or the desire to make an anatomical gift by a written directive such as a living will, medical power of attorney, donor card, driver's license or other means, the medical power of attorney representative or surrogate shall follow the person's expressed wishes regarding autopsy, funeral arrangements or cremation, organ and tissue donation or anatomical gift. In the absence of any written directives, any decision regarding anatomical gifts shall be made pursuant to the provisions of article nineteen of this chapter.

g. If a person is incapacitated at the time of the decision to withhold or withdraw life-prolonging intervention, the person's living will or medical power of attorney executed in accordance with section four of this article is presumed to be valid. For the purposes of this article, a physician or health facility may presume in the absence of actual notice to the contrary that a person who executed a living will or medical power of attorney was a competent adult when it was executed. The fact that a person executed a living will or medical power of attorney is not an indication of the person's mental incapacity.

§16-30-7. Determination of incapacity.

a. For the purposes of this article, a person may not be presumed to be incapacitated merely by reason of advanced age or disability. With respect to a person who has a diagnosis of mental illness or mental retardation, such a diagnosis is not a presumption that the person is incapacitated. A determination that a person is incapacitated shall be made by the attending physician, a qualified physician, a qualified psychologist or an advanced nurse practitioner who has personally examined the person.

b. The determination of incapacity shall be recorded contemporaneously in the person's medical record by the attending physician, a qualified physician, advanced nurse practitioner or a qualified psychologist. The recording shall state the basis for the determination of incapacity, including the cause, nature and expected duration of the person's incapacity, if these are known.

c. If the person is conscious, the attending physician shall inform the person that he or she has been determined to be incapacitated and that a medical power of attorney representative or surrogate decisionmaker may be making decisions regarding life-prolonging intervention or mental health treatment for the person.

§16-30-8. Selection of a surrogate.

a. When a person is or becomes incapacitated, the attending physician or the advanced nurse practitioner with the assistance of other health care providers as necessary, shall select, in writing, a surrogate. The attending physician or advanced nurse practitioner shall reasonably attempt to determine whether the incapacitated person has appointed a representative under a medical power of attorney, in accordance with the provisions of section four of this article, or if the incapacitated person has a court-appointed guardian in accordance with the provisions of article one, chapter forty-four-a of this code. If no representative or court-appointed guardian is authorized or capable and willing to serve, the attending physician or advanced nurse practitioner is authorized to select a health care surrogate. In selecting a surrogate, the attending physician or advanced nurse practitioner must make a reasonable inquiry as to the existence and availability of a surrogate from the following persons:

1.The person's spouse;

2. The person's adult children;

3. The person's parents;

4. The person's adult siblings;

5. The person's adult grandchildren;

6. The person's close friends;

7. Any other person or entity, including, but not limited to, public agencies, public guardians, public officials, public and private corporations and other persons or entities which the department of health and human resources may from time to time designate in rules promulgated pursuant to chapter twenty-nine-a of this code.

b. After inquiring about the existence and availability of a medical power of attorney representative or a guardian as required by subsection (a) of this section and determining that such persons either do not exist or are unavailable, incapable or unwilling to serve as a surrogate, the attending physician or an advanced nurse practitioner shall select and rely upon a surrogate in the order of priority set forth in subsection (a) of this section, subject to the following conditions:

1.Where there are multiple possible surrogate decisionmakers at the same priority level, the attending physician or the advanced nurse practitioner shall, after reasonable inquiry, select as the surrogate the person who reasonably appears to be best qualified. The following criteria shall be considered in the determination of the person or entity best qualified to serve as the surrogate:

A. Whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the known wishes of the person or in accordance with the person's best interests;

B. The proposed surrogate's regular contact with the person prior to and during the incapacitating illness;

C. The proposed surrogate's demonstrated care and concern;

D. The proposed surrogate's availability to visit the incapacitated person during his or her illness; and

E. The proposed surrogate's availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the decision-making process;

2. The attending physician or the advanced nurse practitioner may select a proposed surrogate who is ranked lower in priority if, in his or her judgment, that individual is best qualified, as described in this section, to serve as the incapacitated person's surrogate. The attending physician or the advanced nurse practitioner shall document in the incapacitated person's medical records his or her reasons for selecting a surrogate in exception to the priority order provided in subsection (a) of this section.

c. The surrogate is authorized to make health care decisions on behalf of the incapacitated person without a court order or judicial involvement.

d. A health care provider or health care facility may rely upon the decisions of the selected surrogate if the provider believes, after reasonable inquiry, that:

