No. SJC-13194

Supreme Judicial Court

SUFFOLK COUNTY 2022 SITTING

ROGER M. KLIGLER & ANOTHER,
Appellant,

v.

MAURA HEALEY & ANOTHER,
Appellee.

ON APPEAL FROM A JUDGMENT
OF THE SUPERIOR COURT

BRIEF FOR AMICUS CURIAE DR. KONSTANTIN TRETYAKOV NOT IN SUPPORT OF EITHER PARTY AND SUPPORTING NEITHER AFFIRMANCE NOR REVERSAL

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STATEMENT OF INTEREST OF AMICUS CURIAE

Dr. Konstantin Tretyakov is an attorney admitted to practice law in Massachusetts. He holds the Doctor of Juridical Science degree from Harvard Law School, where he defended a doctoral thesis on the "right to die." Dr. Tretyakov authored several publications on the topic of medical aid in dying, including "Medical Aid in Dying by Telehealth," 30 Health Matrix 325 (2020), "The Right to Die in the United States, Canada, and China: Legal Fictions and Their Utility in a Comparative Perspective," 21 University of Pennsylvania Journal of Law and Social Change 79 (2018), and "Medical Assistance in Dying and 'Suicide Tourism' to Canada: Bill C-14 from Comparative Perspective," [open volume] Journal of Ethics in Mental Health (2016) (with I. Glenn Cohen). Dr. Tretyakov's interest is in sound development of the law.

DECLARATION OF AMICUS CURIAE

In accordance with Mass. R. App. P. 17(c), the undersigned declares that: (a) no party nor party's counsel authored this brief in whole or in part; (b) no party nor party's counsel contributed money that was intended to fund preparing or submitting this brief; (c) no person or entity other than the amicus curiae contributed money that was intended to fund preparing or submitting this brief; (d) the amicus

curiae does not represent and has not represented one of the parties to the present appeal in another proceeding involving similar issue.

ISSUE PRESENTED

Whether a physician is subject to prosecution for manslaughter, where, in accordance with a medically acceptable standard of care, the physician prescribes medication for a competent, terminally ill, adult patient, who subsequently ingests the medication, ending his or her own life.

ARGUMENT

A. Summary of the Argument.

The issue presented in this case lies at the intersection of criminal and constitutional law. Acknowledging the constitutional arguments made by both parties, this brief focuses on the criminal law side of the case. The brief discusses four issues, which could assist the Court in resolving this matter.

First, in formulating the question for amici curiae, the Court rightly assumed that there exists a medically acceptable standard of care for medical aid in dying. The standard is prescribed by statutes in the States where the procedure has been legalized; it is also followed in Montana, where the procedure has been partially decriminalized by

judicial order. The brief describes the standard of care to provide the Court with the context necessary to decide whether medical aid in dying has the elements of involuntary manslaughter.[1] Pp. 10–15.

Second, in this case the motion judge's ruling created an apparent tension between this Court's holdings in the Carter cases and the law of joint venture. Specifically, the judge concluded that while medical aid in dying is involuntary manslaughter, discussing it with patients and referring them to other physicians to get it is not a crime. While the latter part of the judge's order is firmly grounded in the Court's recent decisions, the ruling taken as a whole does not seem to address the issue that if medical aid in dying is a felony, then, under the law of accomplice liability, so is counselling and procuring it—that is, referring

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[1] In responding to the Court's question, the amicus focuses on involuntary manslaughter, which is "an unlawful homicide unintentionally caused by an act which constitutes such a disregard of probable harmful consequences to another as to amount to wanton or reckless conduct." Commonwealth v. Gonzalez, 443 Mass. 799, 808 (2005) (citation omitted) (quotation marks omitted). Both parties appear to agree that the elements of voluntary manslaughter are not present in the context of medical aid in dying. Commonwealth v. Brea, 488 Mass. 150, 171 (2021), quoting Commonwealth v. Haith, 452 Mass. 409, 415 (2008) ("'[V]oluntary manslaughter an intentional killing that is mitigated by extenuating circumstances[,]' . . . such as reasonable provocation, sudden combat, or excessive use of force in defense of another").

a patient to another medical professional when done with intent that the patient receive lethal medication. The Court should resolve this contradiction by either overruling or limiting the scope of its previous decisions, or holding that if referral of a patient for medical aid in dying is not a crime, neither is medical aid in dying itself. Pp. 16–22.

Third, the Court should consider whether in the context of medical aid in dying the death of a qualifying patient is "substantial harm," the infliction of which should be prosecuted. While death squarely falls under the traditional definition of substantial harm, this definition is based on the Commonwealth's interest in protecting human life. As a terminally ill patient approaches their death, however, this interest fades and transforms into the imposition of a "duty to live." For qualifying patients, dying by taking lethal medication is not harm, let alone "substantial harm"—it is a deliberate, conscious, voluntary choice of a competent adult who is going to die anyway and wishes to end their life with dignity. The opportunity to die with dignity does not harm qualifying patients—in the days leading up to their inevitable death, it improves the quality of their life. Pp. 22–27.

Fourth, assuming arguendo death is substantial harm in medical aid in dying, the Court should demand the Commonwealth to present the evidence that when a prescription for lethal medication is written, there is a high degree of likelihood that the patient will in fact ingest the medication and die. Empirical data from the States where medical aid in dying is legal does not support the conclusion that such high degree of likelihood exists; in fact, it supports the opposite conclusion—that there is no high degree of likelihood that a patient prescribed with lethal medication will ingest it. In light of the scarcity of other possible evidence that could prove a high degree of likelihood of substantial harm, the Court should determine whether this data would be fatal to prosecuting medical aid in dying as involuntary manslaughter. Pp. 27–32.

B. The Standard of Care for Medical Aid in Dying.

In formulating the question to amici curiae, this Court rightly assumed that there exists "a medically acceptable standard of care" that governs the procedure of providing medical aid in dying. See generally Gonzales v. Oregon, 546 U.S. 243, 274, 275 (2006) (individual States may decide whether medical aid in dying is a recognized option of

medical treatment). See also Morris v. Brandenburg, 376 P.3d 836, 840–841 (N.M. 2016) (physician who practices medical aid in dying in Montana relies on the standard of care set forth in the Oregon Death with Dignity Act). As of February 2022, statutes legalizing medical aid in dying have been enacted in nine States[2] and in the District of Columbia. Cal. Health & Safety Code § 443 (2016); Colo. Rev. Stat. Ann. § 25-48-101 et seq. (2016); Haw. Rev. Stat. Ann. c. 327L (2018); Me. Rev. Stat. tit. 22, § 2140 (2019); N.J. Stat. Ann. § 26:16 (2019); N.M. Stat. Ann. § 24-7C (2021); Or. Rev. Stat. § 127.800 et seq. (2017); Vt. Stat. Ann. tit. 18, § 5281 et seq. (2015); Wash. Rev. Code § 70.245.010 et seq. (2009); D.C. Code § 7-661.01 et seq. (2017). These statutes prescribe

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[2] California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington. In Montana, there is no statute legalizing medical aid in dying, but the State high court recognized the statutory defense of consent against criminal charges of homicide brought against physicians who participated in medical aid in dying that resulted in the patient's death. Baxter v. State, 224 P.3d 1211, 1215 (Mont. 2009). It is less clear, however, whether defense of consent lies when medical aid in dying does not result in the patient's death. Id. at 1220. ("The narrow scenario we have been asked to consider on appeal involves the situation in which a terminally ill patient affirmatively seeks a lethal dose of medicine and subsequently self-administers it, causing his own death"). Accord Mont. Code Ann. § 45-5-105 (1973) ("A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide").

the standard of care for medical aid in dying, which is largely similar across the States. What follows is a description of this standard of care, which could assist the Court in deciding this case.[3]

Medical aid in dying is available only to State residents who are eighteen or older, are capable of making medical decisions, seek medical aid in dying voluntarily, and have an irreversible, incurable disease, which, within reasonable medical judgment, is likely to result in death in six months or less (terminal disease). See, e.g., Or. Rev. Stat. Ann. § 127.805 (1999); Me. Rev. Stat. tit. 22, § 2140 (2019). On the providers' side, medical aid in dying is furnished by a team of medical professionals licensed to practice medicine in the State. That team includes an attending physician, a consulting (or second) physician, a mental health specialist (psychologist, psychiatrist, or social worker), and a pharmacist. See, e.g., Vt. Stat. Ann. tit. 18, § 5283 (2013).

The process of obtaining medical aid in dying starts with the patient's request filed with their attending physician. The patient must make two oral requests (separated by a waiting period, which can last

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[3] The following description is derived from Tretyakov, "Medical Aid in Dying by Telehealth," 30 Health Matrix 325, 332–336 (2020). See also addendum at 69–81, 243.

from forty-eight hours to twenty days) and one written request. See, e.g., Cal. Health & Safety Code § 443.3 (2021); Haw. Rev. Stat. Ann. § 327L-2 (2018); Wash. Rev. Code Ann. § 70.245.090 (2009). The written request must be made in the presence of two witnesses who certify that the patient is mentally capable, is acting voluntarily, and is not being coerced to sign the request.[4] See, e.g., Me. Rev. Stat. tit. 22, § 2140(5)(c) (2019). In addition, at least fifteen or twenty days must pass between the first oral request and the dispensation of the medication to the patient, and at least forty-eight hours must pass between the written request and the dispensation of medication. See, e.g., Or. Rev. Stat. Ann. § 127.850 (2019). The patient can withdraw request for medical aid in dying at any time. See, e.g., Wash. Rev. Code Ann. § 70.245.100 (2009); Vt. Stat. Ann. tit. 18, § 5283 (2013).

Upon receiving the patient's request, the attending physician must confirm that the patient meets the aforementioned eligibility requirements and inform the patient about their diagnosis and

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[4] One of the witnesses must be a person who is not a relative of the patient by blood, marriage, or adoption; a person who at the time the form is signed would be entitled to any portion of the estate of the patient upon death; or an owner, operator or employee of a health care facility where the patient is receiving medical treatment or is a resident.

prognosis, the risks associated with taking the medication, the results of taking that medication, and alternative end-of-life care options (palliative care, hospice care, pain control). The attending physician must tell the patient about the opportunity to revoke medical aid in dying request at any time and about the option not to take the medication after receiving it. See, e.g., Vt. Stat. Ann. tit. 18, § 5283 (2013); Me. Rev. Stat. tit. 22, § 2140 (2019).

The attending physician also must refer the patient to a consulting physician who examines the patient and their medical record and can confirm the patient's diagnosis and prognosis, as well as the fact that the patient is capable and is making an informed, voluntary decision to get the medication. See, e.g., Cal. Health & Safety Code § 443.5 (2021); Or. Rev. Stat. Ann. § 127.815 (2019). If the attending physician believes that the patient lacks capacity to make an informed decision, she must refer the patient to a mental health specialist who can confirm that the patient's judgment is not impaired by a psychological or psychiatric disorder or depression. See, e.g., Vt. Stat. Ann. tit. 18, § 5283 (2013).

If, following these steps, the patient is found to meet the statutory eligibility requirements, the attending physician informs the patient about the logistics of the procedure (the importance of notifying the patient's family, not taking the medication in a public place, not taking the medication alone) and once again makes sure that the patient's choice is a free and informed one. See, e.g., Colo. Rev. Stat. Ann. § 25-48-106 (2019); Cal. Health & Safety Code § 443.5 (2021). After that, the physician writes a prescription for the medication and either dispenses the medication to the patient directly, or, with the patient's consent, sends the prescription to a pharmacist, who can then dispense it to the physician, the patient, or the patient's designee. The attending physician must notify the State authorities about writing the prescription. At all stages of medical aid in dying, the involved medical professionals must carefully document the aforementioned steps in the patient's medical record. See, e.g., Me. Rev. Stat. tit. 22, § 2140 (2019); Vt. Stat. Ann. tit. 18, § 5283 (2013).

C. If Medical Aid in Dying Is Involuntary Manslaughter, Then So Is Referral of Patients for That Purpose under the Law of Joint Venture.

An adult resident of Massachusetts who is competent and terminally ill requests medical aid in dying from a Massachusetts-licensed physician. The physician, while expressing her utmost sympathy for the patient, explains that she is legally prohibited from providing medical aid in dying in Massachusetts but knows a doctor in Vermont who could help. (In fact, the Massachusetts physician, as is customary in medical practice, has a referral agreement with a Vermont-licensed physician.) Acting with the patient's consent, the Massachusetts physician sends a referral to her colleague in Vermont, in which she includes the reason for the referral (medical aid in dying), the patient's relevant medical history, and test results. In the meantime, the patient establishes Vermont residency by signing a lease in that State.

After receiving the referral, the Vermont physician arranges an appointment for the patient. Following the process described supra, the Vermont physician finds that the patient meets the eligibility requirements for medical aid in dying and gives him a vial with a lethal

dose of secobarbital. The patient returns to Massachusetts, takes the medication, and dies.

If medical aid in dying is involuntary manslaughter, then in this scenario the Massachusetts physician is guilty of this crime as a joint venturer.[5] By reaching an agreement about referring her patients to the Vermont physician and acting under the agreement with the intent that the patient obtain medical aid in dying, the Massachusetts physician acts "in the concerted action and cooperation" with her colleague in Vermont "in helping to bring about" medical aid in dying for the patient. Commonwealth v. Atencio, 345 Mass. 627, 629 (1963). See also Commonwealth v. Carter, 481 Mass. 352, 365 (2019), citing Commonwealth v. Bowen, 13 Mass. 356 (1816) ("[T]he legal principle that procuring a suicide 'by advice or otherwise' may constitute a

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[5] The fact that medical aid in dying is not a crime in Vermont is immaterial for this analysis: if it is a felony in Massachusetts, then the physician counsels and procures commission of a felony while being present within the boundaries of the Commonwealth. Commonwealth v. Combs, 480 Mass. 55, 61 (2018) (where "a criminal act occurred within the territorial boundaries of the Commonwealth, . . . the Commonwealth has jurisdiction over the individual charged with that act"). Furthermore, the patient dies in Massachusetts, so that the "effect" of medical aid in dying occurs in the Commonwealth as well. Matter of Vasquez, 428 Mass. 842, 848 (1999) (State can punish the cause of the harm that occurred within its boundaries).

homicide is clear"); Commonwealth v. Silva, 471 Mass. 610, 621 (2015), citing Commonwealth v. Zanetti, 454 Mass. 449, 466 (2009) (to prove joint venture, "what matters is only that there be proof of (1) the defendant's knowing participation in some manner in the commission of the offense; and (2) the defendant's intent—i.e., proof that the defendant had or shared in the intent necessary for the offense of which he is convicted") (emphasis supplied). Put differently, the Massachusetts physician does not merely associate with her colleague in Vermont: instead, she meaningfully participates in medical aid in dying and does so with the intent that the patient gets it. G.L. c. 274, § 2 ("Whoever . . . is accessory [to a felony] before the fact by counselling, hiring or otherwise procuring such felony to be committed, shall be punished in the manner provided for the punishment of the principal felon"); Marshall v. Commonwealth, 463 Mass. 529, 536–537 (2012) (recognizing that "a wide range of conduct underlying a person's liability for a criminal offense, including that which had historically been described as accessory before the fact to a felony . . . , plainly falls under the rubric of accomplice liability, and, consequently, may be charged as the substantive offense"). This means that referring a

patient for medical aid in dying makes a Massachusetts physician an accomplice—if medical aid in dying itself is involuntary manslaughter. Cf. United States v. Indivior Inc., 451 F. Supp. 3d 553, 558 (W.D. Va. 2020) (denying motion to dismiss indictment charging wire fraud under accomplice liability for defendants' referral of patients to physician).

In this case, the motion judge concluded that medical aid in dying is involuntary manslaughter (Plaintiffs' Addendum at 54). Under the law of aiding and abetting discussed supra, this would also mean that a physician who, acting with intent that patient obtain medical aid in dying, refers her patient to another doctor for that purpose, is "counselling, hiring or otherwise procuring such felony to be committed" and would be guilty of this "crime" as an accomplice. G.L. c. 274, § 2. In this respect, however, the motion judge reached the exact opposite conclusion, which is not challenged by either party: "Any physician is free to provide information on the jurisdictions where [medical aid in dying] is legal, guidance and information on the procedures and requirements in those jurisdictions, and referrals to physicians who can provide [medical aid in dying] in those jurisdictions. Such conduct, without more, does not constitute involuntary manslaughter."

(Plaintiffs' Addendum at 57) In reaching this conclusion, the judge relied on this Court's repeated holdings that counselling patients about medical aid in dying is not prosecutable conduct. Commonwealth v. Carter, 481 Mass. 352, 368 (2019) (Carter II) ("[T]his case does not involve the prosecution of end-of-life discussions between a doctor . . . and a mature, terminally ill adult confronting the difficult personal choices that must be made when faced with the certain physical and mental suffering brought upon by impending death. . . . Only the wanton or reckless pressuring of a person to commit suicide that overpowers that person's will to live has been proscribed.") (footnote omitted); Commonwealth v. Carter, 474 Mass. 624, 636 (2016) (Carter I) ("[This involuntary manslaughter case] is not about a person seeking to ameliorate the anguish of someone coping with a terminal illness and questioning the value of life. Nor is it about a person offering support, comfort, and even assistance to a mature adult who, confronted with such circumstances, has decided to end his or her life").

As a result, the motion judge's ruling effectively adjudged that while medical aid in dying is a crime, acting as an accomplice to it is not. This is an anomalous result, which in its own right can raise

constitutional issues with the vagueness of such approach. Nor can it be salvaged under the freedom of speech jurisprudence: where the act of speech itself is integral to criminal conduct, such as counselling commission of a felony, it is not protected under the First Amendment. Commonwealth v. Johnson, 470 Mass. 300, 309 (2014) ("[S]peech or writing used as an integral part of conduct in violation of a valid criminal statute is not protected by the First Amendment"). Accord Carter II, 481 Mass. 367 (speech integral to a course of criminal conduct is punishable under Carter I). Notably, in Carter I & II, the Court was not presented with the issue of medical aid in dying and therefore did not rule whether it constitutes a crime. If in this case the Court holds that medical aid in dying is involuntary manslaughter, then counselling it automatically becomes counselling commission of a felony—and thus integral to a course of criminal conduct—which, again, would directly contradict the Court's previous holdings.

This result can be avoided by recognizing that if participating in medical aid in dying through a referral process is not a crime, neither is medical aid in dying itself. This conclusion would be congruent with the established law of joint venture and the holdings of both Carter cases.

In the alternative, the Court could hold that patient referrals for medical aid in dying give grounds for accomplice liability for involuntary manslaughter; this, however, would require overruling or limiting the scope of the Court's previous holdings in Carter I & II and reversing the part of the motion judge's order that neither party challenges on appeal.

D. Death of a Terminally Ill, Competent Adult Who Voluntarily Makes Repeated Requests for Medical Aid in Dying Is Not Prosecutable Harm.

"Involuntary manslaughter is 'an unlawful homicide unintentionally caused by . . . wanton or reckless conduct.'" Commonwealth v. Life Care Centers of Am., Inc., 456 Mass. 826, 832 (2010), quoting Commonwealth v. Gonzalez, 443 Mass. 799, 808 (2005). Wanton or reckless conduct is intentional conduct that "involves a high degree of likelihood that substantial harm will result to another." Commonwealth v. Carrillo, 483 Mass. 269, 275 (2019), quoting Commonwealth v. Welansky, 316 Mass. 383, 399 (1944). Therefore, substantial harm—a high degree of likelihood thereof—must be present in order to convict for involuntary manslaughter.

Death squarely falls under the traditional definition of substantial harm. Carrillo, 483 Mass. at 276 ("[T]he harm to another person must be substantial, involving death or grave bodily injury"). This traditional definition, however, has been applied in involuntary manslaughter cases involving individuals who were not terminally ill and who either expressed no desire to end their lives, or were in a mental state so fragile that their willpower to live was overcome by defendants. See, e.g., Commonwealth v. Bowen, 13 Mass. 356, 356 (1816) (prisoner sentenced to death hang himself after being "repeatedly and frequently" urged to do so by defendant); Commonwealth v. Peach, 239 Mass. 575, 579 (1921) (victim of car accident); Welansky, 316 Mass. at 393 (victims of fire in night club); Commonwealth v. Bouvier, 316 Mass. 489, 495 (1944) (husband killed by wife); Persampieri v. Commonwealth, 343 Mass. 19, 22–23 (1961) (victim who had consumed alcohol, attempted committing suicide on two prior occasions, and was "emotionally disturbed" assisted by defendant in shooting herself); Commonwealth v. Atencio, 345 Mass. 627, 628–629 (1963) (victim of game of "Russian roulette" with defendants); Commonwealth v. Pugh, 462 Mass. 482, 486–487 (2012) (viable fetus died during unassisted childbirth);

Carrillo, 483 Mass. at 274 (student died from heroin overdose); Carter II, 481 Mass. at 359 (victim in fragile mental state and history of suicide attempts suffocated to death after being told by defendant to get back into car filled with carbon monoxide).

In all these cases, the Commonwealth had a compelling interest in protecting human life. Recognizing death as substantial harm for purposes of defining wanton or reckless conduct logically follows from recognizing this interest. See Atencio, 345 Mass. at 629 (even where victim's voluntary act "would be a bar" in civil action, "the Commonwealth [has] an interest that the deceased should not be killed by the wanton or reckless conduct of himself and others"). Accord Carter I, 474 Mass. at 633.

Medical aid in dying, however, presents a markedly different situation: a competent adult, whose medical prognosis is death within six months, makes repeated request for lethal medication in order to avoid physical and mental anguish and retain agency and control over the last moments of his or her life. See, e.g., Carter v. Canada (Attorney General), [2015] 1 S.C.R. 331, paras. 11, 12 (Can.) (describing "a fatal neurodegenerative disease, amyotrophic lateral sclerosis [or ALS],

which causes progressive muscle weakness. ALS patients first lose the ability to use their hands and feet, then the ability to walk, chew, swallow, speak and, eventually, breathe"; patients with ALS also suffer pain from muscle deterioration). Under these circumstances, the Commonwealth's insistence that these individuals must continue to suffer until death from natural causes no longer represents a compelling interest in protecting human life—instead, it becomes a paternalistic imposition of the "duty to live" on competent adults who are terminally ill and wish to die with dignity. For these qualifying patients, dying by taking a lethal medication is not harm, let alone "substantial harm"—it is a deliberate, conscious choice of a person who is going to die anyway and wishes to end their life on their own terms, rather than spending their last days sedated into unconsciousness to escape from constant pain, being unaware of their surroundings, and being humiliated by having their vital needs, from eating and drinking to urination and defecation, being taken care of by other people.[6] And

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[6] The other option for these individuals would be taking their own life by violent means. See Carter, [2015] 1 S.C.R. 331, para. 1 (Can.) ("[P]eople who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and

the standard of care for medical aid in dying discussed supra ensures that this choice to die with dignity is voluntary and deliberate.

The Court would be well warranted to conclude that as a patient seeking medical aid in dying is approaching their natural death, the Commonwealth's interest in protecting human life must give way to another important interest—protection of individual autonomy, including an autonomous choice of a competent terminally ill adult to end his or her life. See Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 742 (1977) ("The interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation. There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where . . . the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended"). This also means that in the unique context of medical aid in dying, death of a qualifying patient

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intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel").

should not be considered "substantial harm." This approach would carve out a very narrow exception from the general definition of substantial harm, because medical aid in dying is only available to competent, terminally ill adults. The applicability of this exception would depend not on moral, religious, or policy views, but rather on sound medical judgment.

E. There Is No Indication That Prescribing a Patient with a Lethal Dose of Medication Creates a "High Degree of Likelihood" That the Patient Will in Fact Take the Medication and Die.

If the Court is inclined to uphold the traditional definition of death as substantial harm in the context of medical aid in dying, the Court should next consider whether the Commonwealth, as a matter of law, can prove beyond a reasonable doubt that prescribing lethal medication to a qualifying patient creates a high degree of likelihood that this conduct will in fact cause the patient's death. See Carrillo, 483 Mass. at 276 (2019) ("Where the Commonwealth alleges that a defendant committed involuntary manslaughter by selling or giving heroin to another person, who died from its use, the distribution of that heroin must be proven to be wanton or reckless conduct, which means that the distribution must have created a high degree of likelihood of

death or grave bodily injury") (emphasis supplied). This Court has emphasized that proof beyond a reasonable doubt that conduct creates a high degree of likelihood of death must be based on "empirical factual support." Id. at 281.

With medical aid in dying, in order to prove beyond a reasonable doubt that prescribing a lethal medication creates a high likelihood of substantial harm, the Commonwealth must establish that there is high degree of likelihood that the patient prescribed with the medication will actually take it and that if taken, the medication will cause death. This degree of likelihood is assessed when the medication is being prescribed based on both objective and subjective standard. Pugh, 462 Mass. at 496–497, quoting Welansky, 316 Mass. at 398–399 ("If based on the objective measure of recklessness, the defendant's actions constitute 'wanton or reckless conduct . . . if an ordinary normal [person] under the same circumstances would have realized the gravity of the danger.' If based on the subjective measure, i.e., the defendant's own knowledge, 'grave danger to others must have been apparent and the defendant must have chosen to run the risk rather than alter [their] conduct so as to avoid the act or omission which caused the harm.'") While the efficacy

of the medications used for medical aid in dying appears to be well established, that efficacy does not create a high degree of likelihood of death unless the patient actually ingests the medication. This makes prescribing lethal medication different from, for example, distribution of heroin, where "use of heroin . . . is present in any distribution of heroin." Carrillo, 483 Mass. at 271.

Assessing the degree of likelihood that a patient will ingest the prescribed lethal medication is greatly assisted by years (sometimes decades) of empirical data collected by the authorities in the States where medical aid in dying is legal. This data, among other items, contains information about the total number of qualifying patients prescribed with lethal medication and the number of patients who actually take the medication and die. The relevant data can be summarized as follows.[7] In Oregon and Washington, the share of patients who actually took the lethal medication among all patients who obtained it is 65.80% and 73.34%, respectively. In California, this share is 63.54%. The data from other States that legalized medical aid in

[7] Addendum to this brief contains the State reports and their more detailed analysis.

dying more recently is less voluminous, but could still be instructive. Thus, the percentage of patients actually taking the lethal medication among all patients who obtained the medication reaches 50% in the District of Columbia, 59.70% in Hawaii, 60.78% in Maine, and 55.76% in Vermont.[8]

This empirical data is significant in two respects. First, the probabilities the data represents (from 50% to 73.34%) do not seem to approach anywhere near the legal standard of "high degree of likelihood" that the patient will in fact take the medication and die. See Welansky, 316 Mass. 399 ("The words 'wanton' and 'reckless' are . . . not merely rhetorical or vituperative expressions used instead of negligent or grossly negligent. They express a difference in the degree of risk and in the voluntary taking of risk so marked, as compared with negligence, as to amount substantially and in the eyes of the law to a difference in kind"). Accord Carrillo, 483 Mass. at 275. If anything, the data lends considerable support to the opposite conclusion—that there is no high degree of likelihood that lethal medication will in fact be ingested.

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[8] The relevant data is not available from Colorado, Montana, New Jersey, and New Mexico.

Second, if the Court agrees with this assessment, the Court should demand the Commonwealth to present other evidence purportedly establishing a high degree of likelihood that the patient will ingest the lethal medication in medical aid in dying cases. Otherwise, there would be no evidence that the prescribing physician or any reasonable person in her position would know that the patient would in fact ingest the medication and die. Pugh, 462 Mass. at 496–497.

What other evidence would be available to prove that element of the offense, however, is uncertain. In the case at bar, for example, Dr. Kligler has expressed no definitive determination as to whether, if prescribed with lethal medication, he is going to take it (Plaintiffs' Brief at 6, 7). Nor would it be appropriate for a prescribing physician to inquire directly with a patient about whether he or she actually intends to take the medication: the existing standard of care commands physicians to inform patients of alternative treatment options and remind them about the right not to take the medication. Furthermore, since the physician's intention in medical aid in dying is to enable the patient to make a choice, the option that the patient selects when exercising that choice is not the physician's concern. Finally, the

patient's medical condition alone is not probative of a high degree of likelihood of taking the medication, because patients in other States who decide not to take the medication find themselves in similar unfortunate circumstances.

In sum, if the Court holds that medical aid in dying is involuntary manslaughter, it should demand the Commonwealth to establish beyond a reasonable doubt that prescribing a lethal medication to a qualifying patient creates a high degree of likelihood of death. This requires the Commonwealth to prove beyond a reasonable doubt not only that the medication causes death when ingested (first prong), but also that there is a high degree of likelihood, known to the physician or a reasonable person at the time of writing the prescription, that the patient will ingest the medication (second prong). As to the second prong, not only does available empirical data not support it—it actually appears to establish that no high degree of likelihood exists. The Court should determine whether this data, in light of the scarcity of other possible evidence to prove the second prong beyond a reasonable doubt, would be fatal for prosecuting medical aid in dying as involuntary manslaughter.

CONCLUSION

The amicus curiae hopes that the discussion of these issues will prove useful for the Court in deciding this case.

Respectfully submitted,

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ADDENDUM

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Statistical Data Summary

The following table summarizes the relevant data available from the States where medical aid in dying is legal.

State	Years of data available	Prescription recipients	Deaths from taking medication	Percentage of prescription recipients dying from taking medication
California[9]	5	2,858	1,816	63.54%
Colorado[10]	4	554	n/a	n/a
Hawaii[11]	2	67	40	59.70%
Maine[12]	2	51	31	60.78%
Montana[13]	n/a	n/a	n/a	n/a
New Jersey[14]	2	45	n/a	n/a
New Mexico[15]	n/a	n/a	n/a	n/a
Oregon[16]	23	2,895	1,905	65.80%
Vermont[17]	2	52	29	55.76%
Washington[18]	12	2,302	1,687	73.34%
District of Columbia[19]	1	4	2	50.00%

9 Addendum at 38.

10 Reports from Colorado do not contain information of how many patients took the prescribed lethal medication.

11 Addendum at 51, 58.

12 Addendum at 66, 86.

13 There are no official statistical reports on medical aid in dying from Montana.

14 Reports from New Jersey do not contain information of how many patients took the prescribed lethal medication.

15 There are no official statistical reports on medical aid in dying from New Mexico.

16 Addendum at 109.

17 Addendum at 117.

18 Addendum at 119, 129, 132, 140, 152, 155, 164, 176, 188, 191, 202, 217, 221, 234, 250, 265.

19 Addendum at 277. Only report for 2018 is available from this jurisdiction.

CALIFORNIA END OF LIFE OPTION ACT 2020 DATA REPORT

For more information:
https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx

Contact:
EOLInfo@cdph.ca.gov

July 2021

Executive Summary

California's End of Life Option Act (EOLA) became effective on June 9, 2016. The Act allows terminally ill adults living in California to obtain and self-administer aid-in-dying drugs.[1] The Act requires the California Department of Public Health (CDPH) to provide annual reports under strict privacy requirements. CDPH's reporting requirements are outlined in Health and Safety Code section 443.19 (b), which reads:

> *(b) On or before July 1, 2017, and each year thereafter, based on the information collected in the previous year, the department shall create a report with the information collected from the attending physician follow up form and post that report to its Internet Web site. The report shall include, but not be limited to, all of the following based on the information that is provided to the department and on the department's access to vital statistics:*
>
> *(1) The number of people for whom an aid-in-dying prescription was written.*
>
> *(2) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those individuals.*
>
> *(3) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death.*
>
> *(4) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California.*
>
> *(5) The number of physicians who wrote prescriptions for aid-in-dying drugs.*
>
> *(6) Of people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:*
>
> *(A) Age at death.*
>
> *(B) Education level.*
>
> *(C) Race.*
>
> *(D) Sex.*
>
> *(E) Type of insurance, including whether or not they had insurance.*
>
> *(F) Underlying illness.*

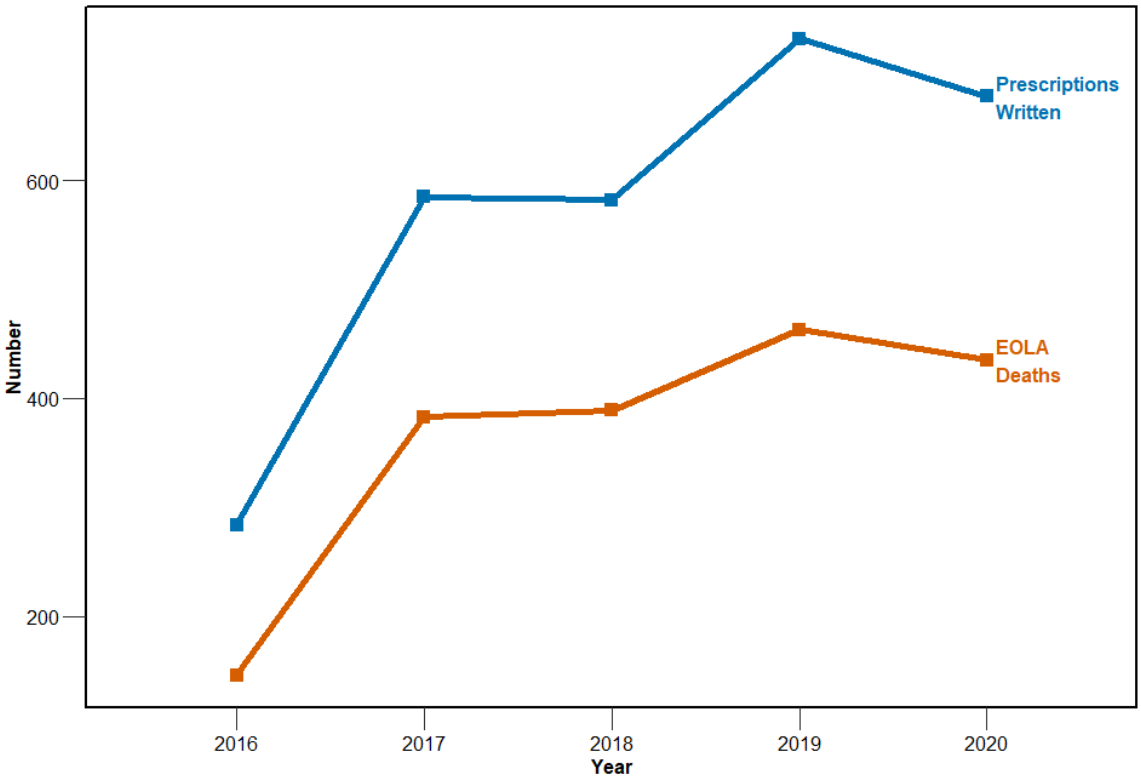
[1] Assembly Bill x2 15 (Eggman), Chapter 1, Statutes of 2015.

This report presents data as reported to CDPH from the EOLA-mandated physician reporting forms received between January 1, 2020 and December 31, 2020, and reflects information on individuals who were prescribed aid-in-dying drugs and died in the calendar year of 2020, as well as cumulative counts for the period commencing January 1, 2016. The information collected has been aggregated to protect the privacy of the individuals.

For the calendar year ending December 31, 2020, 677 individuals received prescriptions under the Act. In 2020, 435 individuals died following their ingestion of the prescribed aid-in-dying drug(s), which includes 34 individuals who received prescriptions prior to 2020. Of the 435 individuals, 90.8 percent were 60 years of age or older, 89.2 percent had health insurance and 86.7 percent were receiving hospice and/or palliative care.

Since the law came into effect June 9, 2016 through December 31, 2020, prescriptions have been written for a total of 2,858 people under the Act and 1,816 individuals, or 63.5 percent, have died from ingesting the medications. Of the 2,858 individuals who have died under the Act, 1,587, or 87.4 percent, were receiving hospice and/or palliative care. Note that cumulative counts reported above do not match prior reports. These differences arise from a number of factors including the timing of forms received, the registration of deaths, and the inclusion of duplicate records in prior reports, which have been removed. A chart illustrating the number of prescriptions written and deaths under the Act from 2016 through 2020 is provided below in Figure 1.

Figure 1: Summary of EOLA Prescriptions and Deaths 2016-2020



Introduction

The EOLA allows an adult diagnosed with a terminal disease, who meets certain qualifications, to request an aid-in-dying drug from a physician. The Act requires physicians to use forms specified in statute for submitting information to CDPH. CDPH is responsible for collecting data from these forms to prepare an annual report. Data presented in this report are based on the information from physicians' forms and California death certificates for calendar year 2020.

More information on the Act, reporting process, and required forms can be found here: https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx.

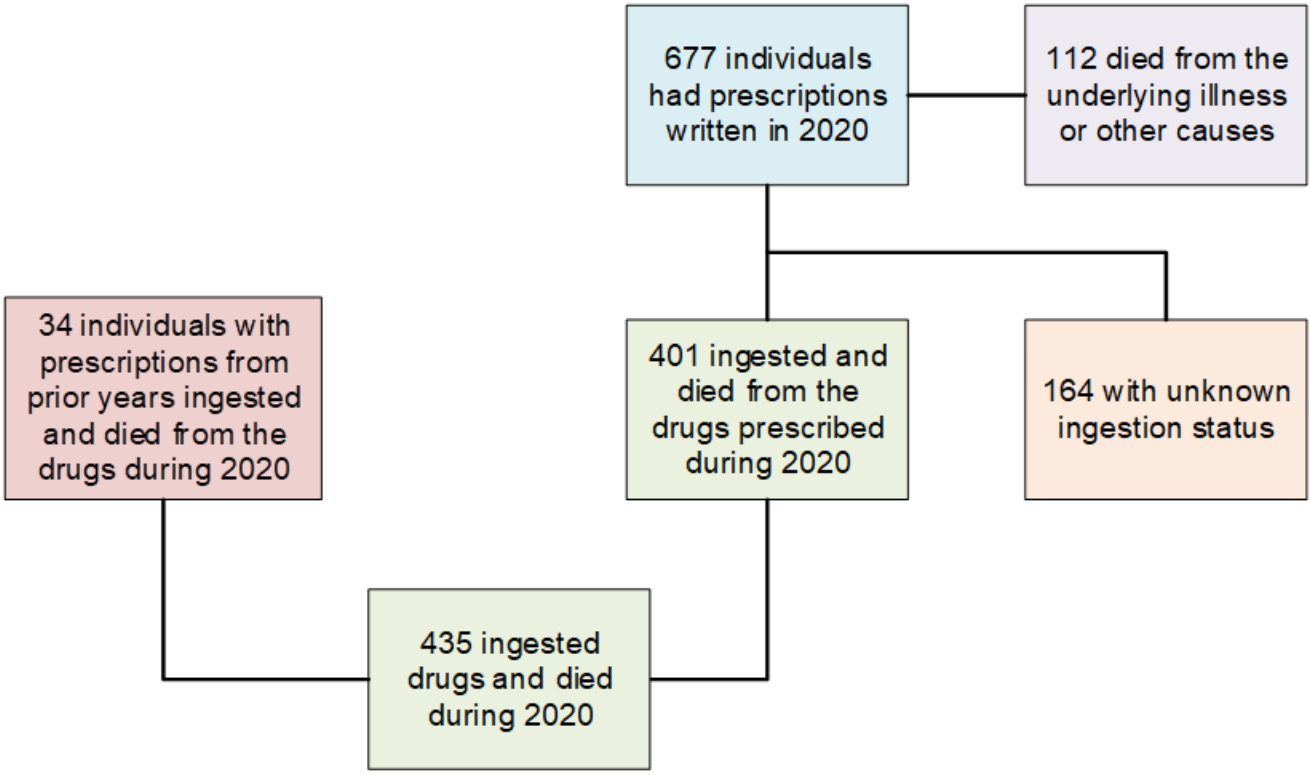
Participation in the End-of-Life Option Activities

For the calendar year 2020, 662 individuals started the end-of-life option process, as set forth in the Act, by making two verbal requests to their physicians at least 15 days apart. A total of 262 physicians prescribed 677 individuals aid-in-dying drugs. The two most common drug categories prescribed were a combination of a cardiotonic, opioid, and sedative at 82.3 percent followed by individuals who were only prescribed a sedative at 0.7 percent. Of the 677 individuals who were prescribed such drugs, 401, or 59.2 percent, were reported by their physician to have died following ingestion of aid-in-dying drugs prescribed under the Act; and 112 individuals, or 16.5 percent, died from the underlying illness or other causes. The ingestion status of the remaining 164 individuals is unknown. Of the remaining 164 individuals, 83, or 12.3 percent, have died, but their ingestion status is unknown because follow up information is not available yet. For the remaining 81 individuals, or 12 percent, both death and ingestion status are pending. Furthermore, 34 individuals with prescriptions written in prior years ingested and died from the drugs during 2020. As a result, the report demographics include the 435 individuals who ingested and subsequently died during the 2020 calendar year from aid-in-dying drugs. A chart illustrating the outcomes is provided below as Figure 2.

In 2020, 435 individuals[2] died from ingestion of aid-in-dying drugs, a rate of 13.8 per 10,000 deaths based on 314,982[3,4] deaths to California residents in 2020. Excluding COVID-19 deaths, the rate of individuals who died from ingestion of aid-in-dying drugs was 15.4 per 10,000 deaths based on 282,559 non-COVID-19 deaths to California residents in 2020.

[2] Total of individuals who received aid-in-dying prescriptions that died in 2020.
[3] California Department of Public Health, California Comprehensive Death File, created in February 2021.
[4] Does not include out-of-state California resident deaths as of February 2021.

Figure 2: Summary of EOLA Prescriptions Written in Prior Years and Drugs Ingested in 2020[5]



Characteristics of Individuals

Of the 435 individuals who died pursuant to EOLA during 2020, 9.2 percent were under 60 years of age, 77.9 percent were 60-89 years of age, and 12.9 percent were 90 years of age and older. The median age was 74 years. The decedents were 87.4 percent white, 50.8 percent were female; 86.7 percent were receiving hospice and/or palliative care, and 76.1 percent had at least some level of college education. In addition, 83.4 percent informed their family of their decision to participate in EOLA. A summary of this information is set forth in Table 1 on pages 9-10 and Table 3 on pages 13-14.

Of the 435 individuals who died pursuant to EOLA during 2020, 70.8 percent were identified as having had malignant neoplasms (cancer). Neurological diseases such as amyotrophic lateral sclerosis and Parkinson's accounted for the second largest underlying illness grouping, totaling 10.8 percent.

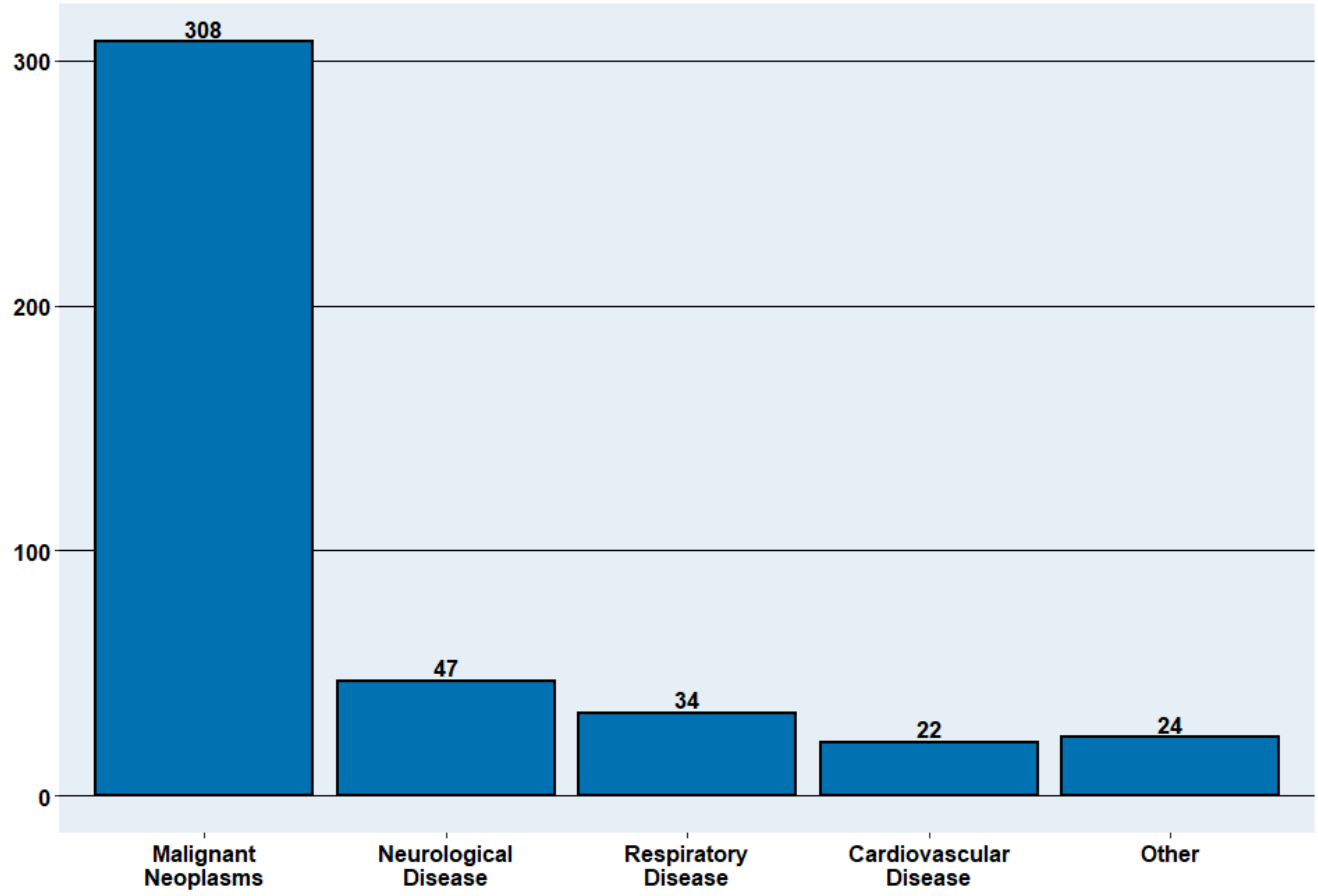
The remaining major categories of underlying illnesses were documented as: respiratory diseases (non-cancer; 7.8 percent), cardiovascular diseases (5.1 percent), and other

[5] Based on forms received as of February 8, 2021.

diseases (5.5 percent). The other diseases were documented as; kidney disease (1.4 percent), cerebrovascular disease (1.1 percent), endocrine, nutritional and metabolic disease (1.1 percent), immune mediated disease (0.2 percent) and other (1.6 percent). The data are presented in Figure 3 below.

