Washington Death With Dignity Initiative 1000
Report Submitted to the Washington State Psychological Association by Judith R. Gordon, Ph.D.
On Behalf of the WSPA End-of-Life Committee
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INTRODUCTION

On January 9, 2008, the Washington Death with Dignity Initiative 1000 (WDWD 1000) was filed with the Secretary of State. With minor adjustments to fit Washington State laws and regulations, it replicates Oregon's Death With Dignity Act (ODWDA), which legalized physician aid-in-dying (PAD) for mentally competent, terminally ill adults to self-administer life-ending medications in 1994 and began enactment in 1998, after numerous legal challenges. Both Acts mandate strict regulatory and reporting protocols. This report summarizes the existing WSPA policy on the issue of PAD, highlights relevant psychosocial aspects of WDWD 1000, reviews the 10 years of empirical data available from Oregon, and concludes with the decision made by the WSPA Council on May 25, 2008, regarding its stance on the WDWD 1000 Initiative.

HISTORY OF WSPA'S ROLE IN THE PAD DEBATE

Since 1996, WSPA has been a leader among national and state psychological associations and other mental health organizations in the debate on physician aid-in-dying. It signed an amicus curiae brief submitted by a coalition of mental health professionals to the U.S. Supreme Court in 1996 (Washington v Glucksberg, 1997 and Vacco v Quill 1997; Werth & Gordon, 2002), and subsequently signed similar briefs submitted to several state district courts in the intervening years (Miller & Werth, 2006; Tucker, 2008).

These briefs state that psychology can provide expertise on the question of whether a terminally ill patient requesting PAD can be competent to make such a decision, and that mental health professionals have adequate diagnostic tools to assess the mental competency of a terminally ill patient making such a request. The briefs, citing ample research, state that (1) the desire to die in a terminally ill person does not necessarily mean that the person is depressed. Even if a terminally ill individual has some symptoms of depression, this does not automatically mean the person has lost decisional capacity. (2) Diagnostic tools and guidelines are available to identify factors in a terminally ill patient's decision to hasten death, examine whether clinical depression is a motivating factor, and evaluate for impaired judgment due to the presence of dementia, delirium, depression, or other mental or psychiatric conditions that could impair judgment and affect decision-making. Both WSPA and APA have consistently held that it is important for mental health professionals to bring their expertise to policy makers and to the public on the matter of physician aid-in-dying. None of these briefs took a position endorsing or opposing legalization of PAD.

In January 8, 2007, by unanimous vote of the Executive Board, WSPA adopted a policy approving the use of value-neutral terminology regarding requests by mentally competent terminally ill individuals for PAD. Thus neutral terms like “physician-assisted dying,” “physician aid-in-dying,” or “physician-assisted death” should be used to avoid emotionally charged terms like “physician-assisted suicide” and to distinguish such choices from suicide:

> WSPA recognizes that the term “suicide” implies psychiatric illness or other emotional distress that impairs judgment and decision-making capacity, and thus may not be an accurate or appropriate term for a terminally ill, mentally competent individual choosing to control the time and manner of his or her death. Therefore WSPA supports value-neutral terminology such as aid-in-dying, patient-directed dying, physician aid-in-dying, physician-assisted dying, or a terminally ill individual’s choice to bring about a peaceful and dignified death. (Gordon, 2007)

Some of the rationale for this refinement of terminology includes:

> The psychiatric suicidal patient has no terminal illness but wants to die for reasons of emotional distress; the DWD [death with dignity] patient has a terminal illness, death is inevitable and fairly imminent, and the person wishes to die on their own terms and with dignity as defined by the individual.
>
> Typical suicides are secretive and often impulsive and violent, bringing shock, tragedy, and trauma to families and friends; DWD deaths are planned, peaceful, and typically supported by loved ones. (Lieberman, 2006)

The APA also distinguishes a terminally ill mentally competent individual’s request for PAD from suicide:

> It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide (Farberman, 1997).

THE WASHINGTON DEATH WITH DIGNITY INITIATIVE 1000

WDWD 1000 allows mentally competent adult Washington residents who have a terminal illness and have 6 months or less to live the option to receive and self-administer life-ending medication to hasten death under the supervision of their doctor.