1. A guardian or representative under a valid, applicable medical power of attorney is unavailable, incapable or unwilling to serve;

2. There is no other applicable advance directive;

3. There is no reason to believe that such health care decisions are contrary to the incapacitated person's religious beliefs; and

4. The attending physician or advanced nurse practitioner has not received actual notice of opposition to any health care decisions made pursuant to the provisions of this section.

e. If a person who is ranked as a possible surrogate pursuant to subsection (a) of this section wishes to challenge the selection of a surrogate or the health care decision of the selected surrogate, he or she may seek injunctive relief or may

file a petition for review of the selection of, or decision of, the selected surrogate with the circuit court of the county in which the incapacitated person resides or the supreme court of appeals. There shall be a rebuttable presumption that the selection of the surrogate was valid and the person who is challenging the selection shall have the burden of proving the invalidity of that selection. The challenging party shall be responsible for all court costs and other costs related to the proceeding, except attorneys' fees, unless the court finds that the attending physician or advanced nurse practitioner acted in bad faith, in which case the person so acting shall be responsible for all costs. Each party shall be responsible for his or her own attorneys' fees.

f. If the attending physician or advanced nurse practitioner is advised that a person who is ranked as a possible surrogate pursuant to the provisions of subsection (a) of this section has an objection to a health care decision to withhold or withdraw a life-prolonging intervention which has been made by the selected surrogate, the attending physician or advanced nurse practitioner shall document the objection in the medical records of the patient. Once notice of an objection or challenge is documented, the attending physician or advanced nurse practitioner shall notify the challenging party that the decision shall be implemented in seventy-two hours unless the attending physician receives a court order prohibiting or enjoining the implementation of the decision as provided in subsection (e) of this section. In the event that the incapacitated person has been determined to have undergone brain death and the selected surrogate has authorized organ or tissue donation, the decision shall be implemented in twenty-four hours unless the attending physician receives a court order prohibiting or enjoining the implementation of the decision as provided in said subsection.

g. If the surrogate becomes unavailable for any reason, the surrogate may be replaced by applying the provisions of this section.

h. If a person who ranks higher in priority relative to a selected surrogate becomes available and willing to be the surrogate, the person with higher priority may be substituted for the identified surrogate unless the attending physician determines that the lower-ranked person is best qualified to serve as the surrogate.

i. The following persons may not serve as a surrogate:

1.A treating health care provider of the person who is incapacitated;

2. an employee of a treating health care provider not related to the person who is incapacitated;

3.an owner, operator or administrator of a health care facility serving the person who is incapacitated; or

4. any person who is an employee of an owner, operator or administrator of a health care facility serving the person who is incapacitated and who is not related to that person.

§16-30-9. Medical power of attorney representative and health care surrogate decision-making standards.

a. General standards.

The medical power of attorney representative or the health care surrogate shall make health care decisions:

1. In accordance with the person's wishes, including religious and moral beliefs; or

2. In accordance with the person's best interests if these wishes are not reasonably known and cannot with reasonable diligence be ascertained; and

3.Which reflect the values of the person, including the person's religious and moral beliefs, to the extent they are reasonably known or can with reasonable diligence be ascertained.

b. Assessment of best interests.

An assessment of the person's best interests shall include consideration of the person's medical condition, prognosis, the dignity and uniqueness of every person, the possibility and extent of preserving the person's life, the possibility of preserving, improving or restoring the person's functioning, the possibility of relieving the person's suffering, the balance of the burdens to the benefits of the proposed treatment or intervention and such other concerns and values as a reasonable individual in the person's circumstances would wish to consider.

§16-30-10. Reliance on authority of living will, physician orders for scope of treatment form, medical power of attorney representative or surrogate decisionmaker and protection of health care providers.

a. A physician, licensed health care professional, health care facility or employee thereof shall not be subject to criminal or civil liability for good-faith compliance with or reliance upon the directions of the medical power of attorney representative in accordance with this article.

b. A health care provider shall not be subject to civil or criminal liability for surrogate selection or good faith compliance and reliance upon the directions of the surrogate in accordance with the provisions of this article.

c. A health care provider, health care facility or employee thereof shall not be subject to criminal or civil liability for good-faith compliance with or reliance upon the orders in a physician orders for scope of treatment form.

d. No health care provider or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-prolonging intervention from a person pursuant to a living will made in accordance with this article shall, as a result thereof, be subject to criminal or civil liability.

e. An attending physician who cannot comply with the living will or medical power of attorney of a principal pursuant to this article shall, in conjunction with the medical power of attorney representative, health care surrogate or other responsible person, effect the transfer of the principal to another physician who will honor the living will or medical power of attorney of the principal. Transfer under these circumstances does not constitute abandonment.