Certifiers[6] (physicians, coroners, and medical examiners) report the underlying terminal disease as the cause of death on the death certificates. This approach complies with applicable law; best ensures the reliability and usefulness of data collected from the death certificate for state, national, and international surveillance purposes; and effectuates the California Legislature's intent to maintain the confidentiality of individuals' participation in the Act.

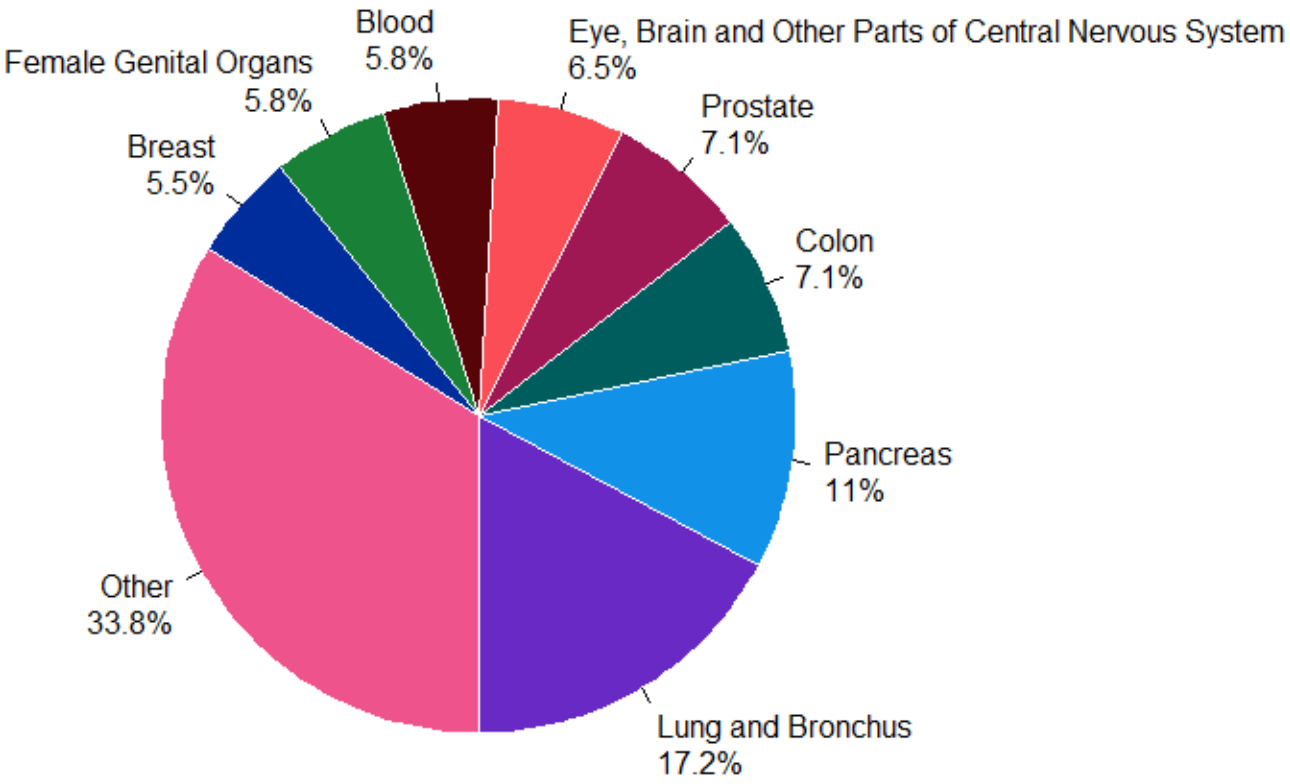
Figure 3: Major Illness Categories for EOLA Individuals in 2020



[6] Health and Safety Code 102825(a) and Health and Safety code 102860

Among individuals with cancer as the underlying terminal disease – the largest group of individuals who utilized the Act–lung cancer accounted for 17.2 percent, pancreatic cancer accounted for 11.0 percent, both colon cancer and prostate cancer constituted 7.1 percent, cancer of the eye, brain, and other parts of central nervous system constituted 6.5 percent, blood cancer and cancer of the female genital organs both comprised 5.8 percent, and breast cancer accounted for 5.5 percent. Other malignant neoplasms accounted for the remaining 33.8 percent, as shown below in Figure 4. Additional information regarding the other types of malignant neoplasms can be found in Table 2 on pages 11-12.

Figure 4: Major Malignant Neoplasm Types for EOLA Individuals in 2020[7]



Most of the individuals who participated in the Act had some form of health insurance (89.2 percent). Of those with health insurance, 62.5 percent of individuals had Medicare or Medicare combined with another type of insurance, while 13.3 percent of individuals had only private insurance. Individuals who had an unspecified type of insurance comprised 10.6 percent of the Act participants followed by individuals with only Medi-Cal at 2.1 percent, and individuals with other governmental insurance (e.g., Covered California or

[7] Percentages presented in this Data Report are rounded to the nearest tenth. Due to rounding, percentages when totaled may not equal 100.0 percent.

Veterans Affairs) at 0.7 percent. 47 individuals, or 10.8 percent, had undetermined health insurance coverage.

A physician or trained healthcare professional was present for 179 individuals, or 41.1 percent, at the time of ingestion of the aid-in-dying drug. Of the 179 individuals who had a physician or trained healthcare professional present at the time of ingestion, another healthcare provider was present for 45.8 percent of individuals, followed by an attending physician, who was present for 44.1 percent of individuals. The majority, or 92.0 percent, of all individuals were in a private home for ingestion.

Additional information regarding insurance status and other characteristics of individuals who died following ingestion of an aid-in-dying drug can be found in Table 3 on pages 13-14.

Conclusion

This Data Report presents data reported to CDPH from EOLA-mandated physician reporting forms and reflects information on all patients who were prescribed aid-in-dying medications in 2020 or prior years, and subsequently died in 2020 of ingesting the prescribed drugs. The information collected by CDPH has been aggregated to protect the privacy of the participants.

Table 1: Demographics of the EOLA Individuals Who Died Following Ingestion of an Aid-in-Dying Drug

EOLA Individuals	2020	(N=435)	2019	(N=463)	2016-2018	(N=918)	Total	(N=1816)
Age	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Under 60	40	(9.2)	55	(11.9)	110	(12.0)	205	(11.3)
60-69	98	(22.5)	98	(21.2)	206	(22.4)	402	(22.1)
70-79	147	(33.8)	131	(28.3)	275	(30.0)	553	(30.5)
80-89	94	(21.6)	117	(25.3)	218	(23.7)	429	(23.6)
90 and Over	56	(12.9)	62	(13.4)	109	(11.9)	227	(12.5)
Median Age (Range)	74	(27-107)	76	(23-104)	74	(27-106)	75	(23-107)
Gender	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Female	221	(50.8)	217	(46.9)	466	(50.8)	904	(49.8)
Male	214	(49.2)	246	(53.1)	452	(49.2)	912	(50.2)
Education	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
No High School Diploma	8	(1.8)	16	(3.5)	30	(3.3)	54	(3.0)
HS Diploma or GED	93	(21.4)	96	(20.7)	176	(19.2)	365	(20.1)
Some College	78	(17.9)	83	(17.9)	168	(18.3)	329	(18.1)
Associate's Degree	40	(9.2)	28	(6.0)	62	(6.8)	130	(7.2)
Bachelor's Degree	120	(27.6)	116	(25.1)	228	(24.8)	464	(25.6)
Master's Degree	53	(12.2)	70	(15.1)	151	(16.4)	274	(15.1)
Doctorate or Professional Degree	40	(9.2)	49	(10.6)	98	(10.7)	187	(10.3)
Unknown	3	(0.7)	5	(1.1)	5	(0.5)	13	(0.7)

Table 1: Demographics of the EOLA Individuals Who Died Following Ingestion of an Aid-in-Dying Drug, continued

EOLA Individuals	2020	(N=435)	2019	(N=463)	2016-2018	(N=918)	Total	(N=1816)
Race/Ethnicity	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
White	380	(87.4)	400	(86.4)	823	(89.7)	1603	(88.3)
Black	4	(0.9)	6	(1.3)	7	(0.8)	17	(0.9)
American Indian/Alaskan Native	0	(0.0)	0	(0.0)	1	(0.1)	1	(0.1)
Asian	33	(7.6)	30	(6.5)	50	(5.4)	113	(6.2)
Hawaiian/Pacific Islander	1	(0.2)	2	(0.4)	1	(0.1)	4	(0.2)
Other	1	(0.2)	1	(0.2)	1	(0.1)	3	(0.2)
Multi-race	1	(0.2)	4	(0.9)	6	(0.7)	11	(0.6)
Hispanic	15	(3.4)	19	(4.1)	29	(3.2)	63	(3.5)
Unknown	0	(0.0)	1	(0.2)	0	(0.0)	1	(0.1)

Table 2: Underlying Illness of the EOLA Individuals Who Died Following Ingestion of an Aid-in-Dying Drug

EOLA Individuals	2020	(N=435)	2019	(N=463)	2016-2018	(N=918)	Total	(N=1816)
Underlying Illness	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Malignant Neoplasms (Cancer)	**308**	**(70.8)**	**320**	**69.1**	**645**	**70.3**	**1273**	**70.1**
Lung and Bronchus	53	(17.2)	51	(15.9)	105	(16.8)	209	(16.4)
Pancreas	34	(11.0)	33	(10.3)	56	(8.7)	123	(9.7)
Prostate	22	(7.1)	27	(8.4)	51	(7.9)	100	(7.9)
Colon	22	(7.1)	27	(8.4)	43	(6.7)	92	(7.2)
Female Genital Organs	18	(5.8)	26	(8.1)	39	(6.0)	83	(6.5)
Breast	17	(5.5)	28	(8.8)	51	(7.9)	96	(7.5)
Other Digestive Organs [e.g., stomach, esophagus]	21	(6.8)	19	(5.9)	45	(7.0)	85	(6.7)
Blood	18	(5.8)	18	(5.6)	43	(6.7)	79	(6.2)
Liver	14	(4.5)	15	(4.7)	22	(3.4)	51	(4.0)
Eye, Brain and Other Parts of Central Nervous System	20	(6.5)	16	(5.0)	38	(5.9)	74	(5.8)
Ill-defined, Secondary, and Unspecified Sites	15	(4.9)	13	(4.1)	30	(4.7)	58	(4.6)
Urinary Tract	18	(5.8)	11	(3.4)	30	(4.7)	59	(4.6)
Lip, Oral Cavity, and Pharynx	13	(4.2)	9	(2.8)	31	(4.8)	53	(4.2)
Skin	6	(1.9)	8	(2.5)	21	(3.3)	35	(2.7)
Bone	1	(0.3)	4	(1.3)	2	(0.3)	7	(.5)
Mesothelial and Soft Tissue	7	(2.3)	4	(1.3)	13	(2.0)	24	(1.9)
Respiratory and Intrathoracic Organs	3	(1.0)	3	(0.9)	5	(0.8)	11	(0.9)
Thyroid and Other Endocrine Glands	1	(0.3)	1	(0.3)	6	(0.9)	8	(0.6)
Other Cancers	5	(1.6)	7	(2.2)	14	(2.2)	26	(2.0)

Table 2: Underlying Illness of the EOLA Individuals Who Died Following Ingestion of an Aid-in-Dying Drug, continued

EOLA Individuals	2020	(N=435)	2019	(N=463)	2016-2018	(N=918)	Total	(N=1816)
Underlying Illness	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Neurological Disease	**47**	**(10.8)**	**45**	**(9.7)**	**106**	**(11.5)**	**198**	**(10.9)**
Amyotrophic Lateral Sclerosis	27	(57.4)	16	(35.6)	73	(68.9)	116	(58.6)
Parkinson's Disease	8	(17.0)	12	(26.7)	14	(13.2)	34	(17.2)
Polio	0	(0)	1	(2.2)	1	(0.9)	2	(1.0)
Other	12	(25.5)	16	(35.6)	18	(17.0)	46	(23.2)
Cardiovascular Disease	**22**	**(5.1)**	**39**	**(8.4)**	**66**	**(7.2)**	**127**	**(7.0)**
Respiratory Disease	**34**	**(7.8)**	**33**	**(7.1)**	**50**	**(5.4)**	**117**	**(6.4)**
Chronic Lower Respiratory Disease	28	(82.4)	21	(63.7)	40	(80)	89	(76.1)
Other	6	(17.6)	12	(36.4)	10	(20)	28	(24.0)
Cerebrovascular Disease	**5**	**(1.1)**	**7**	**(1.5)**	**11**	**(1.2)**	**23**	**(1.3)**
Kidney Disease	**6**	**(1.4)**	**5**	**(1.1)**	**13**	**(1.4)**	**24**	**(1.3)**
Endocrine, Nutritional and Metabolic Disease	**5**	**(1.1)**	**5**	**(1.1)**	**4**	**(0.4)**	**14**	**(0.8)**
Immune Mediated Disease [e.g., Multiple Sclerosis]	**1**	**(0.2)**	**4**	**(0.9)**	**5**	**(0.5)**	**10**	**(0.6)**
Other[8]	**7**	**(1.6)**	**5**	**(1.1)**	**18**	**(2.0)**	**30**	**(1.6)**

[8] Includes Gastrointestinal Disease; Liver Disease; Infectious and Parasitic Disease; Musculoskeletal and Connective Tissue Diseases; Blood Disease

Table 3: Characteristics of the EOLA Individuals Who Died Following Ingestion of an Aid-in-Dying Drug

EOLA Individuals	2020	(N=435)	2019	(N=463)	2016-2018	(N=918)	Total	(N=1816)
Insurance	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Medicare or Medicare with another type of insurance	272	(62.5)	292	(63.1)	593	(64.6)	1157	(63.7)
Private Insurance	58	(13.3)	71	(15.3)	131	(14.3)	260	(14.3)
Medi-Cal	9	(2.1)	10	(2.2)	24	(2.6)	43	(2.4)
Other Governmental Insurance	3	(0.7)	0	(0)	5	(0.5)	8	(0.4)
Has Insurance, but unknown type	46	(10.6)	38	(8.2)	124	(13.5)	208	(11.5)
No Insurance	0	(0.0)	1	(0.2)	4	(0.4)	5	(.28)
Unknown	47	(10.8)	51	(11.0)	37	(4.0)	135	(7.4)
Hospice and/or Palliative care	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Enrolled	377	(86.7)	400	(86.4)	810	(88.2)	1587	(87.4)
Not Enrolled	48	(11.0)	33	(7.1)	96	(10.5)	177	(9.7)
Unknown	10	(2.3)	30	(6.5)	12	(1.3)	52	(2.9)
Aid-in-Dying Drugs	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Cardiotonic, Opioid, Sedative	358	(82.3)	372	(80.3)	290	(31.6)	1020	(56.2)
Sedative	3	(0.7)	10	(2.2)	472	(51.4)	485	(26.7)
Other	32	(7.4)	21	(4.5)	67	(7.3)	120	(6.6)
Unknown	42	(9.7)	60	(13.0)	89	(9.7)	191	(10.5)
Patient Informed Family of Decision	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Yes	363	(83.4)	400	(86.4)	794	(86.5)	1557	(85.7)
No	6	(1.4)	15	(3.2)	21	(2.3)	42	(2.3)
No Family to Inform	9	(2.1)	8	(1.7)	16	(1.7)	33	(1.8)
Unknown	57	(13.1)	40	(8.6)	87	(9.5)	184	(10.1)

Table 3: Characteristics of the EOLA Individuals Who Died Following Ingestion of an Aid-in-Dying Drug, continued

EOLA Individuals	2020	(N=435)	2019	(N=463)	2016-2018	(N=918)	Total	(N=1816)
Physician or Trained Healthcare Provider Present at Ingestion	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Yes	**179**	**(41.1)**	**196**	**(42.3)**	**406**	**(44.2)**	**781**	**(43.0)**
Attending Physician	79	(44.1)	115	(58.7)	270	(66.5)	464	(59.4)
Other Physician	18	(10.1)	10	(5.1)	29	(7.1)	57	(7.3)
Other Healthcare Provider	82	(45.8)	71	(36.2)	107	(26.4)	260	(33.3)
No	**34**	**(7.8)**	**48**	**(10.4)**	**111**	**(12.1)**	**193**	**(10.6)**
Unknown	**222**	**(51.0)**	**219**	**(47.3)**	**401**	**(44.0)**	**842**	**(46.4)**
Location Where Aid-in-Dying Drugs were Ingested	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Private Home	400	(92.0)	408	(88.1)	835	(91.0)	1643	(90.5)
Assisted-Living Residence	14	(3.2)	30	(6.5)	42	(4.6)	86	(4.7)
Nursing Home	17	(3.9)	15	(3.2)	22	(2.4)	54	(3.0)
In-patient Hospice Residence	2	(0.5)	5	(1.1)	16	(1.7)	23	(1.3)
Acute Care Hospital	1	(0.2)	2	(0.4)	0	(0)	3	(0.2)
Other	1	(0.2)	3	(0.6)	3	(0.3)	7	(0.4)

REPORT TO THE THIRTIETH LEGISLATURE

STATE OF HAWAII

2020

PURSUANT TO ACT 2, SESSION LAWS OF HAWAII 2019

(HB2739 H.D. 1)

Prepared by the Department of Health

Office of Planning, Policy, and Program Development

July 1, 2020

Executive Summary
The information compiled in this report covers the collection period from January 1, 2019 through end of December 31, 2019.

During this reporting period, there were a total of thirty (30) qualified patients who received aid-in-dying prescriptions of which twenty-three (23) patients died. Of those patients who died, there where fifteen (15) patients who ingested the aid-in-dying medication. DDMP2 was the primary medication prescribed with DDMA being least prescribed. There were no complications cited.

Some form of cancer was cited as the underlying illness for the majority of patients who died. The status of three (3) qualified patients who received the aid-in-dying medication is unknown. An unknown patient status occurs when a follow-up form is not received by the Department. Follow-up forms are dependent upon the patient's designee to return the form to the attending physician who then mails the form to the Department as report #2.

The eligibility process from the first oral request to the date of receipt of the written prescription was an average of 35 days with the shortest period being 21 days. The average waiting period between the first and second oral request was 28 days ranging from 20 days to 100 days. Patients who received services from within large, well-networked organizations had the shortest waiting periods compared to private practicing providers in the community. Thirteen (13) attending physicians wrote prescriptions during this reporting period. Only one (1) attending physician was located on the neighboring islands on Hawaii Island.

2020 Preliminary Review

Given the implementation of the law is still quite new in Hawaii, the Department is providing the following data for information awareness purposes. From January 1, 2020 through June 26, 2020, there was a total of twenty-four (24) qualified patients who received medical aid-in-dying prescriptions which is an increase from last year compared to this time last year. Thirteen (13) patients ingested the prescribed medication whereas DDMP2 is still the most prescribed. It took an average of 39 days from the first oral request to the date of receipt of the written prescription request whereas one patient process took 179 days. There was also one complication of the prescribed medication, DDMP2, where the patient took over 6 hours until death compared to the 4 hours which is "outside of the clinical guidelines" as cited by the attending provider.

During the 2020 year, there were also five (5) new attending providers. One of the attending providers reside in Maui. Amongst the consulting provider group there were two (2) new physicians on the neighbor islands who could also serve as attending physicians, one on Kauai (Lihue) and another on Hawaii island (Waimea).

Introduction

Act 2, Session Laws of Hawaii (SLH) 2018, authorized Hawai‘i residents with a terminal illness and six (6) months or less to live may request medical-aid-in-dying prescriptions under the OCOCA. To help patients and providers understand the process required by law, the DOH launched a new page on its website where all required forms, instructions, and frequently asked questions can be accessed.

The law establishes eligibility criteria and safeguards to ensure a secure, compassionate, and patient-centered end-of-life process. There are also additional regulatory requirements to address concerns about misuse. Patients interested in seeking a prescription are encouraged to enroll in hospice.

To meet eligibility criteria patients must be:

1. Age 18 or older an a Hawai`i resident;
2. Able to take the prescribed medication themselves;
3. Able to make two oral requests not less than 20 days apart to their attending physician;
4. Able to provide one written request after meeting eligibility criteria from all three (3) health care providers; and
5. Mentally capable to make an informed decision.

Details of the eligibility process may be accessed on the DOH's website: http://health.hawaii.gov/opppd/ococ/

OCOCA Advisory Board

The DOH implemented Act 2 by establishing a five-member OCOCA Advisory Board that held its first meeting on July 31, 2018 followed by consecutive meetings on August 31, 2018, November 29, 2018, and December 7, 2018.

The OCOCA Board Members are listed in the table below:

Member Role	Board Member
Chair – Director of Health	Bruce S. Anderson, Ph.D.
Medical Educator	Lee Buenconsejo-Lum, M.D.
Palliative Care Specialist	Rae Seitz, M.D.
Non-Medical Community Member	Malachy Grange
Hospice Care Specialist	Brenda Ho

OCOCA Advisory Board Staff: There were two DOH employees who served as staff to the OCOCA Advisory Board. Staff members located in the Office of Planning, Policy, and

Program Development are Lorrin J. Kim, Chief Policy Officer, and Laura K.M. Arcibal, State Telehealth and Health Care Access Coordinator.

Permitted Interaction Groups:

Two permitted interaction groups were established following board approval. One permitted interaction group was formed to review and comment on the development of the website and forms. The second permitted interaction group was formed to address community resources. Under the review, guidance, and final approval of the OCOCA Advisory Board, the website and its forms were finalized and made accessible online before the law went into effect on January 1, 2019.

Board Meeting Minutes:

Board meeting minutes may be accessed here: https://health.hawaii.gov/opppd/meetings-reports/

OCOCA Advisory Board discussions resulted in the development of a website to 1) inform both patients and their families, and health care providers of the law and its process; and 2) provide forms for both providers and patients implement the process, document eligibility, and report information required under Act 2. To start the eligibility process, patients and providers must access the website and download its forms here: https://health.hawaii.gov/opppd/ococ/

On the website, patients are informed to start early and talk with their attending physician. Patients are strongly encouraged to enroll in hospice to ensure all end of life care options are available to them and to become familiar with eligibility requirements as he or she works closely with their attending physician and his or her health care team. Health care providers are also informed on the website about the law, the eligibility timeline, and criteria, and the OCOCA required forms reportable to the DOH.

Following execution of the website and its forms, the DOH received its first completed forms in March 2019. On the first report, it took 48 days between the first oral request to the date of the patient's written prescription. The waiting period between the first oral request and second oral request was 24 days. To date, the average is 34 days between the first oral request to the date of written prescription compared to 48 days. And the current average waiting period is 27 days. The longest waiting period of one patient was 100 days between the first and second oral request compared the minimum requirement of 20 days.

Community inquiries to the DOH are minimal via email or phone call and are responded to promptly. Information requested is generally on the gathering of information about the OCOCA for which the response is either to direct the individual to the website or answered directly.

Reportable Information

The DOH collected the following reportable information during the period January 1, 2019 through December 31, 2019 (envelopes post-dated not later than December 31, 2019). The next report will cover the period January 1, 2020 through December 31, 2020. Below is the reportable information:

- The number of qualified patients for whom a prescription was written: **30**
- The number of known qualified patients who died each year for whom a prescription was written: **23**
- The cause of death of the qualified patient(s): metastatic lung cancer, prostatic carcinoma, head and neck cancer, metastatic malignant melanoma, amyotrophic lateral sclerosis, multiple myeloma, Parkinson's disease, metastatic anal carcinoma, metastatic breast cancer, COPD end state, gallbladder cancer, brain cancer, pharyngeal cancer, esophageal cancer, metastatic pancreatic cancer, and bronchiolar adenocarcinoma.
- The total number of prescriptions written: **30**
- The total number of prescriptions for all years beginning with 2019: **30**
- The total number of qualified patients who died while enrolled in hospice or other similar palliative care program: **19**
- The number of known deaths in Hawaii from a prescription written per five-thousand deaths in Hawaii: **15**
- The number of attending providers who wrote prescriptions: **13**
- Location of attending providers who wrote prescriptions:

Kauai	Oahu	Maui	Hawaii Island
0	12	0	1

- Of the people who died as a result of self-administering a prescription, the individual's:

Age	Education	Race	Sex	Type of Insurance	Underlying Illness
75	blank	Caucasian	Male	Medicare/Private	Prostatic Carcinoma
68	Bachelor	Caucasian	Male	Medicare/Private	Progressive head and neck cancer

83	blank	Caucasian	Female	Private	Metastatic Malignant Melanoma
73	Some college	Asian	Male	Medicare/Private	ALS
64	Doctoral	Caucasian	Male	Medicare/Private	Parkinson's Disease
76	Bachelor	Native Hawaiian	Male	Medicare/Private	Lung Cancer
85	blank	Asian	Male	Medicare/Private	COPD End Stage
71	blank	blank	Female	blank	Gallbladder cancer
66	blank	Caucasian	Female	Medicare/Private	Brain Astrocytoma
65	blank	Caucasian	Male	Medicare/Private	Pharyngeal Cancer
80	Bachelor	Caucasian	Female	Medicare	Bronchoalveolar Adenocarcinoma
80	Masters	Hispanic/Latino	Male	United Health Care	Parkinson's Disease
66	Masters	Caucasian	Male	Medicare	Progressive Multiple Sclerosis
80	blank	Caucasian	Male	Medicare	Metastatic Lung Cancer
57	Bachelor	Asian	Male	Private	Metastatic Pancreatic Cancer

Community Education Events

To further inform patients and health care providers, continuing medical education events were held on February 1 and 2, 2019 at the Queen's Conference Center Auditorium and University of Hawaii, John A. Burns School of Medicine, respectively. Other learning opportunities were provided in the private sector, for example at the annual meeting of the Hawaii Pharmacists Association and the annual meeting of the Health Information Management Association of Hawaii.

On October 21, 2019, a health care provider summit was held to capture feedback from participating health care providers, care navigators and support staff. Notes collected from the facilitated meeting captured the group's feedback that is summarized in the bulleted items below.

- Recognized the need for patient continuity and navigation such as the use of care navigators to assist patients through the process in identifying and accessing participating providers in the community;
- Recognized the need for continuity and navigation of the process amongst providers in the community versus within large integrated systems such as Kaiser Permanente;
- Recognized the importance of developing relationships amongst community providers in the palliative care, hospice care, and health care provider communities especially in private practice versus large integrated systems such as Kaiser Permanente;
- Recognized the challenges in accessing available and participating health care providers and especially mental health care providers;
- Recognized process recommendations whereas the waiting period is too long (i.e. patient illness progresses whereby he or she is unable to swallow the medications or limited access to attending physicians who then take leave); and
- Recognized concerns about medication disposal and need for information about its process.

Legislative Recommendations

In closing, the DOH recommends the following changes to the OCOCA.

1. Waiver of any waiting periods if the attending provider and consulting provider agree that patient death is likely prior to the end of the waiting periods.
2. Given access to health care providers is limited, the DOH recommends authorizing advance practice registered nurses to serve as attending providers for patients seeking medical aid in dying.

REPORT TO THE THIRTY-FIRST LEGISLATURE

STATE OF HAWAII

2021

PURSUANT TO ACT 2, SESSION LAWS OF HAWAII 2019

HB2739 H.D. 1, HRS 327L

ESTABLISHES THE OUR CARE, OUR CHOICE ACT

Prepared by the Department of Health Office of Planning, Policy, and Program Development

July 1, 2021

Executive Summary

This annual report covers data collected for the period of January 1, 2020 through December 31, 2020. Pursuant to Act 2 Session Laws of Hawaii (SLH) 2018 and following each full year, the legislative annual report will be submitted on or before July 1. The required data collected from participating attending physicians are qualified patients who received a written prescription.

In 2020, thirty-seven (37) patients qualified and received aid-in-dying prescriptions. Thirty-two (32) patients were reported to have died of which twenty-five (25) patients self-administered the aid-in-dying medication. Some form of cancer was cited as the primary underlying illness of those patients who died. The status of four (4) qualified patients is unknown. An unknown patient status occurs when a required Follow-up Form or optional Final Attestation Form is not received by the Department. DDMP2 was the primary medication prescribed with DDMA being least prescribed whereas there was one complication with ingesting DDMP2.

Fourteen (14) attending physicians wrote prescriptions during this reporting period. Of those attending physicians who participated, three (3) were located on the neighbor islands: one (1) on Hawaii island and two (2) on Maui. However, regarding patient access for 2019 and 2020, there were a total of twenty-two (22) attending physicians who wrote a prescription in the state.

The eligibility process from the first oral request to the date of receipt of the written prescription was an average of 45 days. The average waiting period between the first and second oral request was 30 days ranging from 20 days to 164 days. Patients from within large-networked organizations such as Kaiser Permanente had the shortest waiting periods compared to private practicing providers in the community.

During the 2020 year, the Department was invited and participated in two community provider education webinars hosted by Compassion and Choices on June 16, 2020 and November 4, 2020. You may contact Compassion and Choices or access available webinars here.

Introduction

Act 2 SLH 2018 authorized Hawai‘i residents with a terminal illness and six (6) months or less to live may request medical-aid-in-dying prescriptions under the OCOCA. To help patients and providers understand the process required by law, the DOH launched a new page on its website where all required forms, instructions, and frequently asked questions can be accessed.

The law establishes eligibility criteria and safeguards to ensure a secure, compassionate, and patient-centered end-of-life process. There are also additional regulatory requirements to address concerns about misuse. Patients interested in seeking a prescription are encouraged to enroll in hospice.

To meet eligibility criteria patients must be:

1. Age 18 or older an a Hawai`i resident;
2. Able to take the prescribed medication themselves;
3. Able to make two oral requests not less than 20 days apart to their attending physician;
4. Able to provide one written request after meeting eligibility criteria from all three (3) health care providers; and
5. Mentally capable to make an informed decision.

First oral requests: Physicians who receive a request for medical aid in dying from a patient are highly encouraged to document the date of the oral request in the medical record. A participating attending physician can use the date of the patient's first oral request documented in the medical record by another physician.

Provider forms required to be submitted to the Department, details of the eligibility process, and frequently asked questions may be accessed on the DOH's website here: http://health.hawaii.gov/opppd/ococ/

Implementation Review and Analysis

There is no funding appropriated to the Department for its role in implementing, collecting, and reporting requirements under the law. The Department maintains its role by leveraging time as needed from one staff member situated in the Office of Planning, Policy, and Program Development. Despite shifting work priorities and challenges related to organizational demands due to COVID-19, the responsibilities of the Department related to medical aid and dying continued and were met as required.

OCOCA Advisory Board

In 2020, the Department welcomed a new Director of Health, Dr. Elizabeth Char, on September 16, 2020 to replace the former Director Bruce Anderson who retired. The OCOCA Board Members is updated below to reflect the changes.

Member Role	Board Member
Chair – Director of Health	Elizabeth Char, M.D.
Medical Educator	Lee Buenconsejo-Lum, M.D.
Palliative Care Specialist	Rae Seitz, M.D.
Non-Medical Community Member	Malachy Grange, R.N.
Hospice Care Specialist	Brenda Ho, R.N.

OCOCA Advisory Board Staff: There were two DOH employees who served as staff to the OCOCA Advisory Board. Staff members located in the Office of Planning, Policy, and Program Development are Lorrin J. Kim, Chief Policy Officer, and Laura K.M. Arcibal, State Telehealth and Health Care Access Coordinator.

Board Meeting Minutes:

There were no board meetings held in 2020. All board meeting minutes may be accessed here: https://health.hawaii.gov/opppd/meetings-reports/

Community Engagement and Education Events

Community inquiries to the DOH are minimal via email or phone call and are responded to promptly. Information requested is generally from the community requesting data and from providers seeking clarification on a specific process. Responses are resolved directly, and as needed, with guidance from the Deputy Attorney General's office.

Data Collection

Reportable Information

The DOH collected the following reportable information during the reporting period.

- The number of qualified patients for whom a prescription was written: **37**
- The number of known qualified patients who died each year for whom a prescription was written**:**

2019	2020
27	32

- The cause of death of the qualified patient(s): metastatic lung cancer, esophageal cancer, lung cancer, metastatic prostate cancer, corticobasal degeneration, metastatic prostate cancer, cardiac amyloid multiple myeloma, metastatic colon carcinoma, progressive idiopathic pulmonary fibrosis, heart failure end stage, prostate cancer, metastatic lung cancer, progressive bladder cancer, breast cancer stage IV, congestive heart failure, prostate cancer with bone metastases, COPD with cancer, COPD end stage, advanced hypopharynx cancer, metastatic colon cancer, glioblastoma, stage IV castrate-resistant prostate cancer, malignant melanoma, and kidney cancer.
- The total number of prescriptions written: **37**
- The total number of prescriptions for all years beginning with 2019: **67**
- The total number of qualified patients who died while enrolled in hospice or other similar palliative care program: **28**
- The number of known deaths in Hawaii from a prescription written per five-thousand deaths in Hawaii: **42**
- The number of attending providers who wrote prescriptions: **14**
- Location of attending providers who wrote prescriptions:

Kauai	Oahu	Maui	Hawaii Island
0	11	2	1

- Of the people who died as a result of self-administering a prescription, the individual's (Blank indicates no information provided on the form):

Age	Education	Race	Sex	Type of Insurance	Underlying Illness
87	8th grade	Asian	Male	Medicare/Private	Lung Cancer
80	Some college	White	Female	Medicare	Esophageal Cancer
69	Some college	White	Female	Medicare	Lung Cancer
73	Bachelors degree	White	Male	Medicare	Metastatic Prostate Cancer
76	Bachelors degree	White	Female	Private	Corticobasal Degeneration
76	Bachelors degree	White	Male	Medicare	Metastatic Prostate Cancer
65	Doctoral	White	Male	Medicare	Cardia Amyloid Multiple Myeloma
68	Bachelors degree	White	Male	Medicare	Metastatic Colon Carcinoma
85	Blank	Asian	Male	Medicare	Progressive Idiopathic Pulmonary Fibrosis
81	High School	White	Female	Medicare	Heart Failure End Stage
80	Blank	Asian	Male	Medicare	Prostate Cancer
54	Blank	Pacific Islander	Male	MedQuest	Metastatic Lung Cancer
82	Blank	White	Female	Medicare	Progressive Bladder Cancer
78	Bachelors degree	White	Female	Medicare	Breast Cancer Stage IV
78	Blank	White	Male	Medicare	Congestive Heart Failure
77	Some college; no degree	Asian	Male	Medicare	Prostate Cancer with Bone Metastases
74	High School	White	Male	VA	COPD with Cancer
69	High School	White	Male	Private	COPD End Stage
73	High School	Asian	Male	Medicare	Advanced Hypopharynx Cancer
71	Bachelors degree	White	Female	Medicare	Metastatic Colon Cancer

79	Masters degree	White	Male	Medicare	Glioblastoma
73	Some college; no degree	White	Male	VA	Stage IV Castrate-resistant Prostate Cancer
84	Masters degree	White	Male	Medicare-Medicaid	Malignant Melanoma
66	High School	White	Male	Medicare	Stage IV Lung Cancer
94	Unknown	White	Female	Medicare/Tricare	Kidney Cancer

Additional notes regarding the data:

During the 2020 reporting year, the status of four (4) patients is unknown. An unknown patient status occurs when a required Follow-up Form is not received by the Department. If the Department receives the Final Attestation form instead of the Follow-up Form the patient is counted as a qualified patient who self-administered the medication.

The Department is required to collect and report on qualified patients who received a prescription. The data does not include patients who died prior to receiving a prescription, patients who were ineligible, and patients who provided their first oral request and are currently in-process of being qualified.

Legislative Recommendations

In closing, patient access continues to remain a challenge especially for patients on the neighbor islands and due to physician shortages across the state. The DOH recommends the following changes to the OCOCA.

1. Waiver of any waiting periods if the attending provider and consulting provider agree that patient death is likely prior to the end of the waiting periods.

2. Given access to health care providers is limited, the DOH recommends authorizing advance practice registered nurses to serve as attending providers for patients seeking medical aid in dying.

If you should have any questions regarding the report, please contact the DOH Office of Planning, Policy, and Program Development at 586-4188.

Patient-Directed Care at End of Life Annual Report

April 28, 2020

Pursuant to Title 22, MRS §2140(17)

Prepared by: Kim Haggan, State Registrar
Director of Data, Research, and Vital Statistics
Maine Center for Disease Control and Prevention
Maine Department of Health and Human Services

*Revised May 4, 2020 to update report date

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Executive Summary

In accordance with 22 MRS § 2140(17), the Department of Health and Human Services (Department) shall generate and make available to the public an annual statistical report of information collected under the Maine Death with Dignity Act (Act). The Department is mandated to submit a copy of the report to the Joint Standing Committee of the Legislature having jurisdiction over health matters, annually by March 1st. This first report covers the period of time between September 19, 2019 and December 31, 2019. Subsequent reports will be submitted March 1st and cover the previous calendar year.

This March 2020 report provides statistics concerning the utilization of Patient-directed Care, 22 MRS chapter 418. Specifically, this report provides information about patients who have reportedly met the requirements of the Act, the underlying causes of qualified patient death, and the number of prescriptions for life-ending medication written or dispensed to qualified patients.

Introduction

In 2019, the 129th Maine Legislature passed Public Law 271 known and cited as the Death with Dignity Act (Appendix A). The Act enables physicians to prescribe medication to a Maine resident with a terminal condition with the intent that the medication be self-administered for the purpose of hastening the patient's death. The Act set forth conditions for the patient and the physician for this action to be taken lawfully. Those conditions include, but are not limited to, an oral and written request by the patient to the physician, a reminder that all steps in the process must be voluntary, that the patient be capable of making such a decision, confirmation of the diagnosis and prognosis by a second physician, and an attestation by a qualified witness to these steps.

Once the prescribing physician fulfills all of the statutory requirements, the physician is required to attest to compliance with the Act and submit required report forms to the Department. The fact that a health care provider participates in activities under this Act may not be the sole basis for a complaint or report by another health care provider to the appropriate licensing board under Title 32, including, but not limited to, the Board of Licensure in Medicine, the Board of Osteopathic Licensure and the Maine Board of Pharmacy.

Within six months of the effective date of the Act, the Department is directed to adopt major substantive rules to facilitate the collection of information regarding compliance with the Act. The information collected is confidential, is not a public record and may not be made available for inspection by the public.

On June 12, 2019, Governor Janet Mills issued executive order number 9 FY19/20, directing the Department to conduct rulemaking on an emergency basis following the enactment of 2019 PL c. 271. Emergency rulemaking was conducted in accordance with 5 MRS §8054, and the Death with Dignity Act Reporting Rule, 10-146 CMR chapter 15, was in place when the law became effective on September 19, 2019 (Appendix B). The emergency rule provided guidance on reporting requirements for physicians to demonstrate that the individual made an informed decision about their end-of-life care and to ensure compliance with the law. Reporting forms were developed to collect the information required both in law and in the Governor's executive order.

To coincide with expiration of the emergency rule as means to ensuring continuity, the Department submitted for provisional adoption, a major substantive rule in January 2020. In accordance with the Maine Administrative Procedures Act, this major substantive rule was submitted to the legislature for review and approval for final adoption.

In March 2020, the Health and Human Services Committee voted to pass LD 2068, *Resolve, Regarding Legislative Review of Portions of Chapter 15: Death with Dignity Act Reporting Rule, a Major Substantive Rule of the Department of Health and Human Services, Maine Center for Disease Control and Prevention*, to be engrossed as amended.

Currently in effect, the Death with Dignity Act Reporting Rule requires up to five documents for reporting and compliance purposes. The content of reporting forms required by the Department is consistent with the statute. Forms are found on the Data, Research, and Vital Statistics (DRVS) website[1] or by request to the State Registrar and these forms are: the Request for Medication to End My Life in a Humane and Dignified Manner Form that is to be completed and signed by the patient and two witnesses; Interpreter Attachment Form, if applicable; the Consulting Physician Form that is to be signed by a physician who has reviewed and confirmed the medical opinion of the attending physician; the Attending Physician End-of Life Reporting Form which certifies all the requirements of the Act have been met, including adherence to the waiting periods set forth by the Act; and the End-of-Life Closure Form to be completed by the attending physician within 30 days of the death of the qualified patient (Appendix C).

Summary

The following summary is based on cases reportable under the Act and reported to the Department's Office of Data, Research and Vital Statistics between the time period of September 19, 2019, and December 31, 2019.

General Statistics

- There was one event for this reporting period.
- The underlying diagnosis was prostate cancer.
- The individual was more than 65 years old, a longtime Maine resident, educated with a college degree.
- The mechanism for death was patient choice/self-administered medication.

Prescriptions

- A prescription of digoxin, diazepam, morphine sulfate, and amitriptyline was dispensed.

[1] Maine CDC Office of Data, Research and Vital Statistics; https://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/forms/index.shtml

Appendices

Appendix A
22 MRS chapter 418, available for download at:
http://legislature.maine.gov/legis/statutes/22/title22sec2140.html

Appendix B
10-146 CMR chapter 15, available for download at:
http://www.maine.gov/sos/cec/rules/10/chaps10.htm#146

Appendix C

Reporting Forms (Attending Physician End-of-Life Reporting Form, Consulting Physician Form, Interpreter Attachment Form, Request for Medication to End My Life in a Humane and Dignified Manner Form, End of Life Closure Form), available for download at:
http://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/forms/index.shtml

§2140. Patient-directed care at the end of life

1. Short title. This chapter may be known and cited as "the Maine Death with Dignity Act." [PL 2019, c. 271, §4 (NEW).]

2. Definitions. As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

A. "Adult" means a person who is 18 years of age or older. [PL 2019, c. 271, §4 (NEW).]

B. "Attending physician" means the physician who has primary responsibility for the care of a patient and the treatment of that patient's terminal disease. [PL 2019, c. 271, §4 (NEW).]

C. "Competent" 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 an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available. [PL 2019, c. 271, §4 (NEW).]

D. "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's disease. [PL 2019, c. 271, §4 (NEW).]

E. "Counseling" means one or more consultations between a state-licensed psychiatrist, state-licensed psychologist, state-licensed clinical social worker or state-licensed clinical professional counselor and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [PL 2019, c. 271, §4 (NEW).]

F. "Health care provider" means:

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

(2) A health care facility. [PL 2019, c. 271, §4 (NEW).]

G. "Informed decision" means a decision by a qualified patient to request and obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner that is based on an appreciation of the relevant facts and that is made after being fully informed by the attending physician of:

(1) The qualified patient's medical diagnosis;

(2) The qualified patient's prognosis;

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

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

(5) The feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options. [PL 2019, c. 271, §4 (NEW).]

H. "Medically confirmed" means the medical opinion of an attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records. [PL 2019, c. 271, §4 (NEW).]

I. "Patient" means an adult who is under the care of a physician. [PL 2019, c. 271, §4 (NEW).]

J. "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this State. [PL 2019, c. 271, §4 (NEW).]

STATE OF MAINE

DEATH WITH DIGNITY ACT REPORTING RULE

10-146 CODE OF MAINE RULES CHAPTER 15

Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
Augusta, Maine 04333-0011

Effective Date: September 19, 2019 (Emergency Major Substantive Rule)

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APPENDIX C.

SECTION 1. PURPOSE AND DEFINITIONS

A. **Purpose.** This rule implements 22 MRS chapter 418, the *Maine Death with Dignity Act*, and specifies the Department's authority to collect and use information related to patient-directed care at the end of life.

B. **Definitions.** As used in this rule, unless the context indicates otherwise, the following terms have the following meanings:

1. **Act** means the *Maine Death with Dignity Act*, 22 MRS Chapter 418.

2. **Attending physician** means the physician who has primary responsibility for the care of a patient and the treatment of that patient's terminal disease.

3. **Competent** 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 an informed decision 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 a patient's disease.

5. **Department** means the Department of Health and Human Services, Maine Center for Disease Control and Prevention.

6. **Form** means a form prescribed by the Department that the Department requires to be completed for purposes of compliance with this rule. Forms that are missing required signatures, dates or information will not be considered valid or acceptable.

7. **Life-ending medication** means the medication prescribed or dispensed by a licensed healthcare provider in accordance with the Act to be self-administered by the qualified patient suffering from a terminal disease to end the qualified patient's life in a humane and dignified manner.

8. **Physician** means a doctor of medicine or osteopathy licensed pursuant to 32 MRS chapter 48 or 36.

9. **Qualified patient** means a competent adult who is a resident of this State and who has satisfied the requirements of the Act in order to obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner.

SECTION 2. SCOPE

This rule applies to healthcare providers involved in the decisions pursuant to the Act. This rule establishes reporting requirements related to patient-directed care at the end of life and responsibilities of healthcare providers participating in specific conduct under the Act. This rule does not require a healthcare provider to provide life-ending medication to a qualified patient.

SECTION 3. RESPONSIBILITIES OF HEALTHCARE PROVIDERS

A. **Compliance.** The attending physician must verify that all requirements of the Act have been met before prescribing or dispensing life-ending medication. The attending physician is responsible for ensuring that copies of all required forms are received by the Department. The attending physician must ensure that each original, completed form is retained in the qualified patient's medical record. Copies of required forms must be filed within 30 days after the date the prescription for life-ending medication is written, unless otherwise specified.

B. **Request for Medication to End My Life in a Humane and Dignified Manner.** The Request for Medication to End My Life in a Humane and Dignified Manner Form must be used for all written requests for life-ending medication. This form must be completed by the patient and two witnesses no sooner than 15 days following the patient's first verbal request for life-ending medication, in accordance with 22 MRS §§ 2140(5) and 2140(24). A copy of the completed form must be provided to the qualified patient.

1. **Witnesses.** The qualified patient's signature on this form must be witnessed by at least two individuals who, in the presence of the qualified patient, attest that to the best of their knowledge and belief, the patient is competent, is acting voluntarily, and is not being coerced to sign the request. One witness must be a person who is not a relative of the patient by blood, marriage, or adoption; a person who at the time the form is signed would be entitled to any portion of the estate of the patient upon death, under any will or by operation of any law; or an owner, operator or employee of a health care facility where the patient is receiving medical treatment or is a resident.

    a. **Attending Physician.** The patient's attending physician at the time the written request is signed may not be a witness.

    b. **Patient in a Long-Term Care Facility.** If the patient resides in a long-term care facility at the time of the patient's written request, one witness must be a licensed healthcare provider designated by the facility. The facility's designee may be an owner, operator or employee of the healthcare facility where the patient resides.

C. **Interpreter Attachment.** The Interpreter Attachment Form is only required if an interpreter is used pursuant to 22 MRS §2140(5)(B), to interpret conversations or consultations between the patient and the patient's attending or consulting physician in a language other than English, regarding the written request for life-ending medication. If an interpreter is used, this form, containing the elements required by 22 MRS §2140 (25), must accompany the Request for Medication to End My Life in a Humane and Dignified Manner Form.