Following are some of the highlights of Initiative 1000 relevant to psychological concerns (See Appendix 2, Washington Death With Dignity Act, for the complete document):

SAFEGUARDS: There are numerous safeguards, including:

- The patient must request physician aid-in-dying (PAD) three times, once in writing and twice orally, separated by at least fifteen days. The purpose of this requirement is to prevent an impulsive decision. Patients can change their minds at any time.
- Two physicians must certify the patient is terminally ill and has only six or less months to live. The purpose of this requirement is to ensure that only people whose death is inevitable and fairly imminent can quality, thereby excluding, e.g., persons with disabilities or persons with chronic and even terminal illnesses who are nonetheless not terminal (the 6-month criterion is based on the federal guideline for qualifying for hospice).
- There is a mandatory mental health examination if either of the two physicians has any concern about impaired judgment, to be conducted by a licensed psychiatrist or psychologist.
- All patients wanting to qualify for PAD must be offered hospice and palliative care, to ensure that all palliative care options are made available to the patient.

COMPETENCE: "'Competent' means that, in the opinion of a court or in the opinion of the patient's attending or consulting physicians, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers…"

ASSESSMENT: "…one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression [that could impair] judgment."

INFORMED DECISION: "…a decision by a qualified patient, to request and obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;
(b) His or her prognosis;
(c) The potential risks associated with taking the medication to be prescribed;
(d) The probable result of taking the medication to be prescribed; and
(e) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control."

THE WRITTEN REQUEST requirements are:

"(1) A valid request for medication…shall be…signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage, or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the department of health by rule."

COUNSELING REFERRALS: "If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. Medication…shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."

PROTECTIONS FOR HEALTH CARE PROVIDERS provide "Immunities and Liabilities" for professionals who choose to participate and those who choose not to participate in these requests:

"(a) A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter…

(b) A professional organization or association, or health care provider, may not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter."

THE SIGNIFICANCE OF THE OREGON DATA

The United States Supreme Court, when it reviewed the "physician-assisted suicide" case in 1997, did not conclude that PAD was a constitutionally protected right, but recognized that the "challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States..." (Tucker, 2008).

This "laboratory" has been functioning for ten years in Oregon, where data have been collected and published annually by the Oregon Department of Human Services documenting who makes use of the Oregon law, why, and how the law is working. The 2007 Annual Report of the Oregon Department of Health was just released, making ten years (1998-2007) of empirical data on the effects and implementation of the Oregon law available (see http://oregon.gov/DHS/ph/pas/index.shtml). This report and related reports and articles published in peer-review medical journals constitute the only source of data regarding actual experience with legal, regulated PAD in the United States.

Possible negative social consequences of legalization include the following. (1) Lawmakers, insurance carriers, and physicians might increasingly utilize and even promote PAD instead of devoting resources and enacting legislation to improve and make quality end-of-life care available for all. (2) There might be a high risk of abuse, neglect, manipulation of, and pressure on patients in vulnerable groups such as the elderly, the uninsured, the poor, the disabled, the chronically ill, people with psychiatric illnesses, racial or ethnic or sexual minorities, the uneducated, or women.

Potential problems with regulation include the following. (1) There might be an inevitable slippery slope toward less stringent guidelines and controls. (2) There might be problems with accuracy of reports by physicians and of self-report data from patients, i.e. reasons given for PAD requests. (3) Physicians willing to participate in PAD might be too lenient in granting requests. (4) Physicians are not all trained to detecting the presence of depression.

> Would these patients be pressured, manipulated, or forced to request or accept physician-assisted dying by overburdened family members, callous physicians, or institutions or insurers concerned about their own profits? This slippery-slope argument assumes that abusive pressures would operate on all seriously or terminally ill patients but would selectively disfavor patients whose capacities for decision making are impaired, who are subject to social prejudice, or who may have been socially conditioned to think of themselves as less deserving of care. (Battin et al., 2007)

The following section reviews the data from Oregon that address these issues.