§16-30-11. Negligence.

Nothing in this article shall be deemed to protect a provider from liability for the provider's own negligence in the performance of the provider's duties or in carrying out any instructions of the medical power of attorney representative or surrogate. Nothing in this article shall be deemed to alter the law of negligence as it applies to the acts of any medical power of attorney representative or surrogate or provider, and nothing herein shall be interpreted as establishing a standard of care for health care providers for purposes of the law of negligence.

§16-30-12. Conscience objections.

a. Health care facilities. — Nothing in this article shall be construed to require a health care facility to change published policy of the health care facility that is expressly based on sincerely held religious beliefs or sincerely held moral convictions central to the facility's operating principles.

b. Health care providers. — Nothing in this article shall be construed to require an individual health care provider to honor a health care decision made pursuant to this article if:

1. The decision is contrary to the individual provider's sincerely held religious beliefs or sincerely held moral convictions; and

2.The individual health care provider promptly informs the person who made the decision and the health care facility of

his or her refusal to honor the decision. In such event, the medical power of attorney representative or surrogate decision maker shall have responsibility for arranging the transfer of the person to another health care provider. The individual health care provider shall cooperate in facilitating such transfer, and a transfer under these circumstances shall not constitute abandonment.

§16-30-13. Interinstitutional transfers.

a. In the event that a person admitted to any health care facility in this state has been determined to lack capacity and that person's medical power of attorney has been declared to be in effect or a surrogate decisionmaker has been selected for that person all in accordance with the requirements of this article and that person is subsequently transferred from one health care facility to another, the receiving health care facility may rely upon the prior determination of incapacity and the activation of the medical power of attorney or selection of a surrogate decisionmaker as valid and continuing until such time as an attending physician, a qualified physician, a qualified psychologist or advanced nurse practitioner in the receiving facility assesses the person's capacity. Should the reassessment by the attending physician, a qualified physician, a qualified psychologist or an advanced nurse practitioner at the receiving facility result in a determination of continued incapacity, the receiving facility may rely upon the medical power of attorney representative or surrogate decisionmaker who provided health care decisions at the transferring facility to continue to make all health care decisions at the receiving facility until such time as the person regains capacity.

b. If a person admitted to any health care facility in this state has been determined to lack capacity and the person's medical power of attorney has been declared to be in effect or a surrogate decisionmaker has been selected for that person all in accordance with the requirements of this article and that person is subsequently discharged home in the care of a home health care agency or hospice, the home health care agency or hospice may rely upon the prior determination of incapacity. The home health care agency or hospice may rely upon the medical power of attorney representative or health care surrogate who provided health care decisions at the transferring facility to continue to make all health care decisions until such time as the person regains capacity.

c. If a person with an order to withhold or withdraw life-prolonging intervention is transferred from one health care facility to another, the existence of such order shall be communicated to the receiving facility prior to the transfer and the written order shall accompany the person to the receiving facility and shall remain effective until a physician at the receiving facility issues admission orders.

d. If a person with a physician orders for scope of treatment form is transferred from one health care facility to another, the health care facility initiating the transfer shall communicate the existence of the physician orders for scope of treatment form to the receiving facility prior to the transfer. The physician orders for scope of treatment form shall accompany the person to the receiving facility and shall remain in effect. The form shall be kept at the beginning of the patient's transfer records unless otherwise specified in the health care facility's policy and procedures. After admission, the physician orders for scope of treatment form shall be reviewed by the attending physician and one of three actions shall be taken:

1. The physician orders for scope of treatment form shall be continued without change;

2. The physician orders for scope of treatment form shall be voided and a new form issued; or

3. The physician orders for scope of treatment form shall be voided without a new form being issued.

§16-30-14. Insurance.

a. No policy of life insurance or annuity or other type of contract that is conditioned on the life or death of the person, shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-prolonging intervention from a person in accordance with the provisions of this article, notwithstanding any terms of the policy to the contrary.

b. The withholding or withdrawal of life-prolonging intervention from a principal in accordance with the provisions of this article does not, for any purpose, constitute a suicide and does not constitute the crime of assisting suicide.

c. The making of a living will or medical power of attorney pursuant to this article does not affect in any manner the sale, procurement or issuance of any insurance policy nor does it modify the terms of an existing policy.

d. No health care provider or health care service plan, health maintenance organization, insurer issuing disability insurance, self-insured employee welfare benefit plan, nonprofit medical service corporation or mutual nonprofit hospital service corporation shall require any person to execute a living will or medical power of attorney as a condition for being insured for or receiving health care services.