1. **Interpreter Limitations.** The interpreter must not be a person who is a relative of the patient by blood, marriage, or adoption; a person who at the time the written request is signed would be entitled to any portion of the estate of the patient upon death, under any will or by operation of any law; or an owner, operator, or employee of a health care facility where the patient is receiving medical treatment or is a resident.

D. **Consulting Physician End-of-Life Care Form.** The Consulting Physician End-of-Life Care Form, containing the reporting requirements of 22 MRS §§ 2140 (7) and 2140 (14)(D), must be completed by the consulting physician who has examined the patient, has reviewed the patient's medical record, and who has confirmed the medical opinion of the attending

physician that the patient is suffering from a terminal disease and has verified that the patient is competent, is acting voluntarily, and has made an informed decision.

E. **Attending Physician End-of-Life Reporting Form.** The Attending Physician End-of-Life-Reporting Form must be completed by the attending physician to certify that all requirements of the Act have been met, including the attending physician's responsibilities at 22 MRS §2140(6), the documentation requirements at 22 MRS §2140(14), and the waiting periods set forth at 22 MRS §2140(13). A copy of the written prescription record must accompany this form.

F. **End-of-Life Closure Form.** The End-of-Life Closure Form must be completed by the attending physician within 30 days after the qualified patient's death, in accordance with 22 MRS §2140 (17)(B)(1). If six months have passed from the date the attending physician prescribed or dispensed the life-ending medication and the qualified patient's death has not been confirmed, the attending physician must complete this form and provide a copy to the State Registrar within 30 days following the expiration of that six-month period, retaining the original in the patient's medical record.

SECTION 4. REPORTING AND RECORD RETENTION

A. Reporting.

1. Reporting must be in the manner prescribed by the Department, using the forms specified in this rule. Copies of the forms may be accessed at the Department's Data Research and Vital Statistics website at http://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/forms/index.shtml, or by request to the State Registrar.

2. Copies of completed forms must be mailed to the attention of the State Registrar, Office of Data, Research, and Vital Statistics, 220 Capitol Street, 11 State House Station, Augusta, Maine 04333-0011.

3. All forms must be completed in accordance with the Act and this rule. Unless otherwise specified, all forms must be submitted to the State Registrar no later than 30 days after the date of the prescription for life-ending medication is written. The Department will contact the qualified patient's attending physician when it appears that any required form has not been filed.

4. The Department will collect information from attending physicians who have prescribed or dispensed life-ending medication to ensure compliance with the Act and this rule, and for use in assembling an annual statistical report as required by the Act. Required information will include any information requested on the forms prescribed by the Department and specified in this rule. Additionally, the Department may request from an attending physician any other information reasonably necessary to determine compliance with the Act and this rule.

B. Record Retention.

1. The attending physician prescribing or dispensing life-ending medication to a qualified patient must retain the original of each required form in the patient's medical record.

2. Paper forms submitted to the State Registrar will be retained by the Department to inform the annual report and may be destroyed only after the Department publishes the yearly report required by the Act.

C. Confidentiality. Information collected by the Department pursuant to this rule is confidential, is not a public record, and may not be made available for inspection by the public.

STATUTORY AUTHORITY AND HISTORY

STATUTORY AUTHORITY:
22 MRS Chapter 418 §2140

EFFECTIVE DATE:
September 19, 2019 – filing 2019-170 *(Emergency major substantive)*

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
220 Capitol Street
Augusta, Maine 04333-0011
Tel; (207) 287-5500; Toll Free: (888) 664-9491
TTY: Dial 711 (Maine Relay); Fax (207) 287-5470

Request for Medication to End My Life in a Humane and Dignified Manner

Part One: Declaration of Patient

I, _____, am an adult of sound mind and am a resident of the State of Maine and have been since _____ (month) of _____ (year) and 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 and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result and feasible alternatives, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and contact any pharmacist to fill the prescription.

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 3 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.

Signature	Date

Part Two: Declaration of Witnesses

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing above request:

Initials of Witness 1:

_____ 1. Is personally known to us or has provided proof of identity;

_____ 2. Signed this request in our presence on the date of the person's signature;

_____ 3. Appears to be of sound mind and not under duress, fraud, or undue influence; and

_____ 4. Is not a patient for whom either of us is the attending physician.

Witness 1 Print name	Signature	Date

Initials of Witness 2:

_____ 1. Is personally known to us or has provided proof of identity;

_____ 2. Signed this request in our presence on the date of the person's signature;

_____ 3. Appears to be of sound mind and not under duress, fraud, or undue influence; and

_____ 4. Is not a patient for whom either of us is the attending physician.

Witness 2 Print name	Signature	Date

NOTE: One witness must be a person who is not a relative by blood, marriage, or adoption of the person signing this request, is not entitled to any portion of the person's estate upon death and does not own or operate or is not employed at a health care facility where the person is a patient or resident. The person's attending physician at the time of the request is signed may not be a witness. If the person is an inpatient at a long-term care facility, one of the witnesses must be a licensed healthcare provider designated by the facility; the facility's designee may be an owner, operator, or employee of the health care facility.

To the person signing this request:

Give this completed form to your attending physician. Request a copy to keep for yourself.

To the attending physician:

Retain this completed original form in the patient's medical record. Provide a copy to the State Registrar, Office of Data, Research, and Vital Statistics.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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Form of Interpreter Attachment

I, _____, am fluent in English and _____

(language of patient)

On _____ (date) at approximately _____ (time) I read the "REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER" to _____ (name of patient) in _____ (language of patient).

Mr./Ms. _____ (name of patient) affirmed to me that he/she understands the content of this form, that he/she desires to sign this form under his/her own power and volition and that he/she requested to sign the form after consultations with an attending physician and a consulting physician.

Under penalty of perjury, I declare that I am fluent in English and _____ (language of the patient) and that the contents of this form, to the best of my knowledge, are true and correct.

Executed at _____ (city, county, and state) on _____ (date).

Interpreter's signature: _____
Interpreter's printed name: _____
Interpreter's address: _____
_____

To the interpreter: Give this completed form to the attending physician.

To the attending physician: Retain the original form in the patient's medical record. Mail a copy to the attention of the State Registrar, Office of Data, Research, and Vital Statistics.

Revised 12/2019

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
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11 State House Station
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End-of-Life Closure Form

Dear Physician:

Pursuant to the Department of Health and Human Services' authority to collect information under **the Death with Dignity Act**, 22 M.R.S. chapter 418, the Department requires physicians who write a prescription for medication for a patient to self-administer for the purpose of ending the patient's life in a humane and dignified manner to complete this follow-up form within **30 calendar days** of a patient's death, if known to the physician or **or 6 months of writing the prescription**.

For the Department of Health and Human Services to accept this form, it must be signed by the Attending Physician, whether or not he or she was present at the patient's time of death.

This form should be mailed to the attention of the State Registrar at: 220 Capitol Street, 11 State House Station, Augusta, Maine, 04330. *All information is kept strictly confidential.* If you have any questions, call: 207-287-5459.

Patient's Name:_____**DOB:**_____/_____/_____

Name of Attending Physician**:** _____

Prescription Record

Did the patient die from ingesting the lethal dose of medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink? **If unknown, please mark the form indicating that.**

- ☐ 1. **Patient Choice** (self-administered medication)
- ☐ 2. **Underlying illness**
- ☐ 3. **Unknown**
- ☐ 4. **Other** (please specify):

_____

How was the unused medication disposed of? If unknown, please indicate the same.

_____

Attending Physician Signature: _____

Date:_____/_____/_____

Revised 12/2019

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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Consulting Physician End-of-Life Care

PLEASE PRINT

A	**PATIENT INFORMATION**	
	PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH
B	**REFERRING/ATTENDING PHYSICIAN INFORMATION**	
	NAME	TELEPHONE NUMBER
C	**CONSULTING PHYSICIAN DETERMINATIONS**	
	I examined the above-named patient on _____ (date) at _____ (time). I have also reviewed the patient's relevant medical records. By checking below, I confirm the attending physician's diagnosis that the patient is suffering from a terminal disease, specifically _____ (list diagnosis), and verify that the patient is competent, is acting voluntarily, and had made an informed decision: ☐ a) diagnosis that patient is suffering from a terminal disease; ☐ b) patient is competent; ☐ c) patient is making an informed decision; ☐ d) patient is acting voluntarily in his/her request for medication to end his/her life in a humane and dignified manner.	
D	**CONSULTING PHYSICIAN'S INFORMATION**	
	NAME (please print)	LICENSE NUMBER
	MAILING ADDRESS	
	CITY, STATE, ZIP	TELEPHONE NUMBER
	PHYSICIAN'S SIGNATURE	DATE

To the consulting physician: Provide the completed form to the attending physician.
To the attending physician: Provide a copy of the completed form to the State Registrar, Office of Data, Research, and Vital Statistics. Retain the original in the patient's medical record.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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Attending Physician End-of-Life Reporting Form

PLEASE PRINT

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH
	MEDICAL DIAGNOSIS AND PROGNOSIS	
B	**PHYSICIAN INFORMATION**	
	NAME (LAST, FIRST, MI)	TELEPHONE
	MAILING ADDRESS	
	CITY, STATE, ZIP	
	CONSULTING PHYSICIAN NAME	TELEPHONE
C	**ACTION TAKEN TO COMPLY WITH LAW**	
	1. FIRST ORAL REQUEST	
	☐ The patient made an oral request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner.	DATE
	Comments:	
	2. SECOND ORAL REQUEST (Must be made 15 days or more after the first oral request.)	
	Indicate compliance by checking the boxes. ☐ 1. The patient made a second oral request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner. ☐ 2. Attending physician has offered the patient an opportunity to rescind the request.	DATE
	Comments:	
	3. WRITTEN REQUEST (Must be made 15 days or more after the first oral request.)	
	☑ The patient made a written request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner.	DATE
	Comments:	

4. ATTENDING PHYSICIAN DETERMINATIONS AND ACTIONS

Indicate compliance by checking the boxes.

I have determined that the patient:

- ☐ is at least 18 years of age;
- ☐ is suffering with a terminal disease;
- ☐ is competent; and
- ☐ has made a voluntary request for medication to self-administer for the purpose of ending the patient's life in a humane and dignified manner.

I have requested that the patient:

- ☐ demonstrate he/she is a Maine state resident, and I am satisfied the patient is a Maine state resident.

To ensure the patient is making an informed decision, I have informed the patient of the following:

- ☐ the patient's medical diagnosis;
- ☐ the patient's prognosis;
- ☐ the potential risks associated with taking the medication to be prescribed;
- ☐ the probable result of taking the medication to be prescribed; and
- ☐ the feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options.

I have taken the additional following steps:

- ☐ Referred the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is competent and acting voluntarily;
- ☐ Confirmed that the patient's request does not arise from coercion or undue influence by another individual by discussing with the patient, outside the presence of any other individual, except for an interpreter, whether the patient is making an informed decision;
- ☐ Verified that the patient, based on my evaluation or following a referral for counseling, is not suffering from a psychiatric or psychological disorder or depression causing impaired judgement;
- ☐ Recommended that the patient notify the patient's next of kin;
- ☐ Counseled the patient about the importance of having another person present when the patient takes the medication prescribed, and counseled the patient about not taking the medication prescribed in a public place;
- ☐ Informed the patient that the patient has the opportunity to rescind the request at any time and in any manner; and
- ☐ Verified immediately before writing a prescription for life-ending medication that the patient is making an informed decision.

D MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT

To be prescribed no sooner than **48 hours after** the date of the written request.

MEDICATION PRESCRIBED AND DOSAGE:	DATE PRESCRIBED

NAME OF PHARMACIST AND ADDRESS (if applicable)

E MEDICAL COVERAGE/PATIENT INSURANCE

What is the principal source of medical coverage for the patient?

- ☐ a) Private Insurance
- ☐ b) Government Payor includes Medicare, Indian Health Service, or CHAMPUS
- ☐ c) Mainecare or Medicaid
- ☐ d) Self Pay
- ☐ e) None
- ☐ f) Unknown

To the best of my knowledge, all of the requirements of the Death with Dignity Act, 22 M.R.S. chapter 418, have been met.

PHYSICIAN'S SIGNATURE	DATE

If comments in any section exceed the space provided, please use an attached page. Supplemental comments should be identified using the appropriate alphanumeric notation (e.g., C3). **Retain the original form in the patient's medical record. Provide a copy of the completed form to the State Registrar, Office of Data, Research, and Vital Statistics within 30 days of writing the prescription.**

Report to
The Maine Legislature

PATIENT-DIRECTED CARE
2020 ANNUAL REPORT

Submitted to: Joint Standing Committee on Health and Human Services

Submitted by: Jeanne M. Lambrew, Commissioner, Department of Health and Human Services

Prepared by: Kim Haggan, State Registrar and Director, Data, Research, and Vital Statistics, Maine Center for Disease Control and Prevention

Report date: March 1, 2021

Table of Contents

Executive Summary

In accordance with 22 MRS § 2140(17), the Department of Health and Human Services (Department) shall generate and make available to the public an annual statistical report of information collected under the Maine Death with Dignity Act (Act). The Department is mandated to submit a copy of the report to the Joint Standing Committee of the Legislature having jurisdiction over health matters, annually by March 1. This report is for patients that completed a request for medication to hasten their death in calendar year 2020.

This March 2021 report provides statistics concerning the utilization of Patient-directed Care, 22 MRS chapter 418. Specifically, this report provides information about patients who have reportedly met the requirements of the Act, the underlying causes of qualified patient death, and the number of prescriptions for life-ending medication written or dispensed to qualified patients.

Introduction

In 2019, the 129th Maine Legislature passed Public Law 271 known and cited as the Death with Dignity Act (Appendix A). The Act enables physicians to prescribe medication to a Maine resident with a terminal condition with the intent that the medication be self-administered for the purpose of hastening the patient's death. The Act set forth conditions for the patient and the physician for this action to be taken lawfully. Those conditions include, but are not limited to, an oral and written request by the patient to the physician, a reminder that all steps in the process must be voluntary, that the patient be capable of making such a decision, confirmation of the diagnosis and prognosis by a second physician, and an attestation by a qualified witness to these steps.

Once the prescribing physician fulfills all the statutory requirements, the physician is required to attest to compliance with the Act and submit required report forms to the Department. The fact that a health care provider participates in activities under this Act may not be the sole basis for a complaint or report by another health care provider to the appropriate licensing board under Title 32, including, but not limited to, the Board of Licensure in Medicine, the Board of Osteopathic Licensure and the Maine Board of Pharmacy.

Within six months of the effective date of the Act, the Department is directed to adopt major substantive rules to facilitate the collection of information regarding compliance with the Act. The information collected is confidential, is not a public record and may not be made available for inspection by the public.

On June 12, 2019, Governor Janet Mills issued executive order number 9 FY19/20, directing the Department to conduct rulemaking on an emergency basis following the enactment of 2019 PL c. 271. Emergency rulemaking was conducted in accordance with 5 MRS §8054, and the Death with Dignity Act Reporting Rule, 10-146 CMR chapter 15, was in place when the law became effective on September 19, 2019 (Appendix B). The emergency rule provided guidance on reporting requirements for physicians to demonstrate that the individual made an informed decision about their end-of-life care and to ensure compliance with the law. Reporting forms were developed to collect the information required both in law and in the Governor's executive order.

To coincide with expiration of the emergency rule as means to ensuring continuity, the Department submitted for provisional adoption, a major substantive rule in January 2020. In accordance with the Maine Administrative Procedures Act, this major substantive rule was submitted to the legislature for review and approval for final adoption.

In March 2020, the Health and Human Services Committee voted to pass LD 2068, *Resolve, Regarding Legislative Review of Portions of Chapter 15: Death with Dignity Act Reporting Rule, a Major Substantive Rule of the Department of Health and Human Services, Maine Center for Disease Control and Prevention*, to be engrossed as amended.

Currently in effect, the Death with Dignity Act Reporting Rule requires up to five documents for reporting and compliance purposes. The content of reporting forms required by the Department is consistent with the statute. Forms are found on the Data, Research, and Vital Statistics (DRVS) website[1] or by request to the State Registrar and these forms are:

- **Request for Medication to End My Life in a Humane and Dignified Manner Form** that is to be completed and signed by the patient and two witnesses
- **Interpreter Attachment Form**, if applicable
- **Consulting Physician Form** that is to be signed by a physician who has reviewed and confirmed the medical opinion of the attending physician
- **Attending Physician End-of Life Reporting Form** which certifies all the requirements of the Act have been met, including adherence to the waiting periods set forth by the Act
- **End-of-Life Closure Form** to be completed by the attending physician within 30 days of the death of the qualified patient (Appendix C).

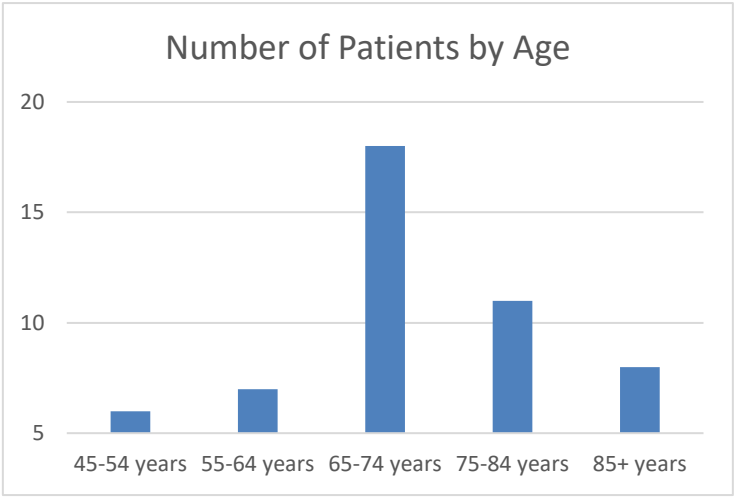
[1] Maine CDC Office of Data, Research and Vital Statistics; https://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/forms/index.shtml

General Statistics

- There were 50 patients who met all the requirements of the Act. At the time of this report, there are four for whom a death certificate could not be found. It is assumed that these patients are still alive.

- The 50 patients included 23 who identified as male and 27 who identified as female.

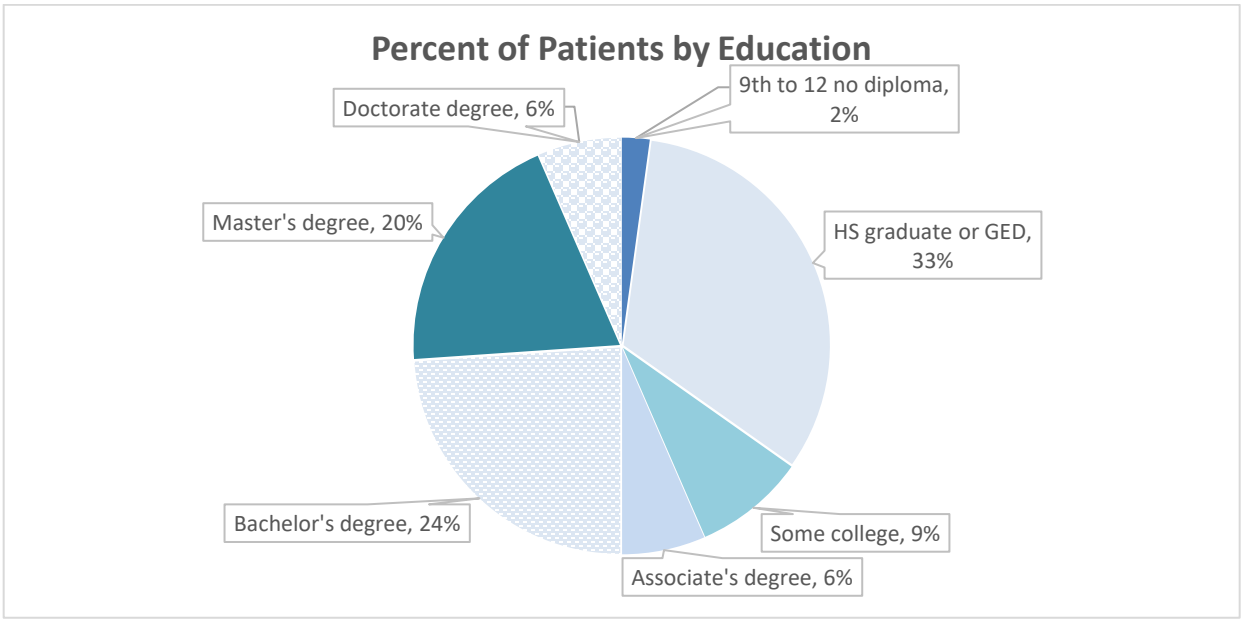
- Ages ranged from the youngest of 50 to the oldest of 96. Thirty-six percent of the patients were between age 65 and 74.



- 49 of the patients were white and non-Hispanic.

- Of the 46 patients with verified death, 30 died by patient choice and 15 from the underlying illness. There is one unknown.

- Over half of those that died had attained some level of a college degree. For one third of the patients, the highest educational attainment was high school or GED education.



Cancer was the terminal condition in 36 of the cases. This represented 72% of the total. ALS had three, Parkinson's disease and conditions of the heart each had two cases, and there were six cases that represented other illnesses.

Appendices

Appendix A
22 MRS chapter 418, available for download at:
http://legislature.maine.gov/legis/statutes/22/title22sec2140.html

Appendix B
10-146 CMR chapter 15, available for download at:
http://www.maine.gov/sos/cec/rules/10/chaps10.htm#146

Appendix C

Reporting Forms (Attending Physician End-of-Life Reporting Form, Consulting Physician Form, Interpreter Attachment Form, Request for Medication to End My Life in a Humane and Dignified Manner Form, End of Life Closure Form), available for download at:
http://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/forms/index.shtml

§2140. Patient-directed care at the end of life

1. Short title. This chapter may be known and cited as "the Maine Death with Dignity Act." [PL 2019, c. 271, §4 (NEW).]

2. Definitions. As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

A. "Adult" means a person who is 18 years of age or older. [PL 2019, c. 271, §4 (NEW).]

B. "Attending physician" means the physician who has primary responsibility for the care of a patient and the treatment of that patient's terminal disease. [PL 2019, c. 271, §4 (NEW).]

C. "Competent" 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 an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available. [PL 2019, c. 271, §4 (NEW).]

D. "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's disease. [PL 2019, c. 271, §4 (NEW).]

E. "Counseling" means one or more consultations between a state-licensed psychiatrist, state-licensed psychologist, state-licensed clinical social worker or state-licensed clinical professional counselor and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [PL 2019, c. 271, §4 (NEW).]

F. "Health care provider" means:

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

(2) A health care facility. [PL 2019, c. 271, §4 (NEW).]

G. "Informed decision" means a decision by a qualified patient to request and obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner that is based on an appreciation of the relevant facts and that is made after being fully informed by the attending physician of:

(1) The qualified patient's medical diagnosis;

(2) The qualified patient's prognosis;

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

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

(5) The feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options. [PL 2019, c. 271, §4 (NEW).]

H. "Medically confirmed" means the medical opinion of an attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records. [PL 2019, c. 271, §4 (NEW).]

I. "Patient" means an adult who is under the care of a physician. [PL 2019, c. 271, §4 (NEW).]

J. "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this State. [PL 2019, c. 271, §4 (NEW).]

STATE OF MAINE

DEATH WITH DIGNITY ACT REPORTING RULE

10-146 CODE OF MAINE RULES CHAPTER 15

Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
Augusta, Maine 04333-0011

Effective Date: September 19, 2019 (Emergency Major Substantive Rule)

TABLE OF CONTENTS

SECTION 1. PURPOSE AND DEFINITIONS

A. **Purpose.** This rule implements 22 MRS chapter 418, the *Maine Death with Dignity Act*, and specifies the Department's authority to collect and use information related to patient-directed care at the end of life.

B. **Definitions.** As used in this rule, unless the context indicates otherwise, the following terms have the following meanings:

1. **Act** means the *Maine Death with Dignity Act*, 22 MRS Chapter 418.

2. **Attending physician** means the physician who has primary responsibility for the care of a patient and the treatment of that patient's terminal disease.

3. **Competent** 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 an informed decision 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 a patient's disease.

5. **Department** means the Department of Health and Human Services, Maine Center for Disease Control and Prevention.

6. **Form** means a form prescribed by the Department that the Department requires to be completed for purposes of compliance with this rule. Forms that are missing required signatures, dates or information will not be considered valid or acceptable.

7. **Life-ending medication** means the medication prescribed or dispensed by a licensed healthcare provider in accordance with the Act to be self-administered by the qualified patient suffering from a terminal disease to end the qualified patient's life in a humane and dignified manner.

8. **Physician** means a doctor of medicine or osteopathy licensed pursuant to 32 MRS chapter 48 or 36.

9. **Qualified patient** means a competent adult who is a resident of this State and who has satisfied the requirements of the Act in order to obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner.

SECTION 2. SCOPE

This rule applies to healthcare providers involved in the decisions pursuant to the Act. This rule establishes reporting requirements related to patient-directed care at the end of life and responsibilities of healthcare providers participating in specific conduct under the Act. This rule does not require a healthcare provider to provide life-ending medication to a qualified patient.

SECTION 3. RESPONSIBILITIES OF HEALTHCARE PROVIDERS

A. **Compliance.** The attending physician must verify that all requirements of the Act have been met before prescribing or dispensing life-ending medication. The attending physician is responsible for ensuring that copies of all required forms are received by the Department. The attending physician must ensure that each original, completed form is retained in the qualified patient's medical record. Copies of required forms must be filed within 30 days after the date the prescription for life-ending medication is written, unless otherwise specified.

B. **Request for Medication to End My Life in a Humane and Dignified Manner.** The Request for Medication to End My Life in a Humane and Dignified Manner Form must be used for all written requests for life-ending medication. This form must be completed by the patient and two witnesses no sooner than 15 days following the patient's first verbal request for life-ending medication, in accordance with 22 MRS §§ 2140(5) and 2140(24). A copy of the completed form must be provided to the qualified patient.

1. **Witnesses.** The qualified patient's signature on this form must be witnessed by at least two individuals who, in the presence of the qualified patient, attest that to the best of their knowledge and belief, the patient is competent, is acting voluntarily, and is not being coerced to sign the request. One witness must be a person who is not a relative of the patient by blood, marriage, or adoption; a person who at the time the form is signed would be entitled to any portion of the estate of the patient upon death, under any will or by operation of any law; or an owner, operator or employee of a health care facility where the patient is receiving medical treatment or is a resident.

    a. **Attending Physician.** The patient's attending physician at the time the written request is signed may not be a witness.

    b. **Patient in a Long-Term Care Facility.** If the patient resides in a long-term care facility at the time of the patient's written request, one witness must be a licensed healthcare provider designated by the facility. The facility's designee may be an owner, operator or employee of the healthcare facility where the patient resides.

C. **Interpreter Attachment.** The Interpreter Attachment Form is only required if an interpreter is used pursuant to 22 MRS §2140(5)(B), to interpret conversations or consultations between the patient and the patient's attending or consulting physician in a language other than English, regarding the written request for life-ending medication. If an interpreter is used, this form, containing the elements required by 22 MRS §2140 (25), must accompany the Request for Medication to End My Life in a Humane and Dignified Manner Form.

1. **Interpreter Limitations.** The interpreter must not be a person who is a relative of the patient by blood, marriage, or adoption; a person who at the time the written request is signed would be entitled to any portion of the estate of the patient upon death, under any will or by operation of any law; or an owner, operator, or employee of a health care facility where the patient is receiving medical treatment or is a resident.

D. **Consulting Physician End-of-Life Care Form.** The Consulting Physician End-of-Life Care Form, containing the reporting requirements of 22 MRS §§ 2140 (7) and 2140 (14)(D), must be completed by the consulting physician who has examined the patient, has reviewed the patient's medical record, and who has confirmed the medical opinion of the attending

physician that the patient is suffering from a terminal disease and has verified that the patient is competent, is acting voluntarily, and has made an informed decision.

E. **Attending Physician End-of-Life Reporting Form.** The Attending Physician End-of-Life-Reporting Form must be completed by the attending physician to certify that all requirements of the Act have been met, including the attending physician's responsibilities at 22 MRS §2140(6), the documentation requirements at 22 MRS §2140(14), and the waiting periods set forth at 22 MRS §2140(13). A copy of the written prescription record must accompany this form.

F. **End-of-Life Closure Form.** The End-of-Life Closure Form must be completed by the attending physician within 30 days after the qualified patient's death, in accordance with 22 MRS §2140 (17)(B)(1). If six months have passed from the date the attending physician prescribed or dispensed the life-ending medication and the qualified patient's death has not been confirmed, the attending physician must complete this form and provide a copy to the State Registrar within 30 days following the expiration of that six-month period, retaining the original in the patient's medical record.

SECTION 4. REPORTING AND RECORD RETENTION

A. Reporting.

1. Reporting must be in the manner prescribed by the Department, using the forms specified in this rule. Copies of the forms may be accessed at the Department's Data Research and Vital Statistics website at http://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/forms/index.shtml, or by request to the State Registrar.

2. Copies of completed forms must be mailed to the attention of the State Registrar, Office of Data, Research, and Vital Statistics, 220 Capitol Street, 11 State House Station, Augusta, Maine 04333-0011.

3. All forms must be completed in accordance with the Act and this rule. Unless otherwise specified, all forms must be submitted to the State Registrar no later than 30 days after the date of the prescription for life-ending medication is written. The Department will contact the qualified patient's attending physician when it appears that any required form has not been filed.

4. The Department will collect information from attending physicians who have prescribed or dispensed life-ending medication to ensure compliance with the Act and this rule, and for use in assembling an annual statistical report as required by the Act. Required information will include any information requested on the forms prescribed by the Department and specified in this rule. Additionally, the Department may request from an attending physician any other information reasonably necessary to determine compliance with the Act and this rule.

B. Record Retention.

1. The attending physician prescribing or dispensing life-ending medication to a qualified patient must retain the original of each required form in the patient's medical record.

2. Paper forms submitted to the State Registrar will be retained by the Department to inform the annual report and may be destroyed only after the Department publishes the yearly report required by the Act.

C. Confidentiality. Information collected by the Department pursuant to this rule is confidential, is not a public record, and may not be made available for inspection by the public.

STATUTORY AUTHORITY AND HISTORY

STATUTORY AUTHORITY:
22 MRS Chapter 418 §2140

EFFECTIVE DATE:
September 19, 2019 – filing 2019-170 *(Emergency major substantive)*

APPENDIX C.

PDF Attachments


Request for Medication


Attending Physician Form


Consulting Physician Form


Interpreter Form


End-of-Life Closure Form

2020

Oregon Death with Dignity Act

2020 Data Summary

Oregon Health Authority
PUBLIC HEALTH DIVISION

Acknowledgments

Report written by: Public Health Division, Center for Health Statistics

Date: February 26, 2021

For more information, see: www.healthoregon.org/dwd

Contact: DWDA.INFO@state.or.us

Executive summary

The Oregon Death with Dignity Act (DWDA) allows terminally ill Oregonians who meet specific qualifications to end their lives through voluntary self-administration of a lethal dose of medications prescribed by a physician for that purpose. The Act requires the Oregon Health Authority (OHA) to collect information about the patients and physicians who participate in the Act and to publish an annual statistical report. In 2020, 370 people were reported to have received prescriptions under the DWDA. As of January 22, 2021, 245 people had died in 2020 from ingesting the prescribed medications, including 22 who had received prescriptions in previous years. Demographic characteristics of DWDA patients were similar to those of previous years: most patients were aged 65 years or older (81%) and white (97%). While cancer still accounted for most underlying illnesses (66%), patients with heart disease (11%) outnumbered those with neurological disease (8%) for the first time in 2020. OHA made no referrals to the Oregon Medical Board for failure to comply with DWDA requirements.

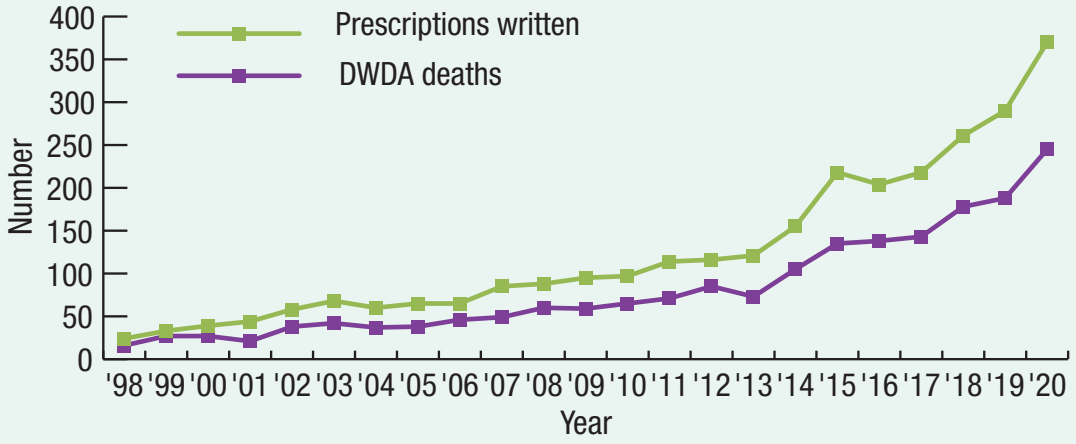
Introduction

The Oregon Death with Dignity Act (DWDA) allows terminally ill Oregonians who meet specific qualifications to end their lives through voluntary self-administration of a lethal dose of medications prescribed by a physician for that purpose. The Act requires the Oregon Health Authority (OHA) to collect information about the patients and physicians who participate in the Act and to publish an annual statistical report.

The DWDA outlines specific patient requirements 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 to health care practitioners, and 4) diagnosed with a terminal illness that will lead to death within six months. The attending and consulting physicians must determine whether a patient meets these requirements and report that fact to OHA at the time a prescription is written. When OHA identifies any issue of noncompliance with the statutory requirements, it reports the fact to the appropriate licensing board.

Data presented in this summary, including the number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of the medications (DWDA deaths), are based on required reporting forms and death certificates received by OHA as of January 22, 2021. More information on the reporting process, required forms and annual reports is available at http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998–2020



As of January 22, 2021

See Table 2 for detailed information

Participation summary and trends

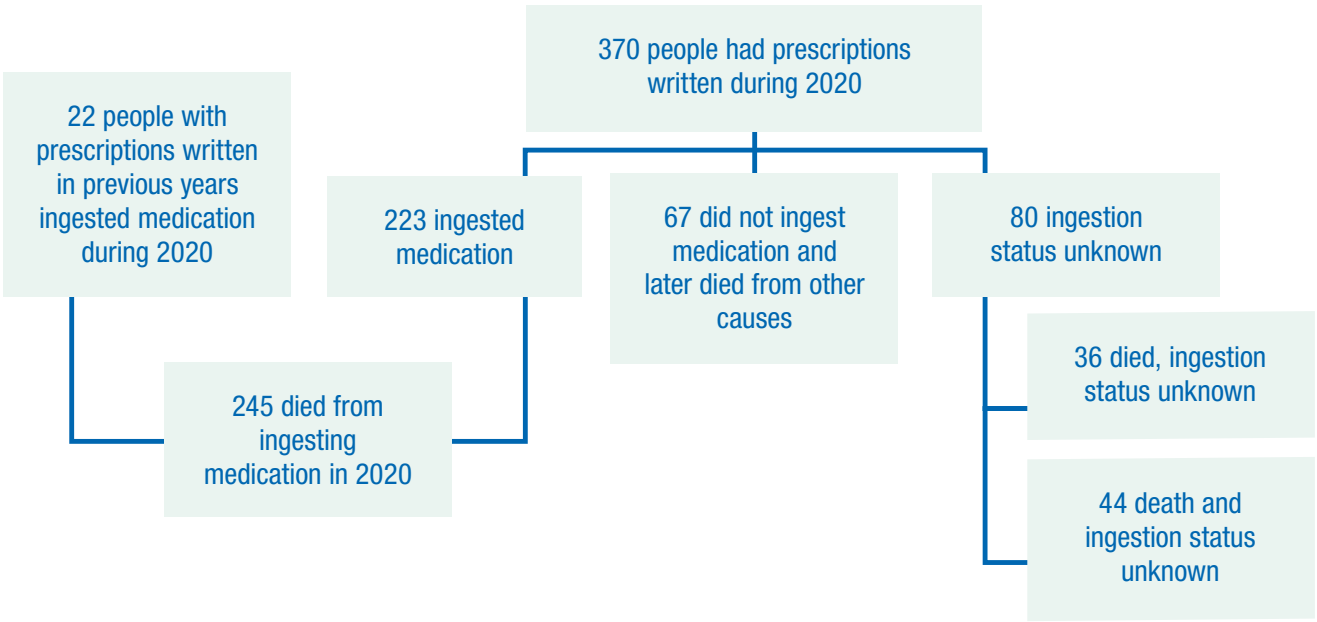
During 2020, 370 people received prescriptions for lethal doses of medications under the provisions of the Oregon DWDA, a 25% increase over the 297 reported during 2019 (Figure 1). As of January 22, 2021, OHA had received reports of 245 people who died during 2020 from ingesting the medications prescribed under the DWDA, an increase from 191 in 2019.

Since the law was passed in 1997, a total of 2,895 people have received prescriptions under the DWDA and 1,905 people (66%) have died from ingesting the medications. During 2020, the estimated rate of DWDA deaths was 65.5 per 10,000 total deaths.[1]

Figure 2 shows a summary of DWDA prescriptions written and medications ingested. Of the 370 patients for whom prescriptions were written during 2020, 223 (60%) died from ingesting the medication. An additional 67 (18%) did not take the medications and later died of other causes.

At the time of reporting, ingestion status was unknown for 80 patients prescribed DWDA medications in 2020. Of these, 36 patients died but follow up information is not yet available. For the remaining 44 patients, both death and ingestion status are not yet known (Figure 2). In all, eight patients (3.3%) outlived their prognosis (i.e., lived more than six months after their prescription).

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2020, as of January 22, 2021



[1] *Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2019 (37,397), the most recent year for which final death data are available.*

Patient characteristics

Table 1 shows the characteristics and end-of-life care for 2020 DWDA deaths, updated data for 2019 DWDA deaths, combined data for 1998–2018 DWDA deaths, and total DWDA deaths. Of the 245 DWDA deaths during 2020, most patients were aged 65 years or older (81%) and white (97%). The median age at death was 74 years. Forty-two percent of patients had at least a bachelor's degree.

Patients' underlying illnesses were somewhat different from those of previous years. Cancer remained the most common underlying illness, but now accounts for only two-thirds (66%) of DWDA deaths. In previous years, with a few exceptions, cancer accounted for 70%–85% of underlying illnesses. In addition, patients with heart disease (11%) outnumbered those with neurological disease (8%) for the first time in 2020.

Most patients died at home (92%) and most were enrolled in hospice care (95%). All patients whose health insurance status was known had some form of coverage. The percent of patients with private insurance declined from 2019 (from 29% to 26%), while patients with Medicare or Medicaid insurance increased (from 70% to 74%).

As in previous years, the three most frequently reported end-of-life concerns were decreasing ability to participate in activities that made life enjoyable (94%), loss of autonomy (93%) and loss of dignity (72%).

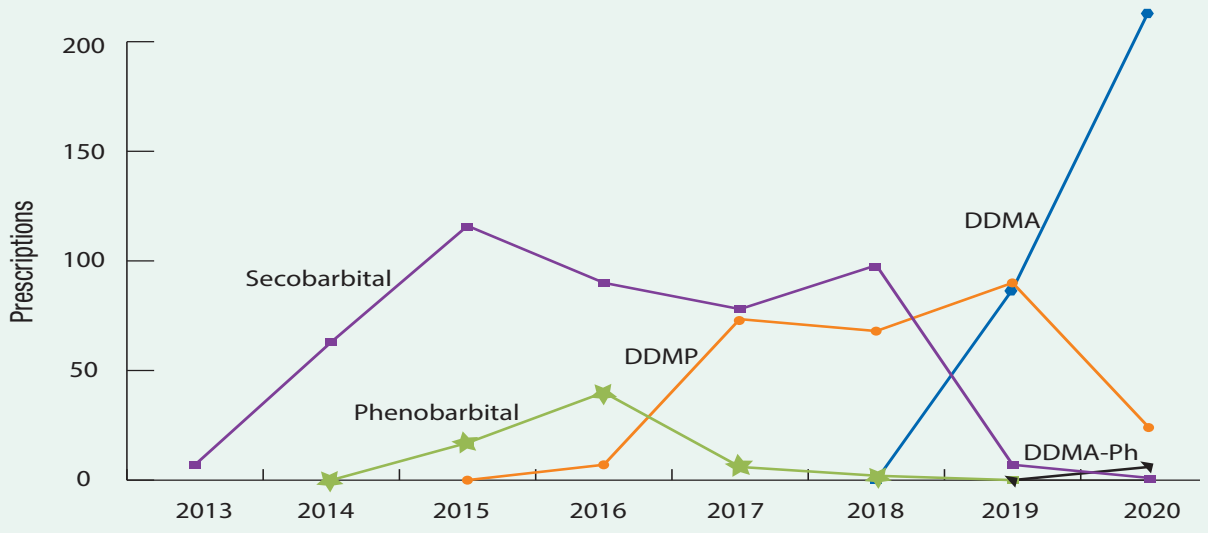
DWDA process

A total of 142 physicians wrote 370 prescriptions during 2020 (1–31 prescriptions per physician; 79% of physicians wrote one or two prescriptions). The number of attending physicians has increased most years since 1998 and has increased at a higher rate since 2014 (Table 2). Almost half of attending and consulting physicians practiced in the Portland metropolitan area (48% and 49%, respectively), while just under 30% practiced in the other northwestern counties (Table 3). Three patients were referred for psychological or psychiatric evaluation. During 2020, OHA made no referrals to the Oregon Medical Board for failure to comply with DWDA requirements.

The DWDA now provides an exemption to the statutory waiting periods for patients expected to live fewer than 15 days from the time of their first oral request for medication. In 2020, 75 patients (20%) were given exemptions.

The medications prescribed to DWDA patients continues to evolve (Table 1). In 2019, more than 90% of DWDA ingestions involved one of two drug combinations: DDMA, consisting of diazepam, digoxin, morphine sulfate, and amitriptyline (47% of ingestions); or DDMP, consisting of diazepam, digoxin, morphine sulfate,

Figure 3: Medication used in DWDA ingestions, 2013-2020



and propranolol (46% of ingestions). In 2020, most ingestions involved DDMA (87%). Only 10% of ingestions used DDMP. In late 2020, some physicians began to prescribe a new drug combination – DDMA-Ph – consisting of DDMA with the addition of phenobarbital (Figure 3).

Prescribing physicians were present at time of death for 29 patients (12%). Fifty-five patients (22%) had other health care providers present, and volunteers were present for 42 deaths (24%).[1] Data on time from ingestion to death are available for 138 DWDA deaths (56%) during 2020.[2] Among those patients, time from ingestion until death ranged from six minutes to eight hours, with a median time of 50 minutes (Table 1).

Table 4 shows the duration from ingestion to death by medication prescribed for all known cases. Median time until death was shorter after DDMA (53 minutes) than after DDMP (85 minutes). All drug combinations have shown longer median times until death than the barbiturates, secobarbital and pentobarbital, which are no longer readily available. There is not yet sufficient data on the new drug combination, DDMA-Ph, to estimate its effectiveness.

[1] Due to COVID-19 precautions, providers and volunteers attended some DWDA ingestions remotely using teleconferencing software (e.g., Zoom).

[2] Includes all reports, not just those from licensed health care providers.

