Case Number _____-_____ ☐ **DWD** ☐ **Illness**

For ODPE use only.

Oregon Death with Dignity Act
Attending Physician Interview

Dear Physician:

The Death with Dignity Act requires physicians who write a prescription for lethal medications under the Act to report to the Oregon Department of Human Services information that documents compliance with the law. Following the patient's ingestion of DWD-related medication, we contact the attending physician to determine whether or not the patient died from taking the medications and to gather information about the patient's end-of-life care and the circumstances surrounding his or her death.

In lieu of the standard follow-up phone call by a representative of the state Office for Disease Prevention and Epidemiology, you may complete this document and mail it to the address on the last page. *All information will be kept strictly confidential.* Please do not write your name or the patient's name on this form; instead, write both on a Post-It© or slip of paper, attaching it to this page. If you have questions, please call 971-673-1162.

Date: ___/___/___

Attending Physician ID Number: _____ _____ _____ _____ _____

For ODPE use only.

1. Did the patient die from the ingestion of lethal medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink? If unknown, please contact the family or patient's representative.

☐ 1 Death with Dignity

☐ 2 Underlying illness *There is no need to complete the document unless the patient consumed the lethal medication but regained consciousness.*

☐ 3 Other (specify) _____

2. On what date did you begin caring for this patient?
___/___/___ (Mo/Da/Yr)

3. On what date was the patient first told about their underlying medical condition?
___/___/___ (Mo/Da/Yr)

4. On what date was the patient told that this condition was terminal -- that is, that they would die from this illness despite medical therapy?
___/___/___ (Mo/Da/Yr)

5. On what date was the DWD prescription written or phoned in?
___/___/___ (Mo/Da/Yr)

6. And, on what date were the lethal medications dispensed to the patient?
___/___/___ (Mo/Da/Yr) ☐ Not Dispensed ☐ Unknown

7. Were you at the patient's bedside when the patient took the lethal medication?
   - ☐ 1 Yes
   - ☐ 2 No, did not offer to be present at the time of ingestion
   - ☐ 3 No, offered to be present, but the patient declined
   - ☐ 8 No, other (specify) _____
   - ☐ 9 Unknown

     If no: Was another physician or trained health care provider or volunteer present when the patient ingested medication?
     - ☐ 1 Yes, another physician
     - ☐ 2 Yes, a trained health-care provider/volunteer
     - ☐ 3 No
     - ☐ 9 Unknown

8. Were you at the patient's bedside at the time of death?
   - ☐ 1 Yes
   - ☐ 2 No

     If no: Was another physician or trained health care provider or volunteer present at the patient's time of death?
     - ☐ 1 Yes, another physician
     - ☐ 2 Yes, a trained health-care provider/volunteer
     - ☐ 3 No
     - ☐ 9 Unknown

     If no: How were you informed of the patient's death?
     - ☐ 1 Family member called M.D.
     - ☐ 2 Friend of patient called M.D.
     - ☐ 3 Another physician
     - ☐ 4 Hospice R.N.
     - ☐ 5 Hospital R.N.
     - ☐ 6 Nursing home/Assisted-living staff
     - ☐ 7 Funeral home
     - ☐ 8 Medical Examiner
     - ☐ 9 Other (specify) _____
     - ☐ 10 Compassion in Dying

9. What lethal medication was prescribed and what was the dosage?
   - ☐ Secobarbital/Seconal
     - ☐ 9 grams
     - ☐ 10 grams
   - ☐ Pentobarbital/Nembutal
     - ☐ 9 grams
     - ☐ 10 grams
   - ☐ Other (specify) _____

10. Did the patient take the lethal medications according to the prescription directions?

☐ 1 Yes
☐ 2 No

If no: Please list the medications the patient took (other than those reported in item 9), the dosages, and the reason for not following the prescription directions. _____

_____

_____

☐ 9 Unknown

11. Were there any complications after DWD medication ingestion, for example, vomiting, seizures, or regaining consciousness?