§16-30-15. Withholding of life support not assisted suicide or murder.

The withholding or withdrawal of life-prolonging intervention from a person in accordance with the decision of a medical power of attorney representative or surrogate decision maker made pursuant to the provisions of this article does not, for any purpose, constitute assisted suicide or murder. The withholding or withdrawal of life-prolonging intervention from a person in accordance with the decisions of a medical power of attorney representative or surrogate decision maker made pursuant to the provisions of this article, however, shall not relieve any individual of responsibility for any criminal acts that may have caused the person's condition. Nothing in this article shall be construed to legalize, condone, authorize or approve mercy killing or assisted suicide.

§16-30-16. Preservation of existing rights and relation to existing law; no presumption.

a. The provisions of this article are cumulative with existing law regarding an individual's right to consent to or refuse medical treatment. The provisions of this article shall not impair any existing rights or responsibilities that a health care provider, a person, including a minor or an incapacitated person or a person's family may have in regard to the withholding or withdrawal of life-prolonging intervention, including any rights to seek or forego judicial review of decisions regarding life-prolonging intervention under the common law or statutes of this state.

b. This article creates no presumption concerning the intention of an individual who has not executed a living will or medical power of attorney to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, including, but not limited to, life-prolonging intervention.

§16-30-17. No abrogation of common law doctrine of medical necessity.

Nothing in this article shall be construed to abrogate the common law doctrine of medical necessity.

§16-30-18. Revocation.

a. A living will or medical power of attorney may be revoked at any time only by the principal or at the express direction of the principal by any of the following methods:

1. By being destroyed by the principal or by some person in the principal's presence and at his or her direction;

2. By a written revocation of the living will or medical

power of attorney signed and dated by the principal or person acting at the direction of the principal. Such revocation shall become effective only upon delivery of the written revocation to the attending physician by the principal or by a person acting on behalf of the principal.

The attending physician shall record in the principal's medical record the time and date when he or she receives notification of the written revocation; or

3. By a verbal expression of the intent to revoke the living will or medical power of attorney in the presence of a witness eighteen years of age or older who signs and dates a writing confirming that such expression of intent was made. Any verbal revocation shall become effective only upon communication of the revocation to the attending physician by the principal or by a person acting on behalf of the principal. The attending physician shall record, in the principal's medical record, the time, date and place of when he or she receives notification of the revocation.

b. There is no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

c. The grant of a final divorce decree shall act as an automatic revocation of the designation of the former spouse to act as a medical power of attorney representative or successor representative.

§16-30-19. Physician's duty to confirm, communicate and document terminal condition or persistent vegetative state; medical record identification.

a. An attending physician who has been notified of the existence of a living will executed under this article, without delay after the diagnosis of a terminal condition or persistent vegetative state of the principal, shall take steps as needed to provide for confirmation, written certification and documentation of the principal's terminal condition or persistent vegetative state in the principal's medical record.

b. Once confirmation, written certification and documentation of the principal's terminal condition or persistent vegetative state is made, the attending physician shall verbally or in writing inform the principal of his or her condition or the principal's medical power of attorney representative or surrogate, if the principal lacks capacity to comprehend such information and shall document such communication in the principal's medical record.

c. All inpatient health care facilities shall develop a system to visibly identify a person's chart which contains a living will or medical power of attorney as set forth in this article.

§16-30-20. Living wills previously executed.

A living will executed prior to the effective date of this article and which expressly provides for the withholding or withdrawal of life-prolonging intervention or for the termination of life-sustaining procedures in substantial compliance with the provisions of section four of this article is hereby recognized as a valid living will, as though it were executed in compliance with the provisions of this article.

§16-30-21. Reciprocity.

A living will or medical power of attorney executed in another state is validly executed for the purposes of this article if it is executed in compliance with the laws of this state or with the laws of the state where executed.