Table 1. Characteristics and end-of-life care of 1,905 DWDA patients who have died from ingesting a lethal dose of medication as of January 22, 2021, Oregon, 1998–2020

Characteristics	2020 (N=245)		2019 (N=191)		1998–2018 (N=1,469)		Total (N= 1,905)	
Sex	**N (%)[1]**		**N (%)[1]**		**N (%)[1]**		**N (%)[1]**	
Male	124	(50.6)	114	(59.7)	767	(52.2)	1,005	(52.8)
Female	121	(49.4)	77	(40.3)	702	(47.8)	900	(47.2)
Age								
18–34	1	(0.4)	1	(0.5)	9	(0.6)	11	(0.6)
35–44	4	(1.6)	4	(2.1)	28	(1.9)	36	(1.9)
45–54	11	(4.5)	11	(5.8)	85	(5.8)	107	(5.6)
55–64	30	(12.2)	32	(16.8)	277	(18.9)	339	(17.8)
65–74	83	(33.9)	56	(29.3)	443	(30.2)	582	(30.6)
75–84	65	(26.5)	56	(29.3)	397	(27.0)	518	(27.2)
85+	51	(20.8)	31	(16.2)	230	(15.7)	312	(16.4)
Median years (range)	74	(33-99)	74	(33-98)	72	(25-102)	72	(25-102)
Race								
White	238	(97.1)	184	(96.3)	1,411	(96.4)	1,833	(96.5)
African American	0	(0.0)	0	(0.0)	1	(0.1)	1	(0.1)
American Indian	0	(0.0)	0	(0.0)	3	(0.2)	3	(0.2)
Asian	3	(1.2)	2	(1.0)	21	(1.4)	26	(1.4)
Pacific Islander	0	(0.0)	0	(0.0)	1	(0.1)	1	(0.1)
Other	1	(0.4)	1	(0.5)	4	(0.3)	6	(0.3)
Two or more races	1	(0.4)	0	(0.0)	7	(0.5)	8	(0.4)
Hispanic	2	(0.8)	4	(2.1)	16	(1.1)	22	(1.2)
Unknown	*0*		*0*		*5*		*5*	
Marital status								
Married (including Registered Domestic Partner)	113	(46.1)	92	(48.2)	671	(46.0)	876	(46.2)
Widowed	58	(23.7)	35	(18.3)	325	(22.3)	418	(22.0)
Never married	19	(7.8)	24	(12.6)	114	(7.8)	157	(8.3)
Divorced	55	(22.4)	40	(20.9)	350	(24.0)	445	(23.5)
Unknown	*0*		*0*		*9*		*9*	
Education								
8th grade or less	4	(1.6)	6	(3.2)	13	(0.9)	23	(1.2)
9th–12th grade, no diploma	9	(3.7)	10	(5.3)	60	(4.1)	79	(4.2)
High school graduate/GED	56	(22.9)	26	(13.7)	321	(22.1)	403	(21.3)
Some college	45	(18.4)	32	(16.8)	308	(21.2)	385	(20.4)
Associate degree	27	(11.0)	15	(7.9)	132	(9.1)	174	(9.2)
Bachelor's degree	52	(21.2)	50	(26.3)	353	(24.3)	455	(24.1)
Master's degree	36	(14.7)	35	(18.4)	159	(10.9)	230	(12.2)
Doctorate or professional degree	16	(6.5)	16	(8.4)	108	(7.4)	140	(7.4)
Unknown	*0*		*1*		*15*		*16*	

Characteristics	2020 (N=245)		2019 (N=191)		1998–2018 (N=1,469)		Total (N= 1,905)	
Residence county/region[2]								
Multnomah	52	(21.3)	37	(19.4)	324	(22.2)	413	(21.8)
Lane	26	(10.7)	26	(13.6)	154	(10.6)	206	(10.9)
Washington	25	(10.2)	16	(8.4)	152	(10.4)	193	(10.2)
Jackson	21	(8.6)	19	(9.9)	91	(6.2)	131	(6.9)
Clackamas	19	(7.8)	21	(11.0)	149	(10.2)	189	(10.0)
Deschutes	16	(6.6)	14	(7.3)	55	(3.8)	85	(4.5)
Marion	13	(5.3)	11	(5.8)	155	(10.6)	179	(9.5)
Other northwest counties	47	(19.3)	29	(15.2)	217	(14.9)	293	(15.5)
Southern Oregon	18	(7.4)	9	(4.7)	115	(7.9)	142	(7.5)
Central Oregon / Columbia Gorge	3	(1.2)	6	(3.1)	21	(1.4)	30	(1.6)
Eastern Oregon	4	(1.6)	3	(1.6)	26	(1.8)	33	(1.7)
Unknown	*1*		*0*		*10*		*11*	
End-of-life care								
Hospice								
Enrolled	232	(94.7)	172	(90.1)	1,295	(90.2)	1,699	(90.8)
Not enrolled	13	(5.3)	19	(9.9)	140	(9.8)	172	(9.2)
Unknown	*0*		*0*		*34*		*34*	
Insurance								
Private	51	(25.6)	48	(29.1)	664	(49.4)	763	(44.7)
Medicare, Medicaid or Other Governmental	148	(74.4)	115	(69.7)	664	(49.4)	927	(54.3)
None	0	(0.0)	2	(1.2)	16	(1.2)	18	(1.1)
Unknown	*46*		*26*		*125*		*197*	
Underlying illness								
Cancer	**162**	**(66.1)**	**132**	**(69.1)**	**1,116**	**(76.0)**	**1,410**	**(74.0)**
Lip, oral cavity, and pharynx	7	(2.9)	4	(2.1)	30	(2.0)	41	(2.2)
Digestive organs	40	(16.3)	41	(21.5)	293	(19.9)	374	(19.6)
Pancreas	*12*	*(4.9)*	*11*	*(5.8)*	*100*	*(6.8)*	*123*	*(6.5)*
Colon	*6*	*(2.4)*	*6*	*(3.1)*	*86*	*(5.9)*	*98*	*(5.1)*
Other digestive organs	*22*	*(9.0)*	*24*	*(12.6)*	*107*	*(7.3)*	*153*	*(8.0)*
Respiratory and intrathoracic organs	31	(12.7)	20	(10.5)	248	(16.9)	299	(15.7)
Lung and bronchus	*29*	*(11.8)*	*17*	*(8.9)*	*234*	*(15.9)*	*280*	*(14.7)*
Other respiratory and intrathoracic organs	*2*	*(0.8)*	*3*	*(1.6)*	*14*	*(1.0)*	*19*	*(1.0)*
Melanoma and other skin	4	(1.6)	1	(0.5)	39	(2.7)	44	(2.3)
Mesothelial and soft tissue	3	(1.2)	4	(2.1)	27	(1.8)	34	(1.8)
Breast	14	(5.7)	12	(6.3)	102	(6.9)	128	(6.7)
Female genital organs	17	(6.9)	5	(2.6)	84	(5.7)	106	(5.6)
Prostate	13	(5.3)	12	(6.3)	64	(4.4)	89	(4.7)
Urinary tract	8	(3.3)	4	(2.1)	42	(2.9)	54	(2.8)

Characteristics	2020 (N=245)		2019 (N=191)		1998–2018 (N=1,469)		Total (N= 1,905)	
Eye, brain, central nervous system	5	(2.0)	5	(2.6)	49	(3.3)	59	(3.1)
Brain	*4*	*(1.6)*	*5*	*(2.6)*	*44*	*(3.0)*	*53*	*(2.8)*
Eye and central nervous system	*1*	*(0.4)*	*0*	*(0.0)*	*5*	*(0.3)*	*6*	*(0.3)*
Thyroid and other endocrine	0	(0.0)	0	(0.0)	7	(0.5)	7	(0.4)
Ill-defined, secondary, and unspecified sites	6	(2.4)	7	(3.7)	37	(2.5)	50	(2.6)
Lymphoma and leukemia	9	(3.7)	9	(4.7)	67	(4.6)	85	(4.5)
Other cancers	5	(2.0)	8	(4.2)	27	(1.8)	40	(2.1)
Neurological disease	**20**	**(8.2)**	**25**	**(13.1)**	**161**	**(11.0)**	**206**	**(10.8)**
Amyotrophic lateral sclerosis	11	(4.5)	18	(9.4)	117	(8.0)	146	(7.7)
Other neurological disease	9	(3.7)	7	(3.7)	44	(3.0)	60	(3.1)
Respiratory disease [e.g., COPD]	**15**	**(6.1)**	**14**	**(7.3)**	**75**	**(5.1)**	**104**	**(5.5)**
Heart/circulatory disease	**28**	**(11.4)**	**9**	**(4.7)**	**67**	**(4.6)**	**104**	**(5.5)**
Infectious disease [e.g., HIV/AIDS]	**1**	**(0.4)**	**0**	**(0.0)**	**13**	**(0.9)**	**14**	**(0.7)**
Gastrointestinal disease [e.g., liver disease]	**5**	**(2.0)**	**3**	**(1.6)**	**9**	**(0.6)**	**17**	**(0.9)**
Endocrine/metabolic disease [e.g., diabetes]	**5**	**(2.0)**	**2**	**(1.0)**	**11**	**(0.7)**	**18**	**(0.9)**
Other illnesses[3]	**9**	**(3.7)**	**6**	**(3.1)**	**17**	**(1.2)**	**32**	**(1.7)**
DWDA process								
Outlived 6-month prognosis	8	(3.3)	6	(3.1)	63	(4.3)	77	(4.0)
Referred for psychiatric evaluation	3	(1.2)	1	(0.5)	65	(4.4)	69	(3.6)
Patient informed family of decision[4]	234	(97.1)	181	(96.8)	1,302	(95.5)	1,717	(95.9)
Patient died at								
Home (patient, family or friend)	226	(92.2)	180	(94.2)	1,352	(92.4)	1,758	(92.6)
Assisted living or foster care facility	15	(6.1)	5	(2.6)	72	(4.9)	92	(4.8)
Nursing home	0	(0.0)	4	(2.1)	14	(1.0)	18	(0.9)
Hospital	0	(0.0)	0	(0.0)	4	(0.3)	4	(0.2)
Hospice facility	0	(0.0)	1	(0.5)	2	(0.1)	3	(0.2)
Other	4	(1.6)	1	(0.5)	19	(1.3)	24	(1.3)
Unknown	*0*		*0*		*6*		*6*	
Lethal medication[5]								
DDMA	214	(87.3)	89	(46.6)	0	(0.0)	303	(15.9)
DDMP-2	24	(9.8)	87	(45.5)	81	(5.5)	192	(10.1)
DDMA-Ph	6	(2.4)	0	(0.0)	0	(0.0)	6	(0.3)
Secobarbital	1	(0.4)	7	(3.7)	852	(58.0)	860	(45.1)
DDMP-1	0	(0.0)	3	(1.6)	68	(4.6)	71	(3.7)
Phenobarbital	0	(0.0)	0	(0.0)	65	(4.4)	65	(3.4)
Pentobarbital	0	(0.0)	0	(0.0)	386	(26.3)	386	(20.3)
Other	0	(0.0)	5	(2.6)	17	(1.2)	22	(1.2)

Characteristics	2020 (N=245)		2019 (N=191)		1998–2018 (N=1,469)		Total (N= 1,905)	
End-of-life concerns[6]								
Less able to engage in activities making life enjoyable	231	(94.3)	172	(90.1)	1,310	(89.2)	1,713	(89.9)
Losing autonomy	228	(93.1)	166	(86.9)	1,331	(90.6)	1,725	(90.6)
Loss of dignity[7]	176	(71.8)	137	(71.7)	995	(74.3)	1,308	(73.6)
Burden on family, friends/caregivers	130	(53.1)	113	(59.2)	662	(45.1)	905	(47.5)
Losing control of bodily functions	92	(37.6)	76	(39.8)	654	(44.5)	822	(43.1)
Inadequate pain control, or concern about it	80	(32.7)	64	(33.5)	378	(25.7)	522	(27.4)
Financial implications of treatment	15	(6.1)	14	(7.3)	57	(3.9)	86	(4.5)
Health care provider present (collected since 2001)	**(N=245)**		**(N=191)**		**(N=1,397)**		**(N=1,833)**	
When medication was ingested								
Prescribing physician	29		36		221		286	
Other provider, prescribing physician not present	59		26		347		432	
Volunteer	42		53		3		98	
No provider or volunteer	34		14		116		164	
Unknown	*81*		*62*		*782*		*925*	
At time of death								
Prescribing physician	29	(11.8)	34	(17.9)	201	(14.6)	264	(14.6)
Other provider, prescribing physician not present	55	(22.4)	29	(15.3)	354	(25.7)	438	(24.2)
Volunteer	42	(17.1)	45	(23.7)	20	(1.5)	107	(5.9)
No provider or volunteer	119	(48.6)	82	(43.2)	800	(58.2)	1,001	(55.3)
Unknown	*0*		*1*		*22*		*23*	
Complications[8]	**(N=245)**		**(N=191)**		**(N=1,469)**		**(N=1,905)**	
Difficulty ingesting/regurgitated	3		2		28		33	
Seizures	1		0		2		3	
Other	1		4		11		16	
None	67		56		652		775	
Unknown	*173*		*129*		*776*		*1078*	
Other outcomes								
Regained consciousness after ingesting DWDA medications	0		0		8		8	
Timing of DWDA event								
Duration (weeks) of patient-physician relationship								
Median	8		15		12		12	
Range	0 – 1020		1 – 1222		0 – 2138		0 – 2138	
Patients with information available	*238*		*190*		*1,459*		*1,887*	
Patients with information unknown	*7*		*1*		*10*		*18*	

Characteristics	2020 (N=245)	2019 (N=191)	1998–2018 (N=1,469)	Total (N= 1,905)
Duration (days) between first request and death				
Median	32	43	47	45
Range	0 – 1080	15 – 1503	14 – 1009	0 – 1503
Patients with information available	*241*	*191*	*1,469*	*1,901*
Patients with information unknown	*4*	*0*	*0*	*4*
Duration (minutes) between ingestion and unconsciousness				
Median	*5*	*5*	*5*	*5*
Range	*1 – 45*	*1 – 90*	*1 – 240*	*1 – 240*
Patients with information available	*125*	*120*	*755*	*1,000*
Patients with information unknown	*120*	*125*	*714*	*905*
Duration (minutes) between ingestion and death				
Median	*50*	*52*	*27*	*30*
Range	*6min-8hrs*	*1min-47hrs*	*1min-104hrs*	*1min-104hrs*
Patients with information available	*138*	*128*	*772*	*1,038*
Patients with information unknown	*107*	*117*	*697*	*867*

1 Unknowns are excluded when calculating percentages.

2 **Other northwest counties:** Benton, Clatsop, Columbia, Lincoln, Linn, Polk, Tillamook, and Yamhill.
Southern: Coos, Curry, Douglas, Josephine, Klamath, and Lake.
Central/Columbia Gorge: Crook, Gilliam, Hood River, Jefferson, Sherman, Wasco, and Wheeler.
Eastern: Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, and Wallowa.

3 Includes deaths due to arthritis, arteritis, blood disease, complications from a fall, kidney failure, medical care complications, musculoskeletal system disorders, sclerosis, and stenosis.

4 First recorded in 2001. Since then, 74 patients (4.1%) have chosen not to inform their families, and 30 patients (1.6%) have had no family to inform. Information is unknown for 14 patients.

5 **DDMA** is a combination of diazepam, digoxin, morphine sulfate, and amitriptyline.
DDMP is a combination of diazepam, digoxin, morphine sulfate, and propranolol. DDMP-1 contains 10g of morphine sulfate; DDMP-2 contains 15g.
DDMP-Ph is a a combination of diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital.
Phenobarbital is dispensed as a combination of phenobarbital, chloral hydrate, and morphine sulfate.

6 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive.

7 First asked in 2003. Data available for 1,776 patients.

8 Information about complications is reported only when a physician or another health care provider is present at the time of death.

Table 2. Number of DWDA prescription recipients, DWDA deaths, and attending physicians, 1998–2020

Year	Prescription recipients	DWDA deaths	Attending physicians
1998	24	16	n/a
1999	33	27	n/a
2000	39	27	22
2001	44	21	33
2002	58	38	33
2003	68	42	42
2004	60	37	40
2005	65	38	40
2006	65	46	41
2007	85	49	46
2008	88	60	60
2009	95	59	64
2010	97	65	59
2011	114	71	62
2012	116	85	62
2013	121	73	62
2014	155	105	83
2015	218	135	106
2016	204	139	101
2017	218	158	92
2018	261	178	108
2019	297	191	113
2020	370	245	142
Total	**2,895**	**1,905**	

Table 3. Primary location of practice, DWDA physicians, 2020

Region[2]	Attending physicians		Consulting physicians	
	N	(%)[1]	N	(%)[1]
Metro counties (Clackamas, Multnomah, Washington)	68	(48.2)	100	(49.0)
Northwest Oregon (excludes metro counties)	42	(29.8)	59	(28.9)
Southern Oregon	21	(14.9)	28	(13.7)
Central Oregon / Columbia Gorge	9	(6.4)	15	(7.4)
Eastern Oregon	1	(0.7)	2	(1.0)
Unknown	*1*		*2*	

1 Unknowns are excluded when calculating percentages.
2 **Northwest Oregon**: Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook and Yamhill.
Southern Oregon: Coos, Curry, Douglas, Jackson, Josephine, Klamath and Lake.
Central / Columbia Gorge: Crook, Deschutes, Gilliam, Hood River, Jefferson, Sherman, Wasco and Wheeler.
Eastern Oregon: Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union and Wallowa.

Table 4. Duration between ingestion and death, DWDA deaths, 2001–2020

Drug(%)	Total	Unknown duration	Known duration		<1hr		1– 6 hours		>6 hours		Median	Mean	Range	Regained consciousness[6]
Secobarbital[1]	792	403	389	(100.0)	293	(75.3)	69	(17.7)	27	(6.9)	25	137	2min – 83 hrs	5
Pentobarbital[1]	384	156	228	(100.0)	188	(82.5)	31	(13.6)	9	(3.9)	20	97	1min – 104 hrs	0
DDMA[2]	303	108	195	(100.0)	107	(54.9)	84	(43.1)	4	(2.1)	53	80	1min – 19 hrs	0
DDMP-2[3]	192	89	103	(100.0)	45	(43.7)	36	(35.0)	22	(21.4)	85	253	5min – 47 hrs	2
DDMP-1[3]	71	47	24	(100.0)	12	(50.0)	7	(29.2)	5	(20.8)	67	203	10min – 21 hrs	0
Phenobarbital[4]	65	43	22	(100.0)	4	(18.2)	13	(59.1)	5	(22.7)	73	439	20min – 72 hrs	0
DDMA-Ph[5]	6	5	1	(100.0)	1	(100.0)	0	(0.0)	0	(0.0)	--	--	--	0
Other	22	6	16	(100.0)	7	(43.8)	7	(43.8)	2	(12.5)	68	174	1min – 14 hrs	1
TOTAL	**1,835**	**857**	**978**	**(100.0)**	**657**	**(67.2)**	**247**	**(25.3)**	**74**	**(7.6)**	**30**	**137**	**1min – 104 hrs**	**8**

1 Pentobarbital has been unavailable for DWDA use since 2015; secobarbital since 2019.

2 DDMA is a combination of diazepam, digoxin, morphine sulfate, and amitriptyline.

3 DDMP is a combination of diazepam, digoxin, morphine sulfate, and propranolol. DDMP-1 contains 10g of morphine sulfate; DDMP-2 contains 15g.

4 Phenobarbital is dispensed as a combination of phenobarbital, chloral hydrate, and morphine sulfate.

5 DDMA-Ph is a combination of diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital.

6 Patients who regained consciousness after ingestion are not considered DWDA deaths, and are not included in the other columns in this table.

NOTE: Table includes all reported durations, not just those from licensed providers. Complete information not available before 2001. Unknown values are excluded when calculating percentages.

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OHA 8579 (02/2021)

Report to
The Vermont Legislature

Report Concerning Patient Choice at the End of Life

In Accordance with Act 27 (2015), Section 1
An act relating to repealing the sunset on provisions pertaining to patient choice at end of life

Submitted to: **House Committees on Human Services and on Health Care; and Senate Committee on Health and Welfare.**

Submitted by: **Mark Levine, M.D., Commissioner, Vermont Department of Health**

Prepared by: **David C. Englander, Esq., Vermont Department of Health**

Report date: **January 15, 2018**

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF HEALTH

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Contents

Executive Summary

In accordance with Act 27 (2015), beginning in 2018, the Department of Health shall generate and make available to the public a biennial statistical report of the information collected by the Department, as long as releasing the information complies with the federal Health Insurance Portability and Accountability Act (HIPAA).

This report provides statistics concerning the utilization of Patient Choice at the End of Life, consistent with the HIPAA Privacy Rule that protects individually identifiable health information. Specifically, the report provides information on how many patients have met the requirements of the act, the underlying causes of death, and the number of prescriptions that have been filled by qualified patients.

Introduction

In 2013, the General Assembly passed Act 39 that allowed Vermont physicians to prescribe medication to a Vermont resident with a terminal condition with the intent that the medication be self-administered for the purpose of hastening the patient's death. Act 39 set forth conditions for the patient and the physician for this action to be taken lawfully. Those conditions include (but are not limited to) an oral and written request by the patient to the physician, a reminder that all steps in the process must be voluntary, that the patient be capable of making such a decision, confirmation of the diagnosis and prognosis by a second Vermont physician, and an attestation by a non-interested witness to these steps. See Appendix A for the complete requirement set forth in 18 V.S.A. § 5283.

Once the prescribing physician fulfills all of the statutory requirements, the physician is required to report that all such steps have been taken with the Department of Health. The filing of the report confers on health care providers associated with the treatment of the patient for this hastening of his or her death, immunity from professional, criminal, or civil liability.

In 2015, the General Assembly passed Act 27 (see Appendix B) that requires the Department of Health adopt rules to facilitate the collection of information regarding compliance. Act 27 also requires the Department to generate and make available to the public a biennial statistical report of the information collected by the Department, as long as releasing the information complies with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104 - 191.[1]

The Department subsequently adopted the Rule Governing Compliance with Patient Choice at the End of Life (see Appendix C). The rule allows the Department to collect information that includes the number of prescriptions filled under the Act by pharmacists, the number of patients who are known to have died as a direct result of ingesting the prescription, the number of patients who died as a result of causes other than ingesting the prescription, the patient's underlying terminal disease, as well as some limited demographic information. The rule also requires the prescribing physician to file a simple follow-up form to assist the Department in confirming available data.

[1] This means that this report will contain no information that could be used to potentially identify any patients or health care providers who have taken steps under the Acts.

Summary of Underlying Causes of Death

The following summary is based on cases reported to the Vermont Department of Health and met the definition of a reportable event under Act 39 between the time period of May 31, 2013 and June 30th, 2017.

General Statistics

- There were 52 total events that met the definition of Act 39 for this reporting period.
    - The underlying diagnoses fall into the following general disease groups:
        - 83% of cases are Cancer (43 total cases);
        - 14% of cases are ALS (7 total cases); and
        - 3% are other causes.
- 48 out of 52 events have a death certificate on file with the Vital Records' Office. The remaining 4 cases are assumed to still be living since all deaths are reportable to the Health Department, and any Vermont resident dying in other states is reported and recorded by the Vital Records' Office.
- 100% of the death certificates listed the appropriate cause (the underlying disease) and manner of death (natural), per Act 39 requirements. Among the 48 confirmed deaths, the mechanism was:
        - 29 utilized the patient choice prescription (60%);
        - 17 died from the underlying disease (35%);
        - 1 died from other causes (2%); and
        - 1 unknown (2%).

Number of Prescriptions Filled

The Department of Health used the Vermont Prescription Monitoring System (VPMS) to identify patients that had filled a prescription under the Act. The Department positively identified 26 out of the 48 deceased cases that filled the prescription under the Act process. An additional 7 out of the remaining 22 decedents were likely prescribed a medication to hasten their deaths under the Act. There are a variety of reasons that might account for the remainder of the prescriptions not being present in VPMS, including those that were not filled or were filled out of state.

Appendixes

Appendix A:
http://legislature.vermont.gov/assets/Documents/2014/Docs/ACTS/ACT039/ACT039%20As%20Enacted.pdf

Appendix B:
http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT027/ACT027%20As%20Enacted.pdf

Appendix C:
http://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_patient-choice-at-end-of-life-compliance.pdf

Washington State Department of Health 2009 Death with Dignity Act Report

Executive Summary

Washington's Death with Dignity Act allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have six months (180 days) or less to live. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report focuses on the 63 participants for whom medication was dispensed between March 5, 2009, when the act became law, and December 31, 2009. It includes data from the documentation received by the Department of Health as of February 3, 2010.

Medication was dispensed to 63 individuals:

- Prescriptions were written by 53 different physicians
- Prescriptions were dispensed by 29 different pharmacists

Of the 63 people to whom medication was dispensed:

- 47 individuals have died
    - 36 of these people died after ingesting the medication
    - Seven of these people died without having ingested the medication
    - For the remaining four people who died, ingestion status is unknown
- Status is unknown for the remaining 16 people

Of the 47 participants who have died, their characteristics and underlying illnesses include:

- Age range, between 48 and 95 years
- 94 percent lived west of the Cascades
- 79 percent had cancer
- 9 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS)
- 12 percent had respiratory disease or other illnesses
- 89 percent had private, Medicare or Medicaid insurance

Of the 47 participants who have died, Death Certificates were received for 41 of these individuals; their characteristics include:

- 98 percent were white, non-Hispanic
- 46 percent were married
- 61 percent had some college education

Of the 47 participants who have died, After Death Reporting Forms were received for 44 of these individuals; their end-of-life concerns include:

- All were concerned about loss of autonomy, 82 percent about loss of dignity, and 91 percent about losing the ability to participate in activities that made life enjoyable

Of the 36 participants who ingested the medication and died:

- 94 percent were at home and 72 percent were enrolled in hospice care when they ingested the medication
- Complications of ingesting the medication were reported in three individuals
- Emergency Medical Services (EMS) were not called for any intervention after ingestion of the medication; EMS was called to pronounce death for two participants

Overview of Death with Dignity Act

The Washington State Death with Dignity Act (RCW 70.245) was passed by voter initiative on November 4, 2008 and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health's Web site (www.doh.wa.gov/dwda).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the Department of Health. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of a prescription being written for medication under this act the attending physician must file the following forms with the Department of Health:

1. Written Request for Medication to End Life Form (completed by the patient)
2. Attending Physician Compliance Form (completed by the attending physician)
3. Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under RCW 70.245, no forms have to be submitted to the Department of Health.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by RCW 70.245, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington state law, a Death Certificate must be completed within 72 hours of death of an individual and filed with the local health agency where the death occurred. Local health agencies hold Death Certificates for 30 to 60 days before filing them with the state Department of Health. As a result, the state health department may receive an After Death Reporting Form before the Death Certificate is filed with the state.

Data about the Death with Dignity Participants in 2009

For the purposes of this report, a participant of the Death with Dignity Act in 2009 is defined as someone to whom medication was dispensed under the terms of the act in 2009. The Department of Health received the following documentation for 2009 Death with Dignity participants as of February 3, 2010:

Table 1. Documentation Received for 2009 Participants

Form	Number
Written Request to End Life Form	61
Attending Physician Compliance Form	61
Consulting Physician Compliance Form	61
Psychiatric/Psychological Consulting Form	3
Pharmacy Dispensing Record Form	63
After Death Reporting Form	44
Death Certificate	41

In 2009, lethal doses of medication were dispensed to 63 participants under the law. These prescriptions were written by 53 different physicians and dispensed by 29 different pharmacists.

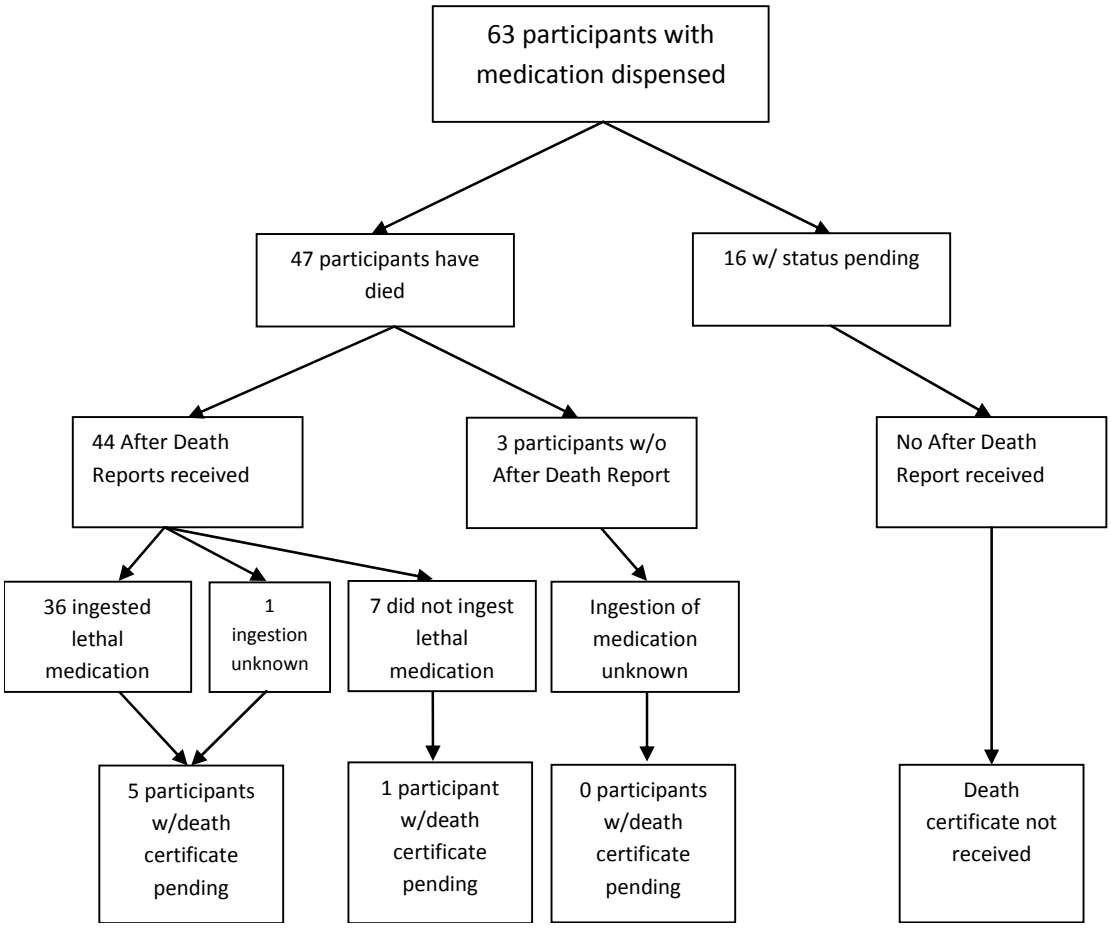
To date, the Department of Health has received fewer Written Requests and Attending and Consulting Physician Compliance Forms than Pharmacy Dispensing Records for the 2009 participants. When all the required paperwork is not received, department staff contacts health care providers to obtain the documentation.

Table 1 only includes the documentation received for individuals defined as participants (i.e., they received medication). The information posted on the Department of Health's Death with Dignity Web site about the number of forms received in 2009 includes all documentation received, including forms for people who did not go on to fill a prescription (and so are defined as non-participants). As a result, the numbers of documents listed in Table 1 do not match the numbers of documents received on the Department of Health Web site.

The Department of Health has received notification that 47 of the 63 participants have died (Figure 1). Death of a participant is established through receipt of the After Death Reporting form and/or the Death Certificate.

The status of the remaining 16 participants is unknown at this time. Some participants may still be alive since they may wait to use the medication or choose not to use it. It's also possible that some participants have taken the medication and died, but the Department of Health has not yet been notified because the After Death Reporting form is due 30 days after death and the Death Certificate is due 60 days after death.

Figure 1. Outcome of the 63 participants with medication dispensed under the terms of the Death with Dignity Act in 2009:



The data in Table 2 of this report describe the 47 participants who received medication under the terms of the Death with Dignity Act in 2009 and are known to have died.

Table 2. Characteristics of the participants of the Death with Dignity Act in 2009 who died:

	Number	%
Sex[1]		
Male	26	55
Female	21	45
Age (years)[1]		
18-34	0	0
35-44	0	0
45-54	6	13
55-64	6	13
65-74	18	38
75-84	10	21
85+	7	15
Range (min-max)	48-95	
Race and Ethnicity[2]		
Non-Hispanic White	40	98
Hispanic and/or Non-White	1	2
Marital Status[2]		
Married	19	46
Widowed	11	27
Divorced	9	22
Never married	2	5
Education[2]		
Less than high school	1	2
High school graduate	15	37
Some college	9	22
Baccalaureate or higher	16	39
Residence[1,3]		
West of the Cascades	44	94
East of the Cascades	3	6
Underlying illness[1]		
Cancer	37	79
Neuro-degenerative disease (incl. ALS[4])	4	9
Respiratory disease (incl. COPD[5])	4	9
Other illnesses	2	3
Insurance Status[6]		
Private only	12	28
Medicare or Medicaid only	19	43
Combination of private and Medicare/Medicaid	8	18
None	0	0
Unknown	5	11

Notes:

[1] Data are collected from multiple documents. At time of publication, data are available for all 47 of the participants in 2009 who died.

[2] Data are collected from the Death Certificate. At time of publication, data are available for 41 of the 47 participants in 2009 who died (see Figure 1).

[3] Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

[4] Amyotrophic Lateral Sclerosis (ALS).

[5] Chronic Obstructive Pulmonary Disease (COPD).

[6] Data are collected from the After Death Reporting form. At the time of publication, data are available for 44 of the 47 participants in 2009 who died.

Table 3. End of life concerns of the participants of the Death with Dignity Act in 2009 who died:

	Number	%
End of Life Concerns[1, 2]		
Losing autonomy	44	100
Less able to engage in activities making life enjoyable	40	91
Loss of dignity	36	82
Losing control of bodily functions	18	41
Burden on family, friends/caregivers	10	23
Inadequate pain control or concern about it	11	25
Financial implications of treatment	1	2

Notes:

[1] Data are collected from the After Death Reporting form. At the time of publication, data are available for 44 of the 47 participants in 2009 who died.

[2] Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent.

Table 4. Death with Dignity Act process for the participants in 2009 who died:

	Number	%
Family and Psychiatric/Psychological involvement		
Referred for psychiatric/psychological evaluation[1]	3	7
Patient informed family of decision[2]	40	89
Medication[3]		
Secobarbital	42	89
Pentobarbital	5	11
Other	0	0
Timing		
Duration of patient-physician relationship[4]		
3 weeks – 24 weeks	23	
25 weeks – 51 weeks	4	
1 year or more	17	
Unknown	0	
Range (min – max)	3 weeks – 27 years	
Duration between first oral request and death[5]		
3 weeks – 24 weeks	41	
25 weeks or more	3	
Unknown	0	
Range (min – max)	3 weeks – 43 weeks	

Notes:

[1] Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 45 of the 47 participants in 2009 who died.

[2] Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 45 of the 47 participants in 2009 who died.

[3] Data are collected from the Pharmacy Dispensing Form. At the time of publication, data are available for all 47 of the participants in 2009 who died.

[4] Data are collected from the After Death Reporting form. At the time of publication, data are available for 44 of the 47 participants in 2009 who died.

[5] Data are collected from multiple documents. At the time of publication, data are available for 44 of the 47 participants in 2009 who died.

Table 5. Circumstances and complications related to ingestion of the medication prescribed under the Death with Dignity Act of the participants in 2009 who died:

	Number	%
Circumstances when medication ingested		
Health-care provider present		
Prescribing physician	3	8
Other provider, prescribing physician not present	17	47
No provider	12	34
Unknown	4	11
Location of patient		
Home (patient, family, friend)	34	94
Long term care, assisted living or foster care facility	0	0
Hospital	0	0
Other	0	0
Unknown	2	6
Hospice care		
Enrolled	26	72
Not enrolled	10	28
Timing		
Minutes between ingestion and unconsciousness		
1 min. - 10 min.	27	
11 min or more	4	
Unknown	5	
Range (min – max)	1 min. – 20 min.	
Minutes between ingestion and death		
1 min - 90 min	25	
91 min or more	6	
Unknown	5	
Range (min – max)	9 min. – 28 hours	
Complications		
Regurgitation	1	3
Seizures	0	0
Awakened after taking prescribed medication	2	5
None	28	78
Unknown	5	14
Emergency Medical Services involvement		
Called for intervention after lethal medication ingested	0	0
Calls for other reason (including to pronounce death)	2	6
Not called after lethal medication ingested	31	86
Unknown	3	8

Notes:

Data are collected from the After Death Reporting form. At the time of publication, data are available for 36 participants in 2009 who are known to have ingested the medication and died.

Confidentiality

The Death with Dignity Act requires that the Washington State Department of Health collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. Consistent with that statutory mandate, the Department of Health will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

Washington State Department of Health 2010 Death with Dignity Act Report

Executive Summary

Washington's Death with Dignity Act allows adult residents in Washington State with six months (180 days) or less to live to request lethal doses of medication from physicians. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report focuses on the 87 participants for whom medication was dispensed between January 1, 2010, and December 31, 2010. It includes data from the documentation received by the Department of Health as of February 9, 2011.

In 2010, medication was dispensed to 87 individuals (defined as 2010 participants):

- Prescriptions were written by 68 different physicians
- Medications were dispensed by 40 different pharmacists

Of the 87 participants in 2010:

- 72 individuals have died
    - 51 of these people died after ingesting the medication
    - 15 of these people died without having ingested the medication
    - For the remaining 6 people who died, ingestion status is unknown
- Status is unknown for the remaining 15 people

Of the 72 participants in 2010 who have died, their characteristics and underlying illnesses include:

- Age range between 52 and 99 years
- 94 percent lived west of the Cascades
- 78 percent had cancer
- 10 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS)
- 12 percent had heart disease or other illnesses
- 88 percent had private, Medicare, Medicaid, or a combination of health insurance

Of the 72 participants in 2010 who have died, Death Certificates were received for 61 of these individuals. Their characteristics include:

- 95 percent were white, non-Hispanic
- 51 percent were married
- 62 percent had at least some college education

Of the 72 participants in 2010 who have died, After Death Reporting Forms were received for 67 of these individuals. Their end-of-life concerns include:

- 90 percent were concerned about loss of autonomy, 64 percent about loss of dignity, and 87 percent about losing the ability to participate in activities that made life enjoyable

Of the 51 participants in 2010 who ingested the medication and died:

- 90 percent were at home and 84 percent were enrolled in hospice care when they ingested the medication
- No complications of ingesting the medication were reported
- Emergency Medical Services (EMS) were not called for intervention after ingestion of the medication by any participant

Death with Dignity Participation in 2010

For the purposes of this report, a participant of the Death with Dignity Act in 2010 is defined as someone to whom medication was dispensed in 2010 under the terms of the act (see Appendix for details of the act). The Department of Health received the following documentation for 2010 Death with Dignity participants as of February 9, 2011:

Table 1. Documentation Received for 2010 Participants

Form	Number
Written Request to End Life Form	84
Attending Physician Compliance Form	83
Consulting Physician Compliance Form	84
Psychiatric/Psychological Consulting Form	3
Pharmacy Dispensing Record Form	87
After Death Reporting Form	67
Death Certificate	61

In 2010, lethal doses of medication were dispensed to 87 participants under the law. These prescriptions were written by 68 different physicians and dispensed by 40 different pharmacists.

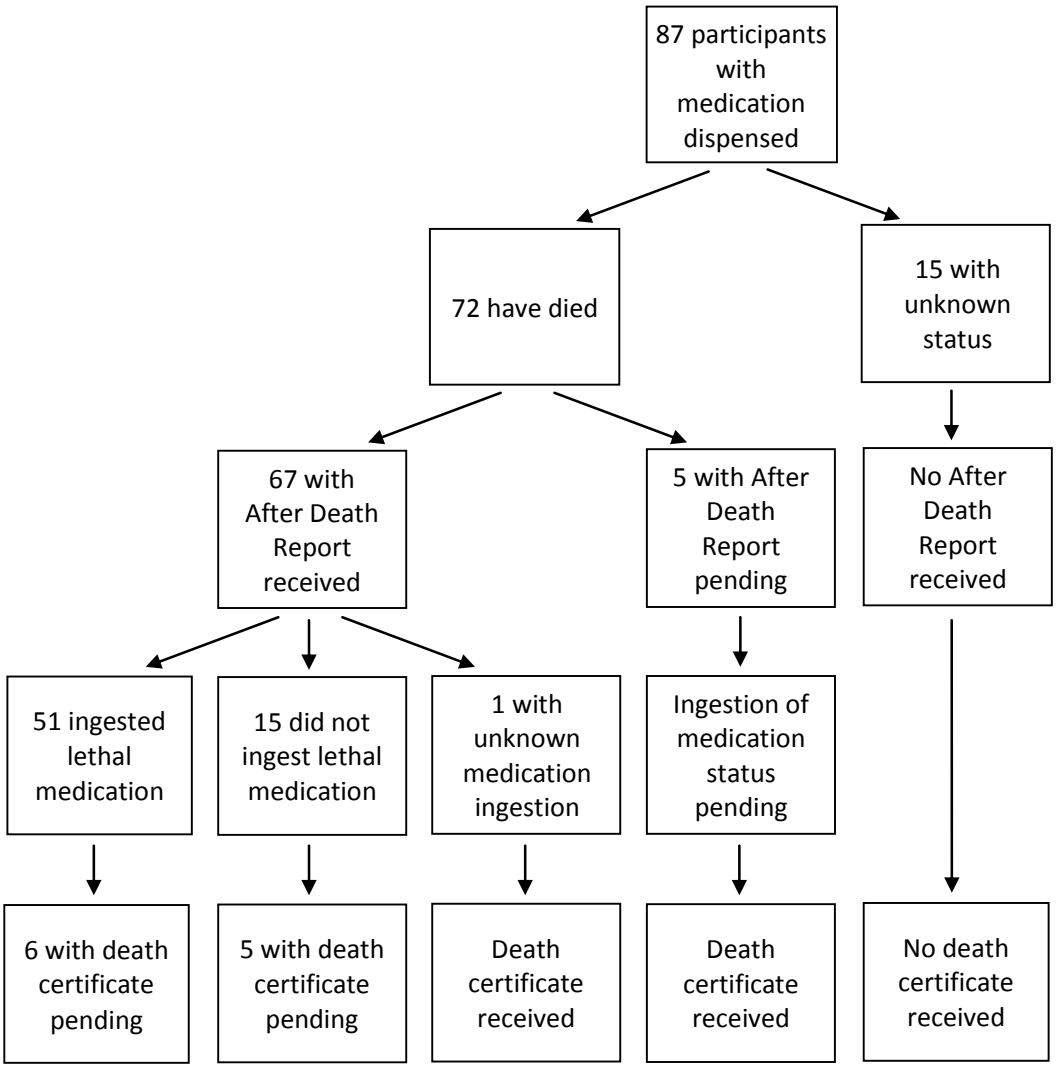
To date, the Department of Health has received fewer Written Requests and Attending and Consulting Physician Compliance Forms than Pharmacy Dispensing Records for the 2010 participants. When all the required paperwork is not received, department staff contacts health care providers to obtain the documentation.

Table 1 only includes the documentation received for individuals defined as participants (i.e., they received medication). The information posted on the Department of Health's Death with Dignity website about the number of forms received in 2010 provides all documentation received, including forms for people who did not have a prescription filled (and so are defined as non-participants), forms for 2009 participants who died in 2010, and some forms for 2011 participants. As a result, the numbers of documents listed in Table 1 do not match the numbers of documents received on the Department of Health website.

The Department of Health has received notification that 72 of the 87 participants in 2010 have died (Figure 1). Death of a participant is established through receipt of the After Death Reporting form and/or the Death Certificate.

The status of the remaining 15 participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the Department of Health because the After Death Reporting form is due 30 days after death and the Death Certificate is due 60 days after death.

Figure 1. Outcome of the 87 participants with medication dispensed in 2010 under the terms of the Death with Dignity Act



Update on Death with Dignity Participation in 2009

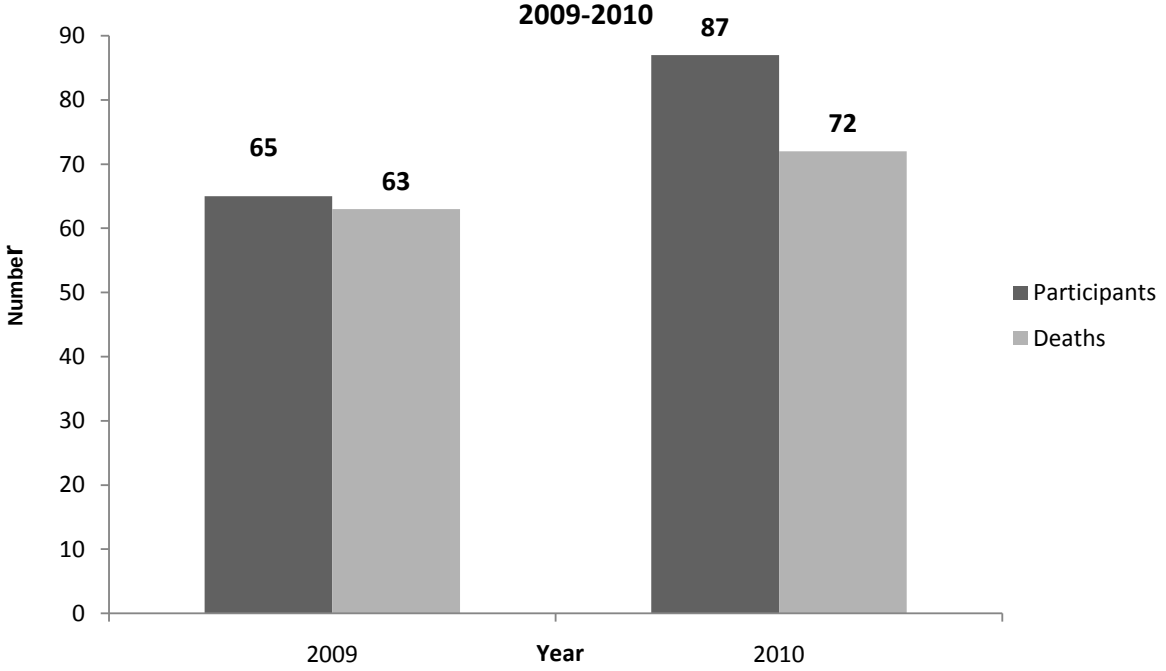
Since the 2009 Death with Dignity report was published on March 4, 2010, the Department of Health received information on two additional people to whom medication was dispensed under the terms of the Act in 2009. This brings the total number of participants in 2009 to 65.

Of these participants, 63 had died as of February 9, 2011. The status of two 2009 participants is still pending. These participants may still be alive or they may have died, but the Department of Health has not yet received documentation of the death.

Trend in Death with Dignity Participation

Data on the number of participants in 2009 and 2010, and the number of these participants who are known to have died as of February 9, 2011, are shown in Figure 2. It is difficult to say if there has been an increase in the number of participants between 2009 and 2010. The Death with Dignity law went into effect on March 5, 2009, so the data for 2009 cover less than 10 months. The data for 2010 reflect a full 12 months. And 2009 was the first year a lethal dose of medication could be prescribed under the Death with Dignity Act, so the procedures were new to the public, physicians, and pharmacists.

Figure 2: Number of Death with Dignity Participants and Deaths for 2009-2010



The data in the remainder of this report describing the participants in 2009 reflects the data published on March 4, 2010.

Table 2. Characteristics of the participants of the Death with Dignity Act who have died:

	2010		2009[1]	
	Number	**(%)**	**Number**	**(%)**
Sex[2]				
Male	36	50	26	55
Female	36	50	21	45
Age (years)[2]				
18-34	0		0	0
35-44	0		0	0
45-54	4	5	6	13
55-64	17	24	6	13
65-74	22	31	18	38
75-84	18	25	10	21
85+	11	15	7	15
Range (min-max)	52-99		48-95	
Race and Ethnicity[3]				
Non-Hispanic White	58	95	40	98
Hispanic and/or Non-White	3	5	1	2
Marital Status[3]				
Married	31	51	19	46
Widowed	17	28	11	27
Divorced	9	15	9	22
Never married	4	6	2	5
Education[3]				
Less than high school	6	10	1	2
High school graduate	17	28	15	37
Some college	11	18	9	22
Baccalaureate or higher	27	44	16	39
Residence[2,4]				
West of the Cascades	68	94	44	94
East of the Cascades	4	6	3	6
Underlying illness[2]				
Cancer	56	78	37	79
Neuro-degenerative disease (incl. ALS[5])	7	10	4	9
Respiratory disease (incl. COPD[6])	1	1	4	9
Heart Disease	6	8	0	0
Other illnesses	2	3	2	3
Insurance Status[7]				
Private only	20	30	12	28
Medicare or Medicaid only	29	43	19	43
Combination of private and Medicare/Medicaid	10	15	8	18
None	2	3	0	0
Unknown	6	9	5	11

*Note: The totals for some categories are less than the number of participants who have died. This is because the data are collected from different forms and not all forms were received for all participants by the time of this report. The footnotes on the following page provide additional explanation.

Notes:

[1] Data published in 2009 report http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf

[2] Data are collected from multiple documents. At time of publication, data are available for all 72 of the participants in 2010 who died.

