# Implementing Washington's Death with Dignity Act

Moreen Dudley, LICSW
Director, Patient and Family Services, Seattle Cancer Care Alliance
Cindy Jacobs, RN, JD
Director, UWMC Risk Management
Tanya Karwaki, JD
Associate Risk Manager, Harborview
January 15, 2009

## "The Laboratory of the States"

- Washington initiatives
  - 1991 failed
  - 2008 passed
  - March, 2009 effective
- California initiative
  - 1992 failed
- Oregon initiatives
  - 1994 passed
  - 1997 repeal rejected
- Other states, countries

2

## I-1000 Summary

- This measure would permit terminally ill, competent, adult Washington residents medically predicted to die within six months to request and self-administer lethal medication prescribed by a physician.
- The measure requires two oral and one written request, two physicians to diagnose the patient and determine the patient is competent, a waiting period, and physician verification of an informed patient decision.
- Physicians, patients and others acting in good faith compliance would have criminal and civil immunity.

# I-1000 passes in 2008

4

# Washington's Death with Dignity Act (DWDA)

- Codified at RCW 70.245.010
- Effective March 5, 2009

# DWDA Key Components

- Patient must be an adult (≥18) Washington resident
- Patient must be mentally competent, verified by two physicians
- Patient must have < 6 months to live, verified by two physicians
- Patient makes requests, without coercion, verified by two physicians
- Patient must be informed of other options incl. palliative and hospice

## DWDA Key Components

- Minimum 15 day waiting period from first oral request to second oral request
- Minimum 48 hour waiting period between written request and writing of the Rx
- Written request signed by at least 2 independent witnesses
- Patient is encouraged to discuss with family
- The patient may change their mind at any time

## "Participation" by WA hospitals *

- Divided into approximately thirds
- "Full" participation
  - University of Washington Medicine
  - Group Health Cooperative
- No participation
  - Catholic hospitals
  - Swedish Medical Center
    - Except that its providers may participate when they are at other facilities
- "Partial" participation
  - Virginia Mason
    - Outpatient clinics only

*Seattle Times, March 5, 2009

## Department of Health Statistics

- Since Act took effect (3/5/09), DOH has posted the cumulative number of DwDA forms it has received, with updates on a weekly basis.
- As of 12/31/2009:

| Written Requests | 60 |
|---|---|
| Psychiatric/ Psychological Consultant's Compliance form | 4 |
| Pharmacy Dispensing Record form | 60 |
| Attending Physician's After Death Reporting form | 39 |

- The Department of Health also will publish an annual report which will include at least information on how many prescriptions are written under this Act and how many people ingest the prescribed medication. The specificity of released data will depend on whether there are adequate numbers in a reporting field to ensure confidentiality.
- The first annual report will include data from March 5, 2009 through December 31, 2009. Statistical reports will be completed annually thereafter.

## HMC– 3 cases to date

- One died before picking up meds
- One completed the process and used the meds
- One made a verbal request but took no further action

## UWMC—3 cases to date

- One referred to Compassion & Choices
  - No available attending
- One referred to SCCA
- One died after requesting and being given initial DwDA information

## SCCA Cases to date

- 38 Patient inquiries
- 21 first oral requests
- 15 written requests
- 13 second oral requests
- 13 prescriptions written
- 12 prescriptions dispensed (one patient will pickup when ready to ingest)
- 8 patients have ingested the medication
- 2 patients died without ingesting the medication
- 2 patients have not chosen to ingest the medication yet.

## UW Medicine policy

- UW Medicine does not mandate that any provider or other UW Medicine employee participate in the Act, nor does it pressure any provider/employee to do so.
- Overall goal is to support the patient's end-of-life wishes, and participation may not necessarily result in medication being prescribed, if patient needs can be met in other ways (like hospice or palliative care).
- UW Medicine allows its faculty physicians and its pharmacists who otherwise qualify by statute to participate Act, if they so choose, and allows other UW Medicine providers/employees to participate in relevant supporting roles.
- UW Medicine participation in the Act is on a team basis.
  - Core team: team liaison (social worker, nurse, physician, or other health professional), attending physician, consulting physician, and pharmacist.
  - Ad hoc: ethics consultant, palliative care consultant, social worker, consulting psychiatrist, nurse manager, spiritual care representative.
- UW Medicine does not permit the ingestion of life-ending medication under the Act in its hospitals, clinics, or elsewhere on its premises.