§16-30-22. Liability for failure to act in accordance with the directives of a living will or medical power of attorney or the directions of a medical power of attorney representative or health care surrogate.

a. A health care provider or health care facility without actual knowledge of a living will or medical power of attorney completed by a person is not civilly or criminally liable for failing to act in accordance with the directives of a principal's living will or medical power of attorney.

b. A health care provider or a health care facility is subject to review and disciplinary action by the appropriate licensing board for failing to act in accordance with a principal's directives in a living will or medical power of attorney, or the decisions of a medical power of attorney representative or health care surrogate: Provided, That the provider or facility had actual knowledge of the directives or decisions.

c. Once a principal has been determined to be incapacitated in accordance with the provisions of this article and his or her living will or medical power of attorney has become effective, any health care provider or health care facility which refuses to follow the principal's directives in a living will or medical power of attorney or the decisions of a medical power of attorney representative or health care surrogate, because the principal has asked the health care provider or health care facility not to follow such directions or decisions, shall have two physicians, one of whom may be the attending physician, or one physician and a qualified psychologist, or one physician and an advanced nurse practitioner, certify that the principal has regained capacity to make the request. If such certification occurs, the provisions of the applicable living will or medical power of attorney, or the statute creating the authority of the health care surrogate shall not apply because the principal has regained decision-making capacity.

§16-30-23. Prohibition.

Under no circumstances may the presence or absence of a living will or medical power of attorney be used to deny a person admission to a health care facility.

§16-30-24. Need for a second opinion regarding incapacity for persons with psychiatric mental illness, mental retardation or addiction.

For persons with psychiatric mental illness, mental retardation or addiction who have been determined by their attending physician or a qualified physician to be incapacitated, a second opinion by a qualified physician or qualified psychologist that the person is incapacitated is required before the attending physician is authorized to select a surrogate. The requirement for a second opinion shall not apply in those instances in which the medical treatment to be rendered is not for the person's psychiatric mental illness.

§16-30-25. Physician orders for scope of treatment form.

a. No later than the first day of July, two thousand three, the secretary of the department of health and human resources shall implement the statewide distribution of standardized physician orders for scope of treatment (POST) forms.

b. Physician orders for scope of treatment forms shall be standardized forms used to reflect orders by a qualified physician for medical treatment of a person in accordance with that person's wishes or, if that person's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with that person's best interest. The form shall be bright pink in color to facilitate recognition by emergency medical services personnel and other health care providers and shall be designed to provide for information regarding the care of the patient, including, but not limited to, the following:

1. The orders of a qualified physician regarding cardiopulmonary resuscitation, level of medical intervention in the event of a medical emergency, use of antibiotics and use of medically administered fluids and nutrition and the basis for the orders;

2. The signature of the qualified physician;

3. Whether the person has completed an advance directive or had a guardian, medical power of attorney representative or surrogate appointed;

4. The signature of the person or his or her guardian, medical power of attorney representative, or surrogate acknowledging agreement with the orders of the qualified physician; and

5. The date, location and outcome of any review of the physician orders for scope of treatment form.

c. The physician orders for scope of treatment form shall be kept as the first page in a person's medical record in a health care facility unless otherwise specified in the health care facility's policies and procedures and shall be transferred with the person from one health care facility to another.

XII.3. DOCUMENTOS

Oregon's Death with Dignity Act*

On October 27, 1997 Oregon enacted the Death with Dignity Act which allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose. The Oregon Death with Dignity Act requires the Oregon Department of Human Services to collect information about the patients and physicians who participate in the Act, and publish an annual statistical report. These data are important to parties on both sides of the issue. Our position is a neutral one, and we offer no opinions about the law.

The Oregon Death with Dignity Act, a citizens' initiative, was first passed by Oregon voters in November 1994 by a margin of 51% in favor and 49% opposed. Immediate implementation of the Act was delayed by a legal injunction. After multiple legal proceedings, including a petition that was denied by the United States Supreme Court, the Ninth Circuit Court of Appeals lifted the injunction on October 27, 1997 and the Act became a legal option for terminally-ill patients in Oregon. In November 1997, Measure 51 (authorized by Oregon House Bill 2954) was placed on the general election ballot and asked Oregon voters to repeal the Death with Dignity Act. Voters chose to retain the Act by a margin of 60% to 40%.

The Death with Dignity Act states that ending one's life in accordance with the law does «not constitute suicide or assisted suicide». The Death with Dignity Act specifically prohibits lethal injection, mercy killing, or active euthanasia, where a physician or other person directly administers a medication to end another's life.