[3]Data are collected from the Death Certificate. At time of publication, data are available for 61 of the 72 participants in 2010 who died (see Figure 1).

[4] Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

[5] Amyotrophic Lateral Sclerosis (ALS).

[6] Chronic Obstructive Pulmonary Disease (COPD).

[7]Data are collected from the After Death Reporting form. At the time of publication, data are available for 67 of the 72 participants in 2010 who died.

Table 3. End of life concerns of the participants of the Death with Dignity Act in 2010 who have died:

	2010		2009[1]	
	Number	**(%)**	**Number**	**(%)**
End of Life Concerns[2, 3]				
Losing autonomy	60	90	44	100
Less able to engage in activities making life enjoyable	58	87	40	91
Loss of dignity	43	64	36	82
Losing control of bodily functions	35	52	18	41
Burden on family, friends/caregivers	19	28	10	23
Inadequate pain control or concern about it	24	36	11	25
Financial implications of treatment	3	4	1	2

Notes:

[1] Data published in 2009 report http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 67 of the 72 participants in 2010 who died.

[3]Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent.

Table 4. Death with Dignity Act process for the participants in 2010 who have died:

	2010		2009[1]	
	Number	**(%)**	**Number**	**(%)**
Family and Psychiatric/Psychological involvement				
Referred for psychiatric/psychological evaluation[2]	2	3	3	7
Patient informed family of decision[3]	61	85	40	89
Medication[4]				
Secobarbital	68	95	42	89
Pentobarbital	3	4	5	11
Other	1	1	0	0
Timing				
Duration of patient-physician relationship[5]				
3 weeks – 24 weeks	34	51	23	52
25 weeks – 51 weeks	8	12	4	9
1 year or more	24	36	17	39
Unknown	1	1	0	0
Range (min – max)	3 wks – 10 yrs		3 wks – 27 yrs	
Duration between first oral request and death[6]				
3 weeks – 24 weeks	61	91	41	93
25 weeks or more	5	7	3	7
Unknown	1	2	0	0
Range (min – max)	3 wks – 54 wks		3 wks – 43 wks	

Notes:

[1] Data published in 2009 report http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf

[2] Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 71 of the 72 participants in 2010 who died.

[3] Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 72 of the 72 participants in 2010 who died.

[4] Data are collected from the Pharmacy Dispensing Form. At the time of publication, data are available for all 72 of the participants in 2010 who died.

[5] Data are collected from the After Death Reporting form. At the time of publication, data are available for 67of the 72 participants in 2010 who died.

[6] Data are collected from multiple documents. At the time of publication, data are available for 71 of the 72 participants in 2010 who died.

Table 5. Circumstances and complications related to ingestion of medication prescribed under the Death with Dignity Act of the participants who have died:

	2010		2009[1]	
	Number	**(%)**	**Number**	**(%)**
Circumstances when medication ingested				
Health-care provider present				
Prescribing physician	2	4	3	8
Other provider, prescribing physician not present	27	53	17	47
No provider	17	33	12	34
Unknown	5	10	4	11
Location of patient				
Home (patient, family, friend)	46	90	34	94
Long term care, assisted living or foster care facility	2	4	0	0
Hospital	0	0	0	0
Other	3	6	0	0
Unknown	0	0	2	6
Hospice care				
Enrolled	43	84	26	72
Not enrolled	5	10	10	28
Unknown	3	6	0	0
Timing				
Minutes between ingestion and unconsciousness				
1 min. - 10 min.	34	67	27	75
11 min or more	5	10	4	11
Unknown	12	23	5	14
Range (min – max)	1 min - 30 min		1 min – 20 min	
Minutes between ingestion and death				
1 min - 90 min	36	71	25	70
91 min or more	8	15	6	16
Unknown	7	14	5	14
Range (min – max)	9 min – 30 hrs		9 min – 28 hrs	
Complications				
Regurgitation	0	0	1	3
Seizures	0	0	0	0
Awakened after taking prescribed medication	0	0	2	5
None	47	92	28	78
Unknown	4	8	5	14
Emergency Medical Services involvement				
Called for intervention after lethal medication ingested	0	0	0	0
Calls for other reason (including to pronounce death)	0	0	2	6
Not called after lethal medication ingested	47	92	31	86
Unknown	4	8	3	8

Notes: [1]Data published in 2009 report http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf

Data are collected from the After Death Reporting form. At the time of publication, data are available for 51 participants in 2010 who are known to have ingested the medication and died.

Confidentiality

The Death with Dignity Act requires that the Washington State Department of Health collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the Department of Health will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

Appendix

Overview of Death with Dignity Act

The Washington State Death with Dignity Act (RCW 70.245) was passed by voter initiative on November 4, 2008 and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health's website (www.doh.wa.gov/dwda).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the Department of Health. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of a prescription being written for medication under this act the attending physician must file the following forms with the Department of Health:

1. Written Request for Medication to End Life Form (completed by the patient)
2. Attending Physician Compliance Form (completed by the attending physician)
3. Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under RCW 70.245, no forms have to be submitted to the Department of Health.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by RCW 70.245, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington law, a Death Certificate must be completed within 72 hours of death of an individual and filed with the local health agency where the death occurred. Local health agencies hold Death Certificates for 30 to 60 days before filing them with the state Department of Health. As a result, the state health department may receive an After Death Reporting Form before the Death Certificate is filed with the state.

Washington State Department of Health 2011 Death with Dignity Act Report

Executive Summary

Washington's Death with Dignity Act allows adult residents in the state with six months (180 days) or less to live to request lethal doses of medication from physicians. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report focuses on the 103 participants for whom medication was dispensed between January 1, 2011 and December 31, 2011. It includes data from the documentation received by the Department of Health as of February 29, 2012.

In 2011, medication was dispensed to 103 individuals (defined as 2011 participants):

- Prescriptions were written by 80 different physicians
- Medications were dispensed by 46 different pharmacists

Of the 103 participants in 2011:

- 94 individuals have died
    - 70 of these people died after ingesting the medication
    - 19 of these people died without having ingested the medication
    - For the remaining 5 people who died, ingestion status is unknown
- For the remaining 9 people, no documentation has been received that indicates death has occurred

Of the 94 participants in 2011 who died, their characteristics and underlying illnesses include:

- Age range between 41 and 101 years
- 95 percent lived west of the Cascades
- 94 percent were white, non-Hispanic
- 46 percent were married
- 75 percent had at least some college education
- 78 percent had cancer
- 12 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS)
- 10 percent had other illnesses, including heart and respiratory diseases
- 87 percent had private, Medicare, Medicaid, or a combination of health insurance

Of the 94 participants in 2011 who died, their end-of-life concerns include:

- Loss of autonomy, 87 percent
- Loss of dignity, 79 percent
- Loss of the ability to participate in activities that make life enjoyable, 89 percent

Of the 70 participants in 2011 who ingested the medication and died:

- 93 percent were at home
- 83 percent were enrolled in hospice care when they ingested the medication

Death with Dignity Participation in 2011

For the purposes of this report, a participant of the Death with Dignity Act in 2011 is defined as someone to whom medication was dispensed in 2011 under the terms of the act. Details of the act are included in the appendix. The Department of Health received the following documentation for 2011 Death with Dignity participants as of February 29, 2012:

Table 1. Documentation Received for 2011 Participants

Form	Number
Written Request to End Life Form	101
Attending Physician Compliance Form	102
Consulting Physician Compliance Form	100
Psychiatric/Psychological Consulting Form	5
Pharmacy Dispensing Record Form	103
After Death Reporting Form	91
Death Certificate	87

In 2011, lethal doses of medication were dispensed to 103 participants under the law. These prescriptions were written by 80 different physicians and dispensed by 46 different pharmacists.

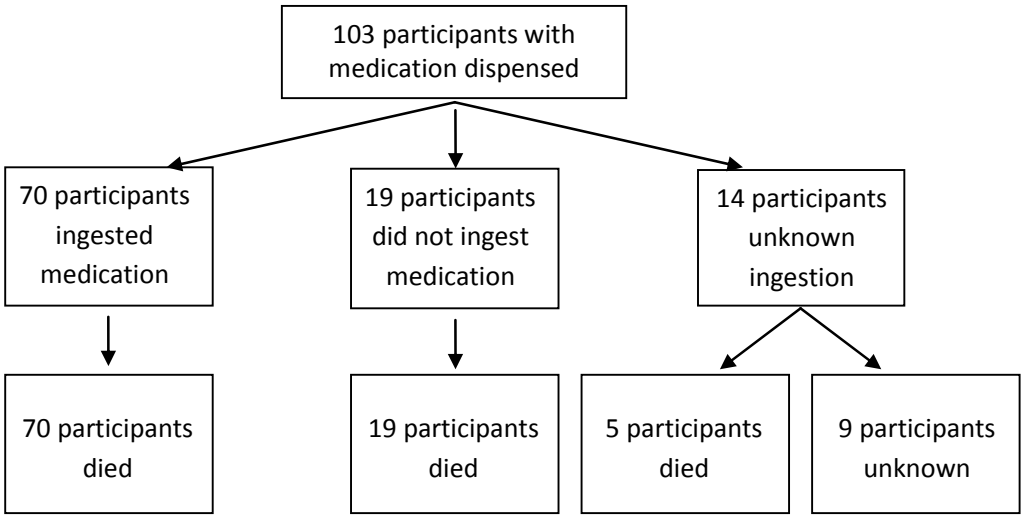
To date, the Department of Health has received fewer Written Request Forms, Attending Physician Compliance Forms, and Consulting Physician Compliance Forms than Pharmacy Dispensing Records for the 2011 participants. When all the required paperwork is not received, agency staff contacts health care providers to obtain the documentation.

Table 1 only includes the documentation received for individuals defined as participants (people who received medication). The information posted on the Department of Health's Death with Dignity website about the number of forms received in 2011 provides all documentation received, including forms for people who did not have a prescription filled (and so are defined as non-participants), forms for 2010 participants who died in 2011, and some forms for 2012 participants. As a result, the numbers of documents listed in Table 1 do not match the numbers of documents received on the Department of Health website.

Among the 103 participants who received medication in 2011, 70 ingested the medication, 19 did not ingest, and the ingestion status is unknown for 14 (Figure 1). The Department of Health has received notification that 94 of the 103 participants in 2011 have died. Death of a participant is established through receipt of the After Death Reporting form and/or the Death Certificate.

The status of the remaining nine participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the Department of Health because the After Death Reporting form is due 30 days after death and the Death Certificate is due 60 days after death.

Figure 1. Outcome of the 103 participants who received medication in 2011 under the terms of the Death with Dignity Act



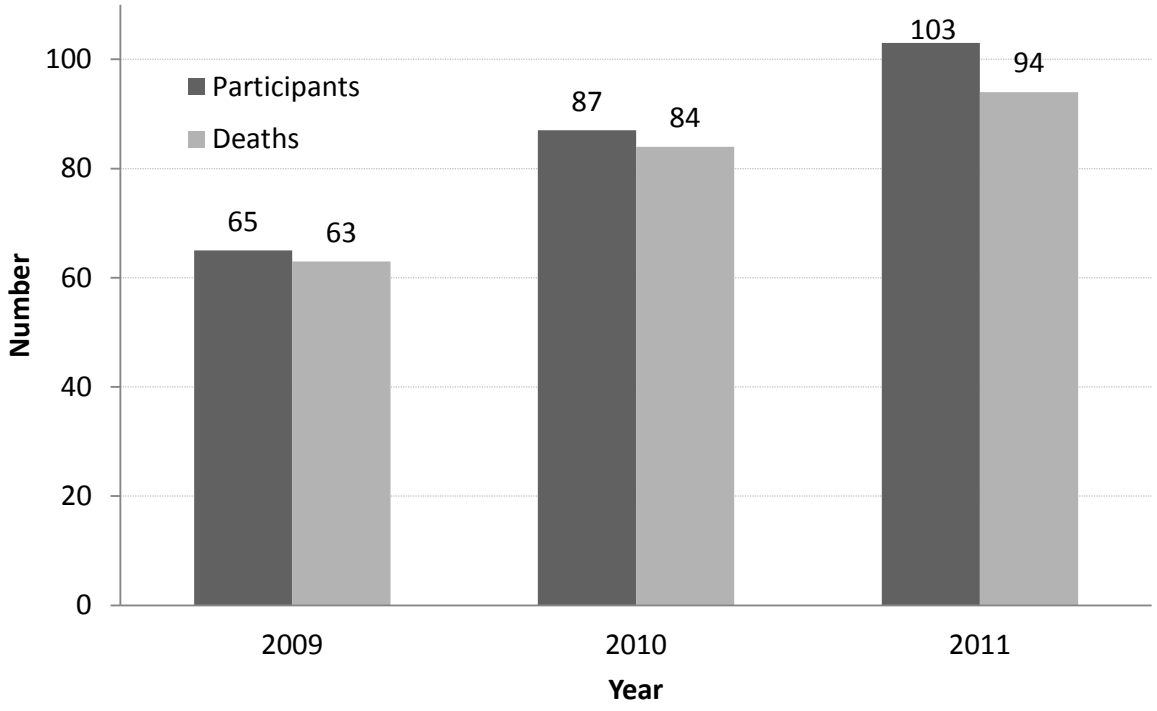
Update on Death with Dignity Participation 2009-2011

Since the last Death with Dignity report was published on March 10, 2011, the Department of Health received additional information on participants from prior years. As of February 29, 2012, 84 of the 87 participants in 2010, and 63 of the 65 participants in 2009 had died. The status of the three remaining participants in 2010 and two remaining participants in 2009 is still pending. These participants may have died, but the Department of Health has not received documentation of the death.

Trend in Death with Dignity Participation

Data on the number of participants in 2009, 2010, and 2011, and the number of these participants who are known to have died as of February 29, 2012, are shown in Figure 2.

Figure 2. Number of Death with Dignity Participants and Known Deaths, 2009-2011



The data in the remainder of this report describing the participants in 2009 and 2010 reflects the data published in the 2009 and 2010 Death with Dignity Reports, respectively.

Table 2. Characteristics of the participants of the Death with Dignity Act who have died:

	2011		2010[2]		2009[1]	
	Number	**(%)**	**Number**	**(%)**	**Number**	**(%)**
Sex[3]						
Male	49	52	36	50	26	55
Female	45	48	36	50	21	45
Age (years)[3]						
18-34	0	0	0		0	0
35-44	3	3	0		0	0
45-54	9	10	4	5	6	13
55-64	22	23	17	24	6	13
65-74	27	29	22	31	18	38
75-84	19	20	18	25	10	21
85+	14	15	11	15	7	15
Range (min-max)	41-101		52-99		48-95	
Race and Ethnicity[4]						
Non-Hispanic White	82	94	58	95	40	98
Hispanic and/or Non-White	5	6	3	5	1	2
Marital Status[4]						
Married	40	46	31	51	19	46
Widowed	13	15	17	28	11	27
Divorced	24	28	9	15	9	22
Never married	10	11	4	6	2	5
Education[4]						
Less than high school	4	5	6	10	1	2
High school graduate	17	20	17	28	15	37
Some college	24	28	11	18	9	22
Baccalaureate or higher	41	46	27	44	16	39
Unknown	1	1	0	0	0	0
Residence[3,5]						
West of the Cascades	89	95	68	94	44	94
East of the Cascades	5	5	4	6	3	6
Underlying illness[3]						
Cancer	73	78	56	78	37	79
Neuro-degenerative disease (incl. ALS[6])	11	12	7	10	4	9
Respiratory disease (incl. COPD[7])	4	4	1	1	4	9
Heart Disease	4	4	6	8	0	0
Other illnesses	2	2	2	3	2	3
Insurance Status[8]						
Private only	31	34	20	30	12	28
Medicare or Medicaid only	36	40	29	43	19	43
Combination of private and Medicare/Medicaid	12	13	10	15	8	18
None	3	3	2	3	0	0
Unknown	9	10	6	9	5	11

*Note: The totals for some categories are less than the number of participants who have died. This is because the data are collected from different forms and not all forms were received for all participants by the time of this report. The footnotes on the following page provide additional explanation.

Notes:

[1] Data published in 2009 report http://www.doh.wa.gov/dwda/

[2] Data published in 2010 report http://www.doh.wa.gov/dwda/

[3] Data are collected from multiple documents. At time of publication, data are available for all 94 of the participants in 2011 who died.

[4] Data are collected from the Death Certificate. At time of publication, data are available for 87 of the 94 participants in 2011 who died.

[5] Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

[6] Amyotrophic Lateral Sclerosis (ALS).

[7] Chronic Obstructive Pulmonary Disease (COPD).

[8] Data are collected from the After Death Reporting form. At the time of publication, data are available for 91 of the 94 participants in 2011who died.

Table 3. End of life concerns of participants of the Death with Dignity Act who have died:

	2011		2010[2]		2009[1]	
	Number	**(%)**	**Number**	**(%)**	**Number**	**(%)**
End of Life Concerns[3,4]						
Losing autonomy	79	87	60	90	44	100
Less able to engage in activities making life enjoyable	81	89	58	87	40	91
Loss of dignity	72	79	43	64	36	82
Losing control of bodily functions	52	57	35	52	18	41
Burden on family, friends/caregivers	49	54	19	28	10	23
Inadequate pain control or concern about it	35	38	24	36	11	25
Financial implications of treatment	4	4	3	4	1	2

Notes:

[1] Data published in 2009 report http://www.doh.wa.gov/dwda/

[2] Data published in 2010 report http://www.doh.wa.gov/dwda/

[3] Data are collected from the After Death Reporting form. At the time of publication, data are available for 91 of the 94 participants in 2011 who died.

[4] Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent.

Table 4. Death with Dignity Act process for the participants who have died:

	2011		2010[2]		2009[1]	
	Number	**(%)**	**Number**	**(%)**	**Number**	**(%)**
Family and Psychiatric/Psychological involvement						
Referred for psychiatric/psychological evaluation[3]	5	5	2	3	3	7
Patient informed family of decision[4]	88	96	61	85	40	89
Medication[5]						
Secobarbital	66	70	68	95	42	89
Pentobarbital	28	30	3	4	5	11
Other	0	0	1	1	0	0
Timing						
Duration of patient-physician relationship[6]						
3 weeks – 24 weeks	43	47	34	51	23	52
25 weeks – 51 weeks	11	12	8	12	4	9
1 year or more	36	40	24	36	17	39
Unknown	1	1	1	1	0	0
Range (min – max)	3 wks – 18 yrs		3 wks – 10 yrs		3 wks – 27 yrs	
Duration between first oral request and death[7]						
3 weeks – 24 weeks	87	95	61	91	41	93
25 weeks or more	5	5	5	7	3	7
Unknown	0		1	2	0	0
Range (min – max)	3 wks – 53 wks		3 wks – 54 wks		3 wks – 43 wks	

Notes:

[1] Data published in 2009 report http://www.doh.wa.gov/dwda/

[2] Data published in 2010 report http://www.doh.wa.gov/dwda/

[3] Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 93 of the 94 participants in 2011 who died.

[4] Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 92 of the 94 participants in 2011 who died.

[5] Data are collected from the Pharmacy Dispensing Form. At the time of publication, data are available for all 94 of the participants in 2011 who died.

[6] Data are collected from the After Death Reporting form. At the time of publication, data are available for 91of the 94 participants in 2011 who died.

[7] Data are collected from multiple documents. At the time of publication, data are available for 92 of the 94 participants in 2011who died.

Table 5. Circumstances and complications related to ingestion of medication prescribed under the Death with Dignity Act of the participants who have died:

	2011		2010[2]		2009[1]	
	Number	**(%)**	**Number**	**(%)**	**Number**	**(%)**
Circumstances when medication ingested[3]						
Health-care provider present						
Prescribing physician	2	3	2	4	3	8
Other provider, prescribing physician not present	36	51	27	53	17	47
No provider	23	33	17	33	12	34
Unknown	9	13	5	10	4	11
Location of patient						
Home (patient, family, friend)	65	93	46	90	34	94
Long term care, assisted living or foster care facility	4	6	2	4	0	0
Hospital	0	0	0	0	0	0
Other	1	1	3	6	0	0
Unknown	0	0	0	0	2	6
Hospice care						
Enrolled	58	83	43	84	26	72
Not enrolled	11	16	5	10	10	28
Unknown	1	1	3	6	0	0
Timing[3]						
Minutes between ingestion and unconsciousness						
1 min – 10 min	44	63	34	67	27	75
11 min or more	7	10	5	10	4	11
Unknown	19	27	12	23	5	14
Range (min – max)	1 min – 120 min		1 min – 3 min		1 min – 20 min	
Minutes between ingestion and death						
1 min – 90 min	40	57	36	71	25	70
91 min or more	14	20	8	15	6	16
Unknown	16	23	7	14	5	14
Range (min – max)	5 min – 13 hrs		9 min – 30 hrs		9 min – 28 hrs	
Complications[3]						
Regurgitation	1	1	0	0	1	3
Seizures	0	0	0	0	0	0
Awakened after taking prescribed medication	0	0	0	0	2	5
None	64	92	47	92	28	78
Unknown	5	7	4	8	5	14
Emergency Medical Services involvement[3]						
Called for intervention after lethal medication ingested	0	0	0	0	0	0
Calls for other reason (including to pronounce death)	1	1	0	0	2	6
Not called after lethal medication ingested	66	94	47	92	31	86
Unknown	3	5	4	8	3	8

Notes:

[1] Data published in 2009 report http://www.doh.wa.gov/dwda/

[2] Data published in 2010 report http://www.doh.wa.gov/dwda/

[3] Data are collected from the After Death Reporting form. At the time of publication, data are available for 70 participants in 2011 who are known to have ingested the medication and died.

Confidentiality

The Death with Dignity Act requires that the Washington State Department of Health collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the Department of Health will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

Appendix

Overview of Death with Dignity Act

The Washington State Death with Dignity Act (RCW 70.245) was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health's website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the Department of Health. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the Department of Health:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under RCW 70.245, no forms have to be submitted to the Department of Health.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by RCW 70.245, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington law, a death certificate must be completed within 72 hours of death and filed with the local health agency where the death occurred. Local health officials may hold death certificates for 30 to 60 days before filing them with the state Department of Health. As a result, the state health department may receive an After Death Reporting Form before the death certificate arrives.

DOH 422-109

Washington State Department of Health 2012 Death with Dignity Act Report

Executive Summary

Washington's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from physicians. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report describes available information for the 121 participants for whom medication was dispensed between January 1, 2012 and December 31, 2012. It includes data from the documentation received by the Department of Health as of February 28, 2013.

In 2012, medication was dispensed to 121 individuals (defined as 2012 participants):

- Prescriptions were written by 87 different physicians
- Medications were dispensed by 30 different pharmacists

Of the 121 participants in 2012:

- 104 are known to have died
  - 83 died after ingesting the medication
  - 18 died without having ingested the medication
  - For the remaining 3 people who died, ingestion status is unknown
- For the remaining 17 people, no documentation has been received that indicates death has occurred

The 104 participants in 2012 ranged in age from 35 to 95 years old. Ninety percent lived west of the Cascades. Of the 104 participants in 2012 who died:

- 73 percent had cancer
- 10 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS)
- 17 percent had other illnesses, including heart and respiratory disease

Of the 89 participants in 2012 who died and for whom we have received a death certificate:

- 97 percent were white, non-Hispanic
- 43 percent were married
- 82 percent had at least some college education

Of the 101 participants in 2012 who died and for whom we have received an After Death Report:

- 89 percent had private, Medicare, Medicaid, or a combination of health insurance
- 94 percent reported to their health care provider concerns about loss of autonomy
- 84 percent reported to their health care provider concerns about loss of dignity
- 90 percent reported to their health care provider concerns about loss of the ability to participate in activities that make life enjoyable

Of the 83 participants in 2012 who died after ingesting the medication:

- 89 percent were at home at the time of death
- 92 percent were enrolled in hospice care when they ingested the medication

Death with Dignity Participation in 2012
For the purposes of this report, a participant of the Death with Dignity Act in 2012 is defined as someone to whom medication was dispensed in 2012 under the terms of the act. Details of the act are included in the appendix.

To date, the department has received documentation indicating that lethal doses of medication were dispensed to 121 participants under the law in 2012. These prescriptions were written by 87 different physicians and dispensed by 30 different pharmacists. The department has not yet received all of the required paperwork for all 121 participants. When all the required paperwork is not received, the department contacts health care providers to obtain the documentation.

The Department of Health received the following documentation for 2012 Death with Dignity participants as of February 28, 2013:

Table 1. Documentation Received for 2012 Participants

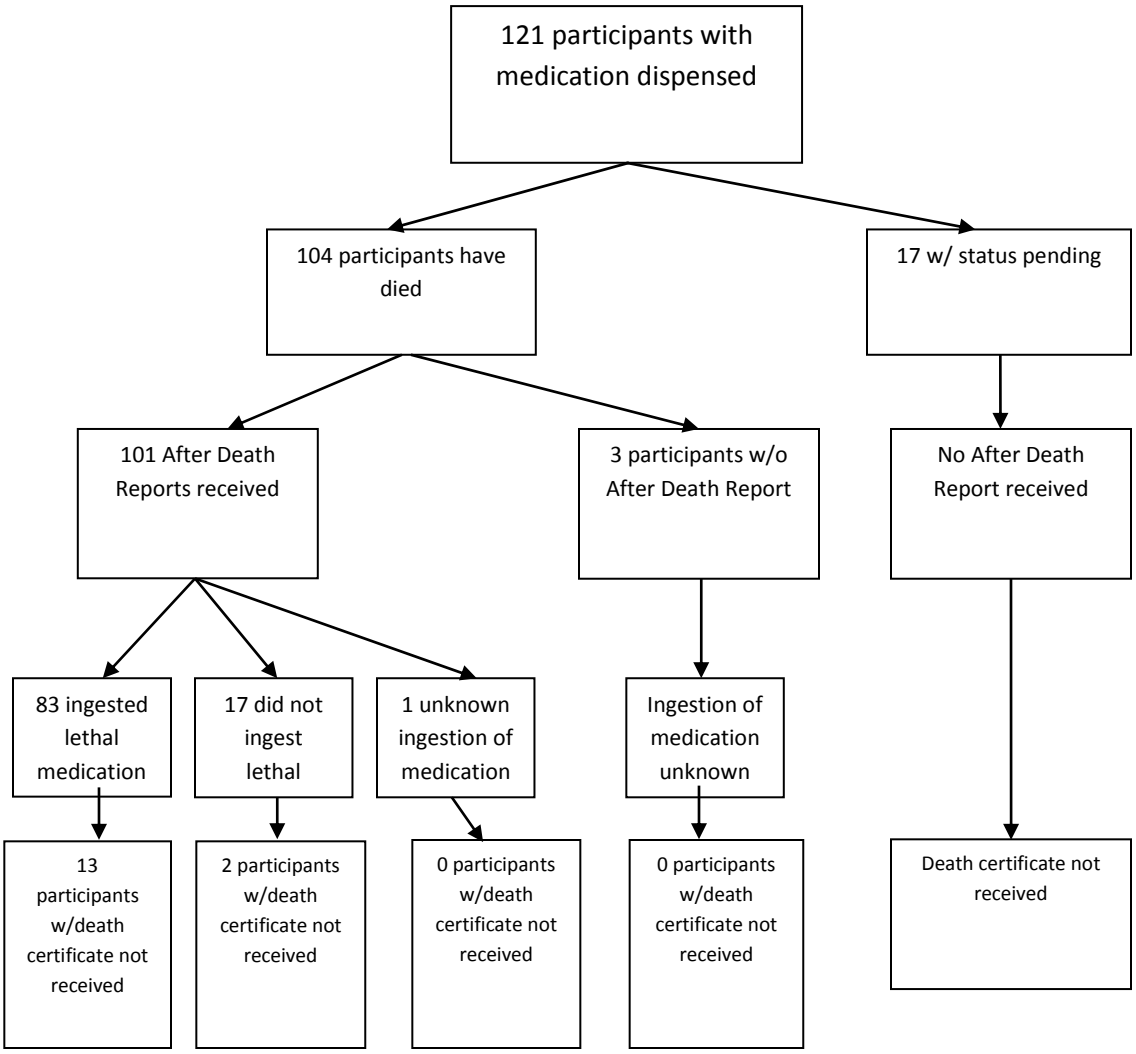
Form	Number
Written Request to End Life Form	111
Attending Physician Compliance Form	112
Consulting Physician Compliance Form	110
Psychiatric/Psychological Consulting Form	3
Pharmacy Dispensing Record Form	117
After Death Reporting Form	101
Death Certificate	89

Table 1 includes the documentation received for individuals defined as participants (people who received medication). The department's Death with Dignity website reports the total number of forms received in 2012, including forms for people who did not have a prescription filled (non-participants), forms for 2011 participants who died in 2012, and some forms for 2013 participants. As a result, the numbers of documents listed in Table 1 do not match the numbers of documents received on the Department of Health website.

Among the 121 participants who received medication in 2012, 83 ingested the medication, 17 did not ingest, and the ingestion status is unknown for 4 (Figure 1). The Department of Health has received notification that 104 of the 121 participants in 2012 have died. Death of a participant is established through receipt of the After Death Reporting form and/or the Death Certificate.

The status of the remaining 17 participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the Department of Health because the After Death Reporting form is due 30 days after death and the Death Certificate is due 60 days after death.

Figure 1. Outcome of the 121 participants who received medication in 2012 under the terms of the Death with Dignity Act



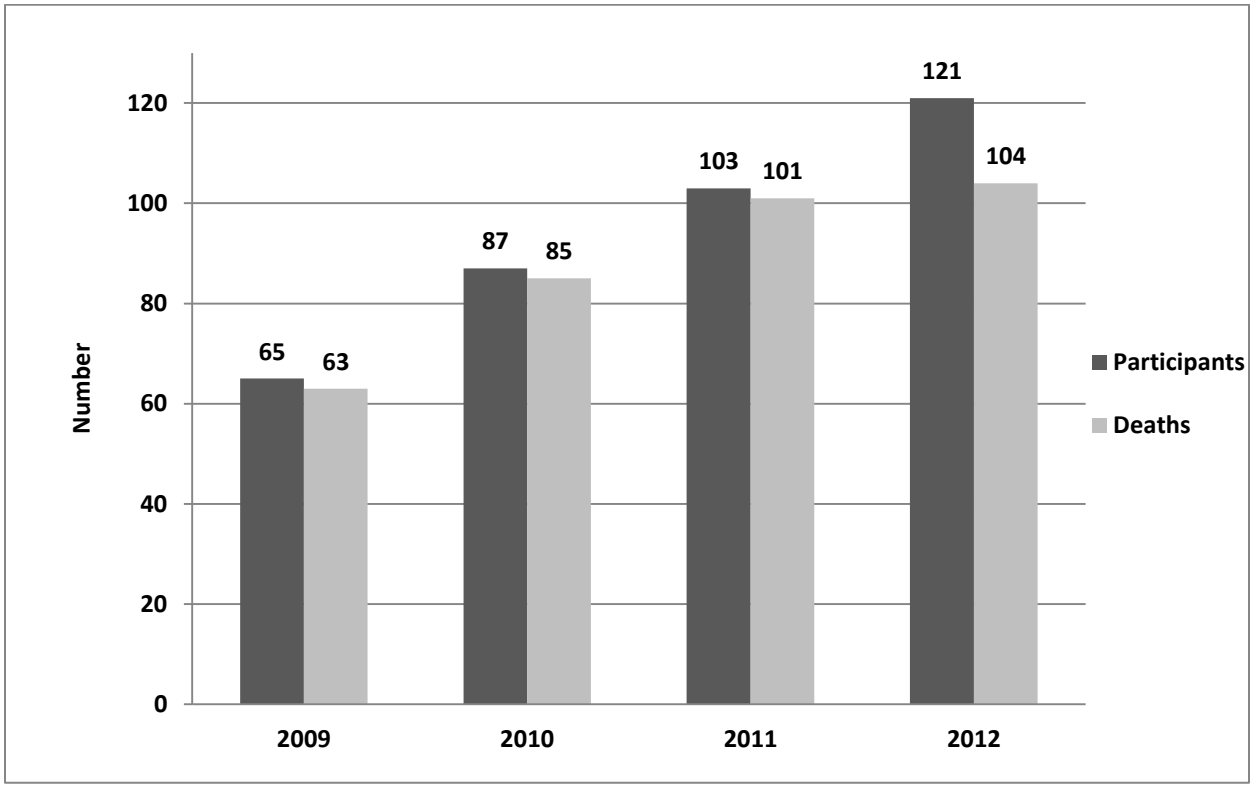
Update on Death with Dignity Participation 2009-2012

Since the last Death with Dignity report was published on May 2, 2012 the Department of Health received additional information on participants from prior years. As of February 28, 2013, 101 of the 103 participants in 2011, 85 of the 87 participants in 2010, and 63 of the 65 participants in 2009 had died. The status of the 2 remaining participants in 2011, the 2 remaining participants in 2010, and the 2 remaining participants in 2009 is still unknown. These participants may have died, but the Department of Health has not received documentation of the death.

Trend in Death with Dignity Participation

The number of participants in 2009, 2010, 2011 and 2012, and the number of these participants who are known to have died as of February 28, 2013, are shown in Figure 2.

Figure 2. Number of Death with Dignity Participants and Known Deaths, 2009-2012



The data in the remainder of this report describing the participants in 2011 reflects the data published in the 2011 Death with Dignity Report. Information on data published in 2009 and 2010 can be found on the Department of Health website.

Table 2. Characteristics of the participants of the Death with Dignity Act who have died

	2012		2011[1]	
	Number	**(%)**	**Number**	**(%)**
Sex[2]				
Male	45	43	49	52
Female	44	42	45	48
Unknown (Death certificate not received)	15	15		
Age (years)[2]				
18-44	1	1	3	3
45-54	3	2	9	10
55-64	31	30	22	23
65-74	35	33	27	29
75-84	24	23	19	20
85+	10	10	14	15
Range (min-max)	35-95		41-101	
Race and Ethnicity[3]				
Non-Hispanic White	86	83	82	94
Hispanic and/or Non-White	3	3	5	6
Unknown **(**Death certificate not received)	15	14		
Marital Status[3]				
Married	38	37	40	46
Widowed	12	12	13	15
Divorced	28	27	24	28
Domestic Partner	3	3		
Never married	8	8	10	11
Unknown (Death certificate not received)	15	13		
Education[3]				
Less than high school	2	2	4	5
High school graduate	13	13	17	20
Some college	23	22	24	28
Baccalaureate or higher	50	48	41	46
Missing	1	1	1	1
Unknown (Death certificate not received)	15	14		
Residence[2,4]				
West of the Cascades	94	90	89	95
East of the Cascades	10	10	5	5
Underlying illness[4]				
Cancer	76	73	73	78
Neuro-degenerative disease (incl. ALS[5])	10	10	11	12
Respiratory disease (incl. COPD[6])	10	10	4	4
Heart Disease	5	4	4	4
Other illnesses	3	3	2	2
Insurance Status[7]				
Private only	22	22	31	34
Medicare or Medicaid only	55	55	36	40
Combination of private and Medicare/Medicaid	12	12	12	13
None	0	0	3	3
Unknown	11	11	9	10

Notes:

[1] Data published in 2011 report http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx

[2] Data are collected from multiple documents. At time of publication, data are available for all 104 of the participants in 2012 who died.

[3] Data are collected from the Death Certificate. At time of publication, data are available for 89 of the 104 participants in 2012 who died.

[4] Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

[5] Amyotrophic Lateral Sclerosis (ALS).

[6] Chronic Obstructive Pulmonary Disease (COPD).

[7] Data are collected from the After Death Reporting form. At the time of publication, data are available for 101 of the 104 participants in 2012 who died.

Table 3. End of life concerns of participants of the Death with Dignity Act who have died:

	2012		2011[1]	
	Number	**(%)**	**Number**	**(%)**
End of Life Concerns[2,3]				
Losing autonomy	94	94	79	87
Less able to engage in activities making life enjoyable	90	90	81	89
Loss of dignity	84	84	72	79
Losing control of bodily functions	56	56	52	57
Burden on family, friends/caregivers	63	63	49	54
Inadequate pain control or concern about it	33	33	35	38
Financial implications of treatment	5	5	4	4

Notes:

[1] Data published in 2011 report http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 101 of the 104 participants in 2012 who died.

[3] Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent.

Table 4. Death with Dignity Act process for the participants who have died:

	2012		2011[1]	
	Number	**(%)**	**Number**	**(%)**
Family and Psychiatric/Psychological involvement				
Referred for psychiatric/psychological evaluation[2]	3	3	5	5
Patient informed family of decision[3]	92	92	88	96
Medication[4]				
Secobarbital	18	17	66	70
Pentobarbital	84	81	28	30
Secobarbital/Pentobarbital Combination	1	1		
Other	1	1	0	0
Timing				
Duration of patient-physician Relationship[5]				
0.3 weeks – 24 weeks	48	47	43	47
25 weeks – 51 weeks	14	14	11	12
1 year or more	39	39	36	40
Unknown			1	1
Range (min – max)	.3 wks – 26 yrs		3 wks – 18 yrs	
Duration between first oral request and Death[6]				
3 weeks – 24 weeks	82		87	95
25 weeks or more	17		5	5
Unknown	0		0	
Range (min – max)	3 wks – 150 wks		3 wks – 53 wks	

Notes:

[1] Data published in 2011 report http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx

[2] Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 103 of the 104 participants in 2012 who died.

[3] Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 100 of the 104 participants in 2012 who died.

[4] Data are collected from multiple documents. At the time of publication, data are available for all 104 of the participants in 2012 who died.

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[6] Data are collected from multiple documents. At the time of publication, data are available for 101 of the 104 participants in 2012 who died.

Table 5. Circumstances and complications related to ingestion of medication prescribed under the Death with Dignity Act of the participants who have died:

	2012		2011[1]	
	Number	**(%)**	**Number**	**(%)**
Circumstances when medication ingested[2]				
Health-care provider present				
Prescribing physician	5	6	2	3
Other provider, prescribing physician not present	59	71	36	51
No provider	15	18	23	33
Unknown	4	5	9	13
Location of patient				
Home (patient, family, friend)	74	89	65	93
Long term care, assisted living or foster care facility	8	10	4	6
Hospital	0	0	0	0
Other	1	1	1	1
Unknown	0	0	0	0
Hospice care				
Enrolled	76	76	58	83
Not enrolled	7	7	11	16
Unknown	0	0	1	1
Timing[2]				
Minutes between ingestion and unconsciousness				
1 min – 10 min	65	78	44	63
11 min or more	8	10	7	10
Unknown	10	12	19	27
Range (min – max)	1 min – 45 min		1 min – 120 min	
Minutes between ingestion and death				
1 min – 90 min	66	78	40	57
91 min or more	9	10	14	20
Unknown	8	12	16	23
Range (min – max)	3 min – 16 hrs		5 min – 13 hrs	
Complications[2]				
Regurgitation	0	0	1	1
Seizures	0	0	0	0
Awakened after taking prescribed medication	0	0	0	0
Other	1	1		
None	79	95	64	92
Unknown	3	4	5	7
Emergency Medical Services involvement[2]				
Called for intervention after lethal medication ingested	0	0	0	0
Called for other reason (including to pronounce death)	3	4	1	1
Not called after lethal medication ingested	77	92	66	94
Unknown	3	4	3	5

Notes:

[1] Data published in 2011 report

http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 83 participants in 2012 who are known to have ingested the medication and died.

Confidentiality

The Death with Dignity Act requires that the Washington State Department of Health collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the Department of Health will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

Appendix

Overview of Death with Dignity Act

The Washington State Death with Dignity Act (RCW 70.245) was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health's website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the Department of Health. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the Department of Health:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under RCW 70.245, no forms have to be submitted to the Department of Health.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by RCW 70.245, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington law, a death certificate must be completed within 72 hours of death and filed with the local health agency where the death occurred. Local health officials may hold death certificates for 30 to 60 days before filing them with the state Department of Health. As a result, the state health department may receive an After Death Reporting Form before the death certificate arrives.

DOH 422-109 2013

Washington State Department of Health 2013 Death with Dignity Act Report

Executive Summary

Washington's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from physicians. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report describes available information for the 173 participants for whom medication was dispensed between January 1, 2013 and December 31, 2013. It includes data from the documentation received by the Department of Health as of February 28, 2014.

In 2013, medication was dispensed to 173 individuals (defined as 2013 participants):

- Prescriptions were written by 89 different physicians
- Medications were dispensed by 23 different pharmacists

Of the 173 participants in 2013:

- 159 are known to have died
  - 119 died after ingesting the medication
  - 26 died without having ingested the medication
  - For the remaining 14 people who died, ingestion status is unknown
- For the remaining 14 people, the department has received no documentation that indicates death has occurred

The 159 participants who died in 2013 ranged in age from 29 to 95 years old. Ninety-six percent lived west of the Cascades. Of the 159 participants in 2013 who died:

- 77 percent had cancer
- 15 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS)
- 8 percent had other illnesses, including heart and respiratory disease

Of the 151 participants in 2013 who died and for whom we have received a death certificate:

- 97 percent were white, non-Hispanic
- 52 percent were married
- 76 percent had at least some college education

Of the 145 participants in 2013 who died and for whom we have received an After Death Report:

- 95 percent had private, Medicare, Medicaid, or a combination of health insurance
- 91 percent reported to their health care provider concerns about loss of autonomy
- 79 percent reported to their health care provider concerns about loss of dignity
- 89 percent reported to their health care provider concerns about loss of the ability to participate in activities that make life enjoyable

Of the 119 participants in 2013 who died after ingesting the medication:

- 84 percent were at home at the time of death
- 86 percent were enrolled in hospice care when they ingested the medication

Death with Dignity Participation in 2013

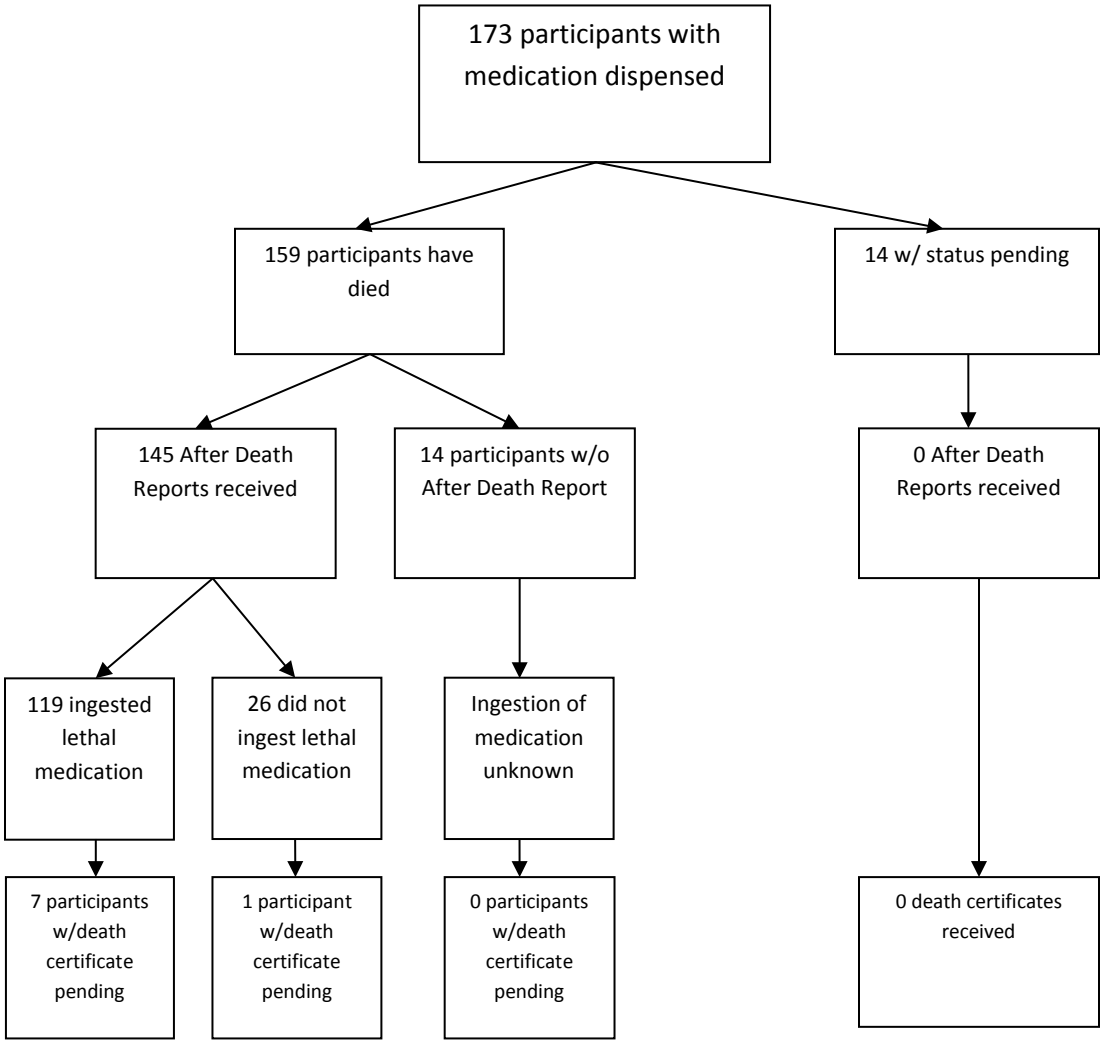
For the purposes of this report, a participant of the Death with Dignity Act in 2013 is defined as someone to whom medication was dispensed in 2013 under the terms of the act. Details of the act are included in Appendix A.

To date, the department has received documentation indicating that lethal doses of medication were dispensed to 173 participants under the law in 2013. These prescriptions were written by 89 different physicians and dispensed by 23 different pharmacists. The department has not yet received all of the required paperwork for all 173 participants. Table 5 in Appendix A shows details of the documentation that has been received by the department. When all the required paperwork is not received, the department contacts health care providers to obtain the documentation.

Among the 173 participants who received medication in 2013, the department has confirmed that 159 have died. One hundred nineteen ingested the medication, 26 did not ingest, and the ingestion status is unknown for 14 (Figure 1). Death of a participant is established through receipt of the After Death Reporting form and/or a death certificate.

The status of the remaining 14 participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the department because the After Death Reporting form is due 30 days after death and the death certificate is due 60 days after death.