## Seattle Cancer Care Alliance Policy

- The Seattle Cancer Care Alliance's (SCCA) goal is to support our patients' end-of-life care wishes.
- The SCCA allows faculty physicians and pharmacists who otherwise qualify by statute to participate in the Washington State Death with Dignity Act, if they so choose, and allows other SCCA providers/employees to participate in relevant supporting roles.
- The SCCA sent out a confidential survey to our 200 physicians to find who might be willing to participate.
- Out of 80 responses, 30 were willing to serve as either an attending/prescribing physician for their own or their colleagues' patients and 20 were willing to serve as a consulting physician.

## SCCA's DWDA Policy

- Based on model from Oregon Health & Science University
- SCCA participation in the Washington State Death with Dignity Act (DWDA) is on a **team basis**.
- The team consists of a patient advocate, an attending physician, a consulting physician, and a pharmacist.
- Every patient inquires/requests DWDA is referred to the Patient Advocate.
- Patient Advocate facilitates and coordinates the process
- Patient Advocate meets with patient & family - explains the process, answers questions and remains in contact throughout the process and afterwards.
- Patient Advocate meets with attending physician and the consulting physician - explains the process and sets up all the appointments with the physicians and the pharmacist
- Patient Advocate is responsible for making sure that the patient meets the criteria set forth in the law and that all documentation is complete and the DOH forms are mailed in.

## SCCA experience with Patients and Families

- There have been notably few patient/family issues.
- Patients and their families have been extremely knowledgeable about the law.
- Our experience has been similar to Oregon's – patients have typically been very independent.
- All SCCA patients have involved at least some members of their families and always the next of kin.
- Patients and families have been very appreciative to the SCCA, the patient advocate, physicians and pharmacists during the process and afterwards.
- The one question that everyone has asked is; "How long does it take for me to fall asleep?"

## The Bigger Picture (Beyond your institution)

- Media - This is a polarizing topic so ripe for media attention if something went awry
  - There have been patient/family requests to have the process "covered" by a newspaper or TV station
  - What if this request was made at your institution?
- Advocacy Groups – Compassion and Choices
  - A national organization with a Washington section which:
    - Provides counseling and client support services
    - "Steward, protect, and uphold Washington's DWDA"

## What Does This Mean for Risk Management?

- Documentation
  - The only "enforcement teeth" in the Act?
  - Inherent risk is prosecution and/or DOH licensing action
    - Act functions as a "safe harbor"?
- Policy and Procedure

## Looking Into the Crystal Ball

- Other State Developments
- Netherlands
- What may play in Washington?

## The Latest State Development

## Baxter v. Montana
### 2009 MT 449

- Facts: Baxter, a retired truck driver from Billings, was terminally ill with lymphocytic leukemia.

## Baxter v. Montana

- Procedure:
  - Baxter, 4 physicians, and Compassion and Choices sued in District Court challenging the constitutionality of Montana's homicide statutes to physicians providing aid in dying to competent, terminally ill patients.
  - District Court held that competent, terminally ill patients had a constitutional right to die with dignity and physicians were protected from prosecution under State's homicide statutes.

## Baxter v. Montana

- Procedure con't:
  - State appeals.
  - Parties submitted extensive briefing on constitutional issues.
  - MT Supreme Court declined to reach constitutional issues because they were able to decide the case without reaching such questions.

## Baxter v. Montana

- Issue:
  - Does consent of a patient constitute a statutory defense to a homicide charge against a physician?
    - 1) Does the consent defense apply to physicians providing aid in dying?
    - 2) Is patient consent rendered ineffective because it is against public policy?

## Baxter v. Montana

- Analysis:
  - "The State of Washington is home to an unusual volume of these public policy exception cases."
  - For example, State v. Hiott (BB guns). Other examples include bar brawling and a prison fight.

## Baxter v. Montana

- Analysis con't:
  - These cases are distinguishable because the defendant alone performed a violent act causing harm and breaching public peace.
  - Here, the physician is not directly involved in the final decision or the final act. The patient makes the private decision to take the medication and does not breach the public peace or endanger others.