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FAQ about the Death With Dignity Act

In 1997, Oregon enacted the Death with Dignity Act (the Act) which allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose. This law requires the Oregon Department of Human Services to collect and analyze data on who participates in the Act and issue an annual report. These data are important to parties on both sides of the issue. Our position is a neutral one, and we offer no subjective opinions about these questions. We routinely receive inquiries about the Act. Here are some answers to frequently asked questions.

Q: What is Oregon's Death with Dignity Act?

A: The Death with Dignity Act (the Act) allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.

The Act was a citizens' initiative passed twice by Oregon voters. The first time was in a general election in November 1994 when it passed by a margin of 51% to 49%. An injunction delayed implementation of the Act until it was lifted on October 27, 1997. In November 1997, a measure was placed on the general election ballot to repeal the Act. Voters chose to retain the Act by a margin of 60% to 40%.

There is no state «program» for participation in the Act. People do not «make application» to the State of Oregon or the Department of Human Services. It is up to qualified patients and licensed physicians to implement the Act on an individual basis. The Act requires the Department of Human Services to collect information about patients who participate each year and to issue an annual report.

Q: Who can participate in the Act?

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

Q: Can someone who doesn't live in Oregon participate in the Act?

A: No. Only patients who establish that they are residents of Oregon can participate if they meet certain criteria.

Q: How does a patient demonstrate residency?

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

Q: How long does someone have to be a resident of Oregon to participate in the Act?

A: There is no minimum residency requirement. A patient must be able to establish that s/he is currently a resident of Oregon.

Q: Can a non-resident move to Oregon in order to participate in the Act?

A: There is nothing in the law that prevents someone from doing this. However, the patient must be able to prove to the attending doctor that s/he is currently a resident of Oregon.

Q: Are participating patients reported to the State of Oregon by name?

A: The State does collect the names of patients in order to cross-check death certificates. However, the law guarantees the

* Fuente: Department of Human Services.- http://www.oregon.gov/DHS/ph/pas/about_us.shtml

confidentiality of all participating patients (as well as physicians) and the Department of Human Services does not release this information to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed.

Q: Who can give a patient a prescription under the Act?

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

Q: If a patient's doctor does not participate in the Act, how can s/he get a prescription?

A: The patient must find another M.D. or D.O. licensed to practice medicine in Oregon who is willing to participate. The Oregon Department of Human Services does not recommend doctors, nor do we provide the names of participating physicians or patients due to the need to protect confidentiality.

Q: If a patient's primary care doctor is located in another state, can that doctor write a prescription for the patient?

A: No. Only M.D.s or D.O.s licensed to practice medicine by the Board of Medical Examiners for the State of Oregon can write a valid prescription for lethal medication under the Act.

Q: How does a patient get a prescription from a participating physician?

A: The patient must meet certain criteria to be able to request to participate in the Act. Then, the following steps must be fulfilled: 1) the patient must make two oral requests to the attending physician, separated by at least 15 days; 2) the patient must provide a written request to the attending physician, signed in the presence of two witnesses, at least one of whom is not related to the patient; 3) the attending physician and a consulting physician must confirm the patient's diagnosis and prognosis; 4) the attending physician and a consulting physician must determine whether the patient is capable of making and communicating health care decisions for him/herself; 5) if either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder (such as depression), the patient must be referred for a psychological examination; 6) the attending physician must inform the patient of feasible alternatives to the Act including comfort care, hospice care, and pain control; 7) the attending physician must request, but may not require, the patient to notify their next-of-kin of the prescription request. A patient can rescind a request at any time and in any manner. The attending physician will also offer the patient an opportunity to rescind his/her request at the end of the 15-day waiting period following the initial request to participate.

Physicians must report all prescriptions for lethal medications to the Department of Human Services, Vital Records. As of 1999, pharmacists must be informed of the prescribed medication's ultimate use.

Q: What kind of prescription will a patient receive?

A: It is up to the physician to determine the prescription. To date, most patients have received a prescription for an oral dosage of a barbiturate.

Q: What will happen if a physician doesn't follow the prescribing or reporting requirements of the Act?

A: The Department of Human Services will notify the Board of Medical Examiners of any deviations. If a formal investigation is warranted by the Board of Medical Examiners, physicians might be subject to disciplinary action.

Q: Must a physician be present at the time the medications are taken?

A: The law does not require the presence of a physician when a patient takes lethal medication. A physician may be present if a patient wishes it, as long as the physician does not administer the medication him/herself.

Q: Can a patient rescind a request to participate in the Act?