Figure 1. Outcome of the 173 participants who received medication in 2013 under the terms of the Death with Dignity Act



Update on Death with Dignity Participation 2009-2013

Since the last Death with Dignity report was published on May 2, 2013, the department received additional information on participants from prior years. As of February 28, 2014, 116 of the 121 participants in 2012, 101 of the 103 participants in 2011, 85 of the 87 participants in 2010, and 64 of the 65 participants in 2009 had died. The status of the five remaining participants in 2012, the two remaining participants in 2011, the two remaining participants in 2010, and the one remaining participant in 2009 remains unknown. These participants may have died, but the department has not received documentation of the death. The number of participants in 2009-2013, and the number of these participants who are known to have died as of February 28, 2014, is shown in Figure 2.

Figure 2. Number of Death with Dignity Participants and Known Deaths, 2009-2013

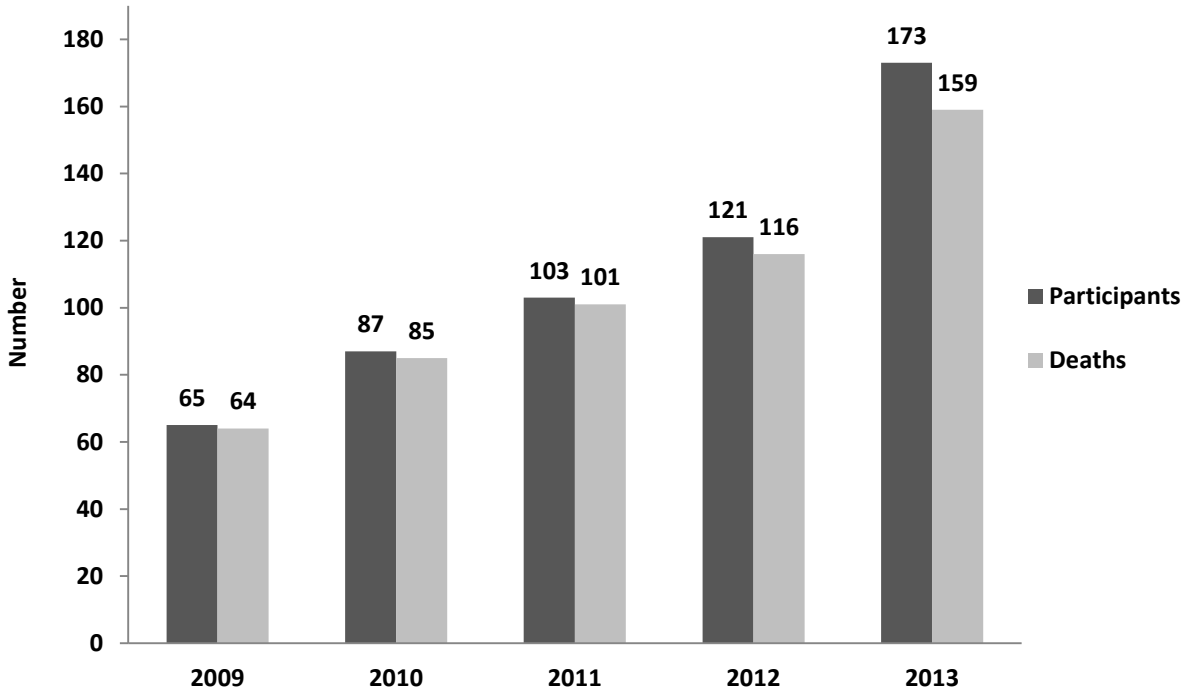


Table 1. Characteristics of the participants of the Death with Dignity Act who have died

	2013		2012[1]	
	Number	**(%)**	**Number**	**(%)**
Sex[3]				
Male	80	53	60	52
Female	71	47	55	47
Age (years)[2]				
18-44	5	3	1	1
45-54	9	6	4	3
55-64	28	17	33	29
65-74	47	30	41	35
75-84	38	24	25	22
85+	32	20	12	10
Range (min-max)	29-95		35-95	
Race and Ethnicity[3]				
Non-Hispanic White	146	97	110	96
Hispanic and/or Non-White	5	3	5	4
Marital Status[3]				
Married	78	52	47	41
Widowed	26	17	18	16
Divorced	36	24	35	30
Domestic partner (state-registered)	0	0	3	3
Never married	11	7	12	10
Education[3]				
Less than high school	1	1	2	2
High school graduate	34	23	17	15
Some college	39	26	31	27
Baccalaureate or higher	76	50	64	56
Missing	1	1	1	1
Residence[2,4]				
West of the Cascades	153	96	94	90
East of the Cascades	6	4	10	10
Underlying illness[2]				
Cancer	123	77	76	73
Neuro-degenerative disease (including ALS[5])	24	15	10	10
Respiratory disease (including COPD[6])	7	5	10	10
Heart disease	3	2	5	4
Other illnesses	2	1	3	3
Insurance Status[7]				
Private only	27	19	22	22
Medicare or Medicaid only	86	59	55	55
Combination of private and Medicare/Medicaid	24	17	12	12
None	0	0	0	0
Unknown	8	5	11	11

Notes:

[1] Data derived from the death certificate (sex, age, race/ethnicity, marital status, and education) have been updated for 27 of the 2012 participants with information received since the 2012 report was published. At time of publication, death certificate data are available for 115 of the 2012 participants.

[2] Data are collected from multiple documents. At time of publication, data are available for all 159 of the participants in 2013 who died.

[3] Data are collected from the death certificate. At time of publication, data are available for 151 of the 159 participants in 2013 who died.

[4] Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

[5] Amyotrophic Lateral Sclerosis (ALS).

[6] Chronic Obstructive Pulmonary Disease (COPD).

[7] Data are collected from the After Death Reporting form. At the time of publication, data are available for 145 of the 159 participants in 2013.

Table 2. End of life concerns of participants of the Death with Dignity Act who have died

	2013		2012[1]	
	Number	**(%)**	**Number**	**(%)**
End of Life Concerns[2,3]				
Losing autonomy	132	91	94	94
Less able to engage in activities making life enjoyable	129	89	90	90
Loss of dignity	115	79	84	84
Burden on family, friends/caregivers	88	61	63	63
Losing control of bodily functions	75	52	56	56
Inadequate pain control or concern about it	53	36	33	33
Financial implications of treatment	19	13	5	5

Notes:

[1] Data published in 2012 report
http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 145 of the 159 participants in 2013 who died.

[3] Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent.

Table 3. Death with Dignity Act process for the participants who have died

	2013		2012[1]	
	Number	**(%)**	**Number**	**(%)**
Family and Psychiatric/Psychological involvement				
Referred for psychiatric/psychological evaluation[2]	6	4	3	3
Patient informed family of decision[3]	132	88	92	92
Medication[4]				
Secobarbital	16	10	18	17
Pentobarbital	142	89	84	81
Secobarbital/Pentobarbital Combination	0	0	1	1
Other	1	1	1	1
Timing				
Duration of patient-physician relationship[5]				
<25 weeks	74	51	48	47
25 weeks – 51 weeks	15	10	14	14
1 year or more	56	39	39	39
Unknown	0	0		
Range (min – max)	<1 wk – 28 yrs		<1 wk – 26 yrs	
Duration between first oral request and Death[2]				
<25 weeks	130	89	82	83
25 weeks or more	16	11	17	17
Unknown	0	0	0	0
Range (min – max)	2 wks – 73 wks		3 wks – 150 wks	

Notes:

[1] Data published in 2012 report http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.

[2] Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 146 of the 159 participants in 2013 who died.

[3] Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 150 of the 159 participants in 2013 who died.

[4] Data are collected from multiple documents. At the time of publication, data are available for all 159 of the participants in 2013 who died.

[5] Data are collected from the After Death Reporting form. At the time of publication, data are available for 145 of the 159 participants in 2013 who died.

Table 4. Circumstances and complications related to ingestion of medication prescribed under the Death with Dignity Act of the participants who have died

	2013		2012[1]	
	Number	**(%)**	**Number**	**(%)**
Circumstances when medication ingested[2]				
Healthcare provider present				
Prescribing physician	2	2	5	6
Other provider, not prescribing physician, present	62	52	59	71
No provider	48	40	15	18
Unknown	7	6	4	5
Location of patient				
Home (patient, family, friend)	100	84	74	89
Long term care, assisted living or foster care facility	15	12	8	10
Hospital	1	1	0	0
Other	2	2	1	1
Unknown	1	1	0	0
Hospice care				
Enrolled	102	86	76	76
Not enrolled	16	13	7	7
Unknown	1	1	0	0
Timing[2]				
Minutes between ingestion and unconsciousness				
1 min – 10 min	80	67	65	78
11 min or more	5	4	8	10
Unknown	34	29	10	12
Range (min – max)	1 min – 180 min		1 min – 45 min	
Minutes between ingestion and death				
1 min – 90 min	90	76	66	78
91 min or more	4	3	9	10
Unknown	25	21	8	12
Range (min – max)	2 min – 41hrs		3 min – 16 hrs	
Complications[2]				
Regurgitation	3	3	0	0
Seizures	0	0	0	0
Awakened after taking prescribed medication	0	0	0	0
Other	0	0	1	1
None	106	89	79	95
Unknown	10	8	3	4
Emergency Medical Services involvement[2]				
Called for intervention after lethal medication ingested	0	0	0	0
Called for other reason (including to pronounce death)	3	3	3	4
Not called after lethal medication ingested	108	91	77	92
Unknown	8	7	3	4

Notes:

[1] Data published in 2012 report
http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 119 participants in 2013 who are known to have ingested the medication.

Appendix A

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the department's website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the department. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the department:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms have to be submitted to the department.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington law, a death certificate must be completed within 72 hours of death and filed with the local health jurisdiction where the death occurred. Local health officials may hold death

certificates for 30 to 60 days before filing them with the department. As a result, the department may receive an After Death Reporting Form before the death certificate arrives.

The department received the following documentation for 2013 Death with Dignity participants (people who received medication) as of February 28, 2014:

Table 5. Documentation Received for 2013 Participants

Form	Number
Written Request to End Life Form	153
Attending Physician Compliance Form	158
Consulting Physician Compliance Form	160
Psychiatric/Psychological Consulting Form	6
Pharmacy Dispensing Record Form	171
After Death Reporting Form	147
Death Certificate	151

Confidentiality

The Death with Dignity Act requires that the department collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the department will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

DOH 422-109 2014

Washington State Department of Health 2014 Death with Dignity Act Report

Executive Summary

Washington's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from a physician. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report describes available information for the 176 participants for whom medication was dispensed between January 1, 2014 and December 31, 2014. It includes data from the documentation received by the Department of Health as of March 16, 2015.

In 2014, medication was dispensed to 176 individuals (defined as 2014 participants):

- Prescriptions were written by 109 different physicians
- Medications were dispensed by 57 different pharmacists

Of the 176 participants in 2014:

- 170 are known to have died
  - 126 died after ingesting the medication
  - 17 died without having ingested the medication
  - For the remaining 27 people who died, ingestion status is unknown
- For the six participants not included among those known to have died, the state health department has received no documentation that indicates death has occurred

The 170 participants who died in 2014 ranged in age from 21 to 101 years old. Ninety-five percent lived west of the Cascades. Of the 170 participants in 2014 who died:

- 73 percent had cancer
- 13 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS)
- 14 percent had other illnesses, including heart and respiratory disease

Of the 169 participants in 2014 who died for whom a death certificate was provided to the state:

- 92 percent were white, non-Hispanic
- 56 percent were married
- 76 percent had at least some college education

Of the 143 participants in 2014 who died and for whom an After Death Report was received:

- 93 percent had private, Medicare, Medicaid, or a combination of health insurance
- 89 percent reported to their health care provider concerns about loss of autonomy
- 79 percent reported to their health care provider concerns about loss of dignity
- 94 percent reported to their health care provider concerns about loss of the ability to participate in activities that make life enjoyable

Of the 126 participants in 2014 who died after ingesting the medication:

- 92 percent were at home at the time of death
- 68 percent were enrolled in hospice care when they ingested the medication

Death with Dignity Participation in 2014

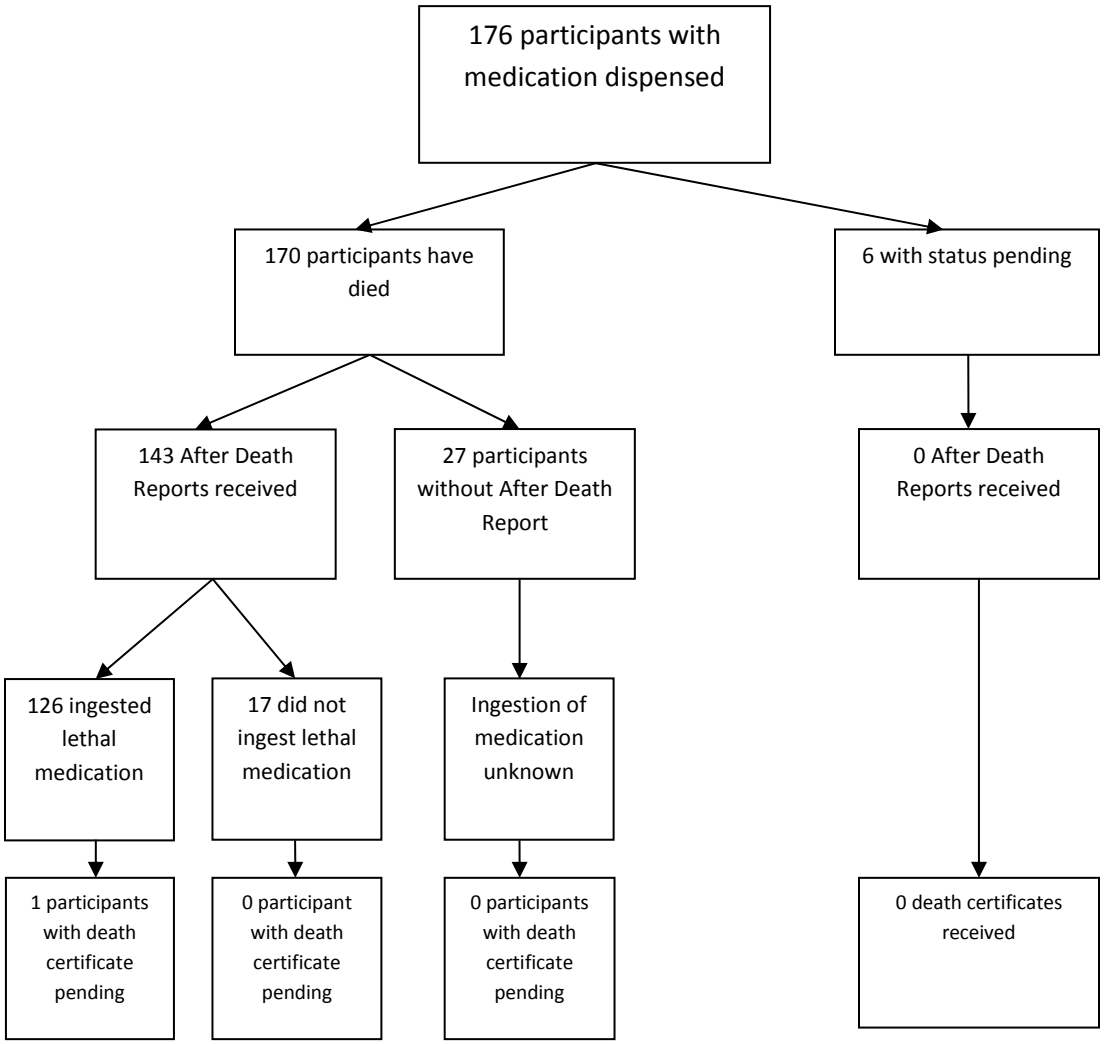
For the purposes of this report, a participant of the Death with Dignity Act in 2014 is defined as someone to whom medication was dispensed in 2014 under the terms of the act. Details of the act are included in Appendix A.

To date, the state health department has received documentation indicating that lethal doses of medication were dispensed to 176 participants under the law in 2014. These prescriptions were written by 109 different physicians and dispensed by 57 different pharmacists. The department has not yet received all of the required paperwork for all 176 participants. Table 5 in Appendix A shows details of the documentation that has been received by the department. When all the required paperwork is not received, department staff contacts health care providers to obtain the documentation.

Among the 176 participants who received medication in 2014, the department has received confirmation that 170 have died. One hundred twenty-six ingested the medication, 17 did not ingest, and the ingestion status is unknown for 27 (Figure 1). Death of a participant is established through receipt of the After Death Reporting form and/or a death certificate.

The status of the remaining six participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the department because the After Death Reporting form is due 30 days after death and the death certificate is due 60 days after death.

Figure 1. Outcome of the 176 participants who received medication in 2014 under the terms of the Death with Dignity Act



Update on Death with Dignity Participation 2009-2014

Since the last Death with Dignity report was published on June 4, 2014 the department received additional information on participants from prior years. As of March 16, 2015, 169 of the 173 participants in 2013, 121 of the 121 participants in 2012, 102 of the 103 participants in 2011, 86 of the 87 participants in 2010, and 64 of the 65 participants in 2009 had died. The status of the four remaining participants in 2013, the one remaining participant in 2011, the one remaining participant in 2010, and the one remaining participant in 2009 remains unknown. These participants may have died, no documentation of the death has been received. The number of participants in 2009-2014, and the number of these participants who are known to have died as of March 16, 2015, is shown in Figure 2.

Figure 2. Number of Death with Dignity Participants and Known Deaths, 2009-2014

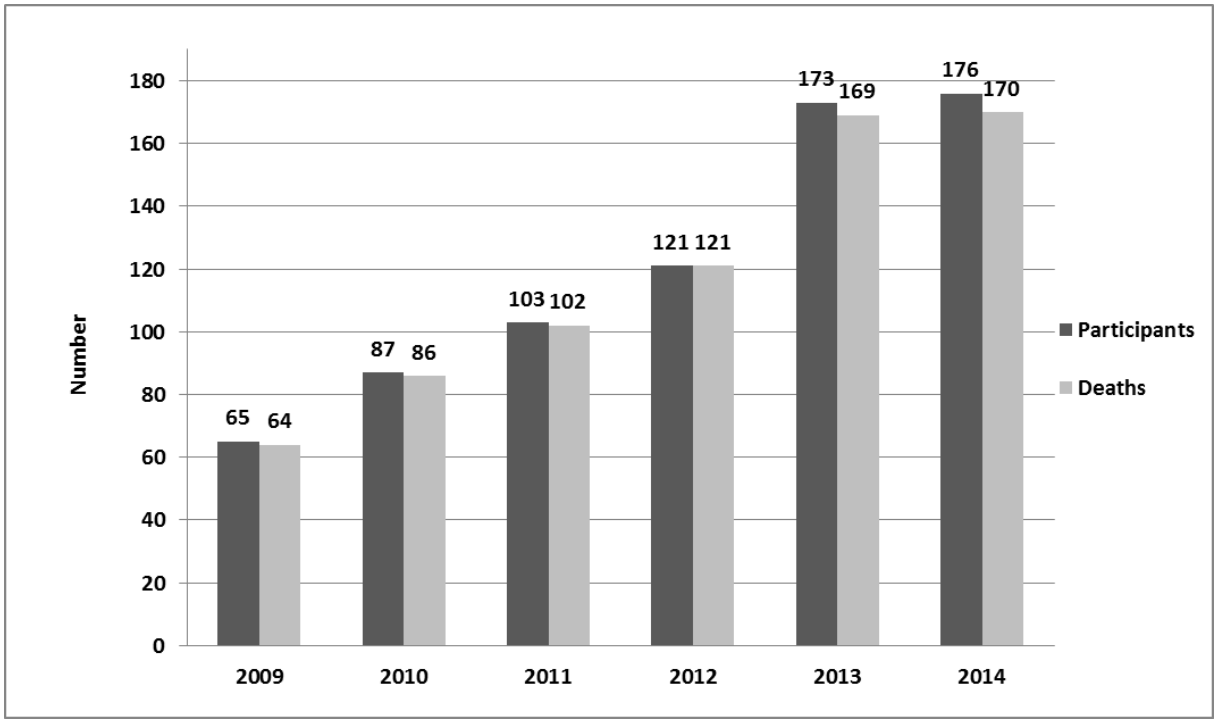


Table 1. Characteristics of the participants of the Death with Dignity Act who have died

	2014		2013[1]	
	Number	**%**	**Number**	**%**
Sex[3]				
Male	73	43	86	52
Female	96	57	79	48
Age (years)[2]				
18-44	6	3	5	3
45-54	10	6	9	5
55-64	32	19	29	17
65-74	53	31	53	32
75-84	40	24	41	24
85+	29	17	32	19
Range (min-max)	21-101		29-95	
Race and Ethnicity[3]				
Non-Hispanic White	156	92	159	96
Hispanic and/or Non-White	12	7	6	4
Unknown	1	1		
Marital Status[3]				
Married	80	47	84	51
Widowed	34	20	27	16
Divorced	36	21	43	26
Domestic partner (state-registered)	1	1	0	0
Never married	17	10	11	7
Unknown	1	1		
Education[3]				
Less than high school	4	2	1	1
High school graduate	34	20	40	24
Some college	42	25	44	26
Baccalaureate or higher	86	50	79	48
Unknown	3	3	1	1
Residence[2,4]				
West of the Cascades	161	95	153	96
East of the Cascades	9	5	6	4
Underlying illness[2]				
Cancer	129	76	123	77
Neuro-degenerative disease (including ALS[5])	21	13	24	15
Respiratory disease (including COPD[6])	4	2	7	5
Heart disease	10	6	3	2
Other illnesses	6	3	2	1
Insurance Status[7]				
Private only	33	23	27	19
Medicare or Medicaid only	82	57	86	59
Combination of private and Medicare/Medicaid	18	13	24	17
None	3	2	0	0
Unknown	7	5	8	5

Notes:

[1] Data derived from the death certificate (sex, age, race/ethnicity, marital status, and education) have been updated for 14 of the 2013 participants with information received since the 2013 report was published. At time of publication, death certificate data are available for 165 of the 2013 participants.

[2] Data are collected from multiple documents. At time of publication, data are available for all 170 of the participants in 2014 who died.

[3] Data are collected from the death certificate. At time of publication, data are available for 169 of the 170 participants in 2014 who died.

[4] Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

[5] Amyotrophic Lateral Sclerosis (ALS).

[6] Chronic Obstructive Pulmonary Disease (COPD).

[7] Data are collected from the After Death Reporting form. At the time of publication, data are available for 143 of the 170 participants in 2014.

Table 2. End of life concerns of participants of the Death with Dignity Act who have died

	2014		2013[1]	
	Number	**%**	**Number**	**%**
End of Life Concerns[2,3]				
Losing autonomy	127	89	132	91
Less able to engage in activities making life enjoyable	135	94	129	89
Loss of dignity	113	79	115	79
Burden on family, friends/caregivers	85	59	88	61
Losing control of bodily functions	73	51	75	52
Inadequate pain control or concern about it	59	41	53	36
Financial implications of treatment	12	8	19	13

Notes:

[1] Data published in 2013 report
http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 143 of the 170 participants in 2014 who died.

[3] Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent.

Table 3. Death with Dignity Act process for the participants who have died

	2014		2013[1]	
	Number	**%**	**Number**	**%**
Family and Psychiatric/Psychological involvement				
Referred for psychiatric/psychological evaluation[2]	6	4	6	4
Patient informed family of decision[3]	146	88	132	88
Medication[4]				
Secobarbital	112	64	16	10
Pentobarbital	64	36	142	89
Secobarbital/Pentobarbital Combination	0	0	0	0
Other	0	0	1	1
Timing				
Duration of patient-physician relationship[5]				
<25 weeks	62	43	74	51
25 weeks – 51 weeks	18	13	15	10
1 year or more	57	40	56	39
Unknown	6	4	0	0
Range (min – max)	<1 wk – 23 yrs		<1 wk – 28 yrs	
Duration between first oral request and Death[2]				
<25 weeks	145	87	130	89
25 weeks or more	15	9	16	11
Unknown	7	4	0	0
Range (min – max)	2 wks – 57 wks		2 wks – 73 wks	

Notes:

[1] Data published in 2013 report http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.

[2] Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 167 of the 170 participants in 2014 who died.

[3] Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 165 of the 170 participants in 2014 who died.

[4] Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 176 of the participants in 2014 who received medication.

[5] Data are collected from the After Death Reporting form. At the time of publication, data are available for 143 of the 170 participants in 2014 who died.

Table 4. Circumstances and complications related to ingestion of medication prescribed under the Death with Dignity Act of the participants who have died

	2014		2013[1]	
	Number	**%**	**Number**	**%**
Circumstances when medication ingested[2]				
Healthcare provider present				
Prescribing physician	7	6	2	2
Other provider, not prescribing physician, present	78	62	62	52
No provider	21	16	48	40
Unknown	20	16	7	6
Location of patient				
Home (patient, family, friend)	116	92	100	84
Long term care, assisted living or foster care facility	7	5	15	12
Hospital	0	0	1	1
Other	2	2	2	2
Unknown	1	1	1	1
Hospice care				
Enrolled	86	69	102	86
Not enrolled	35	28	16	13
Unknown	5	4	1	1
Timing[2]				
Minutes between ingestion and unconsciousness				
1 min – 10 min	84	67	80	67
11 min or more	11	9	5	4
Unknown	31	24	34	29
Range (min – max)	1 min – 60 min		1 min – 180 min	
Minutes between ingestion and death				
1 min – 90 min	91	72	90	76
91 min or more	10	8	4	3
Unknown	25	20	25	21
Range (min – max)	3 min – 18hrs		2 min – 41hrs	
Complications[2]				
Regurgitation	2	2	3	3
Seizures	1	1	0	0
Awakened after taking prescribed medication	0	0	0	0
Other	0	0	0	0
None	121	96	106	89
Unknown	2	1	10	8
Emergency Medical Services involvement[2]				
Called for intervention after lethal medication ingested	0	0	0	0
Called for other reason (including to pronounce death)	2	2	3	3
Not called after lethal medication ingested	117	93	108	91
Unknown	7	5	8	7

Notes:

[1] Data published in 2013 report http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 143 participants in 2014 who are known to have ingested the medication.

Appendix A

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the department. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the department:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms have to be submitted to the department.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington law, a death certificate must be completed within 72 hours of death and filed with the local health agency where the death occurred. Local health officials may hold death

certificates for 30 to 60 days before filing them with the state health department. As a result, an After Death Reporting Form may reach the state before the death certificate arrives.

The department received the following documentation for 2014 Death with Dignity participants (people who received medication) as of March 16, 2015:

Table 5. Documentation Received for 2014 Participants

Form	Number
Written Request to End Life Form	165
Attending Physician Compliance Form	167
Consulting Physician Compliance Form	162
Psychiatric/Psychological Consulting Form	6
Pharmacy Dispensing Record Form	176
After Death Reporting Form	143
Death Certificate	169

Confidentiality

The Death with Dignity Act requires that the department collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the department will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

DOH 422-109 2015

Washington State Department of Health 2015 Death with Dignity Act Report

Executive Summary

Washington's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from a physician. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report describes available information for the 213 participants for whom medication was dispensed between January 1, 2015 and December 31, 2015. It includes data from the documentation received by the Department of Health as of March 25, 2016.

In 2015, medication was dispensed to 213 individuals (defined as 2015 participants):

- Prescriptions were written by 142 different physicians
- Medications were dispensed by 49 different pharmacists

Of the 213 participants in 2015:

- 202 are known to have died
  - 166 died after ingesting the medication
  - 24 died without having ingested the medication
  - For the remaining 12 people who died, ingestion status is unknown
- For the eleven participants not included among those known to have died, the state health department has received no documentation that indicates death has occurred

The 202 participants who died in 2015 ranged in age from 20 to 97 years old. Ninety-five percent lived west of the Cascades. Of the 202 participants in 2015 who died:

- 72 percent had cancer
- 8 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS)
- 20 percent had other illnesses, including heart and respiratory disease

Of the 199 participants in 2015 who died for whom a death certificate was provided to the state:

- 98 percent were white, non-Hispanic
- 47 percent were married
- 74 percent had at least some college education

Of the 197 participants in 2015 who died and for whom an After Death Report was received:

- 95 percent had private, Medicare, Medicaid, or a combination of health insurance
- 86 percent reported to their health care provider concerns about loss of autonomy
- 69 percent reported to their health care provider concerns about loss of dignity
- 86 percent reported to their health care provider concerns about loss of the ability to participate in activities that make life enjoyable

Of the 166 participants in 2015 who died after ingesting the medication:

- 86 percent were at home at the time of death
- 81 percent were enrolled in hospice care when they ingested the medication

Death with Dignity Participation in 2015

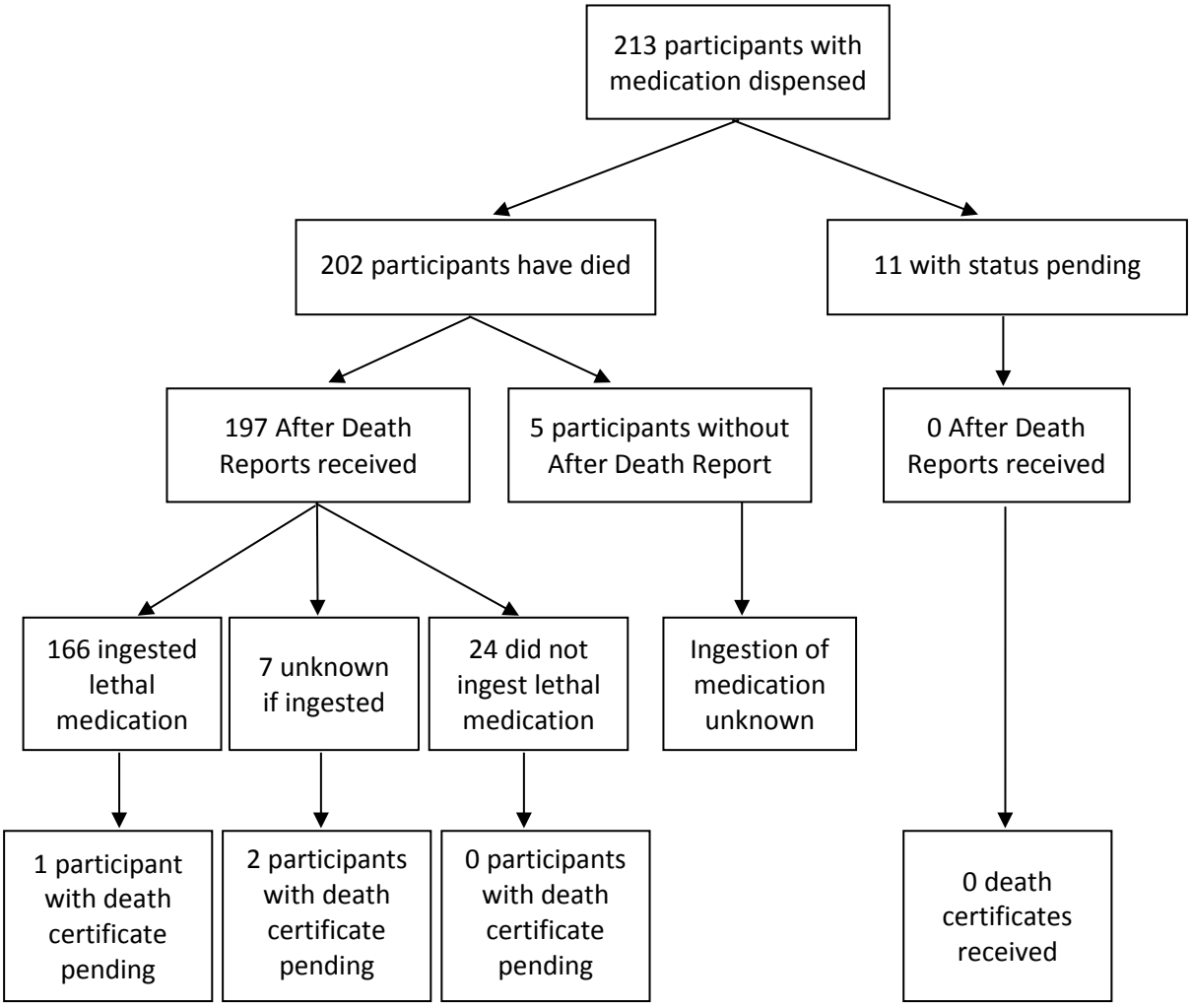
For the purposes of this report, a participant of the Death with Dignity Act in 2015 is defined as someone to whom medication was dispensed in 2015 under the terms of the act. Details of the act are included in Appendix A.

To date, the state health department has received documentation indicating that lethal doses of medication were dispensed to 213 participants under the law in 2015. These prescriptions were written by 142 different physicians and dispensed by 49 different pharmacists. The department has not yet received all of the required paperwork for all 213 participants. Table 5 in Appendix A shows details of the documentation that has been received by the department. When all the required paperwork is not received, department staff contacts health care providers to obtain the documentation.

Among the 213 participants who received medication in 2015, the department has received confirmation that 199 have died. One hundred sixty-six ingested the medication, 24 did not ingest, and the ingestion status is unknown for 12 (Figure 1). Death of a participant is established through receipt of the After Death Reporting form and/or a death certificate.

The status of the remaining eleven participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the department because the After Death Reporting form is due 30 days after death and the death certificate is due 60 days after death.

Figure 1. Outcome of the 213 participants who received medication in 2015 under the terms of the Death with Dignity Act



Update on Death with Dignity Participation 2009-2015

Since the last Death with Dignity report was published on July 28, 2015 the department received additional information on participants from prior years. As of March 25, 2016, 172 of the 176 2014 participants, 169 of the 173 participants in 2013, 121 of the 121 participants in 2012, 102 of the 103 participants in 2011, 87 of the 87 participants in 2010, and 64 of the 65 participants in 2009 had died. The status of the four remaining participants in 2014, the four remaining participants 2013, the one remaining participant in 2011, and the one remaining participant in 2009 remains unknown. These participants may have died, but no documentation of the death has been received. The number of participants in 2009-2015, and the number of these participants who are known to have died as of March 25, 2016, is shown in Figure 2.

Figure 2. Number of Death with Dignity Participants and Known Deaths, 2009-2015

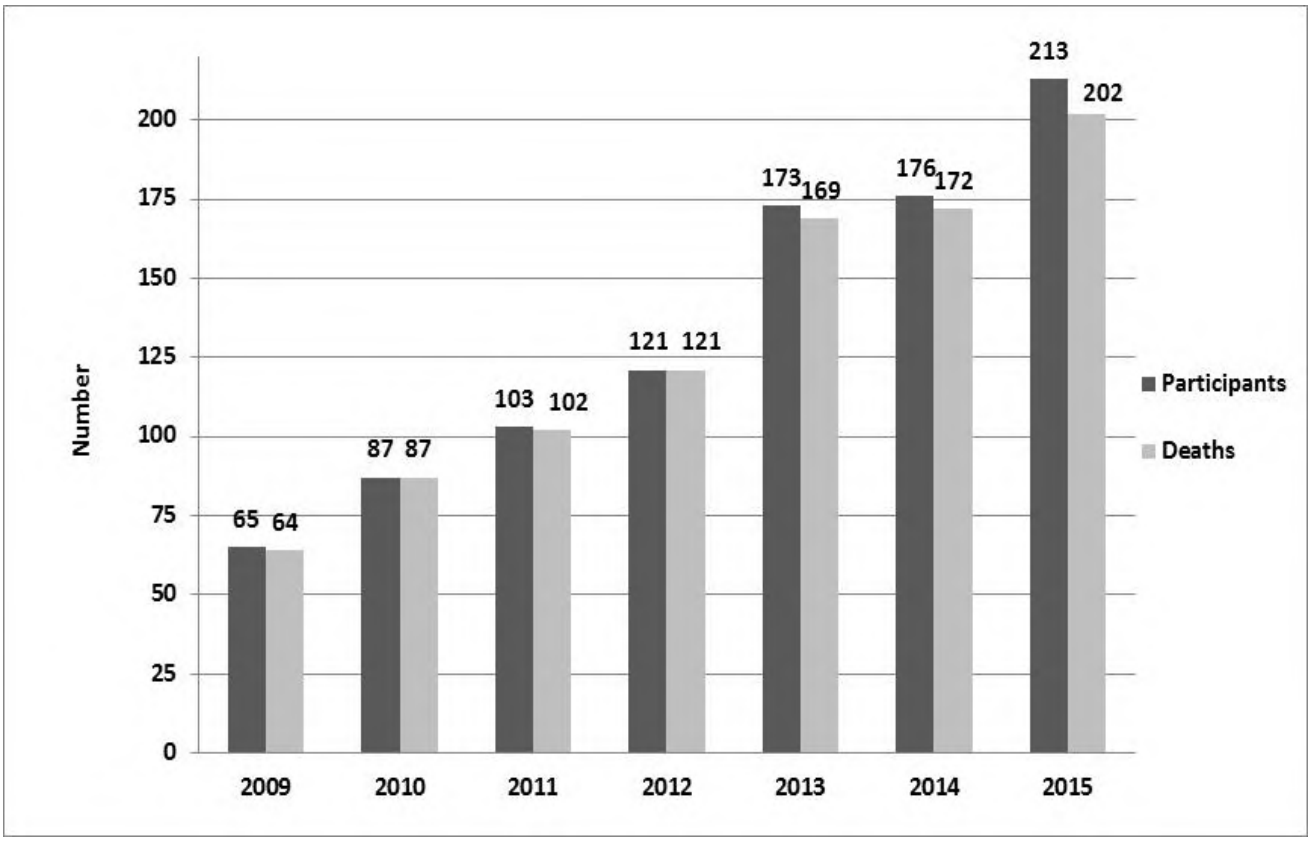


Table 1. Characteristics of the participants of the Death with Dignity Act who have died

	2015		2014[1]	
	Number	**%**	**Number**	**%**
Sex[3]				
Male	106	53	75	44
Female	93	47	97	56
Age (years)[2]				
18-44	5	2	7	4
45-54	12	6	10	6
55-64	38	19	33	19
65-74	63	31	53	31
75-84	42	21	40	23
85+	42	21	29	17
Range (min-max)	20–97		21–101	
Race and Ethnicity[3]				
Non-Hispanic White	194	98	159	92
Hispanic and/or Non-White	5	2	12	7
Unknown			1	1
Marital Status[3]				
Married	93	47	81	47
Widowed	41	20	34	20
Divorced	53	27	37	21
Domestic partner (state-registered)	0	0	18	10
Never married	12	6	1	1
Unknown			1	1
Education[3]				
Less than high school	8	4	4	2
High school graduate	42	21	37	22
Some college	55	27	42	24
Baccalaureate or higher	93	47	86	50
Unknown	1	1	3	2
Residence[2,4]				
West of the Cascades	191	95	161	95
East of the Cascades	11	5	9	5
Underlying illness[2]				
Cancer	146	72	129	76
Neuro-degenerative disease (including ALS[5])	17	8	21	13
Respiratory disease (including COPD[6])	11	6	4	2
Heart disease	18	9	10	6
Other illnesses	10	5	6	3
Insurance Status[7]				
Private only	28	14	33	23
Medicare or Medicaid only	140	71	82	57
Combination of private and Medicare/Medicaid	20	10	18	13
None	4	2	3	2
Unknown	5	3	7	5

Notes:

[1] Data derived from the death certificate (sex, age, race/ethnicity, marital status, and education) have been updated for 3 of the 2014 participants with information received since the 2014 report was published. At time of publication, death certificate data are available for 172 of the 2014 participants.

[2] Data are collected from multiple documents. At time of publication, data are available for all 202 of the participants in 2015 who died.

[3] Data are collected from the death certificate. At time of publication, data are available for 199 of the 202 participants in 2015 who died.

[4] Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

[5] Amyotrophic Lateral Sclerosis (ALS).

[6] Chronic Obstructive Pulmonary Disease (COPD).

[7] Data are collected from the After Death Reporting form. At the time of publication, data are available for 197 of the 213 participants in 2015.

Table 2. End of life concerns of participants of the Death with Dignity Act who have died

	2015		2014[1]	
	Number	**%**	**Number**	**%**
End of Life Concerns[2,3]				
Losing autonomy	169	86	127	89
Less able to engage in activities making life enjoyable	170	86	135	94
Loss of dignity	135	69	113	79
Burden on family, friends/caregivers	105	52	85	59
Losing control of bodily functions	96	49	73	51
Inadequate pain control or concern about it	70	35	59	41
Financial implications of treatment	25	13	12	8

Notes:

[1] Data published in 2014 report
http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 197 of the 202 participants in 2015 who died.

[3] Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent.

Table 3. Death with Dignity Act process for the participants who have died

	2015		2014[1]	
	Number	**%**	**Number**	**%**
Family and Psychiatric/Psychological involvement				
Referred for psychiatric/psychological evaluation[2]	8	4	6	4
Patient informed family of decision[3]	170	94	146	88
Medication[4]				
Secobarbital	106	52	112	64
Pentobarbital	2	1	64	36
Secobarbital/Pentobarbital Combination	0	0	0	0
Phenobarbital	92	46	0	0
Other	1	1	0	0
Timing				
Duration of patient-physician relationship[5]				
<25 weeks	100	51	62	43
25 weeks – 51 weeks	15	8	18	13
1 year or more	80	40	57	40
Unknown	2	1	6	4
Range (min – max)	<1 wk– 2 yrs		<1 wk–23 yrs	
Duration between first oral request and death[2]				
<25 weeks	163	84	145	87
25 weeks or more	32	16	15	9
Unknown	0	0	7	4
Range (min – max)	2 wks–95 wks		2 wks–57 wks	

Notes:

[1] Data published in 2014 report http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.

[2] Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 195 of the 202 participants in 2015 who died.

[3] Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 183 of the 202 participants in 2015 who died.

[4] Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 213 of the participants in 2015 who received medication.

[5] Data are collected from the After Death Reporting form. At the time of publication, data are available for 197 of the 202 participants in 2015 who died.

Table 4. Circumstances and complications related to ingestion of medication prescribed under the Death with Dignity Act of the participants who have died

	2015		2014[1]	
	Number	**%**	**Number**	**%**
Circumstances when medication ingested[2]				
Healthcare provider present				
Prescribing physician	9	5	7	6
Other provider, not prescribing physician, present	116	70	78	62
No provider	39	24	21	16
Unknown	2	1	20	16
Location of patient				
Home (patient, family, friend)	143	86	116	92
Long term care, assisted living or foster care facility	17	10	7	5
Hospital	0	0	0	0
Other	1	1	2	2
Unknown	5	3	1	1
Hospice care				
Enrolled	135	81	86	69
Not enrolled	19	12	35	28
Unknown	12	7	5	4
Timing[2]				
Minutes between ingestion and unconsciousness				
1 min – 10 min	120	72	84	67
11 min or more	9	6	11	9
Unknown	37	22	31	24
Range (min – max)	1 min–72 min		1 min–60 min	
Minutes between ingestion and death				
5 min – 90 min	104	63	91	72
91 min or more	33	20	10	8
Unknown	29	17	25	20
Range (min – max)	5 min–30hrs		3 min–18hrs	
Complications[2]				
Regurgitation	2	1	2	2
Seizures	0	0	1	1
Awakened after taking prescribed medication	0	0	0	0
Other	1	1	0	0
None	149	90	121	96
Unknown	14	8	2	1
Emergency Medical Services involvement[2]				
Called for intervention after lethal medication ingested	0	0	0	0
Called for other reason (including to pronounce death)	2	1	2	2
Not called after lethal medication ingested	149	90	117	93
Unknown	15	9	7	5

Notes:

[1] Data published in 2014 report http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 166 participants in 2015 who are known to have ingested the medication.

Appendix A

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the department. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the department:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms have to be submitted to the department.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington law, a death certificate must be completed within 72 hours of death and filed with the local health agency where the death occurred. Local health officials may hold death

certificates for 30 to 60 days before filing them with the state health department. As a result, an After Death Reporting Form may reach the state before the death certificate arrives.

The department received the following documentation for 2015 Death with Dignity participants (people who received medication) as of March 25, 2016:

Table 5. Documentation Received for 2015 Participants

Form	Number
Written Requests to End Life	183
Attending Physician Compliance	195
Consulting Physician Compliance	189
Psychiatric/Psychological Consulting	8
Pharmacy Dispensing Form	213
After Death Reporting Form	197
Death Certificates	199

Confidentiality

The Death with Dignity Act requires that the department collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the department will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

Washington State

2016 Death With Dignity Act Report

September 2017

Washington State Department of Health

DOH 422-109 201

For more information contact:

Center for Health Statistics
deathwithdignity@doh.wa.gov
360-236-4324

For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

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Executive Summary

Washington's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from a physician. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report describes available information for the 248 participants for whom medication was dispensed between January 1, 2016 and December 31, 2016. It includes data from the documentation received by the Department of Health as of June 30, 2017.

In 2016, medication was dispensed to 248 individuals (defined as 2016 participants):

- Prescriptions were written by 140 different physicians
- Medications were dispensed by 47 different pharmacists

Of the 248 participants in 2016:

- 240 are known to have died
    - 192 died after ingesting the medication
    - 36 died without having ingested the medication
    - For the remaining 12 people who died, ingestion status is unknown
- For the 8 participants not included among those known to have died, the state health department has received no documentation (death certificate or after death form) that indicates death has occurred

The state has received death certificates for 239 participants in 2016; we are awaiting death certificate information on 1 additional participant.