## Baxter v. Montana

- Holding: Physician aid in dying is not against public policy.
- So, the court side stepped the constitutional question and the issue remains in the legislative arena.

## Netherlands (the model?)*

- Legal parameters in the Netherlands
  - Euthanasia: administration of drugs with the explicit intention to end life at the explicit request of a patient.
  - Physician-assisted suicide: administration, supply or prescription of drugs with the explicit intention to enable the patient to end his or her life.
  - Does not include:
    - withdrawing or withholding potentially life-prolonging treatments;
    - intensified measures to alleviate pain or other symptoms while taking into account the possible hastening of death or appreciating that possibility;
    - actively ending the patient's life without an explicit request.
- Both euthanasia and physician-assisted suicide have been lawful in the Netherlands since 2002.

*Rietjens JA, et al., "Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?", J Bioeth Inq. 2009 Sep;6(3):271-283.

## Netherlands timeline

- Dutch Medical Association developed standards in mid-1980s that led to the present law's "criteria for due care"
- 1990—mechanism for reporting to medical examiner
  - Physicians who had complied with the criteria for due care for euthanasia would not be prosecuted.
- 1998—national reporting procedure
- 2002—formal legalization

## Netherlands Outcomes*

| | 1990 | 1995 | 2001 |
|---|---|---|---|
| **NUMBERS** | | | |
| Without medical decision to end life | 78,513 | 78,689 | 79,354 |
| With medical decision to end life | 50,311 | 56,986 | 61,024 |
| • not starting and/or ending treatment, taking into account the probability that life will be shortened | 11,956 | 9,404 | 10,610 |
| • treating pain and/or symptoms, taking into account the probability that life will be shortened | 19,010 | 21,589 | 25,793 |
| • treating pain and/or symptoms, with the aim to shorten life as well | 4,851 | 3,784 | 2,055 |
| • not starting and/or ending treatment, with the explicit aim to shorten life | 11,113 | 18,038 | 17,902 |
| • providing medication with the explicit aim to shorten life | 3,381 | 4,171 | 4,664 |
| • euthanasia | 2,163 | 3,020 | 3,444 |
| • aid in suicide | 242 | 238 | 283 |
| • action shortening life without explicit request to do so | 976 | 913 | 938 |
| **Total** | **128,824** | **135,675** | **140,377** |

**Statistical Yearbook of the Netherlands, 2004*

## Netherlands Outcomes

| | 1990 | 1995 | 2001 |
|---|---|---|---|
| **PERCENTAGES** | | | |
| Without medical decision to end life | 60.9 | 58.0 | 56.5 |
| With medical decision to end life | 39.1 | 42.0 | 43.5 |
| • not starting and/or ending treatment, taking into account the probability that life will be shortened | 9.3 | 6.9 | 7.6 |
| • treating pain and/or symptoms, taking into account the probability that life will be shortened | 14.8 | 15.9 | 18.4 |
| • treating pain and/or symptoms, with the aim to shorten life as well | 3.8 | 2.8 | 1.5 |
| • not starting and/or ending treatment, with the explicit aim to shorten life providing medication with the explicit aim to shorten life | 8.6 | 13.3 | 12.8 |
| • euthanasia | 1.7 | 2.2 | 2.5 |
| • aid in suicide | 0.2 | 0.2 | 0.2 |
| • action shortening life without explicit request to do so | 0.8 | 0.7 | 0.7 |
| **Total** | **100.0** | **100.0** | **100.0** |

## Public argument very polarized

- Under-reported?
- Abuses?
- Model not based on autonomy?

## What May Play in Washington?

- Will additional provider types be added, such as ARNPs?
- Will there be legal challenges based on alleged discrimination against those not able to self-ingest?
- Will any US states expand toward the Netherlands model?
  - If so, will Oregon be first?

## Web Resources

- End-of-Life decision-making
  http://honormywishes.org/
  http://fivewishes.org/
- Hospice and palliative care
  http://wshpco.org/
- WA DOH website re DWDA
  www.doh.gov/dwda

35

## Web Resources

- WA DOH living will registry website
  www.doh.gov/livingwill
- WSHA website links re DWDA
  www.wsha.org
- Compassion and Choices website
  www.compassionandchoices.org/wa
- OR DOH website re DWDA
  www.egov.oregon.gov/DHS/ph/pas

36

## Questions?