A: Yes, a patient can rescind a request at any time and in any manner. The attending physician will also offer the patient an opportunity to rescind his/her request at the end of the 15-day waiting period following the initial request to participate.

Q: How much does participation cost?

A: We do not collect cost data. However, direct costs for participation in the Act might include office calls relating to the request, a psychological consult (if required), and the cost of the prescription.

Q: Will insurance cover the cost of participation in the Act?

A: The Act does not specify who must pay for the services. Individual insurers determine whether the procedure is covered under their policies (just as they do with any other medical procedure). Oregon statute specifies that participation under the Act is not suicide, so should not affect insurance benefits by that definition. However, federal funding cannot be used for services rendered under the Act. For instance, the Oregon Medicaid program, which is paid for by federal funding, ensures that charges for services relating to the Act are paid only with state funds.

Q: Can a patient's family members request participation in the Act on behalf of the patient (for example, in cases where the patient is comatose)?

A: No. The law requires that the patient ask to participate voluntarily on his or her own behalf.

Q: Does the Act allow euthanasia?

A: No. Euthanasia is a different procedure for hastening death. In euthanasia, a doctor injects a patient with a lethal dosage of medication. In the Act, a physician prescribes a lethal dose of medication to a patient, but the patient – not the doctor – administers the medication. Euthanasia is illegal in every state in the union, including Oregon. The Act has been legal in Oregon since November 1997.

Q: What information is available on Oregon's Death with Dignity Act website?

A: You can find links to all our annual reports, forms, legislation, rules, press releases and other articles. The annual reports themselves contain an historical background of the Act, a description of the laws pertaining to the Act, how data is reported, collected and analyzed, a summary of the year's results, and tables that outline the participant demographics and disease characteristics. The Department of Human Services does not collect some information (such as religious affiliation of participants or cost of the procedure); other information is strictly confidential (such as names of participating patients and physicians).

Q: What is the Department of Human Services' opinion of the Act?

A: The Act was a citizen's initiative, enacted because a majority of voting Oregonians believed that persons afflicted with certain terminal illnesses should have the legal right to hasten their deaths. The role of the Department of Human Services is to collect data on participation in the Act and issue an annual report.

These data are important to parties on both sides of the issue. Our position is a neutral one, and we offer no opinions about the law.

Q: What is the status of the federal lawsuit against Oregon's Death with Dignity law?

A: November 6, 2001: U.S. Attorney General John Ashcroft issues a directive which states, in part, that prescribing, dispensing or administering federally controlled substances to assist suicide violates the Controlled Substances Act (CSA). This new interpretation of the CSA allows the federal Drug Enforcement Agency (DEA) to pursue action to revoke prescription-writing privileges and to pursue federal criminal prosecution of participating Oregon physicians.

November 7, 2001: Oregon Attorney General Hardy Myers files suit in U.S. District Court for a temporary restraining order and preliminary injunction.

November 8, 2001: U.S. District Court Judge Robert Jones issues 10-day stay barring implementation of Ashcroft's order.

November 20, 2001: Judge Jones issues a temporary restraining order against Ashcroft's ruling pending a new hearing.

January 22, 2002: Oregon Attorney General Hardy Myers files a motion for summary judgment.

April 17, 2002: U.S. District Court Judge Robert Jones upholds the Death with Dignity Act. Permanent injunction is filed.

September 23, 2002: Attorney General Ashcroft files an appeal, asking the 9th U.S. Circuit Court of Appeals to overturn the District Court's ruling.

May 26, 2004: a three-judge panel upholds Judge Jones' ruling.

July 13, 2004: Ashcroft files an appeal requesting that the 9th U.S. Circuit Court of Appeals rehear his previous motion with an 11-judge panel.

August 13, 2004: 9th U.S. District Court of Appeals denies Ashcroft's request.

November 9, 2004: Ashcroft appeals the case to the U.S. Supreme Court.

February 22, 2005: U.S. Supreme Court agrees to hear the appeal.

October 5, 2005: U.S. Supreme Court hears oral arguments in the case of Gonzales v. State of Oregon.

January 17, 2006: The U.S. Supreme Court files its opinion and upholds the 9th U.S. District Court of Appeals' decision. Oregon's law remains in effect.

Further information on Gonzales v. Oregon. can be found at the Department of Justice's Physician-Assisted Dying website http://www.doj.state.or.us/hot_topics/11072001.shtml.

Q: Where can I find a copy of the statutes and administrative rules governing the Death with Dignity Act?