Of the 239 participants in 2016 who died and for whom we have death certificates:

- The youngest was 33 years and the oldest was 98 years
- 94 percent lived west of the Cascades
- 97 percent were White
- 43 percent were married at time of death
- 67 percent had at least some college education
- 77 percent had cancer
- 8 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS)
- 16 percent had other illnesses, including heart and respiratory disease, and unknown illnesses

Of the 240 participants in 2016 who died, an After Death Report was provided for 236 participants. Of these 236 participants:

- 92 percent had private, Medicare, Medicaid, other insurance, or a combination of health insurance
- 87 percent reported to their health care provider concerns about loss of autonomy
- 66 percent reported to their health care provider concerns about loss of dignity

- 84 percent reported to their health care provider concerns about loss of the ability to participate in activities that make life enjoyable

Of the 192 participants in 2016 who died after ingesting the medication:

- 88 percent were at home at the time of death
- 77 percent were enrolled in hospice care when they ingested the medication

Death with Dignity Participation in 2016

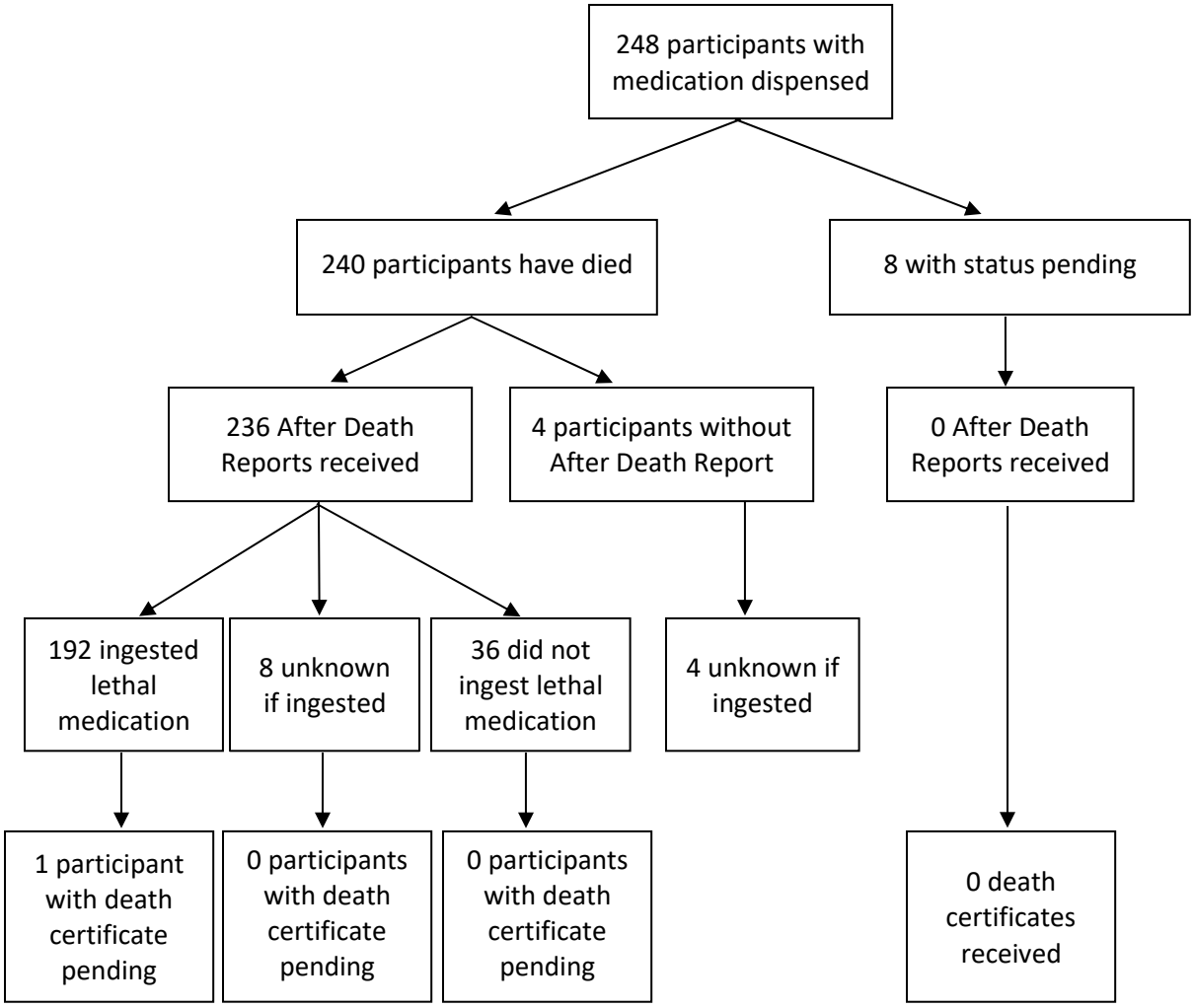
For the purposes of this report, a participant of the Death with Dignity Act in 2016 is defined as someone to whom medication was dispensed in 2016 under the terms of the act. Details of the act are included in Appendix A.

To date, the state health department has received documentation indicating that lethal doses of medication were dispensed to 248 participants under the law in 2016. These prescriptions were written by 140 different physicians and dispensed by 47 different pharmacists. The department has not yet received all of the required paperwork for all participants. Table 5 in Appendix A shows details of the documentation that has been received by the department. When all the required paperwork is not received, department staff contacts health care providers to obtain the documentation.

Among the 248 participants who received medication in 2016, the department has received confirmation that 240 have died; 192 ingested the medication, 36 did not ingest, and the ingestion status is unknown for 12 (Figure 1). Death of a participant is established through receipt of the After Death Reporting form and/or a death certificate.

The status of the remaining 8 participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the department because the After Death Reporting form is due 30 days after death and the death certificate is due 60 days after death.

Figure 1. Outcome of the 248 participants who received medication in 2016 under the terms of the Death with Dignity Act



Update on Death with Dignity Participation 2009-2015

Since the last Death with Dignity report was published in July of 2016 the department received additional information on participants from prior years. As of August 15, 2017, 211 of the 215 participants in 2015, 172 of the 176 participants in 2014, 169 of the 173 participants in 2013, 121 of the 121 participants in 2012, 102 of the 103 participants in 2011, 87 of the 87 participants in 2010, and 64 of the 65 participants in 2009 had died. The status of the four remaining participants in 2015, four remaining participants in 2014, the four remaining participants 2013, the one remaining participant in 2011, and the one remaining participant in 2009 remains unknown. These participants may have died, but no documentation of the death has been received. The number of participants in 2009-2016, and the number of these participants who are known to have died as of August 15, 2017, are shown in Figure 2.

Figure 2. Number of Death with Dignity Participants and Known Deaths, WA 2009-2016

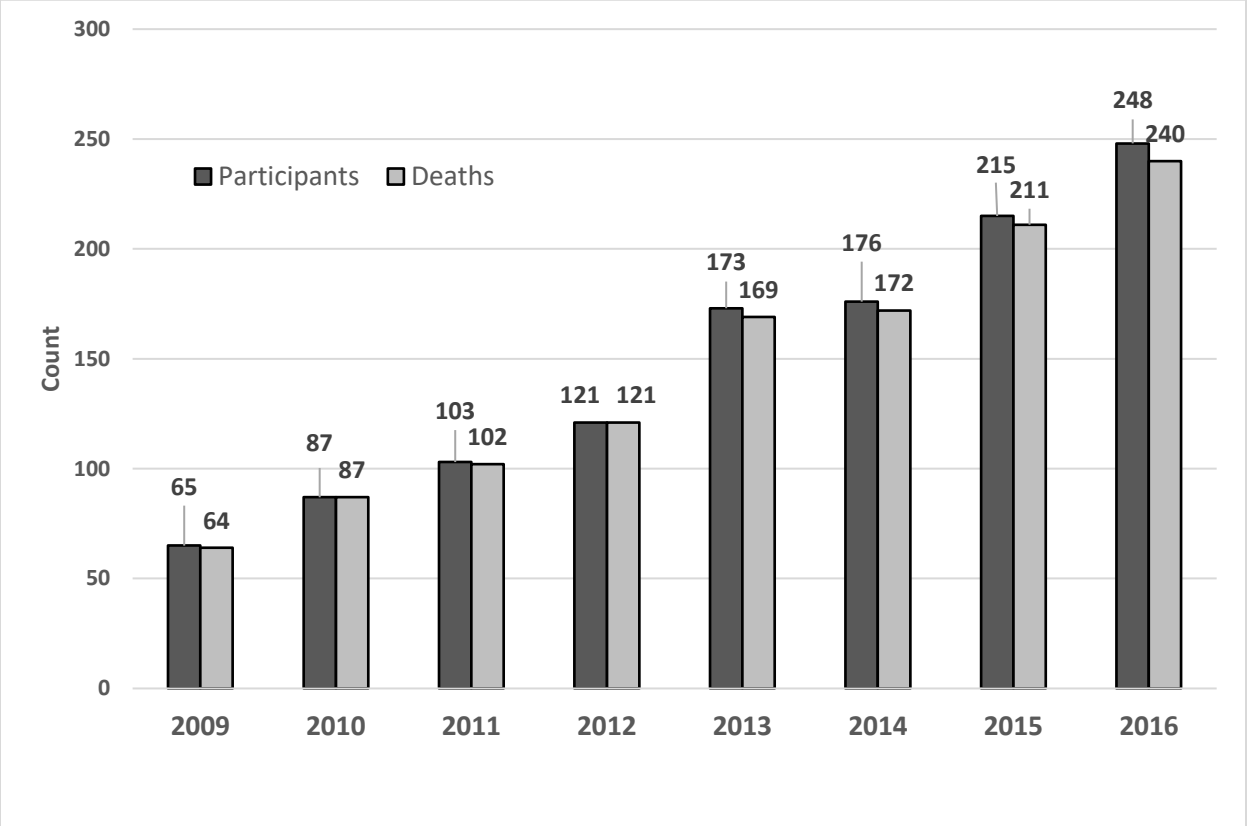


Table 1. Characteristics of the participants of the Death with Dignity Act who have died

	2016		2015[1]		2014	
	Number	**%**	**Number**	**%**	**Number**	**%**
Sex[2]						
Male	120	50	113	54	75	44
Female	119	50	97	46	97	56
Age (years)[2]						
18-44	6	3	5	2	7	4
45-54	12	5	12	6	10	6
55-64	53	22	39	19	33	19
65-74	59	25	65	31	53	31
75-84	67	28	42	20	40	23
85+	42	18	47	22	29	17
Range (min-max)	33-98		20–97		21–101	
Race and Ethnicity[2]						
White	232	97	205	98	159	92
Other	7	3	5	2	12	7
Unknown	0	0	0	0	1	1
Marital Status[2]						
Married	103	43	99	47	81	47
Widowed	47	20	45	21	34	20
Divorced	65	27	54	26	37	21
Domestic partner (state-registered)	2	1	0	0	18	10
Never married/single	17	7	12	6	1	1
Unknown	5	1	0	0	1	1
Education[2]						
Less than high school	10	4	8	4	4	2
High school graduate	65	27	46	22	37	22
Some college	84	35	55	26	42	24
Baccalaureate or higher	77	32	99	47	86	50
Unknown	3	1	2	1	3	2
Residence[3,4]						
West of the Cascades	224	94	199	95	161	95
East of the Cascades	15	6	11	5	9	5
Underlying illness[3]						
Cancer	184	77	148	72	129	76
Neuro-degenerative disease (including ALS[5])	18	8	17	8	21	13
Respiratory disease (including COPD[6])	18	8	18	9	4	2
Heart disease	14	6	11	5	10	6
Other illnesses	5	2	11	5	6	3
Insurance Status[7]						
Private only	43	18	28	14	33	23
Medicare or Medicaid only	109	46	102	50	82	57
Combination of private & Medicare/Medicaid	40	17	20	10	18	13
None	1	<1	3	1	3	2
Unknown	16	6	29	14	7	5
Other (including VA and other insurance)	27	11	20	10		

Notes:

[1] Data derived from the death certificate (sex, age, race/ethnicity, marital status, and education) have been updated for 2015. Data have been updated for 8 of the 2015 participants with information received since the 2015 report was published. At time of publication, death certificate data are available for 210 of the 2015 participants.

[2] Data are collected from the death certificate. At time of publication, data are available 239 of the 240 participants in 2016 who died.

[3] Data are collected from multiple documents (After Death Reporting Form, Attending Physician Compliance Form, and Death Certificate). At time of publication, data are available for 239 of the 240 participants in 2016 who died.

[4] Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

[5] Amyotrophic Lateral Sclerosis (ALS).

[6] Chronic Obstructive Pulmonary Disease (COPD).

[7] Data are collected from the After Death Reporting form. At the time of publication, data are available for 236 of the 240 participants in 2016.

Table 2. End of life concerns of participants of the Death with Dignity Act who have died.

	2016		2015		2014[1]	
	Number	**%**	**Number**	**%**	**Number**	**%**
End of Life Concerns[2, 3]						
Losing autonomy	206	87	170	84	127	89
Less able to engage in activities making life enjoyable	199	84	170	84	135	94
Loss of dignity	156	66	135	67	113	79
Burden on family, friends/caregivers	120	51	96	48	85	59
Losing control of bodily functions	101	43	102	51	73	51
Inadequate pain control or concern about it	97	41	71	35	59	41
Financial implications of treatment	18	8	25	12	12	8

Notes:

[1] Data published in 2014 report:
http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 236 of the 240 participants in 2016 who died.

[3] Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent.

Table 3. Death with Dignity Act process for the participants who have died

	2016		2015		2014[1]	
	Number	**%**	**Number**	**%**	**Number**	**%**
Family and Psychiatric/Psychological involvement						
Referred for psychiatric/psychological evaluation[2]	11	5	8	4	6	4
Patient informed family of decision[3]	221	94	174	93	146	88
Medication[4]						
Secobarbital	77	32	109	51	112	64
Pentobarbital	2	1	4	2	64	36
Secobarbital/Pentobarbital Combination	0	0	0	0	0	0
Phenobarbital	1	<1	10	5	0	0
Phenobarbital/Chloral Hydrate Combination	106	44	88	41		
Chloral Hydrate	1	<1				
Morphine sulfate	52	22	4	2	0	0
Other	1	<1	0	0	0	0
Timing						
Duration of patient-physician relationship[5]						
<25 weeks	125	53	99	49	62	43
25 weeks – 51 weeks	25	11	18	9	18	13
1 year or more	84	36	81	40	57	40
Unknown	2	1	4	2	6	4
Range (min – max)	<1 wk – 31 yrs		<1 wk – 2 yrs		<1 wk – 23 yrs	
Duration between first oral request and death[2]						
<25 weeks	209	89	164	81	145	87
25 weeks or more	24	10	33	16	15	9
Unknown	3	1	5	2	7	4
Range (min – max)	2 wks – 112 wks		0 wks – 95 wks		2 wks – 57 wks	

Notes:

[1] Data published in 2014 report: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.

[2] Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 236 of the 240 participants in 2016 who died.

[3] Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 234 of the 240 participants in 2016 who died.

[4] Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 240 participants in 2016 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.

[5] Data are collected from the After Death Reporting form. At the time of publication, data are available for 236 of the 240 participants in 2016 who died.

Table 4. Circumstances and complications related to ingestion of medication prescribed under the Death with Dignity Act of the participants who have died

	2016		2015		2014[1]	
	Number	**%**	**Number**	**%**	**Number**	**%**
Circumstances when medication ingested[2]						
Healthcare provider present						
Prescribing physician	17	9	9	5	7	6
Other provider, not prescribing physician, present	97	51	117	69	78	62
No provider	25	13	23	14	21	16
Unknown	53	28	20	12	20	16
Location of patient						
Home (patient, family, friend)	168	88	146	86	116	92
Long term care, assisted living or foster care facility	14	7	17	10	7	5
Hospital	0	0	0	0	0	0
Other	3	2	1	1	2	2
Unknown	7	3	5	3	1	1
Hospice care						
Enrolled	148	77	138	82	86	69
Not enrolled	27	14	19	11	35	28
Unknown	17	9	12	7	5	4
Timing[2]						
Minutes between ingestion and unconsciousness						
1 min – 10 min	110	57	122	72	84	67
11 min or more	44	23	9	5	11	9
Unknown	38	20	38	22	31	24
Range (min – max)	1 min – 11 hours		1 min–72 min		1 min–60 min	
Minutes between ingestion and death						
Less than 90 min	102	53	104	62	91	72
91 min or more	57	30	36	21	10	8
Unknown	33	17	29	17	25	20
Range (min – max)	1 min to 22 hrs		5 min–72 hrs		3 min–18hrs	
Complications[2]						
Regurgitation	7	4	3	2	2	2
Seizures	0	0	0	0	1	1
Awakened after taking prescribed medication	0	0	0	0	0	0
Other	2	1	2	1	0	0
None	162	84	150	89	121	96
Unknown	21	11	14	8	2	1
Emergency Medical Services involvement[2]						
Called for intervention after lethal medication ingested	0	0	0	0	0	0
Called for other reason (including to pronounce death)	3	2	2	1	2	2
Not called after lethal medication ingested	171	89	151	89	117	93
Unknown	18	9	16	9	7	5

Notes:

[1] Data published in 2014 report:
http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.

[2] Data are collected from the After Death Reporting form. At the time of publication, data are available for 192 participants in 2016 who are known to have ingested the medication.

Appendix A

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the department. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the department:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms have to be submitted to the department.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington law, a death certificate must be completed within 72 hours of death and filed with the local health agency where the death occurred. Local health officials may hold death

certificates for 30 to 60 days before filing them with the state health department. As a result, an After Death Reporting Form may reach the state before the death certificate arrives.

The department received the following documentation for 2016 Death with Dignity participants (people who received medication) as of June 30, 2017:

Table 5. Documentation Received for 2016 Participants.

Form	Number
Written Requests to End Life	236
Attending Physician Compliance	238
Consulting Physician Compliance	237
Psychiatric/Psychological Consulting	10
Pharmacy Dispensing Form	248
After Death Reporting Form	236
Death Certificates	239

Confidentiality

The Death with Dignity Act requires that the department collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the department will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

Washington State

Death With Dignity Act Report

March 2018

Disease Control and Health Statistics Division

For more information contact:

Center for Health Statistics
deathwithdignity@doh.wa.gov
360-236-4324

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Washington State Department of Health 2017 Death with Dignity Act Report

Executive Summary

Washington's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from a physician. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report describes available information for the 212 participants for whom medication was dispensed between January 1, 2017 and December 31, 2017. It includes data from the documentation received by the Department of Health (department) as of February 6, 2018.

In 2017, medication was dispensed to 212 individuals (defined as 2017 participants):

- Prescriptions were written by 115 different physicians.
- Medications were dispensed by 51 different pharmacists.

Of the 212 participants in 2017:

- 196 are known to have died.
    - 164 died after ingesting the medication.
    - 19 died without having ingested the medication.
    - For the remaining 13 people who died, ingestion status is unknown.
- For the 16 participants not included among those known to have died, the department has received no documentation (death certificate or after death form) that indicates death has occurred.

The department has received death certificates for 196 participants in 2017.

Of the 196 participants in 2017 who died and for whom we have death certificates:

- The youngest was 33 years and the oldest was 98 years.
- 90 percent lived west of the Cascades.
- 94 percent were white.
- 47 percent were married at time of death.
- 75 percent had at least some college education.
- 72 percent had cancer.
- 8 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS).
- 20 percent had other illnesses, including heart and respiratory disease, and unknown illnesses.

Of the 196 participants in 2017 who died, an After Death Report was provided for 186 participants. Of these 186 participants:

- 97 percent had private, Medicare, Medicaid, other insurance, or a combination of health insurance .
- 90 percent reported to their health care provider concerns about loss of autonomy.
- 87 percent reported to their health care provider concerns about loss of the ability to participate in activities that make life enjoyable .

- 73 percent reported to their health care provider concerns about loss of dignity.

Of the 164 participants in 2017 who died after ingesting the medication:

- 88 percent were at home at the time of death.
- 88 percent were enrolled in hospice care when they ingested the medication.

Death with Dignity Participation in 2017

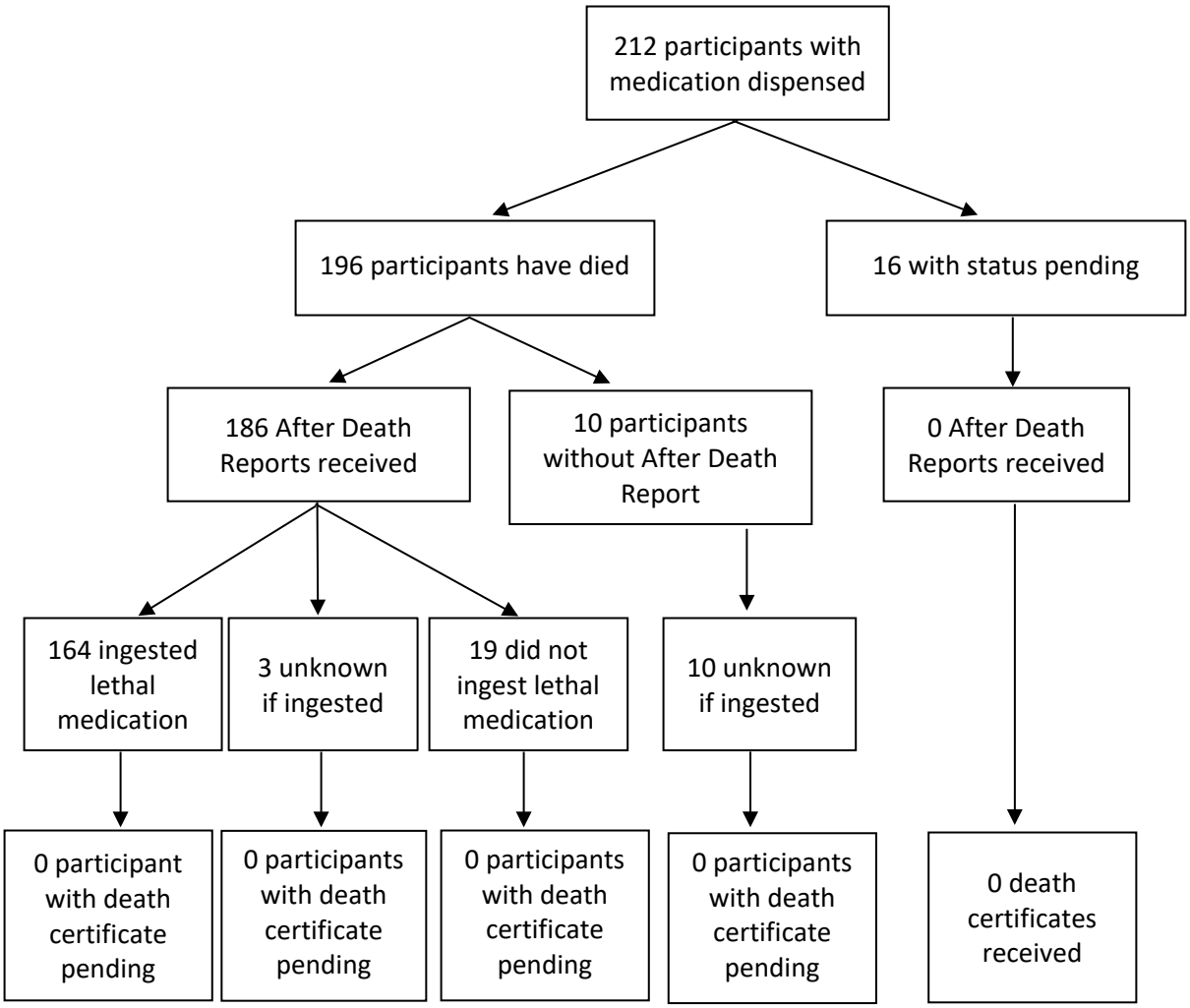
For the purposes of this report, a participant of the Death with Dignity Act in 2017 is defined as someone to whom medication was dispensed in 2017 under the terms of the act. Details of the act are included in Appendix A.

As of February 6, 2018, the department has received documentation indicating that lethal doses of medication were dispensed to 212 participants under the law in 2017. These prescriptions were written by 115 different physicians and dispensed by 51 different pharmacists. The department has not yet received all of the required paperwork for all participants. Table 5 in Appendix A shows details of the documentation that has been received by the department. When all the required paperwork is not received, department staff contact health care providers to obtain the documentation.

Among the 212 participants who received medication in 2017, the department has received confirmation that 196 have died; 164 ingested the medication, 19 did not ingest, and the ingestion status is unknown for 13 (Figure 1). Death of a participant is established through receipt of the After Death Reporting form and/or a death certificate.

The status of the remaining 16 participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the department because the After Death Reporting form is due 30 days after death and the death certificate is due 60 days after death.

Figure 1. Outcome of the 212 participants who received medication in 2017 under the terms of the Death with Dignity Act



Update on Death with Dignity Participation 2009-2016

Since the last Death with Dignity report was published in September of 2017, the department received additional information on participants from prior years. As of February 6, 2018, 242 of the 249 participants in 2016, 211 of the 215 participants in 2015, 172 of the 176 participants in 2014, 169 of the 173 participants in 2013, 121 of the 121 participants in 2012, 102 of the 103 participants in 2011, 87 of the 87 participants in 2010, and 64 of the 65 participants in 2009 had died. The status of the seven remaining participants in 2016, four remaining participants in 2015, four remaining participants in 2014, four remaining participants 2013, one remaining participant in 2011, and one remaining participant in 2009 remains unknown. These participants may have died, but no documentation of the death has been received. The number of participants in 2009-2017, and the number of these participants who are known to have died as of February 6, 2017, are shown in Figure 2.

Figure 2. Number of Death with Dignity Participants and Known Deaths, WA 2009-2017

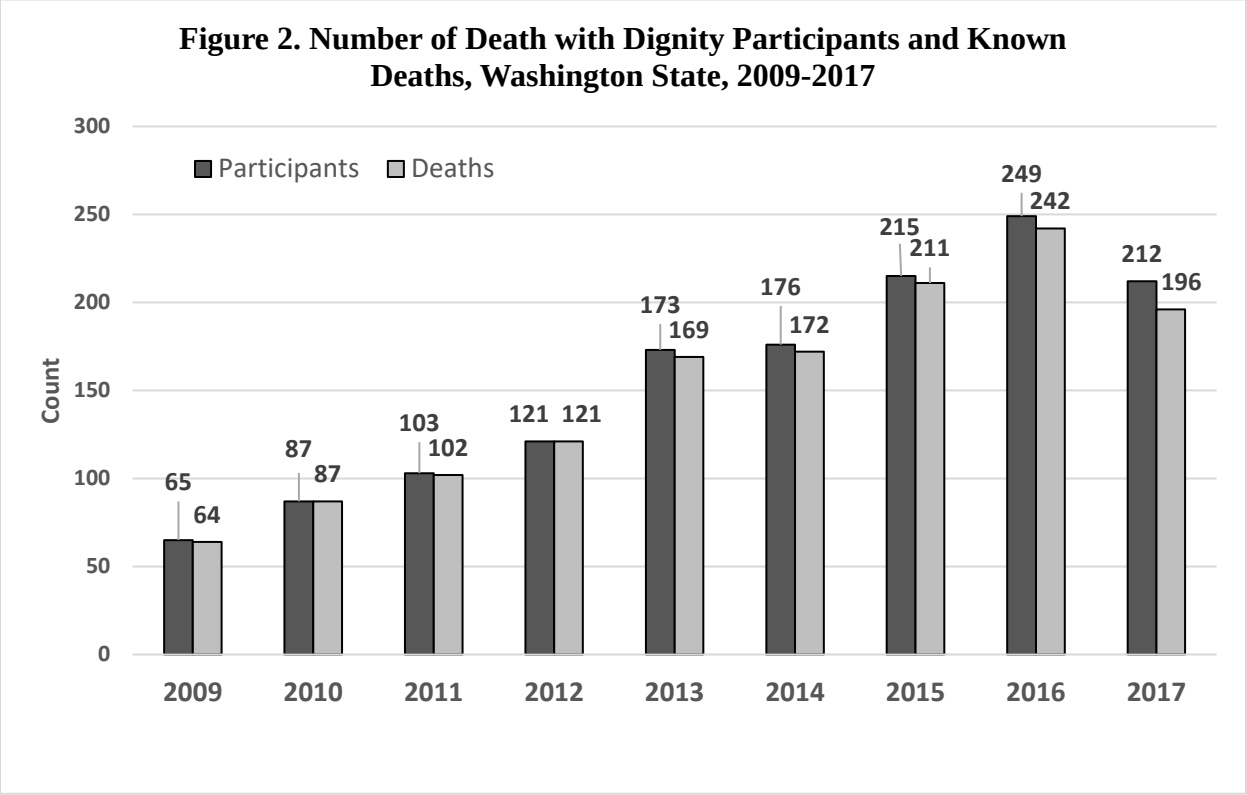


Table 1. Characteristics of the participants of the Death with Dignity Act who have died

	2017		2016[1]		2015[2]	
	Number	%	Number	%	Number	%
Sex[3]						
Male	94	48	121	50	113	54
Female	102	52	120	50	97	46
Age (years)[3]						
18-44	6	3	6	3	5	2
45-54	13	7	12	5	12	6
55-64	31	16	54	22	39	19
65-74	63	32	59	24	65	31
75-84	40	20	68	28	42	20
85+	43	22	42	17	47	22
Range (min-max)	33-98		33-98		20–97	
Race and Ethnicity[3]						
White	185	94	232	96	205	98
Other	10	5	9	4	5	2
Unknown	1	<1	0	0	0	0
Marital Status[3]						
Married	91	47	103	44	99	47
Widowed	40	20	47	20	45	21
Divorced	50	26	65	27	54	26
Domestic partner (state-registered)	0	0	2	1	0	0
Never married/single	15	8	17	7	12	6
Unknown	0	0	7	1	0	0
Education[3]						
Less than high school	9	5	11	4	8	4
High school graduate	38	19	65	27	46	22
Some college	43	22	85	35	55	26
Baccalaureate or higher	104	53	77	32	99	47
Unknown	2	1	3	1	2	1
Residence[4,5]						
West of the Cascades	177	90	224	93	199	95
East of the Cascades	19	10	17	7	11	5
Underlying illness[6]						
Cancer	135	72	185	77	148	72
Neuro-degenerative disease (including ALS[7])	15	8	18	7	17	8
Respiratory disease (including COPD[8])	16	9	19	8	18	9
Heart disease	15	8	14	6	11	5
Other illnesses	6	3	5	2	11	5
Insurance Status[9]						
Private only	40	22	45	19	28	14
Medicare or Medicaid only	100	54	109	46	102	50
Combination of private & Medicare/Medicaid	31	17	40	17	20	10
None	1	<1	1	<1	3	1
Unknown	5	3	16	6	29	14
Other (including VA and other insurance)	9	5	27	11	20	10

Notes:

1. Data derived from the death certificate (sex, age, race/ethnicity, marital status, and education) have been updated for 2016. Data have been updated for 2 of the 2016 participants with information received since the 2016 report was published. At time of publication, death certificate data are available for 241 of the 2016 participants.
2. Data published in 2016 report: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx
3. Data are collected from the death certificate. At time of publication, data are available for all 196 participants in 2017 who died.
4. Data are collected from multiple documents (After Death Reporting Form, Attending Physician Compliance Form, and Death Certificate). At time of publication, residence data are available for all 196 participants in 2017 who died.
5. Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.
6. Data are collected from multiple documents (After Death Reporting Form and Attending Physician Compliance Form). At time of publication, data are available for 187 of the 196 participants in 2017 who died.
7. Amyotrophic Lateral Sclerosis (ALS).
8. Chronic Obstructive Pulmonary Disease (COPD).
9. Data are collected from the After Death Reporting form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.

Table 2. End of life concerns of participants of the Death with Dignity Act who have died.

	2017		2016		2015[1]	
	Number	%	Number	%	Number	%
End of Life Concerns[2, 3]						
Losing autonomy	167	90	208	87	170	84
Less able to engage in activities making life enjoyable	162	87	201	84	170	84
Loss of dignity	135	73	157	65	135	67
Burden on family, friends/caregivers	105	56	122	51	96	48
Losing control of bodily functions	86	46	102	43	102	51
Inadequate pain control or concern about it	70	38	97	40	71	35
Financial implications of treatment	19	10	18	8	25	12

Notes:

1. Data published in 2016 report: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx
2. Data are collected from the After Death Reporting form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
3. Participants may have selected more than one end of life concern. Thus the totals are greater than 100 percent.

Table 3. Death with Dignity Act process for the participants who have died

	2017		2016		2015[1]	
	Number	%	Number	%	Number	%
Family and Psychiatric/Psychological involvement						
Referred for psychiatric/psychological evaluation[2]	4	2	11	5	8	4
Patient informed family of decision[3]	174	94	224	95	174	93
Medication[4]						
Secobarbital	66	34	77	32	109	51
Pentobarbital	0	0	2	1	4	2
Secobarbital/Pentobarbital Combination	0	0	0	0	0	0
Phenobarbital	0	0	2	<1	10	5
Phenobarbital/Chloral Hydrate Combination	0	0	106	44	88	41
Chloral Hydrate	0	0	1	<1		
Morphine sulfate	130	66	53	22	4	2
Other	0	0	1	<1	0	0
Timing						
Duration of patient-physician relationship[5]						
<25 weeks	94	51	125	52	99	49
25 weeks – 51 weeks	21	11	25	10	18	9
1 year or more	71	38	88	37	81	40
Unknown	0	0	2	1	4	2
Range (min – max)	<1 wk – 38 yrs		<1 wk – 31 yrs		<1 wk – 2 yrs	
Duration between first oral request and death[6]						
<25 weeks	167	90	209	88	164	81
25 weeks or more	18	10	28	12	33	16
Unknown	0	0	0	0	5	2
Range (min – max)	2 wks – 81 wks		2 wks – 112 wks		0 wks – 95 wks	

Notes:

1. Data published in 2016 report: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.
2. Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
3. Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.
4. Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 196 participants in 2017 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.
5. Data are collected from the After Death Reporting form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
6. Data are collected from the After Death Reporting form and Attending physician Compliance Form. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.

Table 4. Circumstances and complications related to ingestion of medication prescribed under the Death with Dignity Act of the participants who have died

	2017		2016		2015[1]	
	Number	%	Number	%	Number	%
Circumstances when medication ingested[2]						
Healthcare provider present						
Prescribing physician	13	8	17	9	9	5
Other provider, not prescribing physician, present	84	51	99	51	117	69
No provider	24	15	25	13	23	14
Unknown	43	26	53	27	20	12
Location of patient						
Home (patient, family, friend)	144	88	169	87	146	86
Long term care, assisted living or foster care facility	15	9	14	7	17	10
Hospital	0	0	0	0	0	0
Other	0	0	3	2	1	1
Unknown	5	3	8	4	5	3
Hospice care						
Enrolled	145	88	150	77	138	82
Not enrolled	10	6	27	14	19	11
Unknown	9	5	17	9	12	7
Timing[2]						
Minutes between ingestion and unconsciousness						
1 min – 10 min	109	66	111	57	122	72
11 min or more	21	13	44	23	9	5
Unknown	34	21	39	20	38	22
Range (min – max)	1 min – 6 hrs		1 min – 11 hrs		1 min– 72 min	
Minutes between ingestion and death						
Less than 90 min	106	64	102	53	104	62
91 min or more	31	19	58	30	36	21
Unknown	27	16	34	17	29	17
Range (min – max)	5 min to 35 hrs		1 min to 22 hrs		5 min– 72 hrs	
Complications[2]						
Regurgitation	2	1	7	4	3	2
Seizures	0	0	0	0	0	0
Awakened after taking prescribed medication	0	0	0	0	0	0
Other	2	1	2	1	2	1
None	144	88	163	84	150	89
Unknown	16	10	22	11	14	8
Emergency Medical Services involvement[2]						
Called for intervention after lethal medication ingested	0	0	0	0	0	0
Called for other reason (including to pronounce death)	1	1	3	2	2	1
Not called after lethal medication ingested	153	93	172	89	151	89
Unknown	10	6	19	10	16	9

Notes:

1. Data published in 2016 report: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.
2. Data are collected from the After Death Reporting form. At the time of publication, data are available for 164 of the participants in 2017 who are known to have ingested the medication.

Appendix A

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the department. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the department:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms have to be submitted to the department.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington law, a death certificate must be completed within 72 hours of death and filed with the local health agency where the death occurred. Local health officials may hold death

certificates for 30 to 60 days before filing them with the state health department. As a result, an After Death Reporting Form may reach the state before the death certificate arrives.

The department received the following documentation for 2017 Death with Dignity participants (people who received medication) as of Feb 6, 2018:

Table 5. Documentation Received for 2017 Participants.

Form	Number
Written Requests to End Life	193
Attending Physician Compliance	194
Consulting Physician Compliance	194
Psychiatric/Psychological Consulting	10
Pharmacy Dispensing Form	212
After Death Reporting Form	186
Death Certificates	196

Confidentiality

The Death with Dignity Act requires that the department collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the department will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

2018 Death with Dignity Act Report

July 2019

Chapter 70.245 RCW

Disease Control & Health Statistics
Center for Health Statistics

Washington State Department of Health

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DOH 422-109

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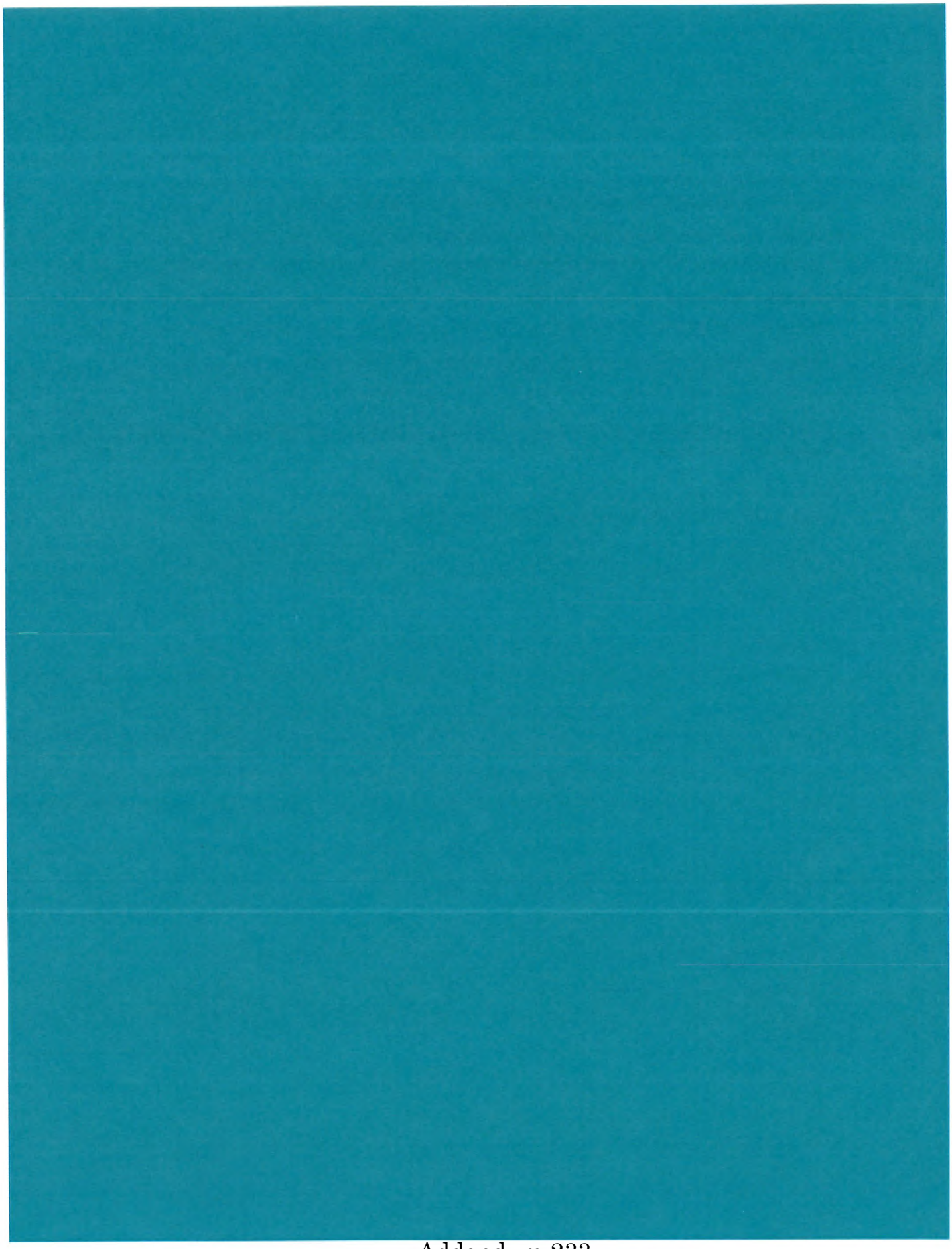


Executive Summary

Washington State's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from a physician. This report provides available information about people who participated in the program between January 1, 2018 and December 31, 2018. The data in the report are from documentation received by the Washington State Department of Health as of May 17, 2019. In this report, a participant is defined as someone to whom medication was dispensed under the terms of the law.

A total of 267 individuals were dispensed the medication in 2018.

- 158 different physicians prescribed the medication.
- 61 different pharmacists dispensed the medication.

The department received death certificates for 251 participants and After Death Reporting Forms for 238 participants.

- 251 participants are known to have died.
  - 203 died after ingesting the medication.
  - 29 died without having ingested the medication.
  - Ingestion status is unknown for the remaining 19 participants.
- The department has not received documentation (death certificate or After Death Reporting Form) that indicates death has occurred for the additional 16 participants.

Out of the 203 that died after ingesting the medication:

- 86 percent were at home at the time of death.
- 92 percent were enrolled in hospice care when they ingested the medication.

Characteristics of participants (as indicated in death certificates, 251 participants):

- The youngest was 28 years and the oldest was 98 years.
- 86 percent lived west of the Cascades.
- 96 percent were white.
- 44 percent were married at time of death.
- 70 percent had at least some college education.
- 75 percent had cancer.
- 10 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS).
- 15 percent had other illnesses, including heart and respiratory disease, and unknown illnesses.
- 94 percent had private, Medicare, Medicaid, other insurance, or a combination of health insurance (as indicated in After Death Reporting Forms, 238 participants).

Participants shared the following concerns with their health care providers (as indicated in After Death Reporting Forms, 238 participants):

- Loss of autonomy (85 percent)
- Loss of the ability to participate in activities that make life enjoyable (84 percent)
- Loss of dignity (69 percent)

Death with Dignity Act Participation in 2018

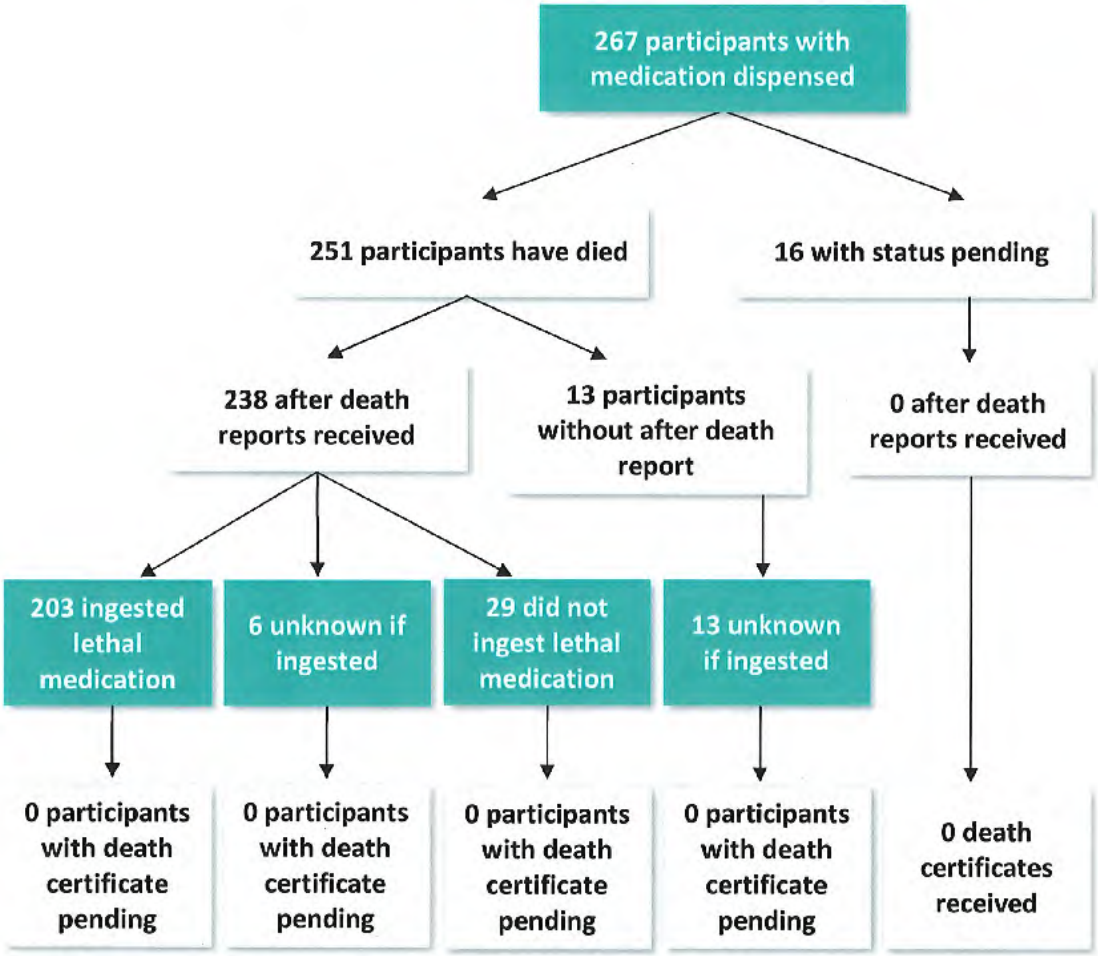
For the purposes of this report, a participant of the Death with Dignity Act in 2018 is defined as someone to whom medication was dispensed in 2018 under the terms of the act. Details of the act are included in Appendix A.

As of May 17, 2019, the department has received documentation indicating that lethal doses of medication were dispensed to 267 participants under the law in 2018. These prescriptions were written by 158 different physicians and dispensed by 61 different pharmacists. The department has not yet received all of the required paperwork for all participants. *Table 5* in Appendix A shows details of the documentation that has been received by the department. When all the required paperwork is not received, department staff contact health care providers to obtain the documentation.

Among the 267 participants who received medication in 2018, the department has received confirmation that 251 have died; 203 ingested the medication, 29 did not ingest, and the ingestion status is unknown for 19 (*Figure 1*). Death of a participant is established through receipt of the After Death Reporting Form and/or a death certificate.

The status of the remaining 16 participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the department because the After Death Reporting Form is due 30 days after death and the death certificate is due 60 days after death.