☐ 1 Yes Please describe _____

_____

_____

☐ 2 No
☐ 9 Unknown

12. Was the Emergency Medical System activated for any reason after the ingestion of the lethal medications?

☐ 1 Yes Please describe _____

_____

_____

☐ 2 No
☐ 9 Unknown

13. What was the time between lethal medication ingestion and unconsciousness?

Minutes: _____ or Hours: _____ ☐ Unknown

14. What was the time between lethal medication ingestion and death?

Minutes: _____ or Hours: _____ ☐ Unknown

If the patient lived longer than six hours....

Do you have any observations on why the patient lived for more than six hours after ingesting the medication? _____

_____

_____

_____

_____

15. Seven possible concerns that may have contributed to the patient's decision to request a prescription for lethal medication are shown below. Please check "yes," "no," or "Don't know," depending on whether or not you believe that concern contributed to the request.

A concern about...

...the financial cost of treating or prolonging his or her terminal condition.
☐ Yes ☐ No ☐ Don't Know

...the physical or emotional burden on family, friends, or caregivers.
☐ Yes ☐ No ☐ Don't Know

...his or her terminal condition representing a steady loss of autonomy.
☐ Yes ☐ No ☐ Don't Know

...the decreasing ability to participate in activities that made life enjoyable.
☐ Yes ☐ No ☐ Don't Know

...the loss of control of bodily functions, such as incontinence and vomiting.
☐ Yes ☐ No ☐ Don't Know

...inadequate pain control at the end of life.
☐ Yes ☐ No ☐ Don't Know

...a loss of dignity.
☐ Yes ☐ No ☐ Don't Know

16. *Immediately* prior to (attempted) DWD, what was the patient's mobility? (ECOG scale)
- ☐ 0 Fully active, no restrictions on pre-disease performance.
- ☐ 1 Restricted in strenuous activity, but ambulatory and able to carry out work.
- ☐ 2 Ambulatory and capable of all self-care, but no work activities; up and about more than 50% of waking hours.
- ☐ 3 Capable of only limited self-care; in bed or chair more than 50% of waking hours.
- ☐ 4 Completely disabled, no self-care, totally confined to bed or chair.
- ☐ 9 Unknown

17. Where did the patient ingest the medication?
- ☐ 1 Private home
- ☐ 2 Assisted-living residence (including foster care)
- ☐ 3 Nursing home
- ☐ 4 Acute care hospital in-patient
- ☐ 5 In-patient hospice resident
- ☐ 6 Other (specify) _____
- ☐ 9 Unknown

18. When the patient initially requested a DWD prescription, was the patient receiving hospice care?

- ☐ 1 Yes
- ☐ 2 No, refused care
- ☐ 3 No, never offered care
- ☐ 4 No, other (specify) _____
- ☐ 9 Unknown

19. At the time of ingestion of the DWD medication, was the patient receiving hospice care?

- ☐ 1 Yes
- ☐ 2 No, refused care
- ☐ 3 No, never offered care
- ☐ 4 No, other (specify) _____
- ☐ 9 Unknown

20. What type of health-care coverage did the patient have for their underlying illness? (*Check all that apply.*)

- ☐ 1 Medicare
- ☐ 2 Oregon Health Plan/Medicaid
- ☐ 3 Military/CHAMPUS
- ☐ 4 V.A.
- ☐ 5 Indian Health Service
- ☐ 6 Private insurance (e.g., Kaiser, Blue Cross, Medigap)
- ☐ 7 No insurance
- ☐ 8 Had insurance, don't know type
- ☐ 9 Unknown

21. What is your medical specialty? (*Check all that apply.*)

- ☐ 1 Family Practice
- ☐ 2 Internal Medicine
- ☐ 3 Oncology
- ☐ 4 Other (specify) _____

22 How many years have you been in practice, not including any training periods, such as residency or fellowship?

Years: _____

23. And lastly, do you have any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us? _____

_____

_____

_____

_____

Please mail this document to:

Mortality Research Analyst
Center for Health Statistics
Office of Disease Prevention & Epi.
Oregon Dept. of Human Services
800 NE Oregon Street, Room 225
Portland, Oregon 97232