A: The statutes can be found at http://egov.oregon.gov/DHS/ph/pas/ors.shtml and the administrative rules are at http://egov.oregon.gov/DHS/ph/pas/oars.shtml.

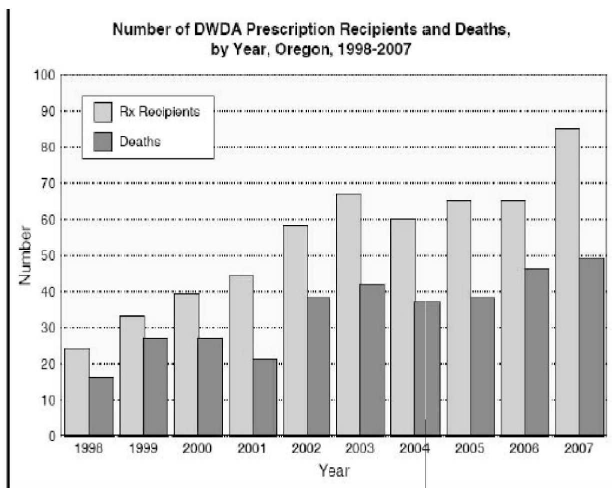
Q: Where can I find the forms used for the Act?

A: http://egov.oregon.gov/DHS/ph/pas/pasforms.shtml.

Death with Dignity Act Annual Reports*

Summary of Oregon's Death with Dignity Act - 2007

Oregon's Death with Dignity Act (DWDA) allows terminally ill adult residents to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Department of Human Services is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2007 are listed below. For more detail, please view the tables on our web site: http://oregon.gov/DHS/ph/pas/index.shtml



- During 2007, 85 prescriptions for lethal medications were written under the provisions of the DWDA compared to 65 during 2006 (Figure). Of these, 46 patients took the medications, 26 died of their underlying disease, and 13 were alive at the end of 2007. In addition, three patients with earlier prescriptions died from taking the medications, resulting in a total of 49 DWDA deaths during 2007. This corresponds to an estimated 15.6 DWDA deaths per 10,000 total deaths.
- Forty-five physicians wrote the 85 prescriptions (range 1-10).
- Since the DWDA was passed in 1997, 341 patients have died under the terms of the law.
- As in prior years, most participants were between 55 and 84 years of age (80%) white (98%), well educated (69% had some college), and had terminal cancer (86%). Patients who died in 2007 were younger (median age 65 years) than in previous years (median age 70 years).
- During 2007, more patients resided in the Portland Metropolitan area (Clackamas, Multnomah, and Washington counties) (55%) compared to prior years (39%).
- All patients had some form of health insurance: 65% had private insurance, and 35% had Medicare or Medicaid.
- As in previous years, the most frequently mentioned end-of-life concerns were: loss of autonomy (100%), decreasing ability to participate in activities that made life enjoyable (86%), and loss of dignity (86%). During 2007, more participants were concerned about inadequate pain control (33%) than in previous years (26%).
- Most patients died at home (90%) and were enrolled in hospice care (88%).
- Complications were reported in three patients during 2007; they all regurgitated some of the medication. One person lived 3½ days.
- During 2007, no physician referrals were made to the Oregon Medical Board.

* Fuente: http://oregon.gov/DHS/ph/pas/docs/year10.pdf

XII.4. DIRECCIONES WEB

U.S. government's official web portal
http://www.usa.gov/index.shtml

U.S. Federal Government
http://www.usa.gov/Agencies/federal.shtml

U.S. State Government
http://www.usa.gov/Agencies/State_and_Territories.shtml

Legal Services Corporation
https://www.oig.lsc.gov/

Office of the Law Revision Counsel
http://uscode.house.gov/

Library of Congress
http://www.loc.gov/index.html

California Medical Association
http://www.cmanet.org/index.cfm

Florida Hospital Association
http://www.fha.org/

NOAH. New York Online Access to Health
http://www.noah-health.org/en/rights/endoflife/adforms.html

Oregon Governor's Web Site Oregon
http://www.oregon.gov/

Oregon's Death with Dignity Act-.-Department of Human Services
http:www.oregon.gov/DHS/ph/pas

Oregon Department of Justice.
http://www.doj.state.or.us/index.shtml

Encyclopedia of Death and Dying
http://www.deathreference.com/index.html

Justia.com
http://law.justia.com

U.S. Living Will Registry
http://www.uslivingwillregistry.com/default.asp