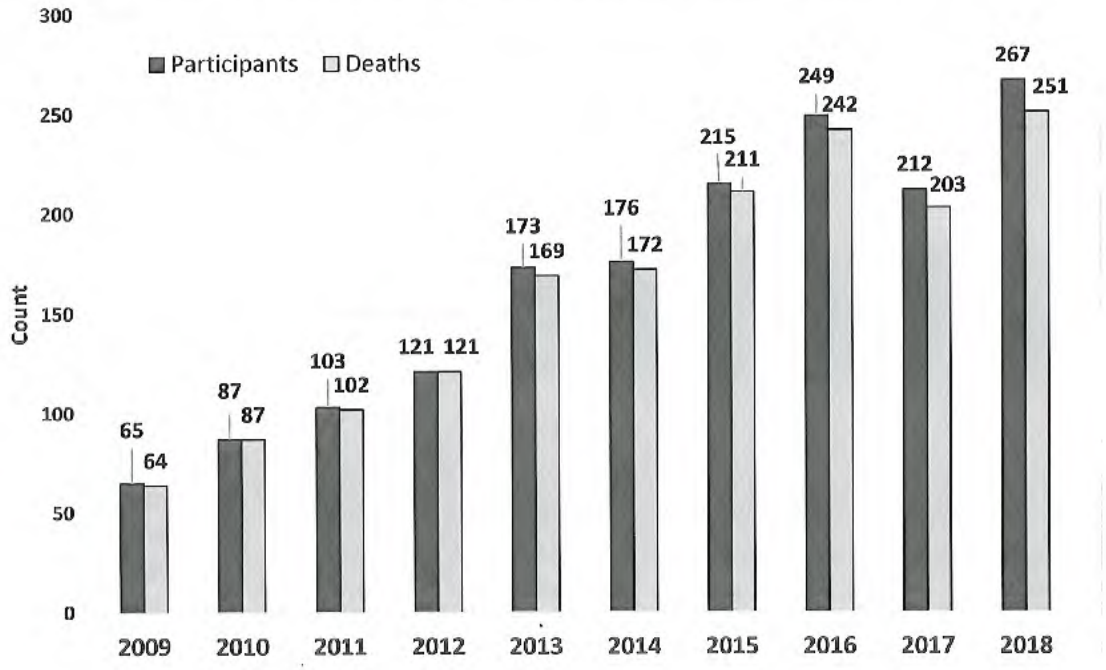
Figure 1. Outcome of the Death with Dignity Act Participants, 2018



Update on Death with Dignity Participation 2009-2017

Since the last Death with Dignity report was published in February of 2018, the department received additional information on participants from prior years. *Figure 2* shows the known number of participants and the number of deaths as of May 17, 2019, for 2009 through 2018. The status of the remaining participants in 2009, 2011, 2013, 2014, 2015, 2016, 2017, and 2018 remains unknown. These participants may have died, but no documentation of the death has been received.

Figure 2. Number of Death with Dignity participants and known deaths, 2009-2018



Data Tables: 2016-2018

Table 1. Characteristics of participants who died, 2016-2018

	2018		2017[1]		2016[2]	
	Number	%	Number	%	Number	%
Sex[3]						
Male	140	44	98	48	121	50
Female	111	56	105	52	120	50
Age (years)[3]						
18-54	15	6	20	10	18	8
55-64	36	14	31	15	54	22
65-74	100	40	64	32	59	24
75-84	64	25	43	21	68	28
85+	36	14	45	22	42	17
Range (min-max)	28 - 98		33-98		33-98	
Race and Ethnicity[3]						
White	241	96	192	5	232	96
Other	10	4	10	5	9	4
Unknown	0	0	1	<1	0	0
Marital Status[3]						
Married	110	44	93	46	103	43
Widowed	50	20	42	20	47	20
Divorced	67	27	52	26	65	27
Never married/single, Other, Unknown	24	9	16	8	26	11
Education[3]						
Less than high school	11	4	10	5	11	4
High school graduate	63	25	38	19	65	27
Some college	61	24	45	22	85	35
Baccalaureate or higher	116	46	108	53	77	32
Unknown	0	0	2	1	3	1
Residence[4,5]						
West of the Cascades	216	86	177	90	224	93
East of the Cascades	29	12	19	10	17	7
Unknown	6	2				
Underlying illness[6]						
Cancer	186	75	135	72	185	77
Neuro-degenerative disease (including ALS[7])	25	10	15	8	18	7
Respiratory disease (including COPD[8])	12	5	16	9	19	8
Heart disease	15	6	15	8	14	6
Other illnesses	10	4	6	3	5	2
Insurance Status[9]						
Private only	38	16	40	22	45	19
Medicare or Medicaid only	156	66	100	54	109	46
Combination of private & Medicare/Medicaid	21	9	31	17	40	17
None, Other, Unknown	23	10	15	8	44	18

Table 1 Notes

1. Data derived from the death certificate (sex, age, race/ethnicity, marital status, and education) have been updated for 2017. Data were updated to include seven additional participants since the 2017.
2. Data published in 2017 report: www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx
3. Data are collected from the death certificates. At time of publication, data were available for all 251 participants in 2018 who died.
4. Data are collected from multiple documents (After Death Reporting Form, Attending Physician Compliance Form, and death certificate). At time of publication, residence data were available for 245 of 251 participants in 2018 who died.
5. Counties west of the Cascades include: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades include: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.
6. Data are collected from multiple documents (After Death Reporting Form and Attending Physician Compliance Form). At time of publication, data were available for 248 of the 251 participants in 2018 who died.
7. Amyotrophic Lateral Sclerosis (ALS)
8. Chronic Obstructive Pulmonary Disease (COPD)
9. Data are collected from After Death Reporting Forms. At the time of publication, data were available for 238 of the 251 participants in 2018 who died.

Table 2. End of life concerns of participants who died, 2016-2018

	2018		2017[1]		2016[1]	
	Number	%	Number	%	Number	%
End of Life Concerns[2, 3]						
Loss of autonomy	203	85	167	90	208	87
Less able to engage in activities making life enjoyable	199	84	162	87	201	84
Loss of dignity	165	69	135	73	157	65
Burden on family, friends/caregivers	121	51	105	56	122	51
Losing control of bodily functions	108	45	86	46	102	43
Inadequate pain control or concern about it	90	38	70	38	97	40
Financial implications of treatment	22	9	19	10	18	8

Table 2 Notes

1. Data published in 2017 report: www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.
2. Data are collected from the After Death Reporting form. At the time of publication, data were available for 238 of the 251 participants in 2018 who died.
3. Participants may have selected more than one end of life concern, thus the totals are greater than 100 percent.

Table 3. Death with Dignity Act process for participants who died, 2016-2018

	2018		2017[1]		2016[1]	
	Number	%	Number	%	Number	%
Family and Psychiatric/Psychological involvement						
Referred for psychiatric/psychological evaluation	10	4	--[7]	--	11	5
Patient informed family of decision3	222	92	174	94	224	95
Medication4						
Secobarbital	56	22	66	34	77	32
Phenobarbital/Chloral Hydrate Combination	0	0	0	0	106	44
Morphine sulfate	195	78	130	66	53	22
Other	0	0	0	0	5	2
Timing						
Duration of patient-physician relationship5						
<25 weeks	118	50	94	51	125	52
25 weeks – 51 weeks	25	11	21	11	25	10
1 year or more	90	38	71	38	88	37
Unknown	5	2	0	0	2	1
Range (min – max)	<1 wk – 23 yrs		<1 wk – 38 yrs		<1 wk – 31 yrs	
Duration between first oral request and death6						
<25 weeks	200	86	167	90	209	88
25 weeks or more	27	12	18	10	28	12
Unknown	5	2	0	0	0	0
Range (min – max)	2 wks –115 wks		2 wks – 81 wks		2 wks –112 wks	

Table 3 Notes

1. Data published in 2017 report: www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.
2. Data are collected from the Attending Physician's Compliance Form. At the time of publication, data were available for 238 of the 251 participants in 2018 who died.
3. Data are collected from the Written Request for Medication to End Life. At the time of publication, data were available for 240 of the 251 participants in 2018 who died.
4. Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data were available for all 251 participants in 2018 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.
5. Data are collected from the After Death Reporting Form. At the time of publication, data were available for 233 of the 251 participants in 2018 who died.
6. Data are collected from the After Death Reporting form and the Attending Physician Compliance form. At the time of publication, data were available for 227 of the 251 participants in 2018 who died.
7. Redacted due to department Small Numbers Guidelines.

Table 4. Circumstances and Complications Related to Ingestion of Medication Prescribed for Participants Who Died, 2016-2018

	2018		2017[1]		2016[1]	
	Number	%	Number	%	Number	%
Circumstances when medication ingested[2]						
Health care provider present						
Prescribing physician	20	10	13	8	17	9
Other provider, not prescribing physician, present	136	67	84	51	99	51
No provider	16	8	24	15	25	13
Unknown	31	15	43	26	53	27
Location of patient						
Home (patient, family, friend)	175	86	144	88	169	87
Long term care, assisted living or foster care facility	17	8	15	9	14	7
Hospital, Other, Unknown	11	5	5	3	11	6
Hospice care						
Enrolled	186	92	145	88	150	77
Not enrolled	11	5	10	6	27	14
Unknown	6	3	9	5	17	9
Timing[2]						
Minutes between ingestion and unconsciousness						
1 min – 10 min	134	66	109	66	111	57
11 min or more	30	15	21	13	44	23
Unknown	39	19	34	21	39	20
Range (min – max)	1 min – 1 hrs		1 min – 6 hrs		1 min – 11 hrs	
Minutes between ingestion and death						
Less than 90 min	110	54	106	64	102	53
91 min or more	62	31	31	19	58	30
Unknown	31	15	27	16	34	17
Range (min – max)	7 min to 30 hrs		5 min to 35 hrs		1 min to 22 hrs	
Complications[2]						
Regurgitation, Seizures, Awakening, Other	8	4	4	2	9	5
None	179	88	144	88	163	84
Unknown	16	8	16	10	22	11
Emergency Medical Services involvement[2]						
Called for intervention after lethal medication ingested	0	0	0	0	0	0
Unknown or Called for other reason (including to pronounce death)	9	4	11	7	22	12
Not called after lethal medication ingested	194	96	153	93	172	89

Table 4 Notes

1. Data published in 2017 report: www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.
2. Data are collected from the After Death Reporting Form. At the time of publication, data were available for 203 of the participants in 2018 who are known to have ingested the medication.

Appendix A

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act
To comply with the act, attending physicians and pharmacists must file documentation with the department. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the department:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms have to be submitted to the department.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from ingestion of a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Under Washington law, a death certificate must be completed within 72 hours of death and filed with the local health agency where the death occurred. Local health officials may hold death certificates for 30 to 60 days before filing them with the state health department. As a result, an Attending Physician After Death Reporting Form may reach the state before the death certificate arrives.

The department received the following documentation for 2018 Death with Dignity participants (people who received medication) as of May 17, 2019:

Table 5. Documentation Received for 2019 Participants

Form	Number
Written Request to End Life Form	244
Attending Physician Compliance Form	242
Consulting Physician Compliance Form	242
Psychiatric/Psychological Consulting	--[1]
Pharmacy Dispensing Form	267
After Death Reporting Form	238
Death Certificate	251

Confidentiality

The Death with Dignity Act requires that the department collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the department will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act. The information presented in this report is limited to items with sufficient numbers in a reporting field to ensure that confidentiality is protected.

[1] Redacted due to Department Small Numbers Guidelines.


Washington State Department of
Health

2019 Death with Dignity Act Report

August 16, 2021

Chapter 70.245 RCW

Disease Control & Health Statistics
Center for Health Statistics

Washington State Department of Health

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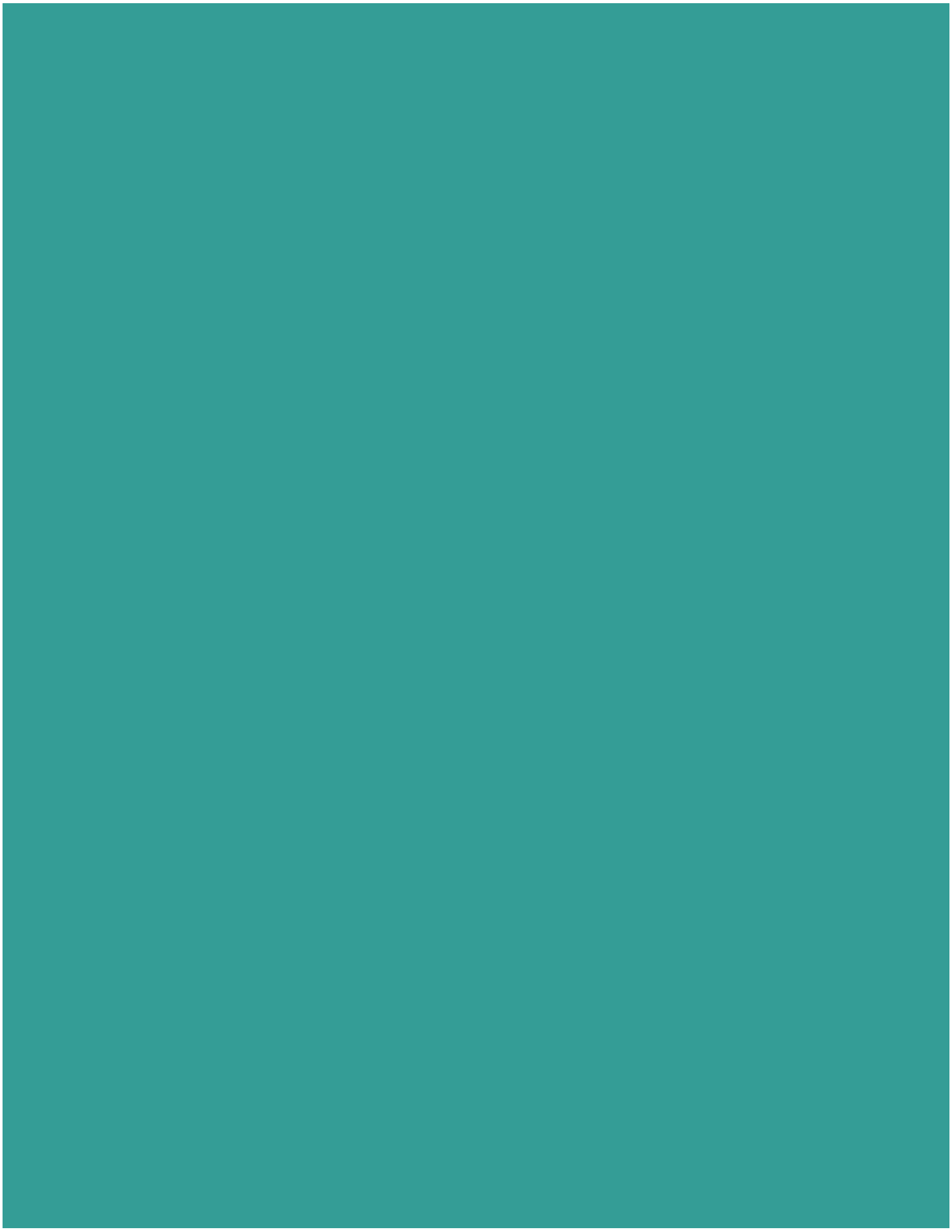
Center for Health Statistics

Umair Shah, MD
Secretary of Health

Contents



Executive Summary

Washington State's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from a physician. This report provides available information about people who participated in the program between January 1, 2019, and December 31, 2019. This report includes data received by the Washington State Department of Health as of August 13, 2021. In this report, a participant is defined as someone to whom medication was given under the terms of the law.

Beginning in 2019, the number of participants who received medication was calculated using expanded criteria. In addition to individuals with a valid prescription date on the pharmacy dispensing form, individuals with a valid prescription date on either the Attending Physician's Compliance Form or the After Death Reporting Form were also included.

A total of 299 individuals received the medication in 2019.

- 153 different physicians prescribed the medication.
- 41 different pharmacists provided the medication.

The department received death certificates for 297 participants and After Death Reporting Forms for 279 participants.

- 299 participants are known to have died.
  - 225 died after taking the medication.
  - 30 died without having taken the medication.
  - We don't know whether the remaining participants took the medicine.

Out of the 225 that died after taking the medication:

- 91% were enrolled in hospice care when they took the medication.
- 88% had some form of health insurance.
- 90% died at home/in a private residence.

Demographics of participants (as indicated in death certificates, 297 participants):

- The average age of participants was 73 years.
- 95% of participants were white. We are unable to report other races due to the small numbers involved and the need to protect participant confidentiality.
- 85% of participants lived west of the Cascade mountains[1].

[1] Based on death certificate information. Counties west of the Cascades: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom.

Notes on Report

For the purposes of this report, a participant of the Death with Dignity Act in 2019 is defined as someone who received medication in 2019 under the terms of the act. Details of the act are included in Appendix A.

Beginning in 2019, the number of participants who received medication was calculated using expanded criteria. In addition to individuals with a valid prescription date on the pharmacy dispensing form, individuals with a valid prescription date on either the Attending Physician's Compliance Form or the After Death Reporting Form were also included[2].

As of August 13, 2021, the department has received documentation indicating that lethal doses of medication were given to 299 participants under the law in 2019. These prescriptions were written by 153 different physicians and provided by 41 different pharmacists. The department has not yet received all required paperwork for all participants. Table 5 in Appendix A shows details of the documentation that has been received by the department. When all the required paperwork is not received, department staff contact health care providers to obtain the documentation.

Among the 299 participants who received medication in 2019, the department has confirmed that 299 have died; 225 took the medication, 30 did not take it , and the ingestion status is unknown for the remaining participants (Figure 2). We established death of a participant through receipt of the After Death Reporting Form and/or a registered death certificate.

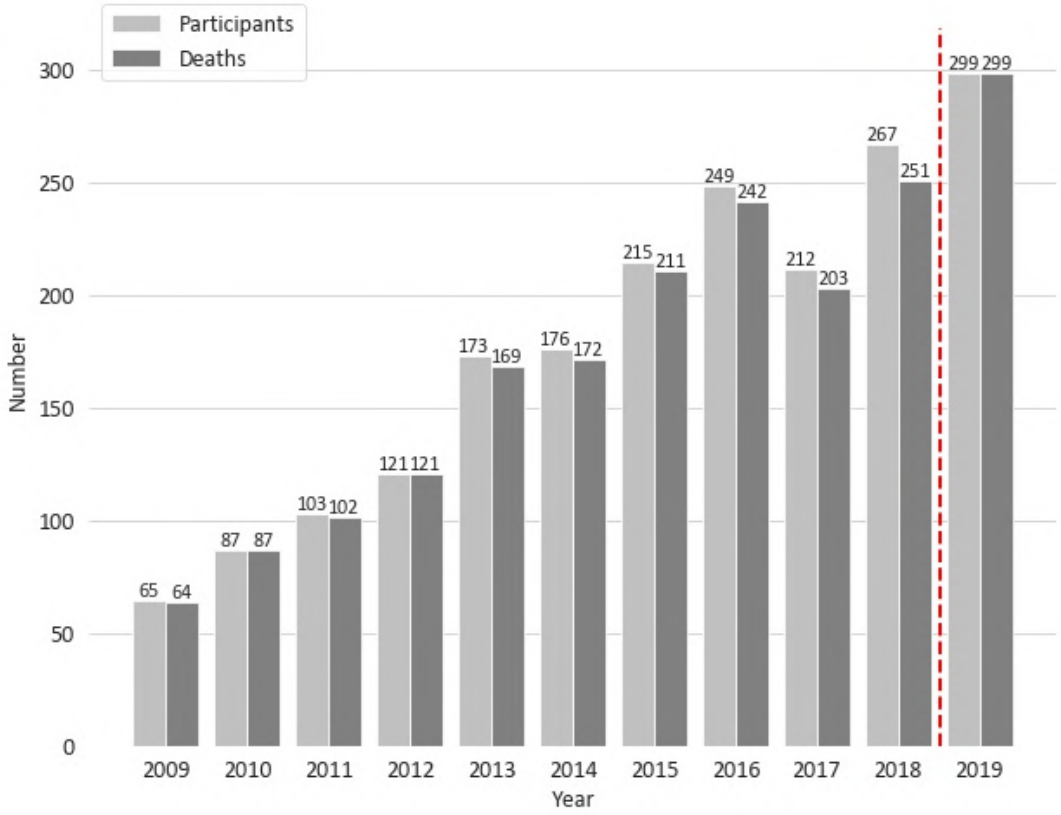
The information presented in this report is subject to the Department of Health Agency Standards for Reporting Data with Small Numbers. Some fields have therefore been suppressed due to their small numbers. For more information, the guidelines can be accessed here: https://www.doh.wa.gov/Portals/1/Documents/1500/SmallNumbers.pdf

[2] These dates were used in a hierarchical manner in the order stated. Any participants with multiple available dates were only counted once.

Death with Dignity Participation Over Time

Since the publication of the last Death with Dignity report, the department received additional information on participants from prior years. Figure 1 shows the number of participants and the number of deaths as of August 13, 2021, for 2009 through 2019. The status of the remaining participants in prior years remains unknown. These participants may have died, but no documentation of their death has been received.

Figure 1. Number of Death with Dignity participants and known deaths, 2009-2019[3] (the dotted line represents a change in inclusion criteria).[4]



[3] Participants prior to 2019 were counted based on receipt of the pharmacy dispensing form. Deaths prior to 2019 were counted based on registered death certificates.

[4] Participants from 2019 onwards were counted using the receipt of the pharmacy dispensing form, or receipt of another form that indicates that medication was dispensed. Deaths were counted based on receipt of a registered death certificate or a valid date of death on an After Death Reporting Form. Due to COVID-19 the Center for Health Statistics had limited capacity for follow-up of incomplete documentation and, in order to ensure we counted all participants, expanded the criteria for inclusion as a death with dignity participant.

Table 1. Death with Dignity Act Participation, 2019

Participant Characteristic	Number	Percent
Sex[5]		
Male	164	55.2
Female	133	44.8
Total	297	100.0
Age (years)[5]		
18-54	13	4.4
55-64	61	20.5
65-74	95	32.0
75-84	72	24.2
85+	56	18.9
Total	297	100.0
Marital Status[5]		
Married	140	47.1
Divorced	73	24.6
Widowed	54	18.2
Never married	28	9.4
Other/unknown	**	**
Total	297	100.0
Education[5]		
Some College/College Degree	226	76.1
Some High School/High School Degree	66	22.2
Unknown	**	**
Total	297	100.0
Residence[6]		
West of Cascades	252	84.8
East of Cascades	45	15.2
Total	297	100.0

[5] Based on death certificate information.
[6] Based on death certificate information. Counties west of the Cascades: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

Insurance Status[7]		
Insured	246	88.2
Uninsured	33	11.8
Total	279	100.0
Patient Race[8]		
White	281	94.6
Asian	**	**
Other	**	**
Black	**	**
Hispanic	**	**
Unknown	**	**
Total	297	100.0

Table 2. Death with Dignity Act Participants' Underlying Illness, 2019

	2019	
	Number	%
Underlying illness[9]		
Cancer	188	72.3
Neurodegenerative	27	10.4
Other	20	7.7
Heart disease	15	5.8
Respiratory disease	10	3.8
Total	260	100.0

[7] Data are collected from After Death Reporting Forms.
[8] Based on death certificate information.
[9] Data are collected from the Attending Physician Compliance Form.

Table 3. End of life concerns of participants who died, 2019

	2019	
	Number	%
End of Life Concerns[10]		
Less able to engage in activities making life enjoyable	232	89.6
Loss of autonomy	229	88.4
Loss of control of bodily functions	137	54.2
Burden on family, friends/caregivers	147	57.6
Loss of dignity	180	71.1
Financial implications of treatment	21	8.4
Inadequate pain control/Concerns about pain control	105	41.3
Total	279	--

[10] Data are collected from the After Death Reporting form. Participants may report more than one concern. Total concerns therefore can exceed the total number of participants.

Table 4. Time Intervals, 2019

	2019	
	Number	%
Time Between First Oral Request and Death[11]		
15-30 days	78	28.9
31-60 days	59	21.9
61-90 days	26	9.6
91-120 days	22	8.1
More than 120 days	49	18.1
Not Known	36	13.3
Total	270	100.0
Time between Ingestion and Loss of Consciousness[12]		
0 to 5 minutes	72	32.0
10 to 20 minutes	22	9.8
6 to 10 minutes	72	32.0
More than 20 minutes	**	**
Not known	52	23.1
Total	225	100.0
Time between Ingestion and Death[12]		
0 to 30 minutes	52	23.1
31 to 60 minutes	53	23.6
61 to 120 minutes	28	12.4
More than 120 minutes	57	25.3
Not known	35	15.6
Total	225	100.0

[11] Based on Pharmacy Dispensing Report
[12] Based on After Death Reporting Form

Appendix A

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the department. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the department:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

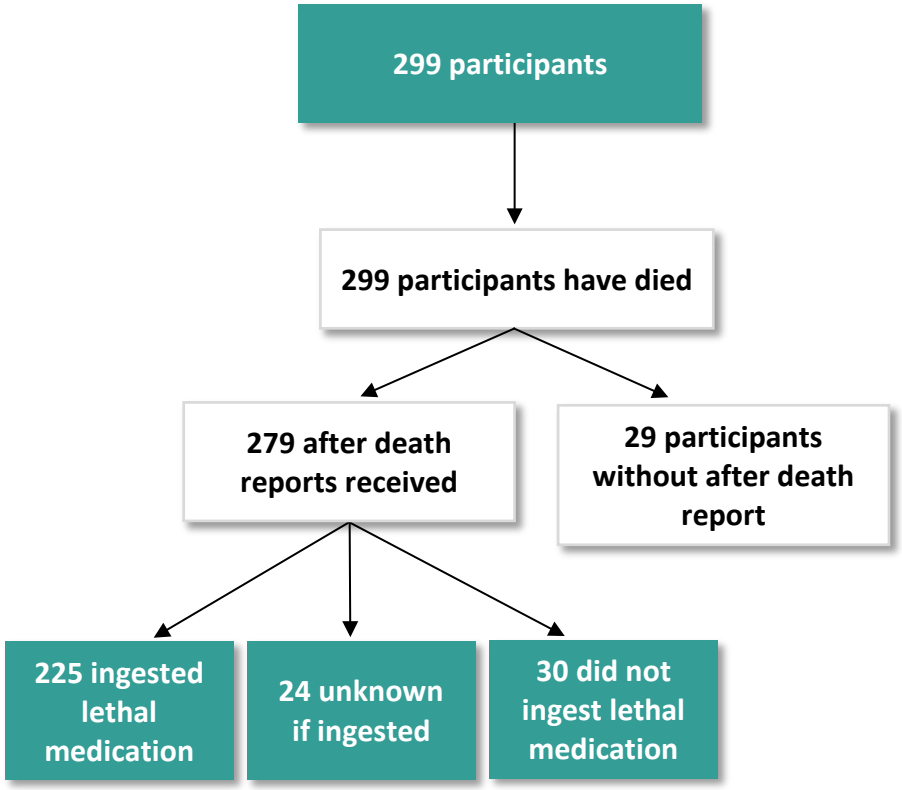
If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms must be submitted to the department.

Within 30 days of providing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from taking a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Figure 2. Outcome of the Death with Dignity Act Participants, 2019



The department received the following documentation for 2019 Death with Dignity participants (people who received medication) as of August 13, 2021:

Table 5. Documentation Received for 2019 Participants

Form	Number
Written Request to End Life Form	258
Attending Physician Compliance Form	260
Consulting Physician Compliance Form	254
Psychiatric/Psychological Consulting	**[13]
Pharmacy Dispensing Form	270
After Death Reporting Form	279
Death Certificate	297
Total Participants	299

Confidentiality

The Death with Dignity Act requires that the department collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the department will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act.

The information presented in this report is subject to the Department of Health Agency Standards for Reporting Data with Small Numbers. Some fields have therefore been suppressed due to their small numbers. For more information, the guidelines can be accessed here: https://www.doh.wa.gov/Portals/1/Documents/1500/SmallNumbers.pdf

[13] Redacted due to Department Small Numbers Guidelines.


Washington State Department of
Health

2020 Death with Dignity Act Report

October 21, 2021

Chapter 70.245 RCW

Disease Control & Health Statistics
Center for Health Statistics

Washington State Department of Health

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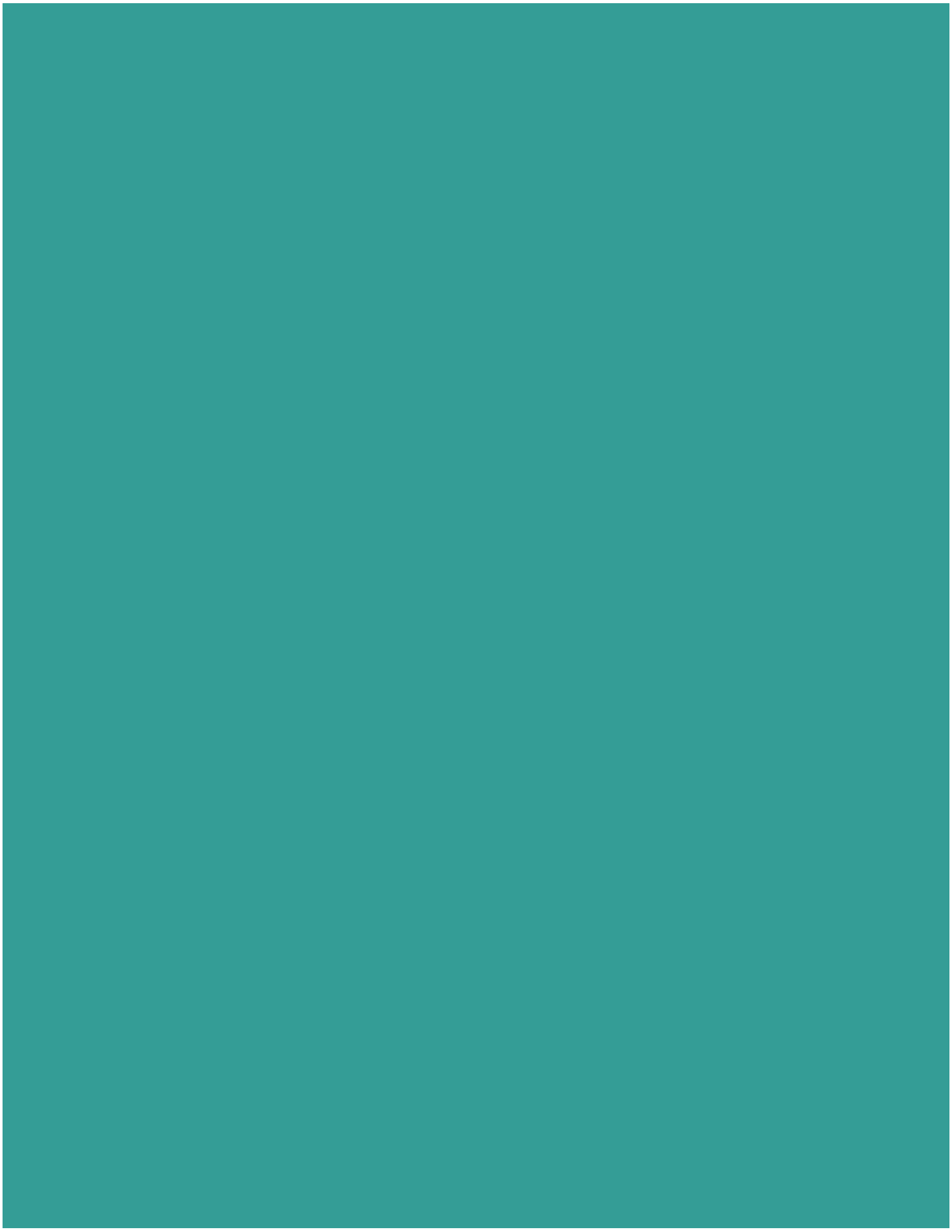


Executive Summary

Washington State's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from a physician. This report provides available information about people who participated in the program between January 1, 2020 and December 31, 2020. This report includes data received by the Washington State Department of Health as of October 21, 2021. In this report, a participant is defined as someone to whom medication was given under the terms of the law.

Beginning in 2019, the number of participants who received medication was calculated using expanded criteria. In addition to individuals with a valid prescription date on the pharmacy dispensing form, individuals with a valid prescription date on either the Attending Physician's Compliance Form or the After Death Reporting Form were also included[1].

A total of 340 individuals received the medication in 2020.

- 169 different physicians prescribed the medication.
- 50 different pharmacists provided the medication.

The department received death certificates for 333 participants and After Death Reporting Forms for 301 participants.

- 334 participants are known to have died.
  - 252 died after taking the medication.
  - 41 died without having taken the medication.
  - Ingestion status is unknown for the remaining participants.

Out of the 252 that died after ingesting the medication:

- 90% were enrolled in hospice care when they ingested the medication.
- 97% had some form of health insurance.
- 91% died at home/in a private residence.

Demographics of participants (as indicated in death certificates, 333 participants):

- The average age of participants was 73 years.
- 93% of participants were white. We are unable to report other races due to the small numbers involved, and the need to protect participant confidentiality.
- 86% of participants lived west of the Cascade mountains[2].

[1] These dates were used in a hierarchical manner in the order stated. Any participants with multiple available dates were only counted once.

[2] Based on death certificate information. Counties west of the Cascades: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom.

For the purposes of this report, a participant of the Death with Dignity Act in 2020 is defined as someone who received medication in 2020 under the terms of the act. Details of the act are included in Appendix A.

As of October 21, 2021, the department has received documentation indicating that lethal doses of medication were given to 340 participants under the law in 2020. These prescriptions were written by 169 different physicians and provided by 50 different pharmacists. The department has not yet received all required paperwork for all participants. Table 5 in Appendix A shows details of the documentation that has been received by the department. When all the required paperwork is not received, department staff contact health care providers to obtain the documentation.

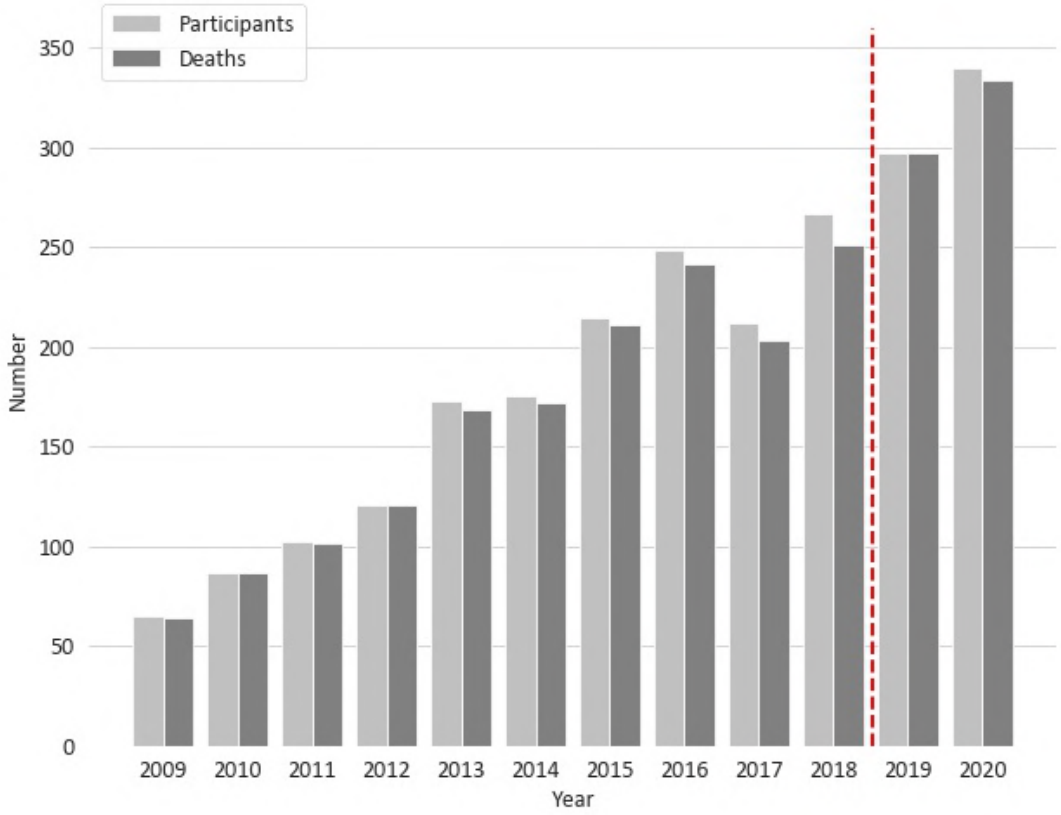
Among the 340 participants who received medication in 2020, the department has confirmed that 334 have died; 252 ingested the medication, 41 did not ingest, and the ingestion status is unknown for the remaining participants (Figure 2). We established through receipt of the After Death Reporting Form and/or a registered death certificate.

The information presented in this report is subject to the Department of Health Agency Standards for Reporting Data with Small Numbers. Some fields have, therefore, been suppressed due to their small numbers. For more information, the guidelines can be accessed here: https://www.doh.wa.gov/Portals/1/Documents/1500/SmallNumbers.pdf.

Death with Dignity Participation Over Time

Since publication of the last Death with Dignity report, the department received additional information on participants from prior years. Figure 1 shows the known number of participants and the number of deaths as of October 21, 2021, for 2009 through 2020. The status of the remaining participants in prior years remains unknown. These participants may have died, but no documentation of the death has been received.

Figure 1. Number of Death with Dignity participants and known deaths, 2009-2020[3]. The dotted line represents a change in inclusion criteria.[4]



[3] Participants prior to 2019 were counted based on receipt of the pharmacy dispensing form. Deaths prior to 2019 were counted based on registered death certificates.

[4] Participants from 2019 onwards were counted using the receipt of the pharmacy dispensing form, or receipt of another form that indicates that medication was dispensed. Deaths were counted based on receipt of a registered death certificate or a valid date of death on an After Death Reporting Form. This was done due to ensure counting all participants; due to COVID-19 the Center for Health Statistics lacked staffing capacity to track down forms that were not submitted.

Table 1. Death with Dignity Act Participation: 2020

Participant Characteristic	Number	Percent
Sex[5]		
Male	183	55.0
Female	150	45.0
Total	333	100.0
Age (years)[5]		
18-54	22	6.6
55-64	41	12.3
65-74	122	36.6
75-84	87	26.1
85+	61	18.3
Total	333	100.0
Marital Status[5]		
Married	160	48.0
Divorced	76	22.8
Widowed	62	18.6
Never married	31	9.3
Other/unknown	4	1.2
Total	333	100.0
Education[5]		
Some College/College Degree	253	76.0
Some High School/High School Degree	78	23.4
Unknown	2	0.6
Total	333	100.0
Residence[6]		
West of Cascades	288	86.5
East of Cascades	45	13.5
Total	333	100.0

[5] Based on death certificate information.
[6] Based on death certificate information. Counties west of the Cascades: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

Insurance Status[7]		
Insured	**	>95.0[8]
Uninsured	**	<5.0
Total	301	100.0
Patient Race[9]		
White	309	92.8
Asian	14	4.2
Other	**	**
Unknown	**	**
Black	**	**
Hispanic	**	**
Total	333	100.0

Table 2. Death with Dignity Act Participants' Underlying Illness(es)

	2020	
	Number	%
Illness Reported[10]		
Cancer	229	74.8
Respiratory disease	29	9.5
Neurodegenerative	20	6.5
Other illness(es) only	19	6.2
Heart disease	17	5.6

[7] Data are collected from After Death Reporting Forms.
[8] All counts for insured have been suppressed to ensure participant confidentiality.
[9] Based on death certificate information.
[10] Data are collected from the Attending Physician Compliance Form. Please note that a patient may have multiple diagnoses, so illnesses are not mutually exclusive. "Other illness only" indicates that a diagnosis was reported without an obvious diagnosis of a cancer, respiratory disease, cardiac disease, or neurodegenerative condition.

Table 3. End of life concerns of participants who died, 2020

	2020	
	Number	%
End of Life Concerns[11]		
Less able to engage in activities making life enjoyable	269	90.6
Loss of autonomy	267	89.6
Loss of control of bodily functions	143	48.8
Burden on family, friends/caregivers	174	58.6
Loss of dignity	220	74.8
Financial implications of treatment	23	7.8
Inadequate pain control/Concerns about pain control	113	38.4
Total	301	--

[11] Data are collected from the After Death Reporting form. Participants may report more than one concern. Total concerns therefore can exceed the total number of participants.

Table 4. Time Intervals

	2020	
	Number	%
Time Between First Oral Request and Death[12]		
0-14 days	**	**
15-30 days	107	36.3
31-60 days	67	22.7
61-90 days	38	12.9
91-120 days	18	6.1
More than 120 days	49	16.6
Not Known	**	**
Total	295	100.0
Time between Ingestion and Loss of Consciousness[13]		
0 to 5 minutes	87	34.5
10 to 20 minutes	20	7.9
6 to 10 minutes	73	29.0
More than 20 minutes	15	6.0
Not known	57	22.6
Total	252	100.0
Time between Ingestion and Death[13]		
0 to 30 minutes	65	25.8
31 to 60 minutes	51	20.2
61 to 120 minutes	43	17.1
More than 120 minutes	48	19.0
Not known	45	17.9
Total	252	100.0

[12] Based on Pharmacy Dispensing Report. Some counts suppressed to maintain participant confidentiality.
[13] Based on After Death Reporting Form

Appendix A

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the department. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the department:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

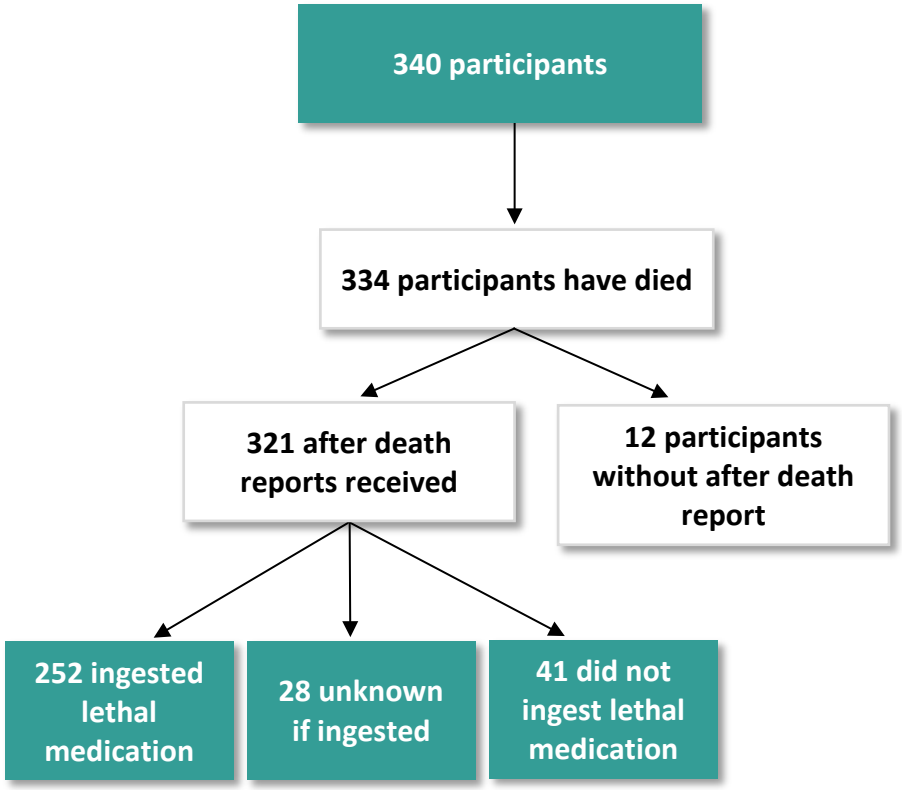
If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms must be submitted to the department.

Within 30 days of providing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from taking a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Figure 2. Outcome of the Death with Dignity Act Participants, 2020



The department received the following documentation for 2020 Death with Dignity participants (people who received medication) as of October 21, 2021:

Table 5. Documentation Received for 2020 Participants

Form	Number
Written Request to End Life Form	295
Attending Physician Compliance Form	306
Consulting Physician Compliance Form	299
Psychiatric/Psychological Consulting	**[14]
Pharmacy Dispensing Form	318
After Death Reporting Form	301
Death Certificate	333
Total Participants	340

Confidentiality

The Death with Dignity Act requires that the department collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the department will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act.

The information presented in this report is subject to the Department of Health Agency Standards for Reporting Data with Small Numbers. Some fields have therefore been suppressed due to their small numbers. For more information, the guidelines can be accessed here: https://www.doh.wa.gov/Portals/1/Documents/1500/SmallNumbers.pdf

[14] Redacted due to DOH Small Numbers Guidelines.


Washington State Department of
Health

District of Columbia Death with Dignity Act

2018 Data Summary

DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Death with Dignity Executive Summary

The District of Columbia Death with Dignity Act of 2016, DC Law 21-182, was effective on February 18, 2017 and applicable as of June 6, 2017. The Act establishes a process by which competent terminally ill residents of the District of Columbia can legally obtain a physician's prescription for drugs to end their life in a humane and peaceful manner. Terminally ill patients must be District of Columbia residents who have been medically confirmed to have less than six months to live.

The Department of Health (DC Health) was engaged in a number of educational activities during the second year the Death with Dignity law was in effect. A *Death with Dignity and Best Practices for the Medical Community* seminar jointly sponsored with Compassion and Choices and DC Health was held for health care professionals on August 10, 2018. The impetus for the presentation was to educate medical providers on the law's requirements and to inform of the process regarding the ACT.

2018 Statistics

The DC Health is required by law to collect compliance information and to issue an annual report. In 2018 there were four prescriptions written for a covered medication, two qualified patients with written prescribed and dispensed medications died. Two qualified patients died before ingesting prescribed covered medications. Three physicians wrote prescriptions for covered medications.

Number of qualified patients for whom a prescription for a covered medication was written.	Number of known qualified patients who died each year for whom a prescription for a covered medication was written, and the cause of death of those patients.	Number of known deaths in the District from using a covered medication.	Number of physicians who wrote prescriptions for a covered medication.
4	4	2	3

Demographic characteristics for qualified patients who consumed a covered medication and died.		
Age at death	81	72
Education level, if known	Some college, no degree	Master's Degree
Race	White	White
Sex	Female	Female
Type of insurance, including whether or not they had insurance, if known	Federal Employment Insurance	Federal Employment Insurance
Terminal disease	Lung Cancer	Breast Cancer Metastatic to Lung

The cause of death for patients whom a prescription for a covered medication was written but died prior to ingesting the covered medication.	
Terminal disease	Merkel Cell Carcinoma
	Pancreatic Cancer

CERTIFICATE OF COMPLIANCE

Mass. R.A.P. 17 (c)(9)

Re: Roger M. Kligler v. Maura Healey,
Supreme Judicial Court No. 13194

I, Konstantin Tretyakov, hereby certify that the brief complies with the rules of court that pertain to the filing of amicus curiae briefs, including Mass. R.A.P. 17 & Mass. R.A.P. 20. I further certify that the proportionally spaced font used to prepare this brief is Century Schoolbook 14 point size, the number of non-excluded words in the brief is 5,493 and the name and version of the word-processing program used to prepare this brief is Microsoft Word 2010.

By: \s\ *Konstantin Tretyakov*
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Dated: February 9, 2022

CERTIFICATE OF SERVICE

Re: Roger M. Kligler v. Maura Healey,
Supreme Judicial Court No. 13194

I, Konstantin Tretyakov, hereby certify that on this day I served the amicus curiae brief on both parties by causing a PDF copy to be sent to their attorneys via the electronic filing system:

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