The Oregon Data

The ten-year Oregon totals show that 545 patients requested and received life-ending prescriptions and 341 patients actually used them, compared with 85,755 Oregonians who died from the same underlying diseases during the same period. Contrary to concerns about increasing usage, the low number of PAD deaths has remained stable throughout the ten years of data available, and a large percentage of those receiving prescriptions do not use them and die from their underlying disease.

The following information describe some of the characteristics of these patients:

<u>Demographics:</u>

-183 men (54%), 158 women (46%), total = 341
- 97% white, 2% Asian, <1% Native American, Hispanic, African American, and other
- 45% married, 21% widowed, 25% divorced, 8% never married
- 20% postbaccalaureate, 21% baccalaureate, 23% some college, 28% high school, 8% less than high school*
- 82% cancer, 8% amyotrophic lateral sclerosis, 10% other
-Age: median 69, range 25-96
*Significantly higher level of education than average.

Reasons for Requests

-87% feared losing autonomy
-87% feared being less able to engage in activities that make life enjoyable
- 80% feared loss of dignity
- 57% feared losing control over bodily functions
- 38% feared being a burden on family, friends, and caregivers
- 26% feared inadequate pain control
-2% feared financial implications of treatment

Similarly, Ganzini et al. (2007), in a study of family members of 83 Oregon decedents who made explicit requests for legalized PAD, including 52 who received but did not use prescriptions for a lethal medication and 32 who died of PAD, found, regarding reasons for requests, that

> Wanting to control the circumstances of death and die at home, worries about loss of dignity and future losses of independence, quality of life, and self-care ability, were the highest, with a median score of 4.5 or greater. No physical symptoms at the time of the request were rated higher than a median of 2 in importance. Worries about symptoms and experiences in the future were, in general, more important reasons than symptoms or experiences at the time of the request. According to family members, the least important reasons their loved ones requested PAD included depression, financial concerns, and poor social support.

These reasons are similar to those found in other studies of people requesting PAD that included Washington State, where it is not legal (Pearlman et al., 2005).

Thus reasons for seeking PAD primarily involve quality of life concerns, desire for autonomy and self-determination, and the wish to die with dignity.

End-of-Life Care: Access and Economic Factors

Hospice
-86% enrolled in hospice

-14% not enrolled in hospice
-2% unknown

Insurance
-62% had private insurance
-36% had Medicare or Medicaid
-1% had no insurance
-1% unknown

Thus most patients requesting PAD were in hospice (the gold standard for end-of-life care), and nearly all had insurance or Medicare/Medicaid. Problems of access to end-of-life care and economic factors do not appear to play a role in PAD requests in Oregon.

Referrals for Psychiatric Evaluation

From 1998-2007 a total of 36 (13%) of individuals who eventually died by life-ending medication had been referred for psychiatric evaluation. Ganzini et al. (2000) reported that

> …a survey of Oregon physicians who had experience with the ODWDA found that 17% of the persons requesting medication had had a mental disorder such as depression that impaired his/her judgment. None of those patients was given a prescription under the Act…[the] data simply do not support the hypothesis that among patients eligible for assistance with suicide under the [ODWDA], vulnerable groups, including mentally ill patients, request assistance with suicide disproportionately or receive lethal prescriptions in place of palliative care (152)

Ganzini et al. (2002) found that depression was rated to be one of the least important reasons for requesting medication (see “reasons for request” above).

Official figures are not available for how many terminally ill individuals requesting PAD never even get to the point of being referred for psychiatric evaluation, because the law does not require this to be recorded. George Eighmey, Executive Director of Compassion & Choices of Oregon, a nonprofit agency that works closely with the Oregon Department of Health in the implementation of ODWDA, states,

> When patients contact Compassion & Choices, their physician, hospice personnel, or other health care providers, we screen out people who are obviously not eligible, and if someone becomes ineligible during the process we place the process on hold. In these cases the patients end up dying from their underlying illness...in hospice care. (personal communication, 1/30/08)

Werth & Wineberg (2004), examined data from 6 years of implementation of the ODWDA to address several areas of criticisms of the law, including the concern about screening out such psychiatric/psychological factors as depression, hopelessness, ambivalence, or lack of capacity that could impair judgment and that should be treated instead with medications or counseling. They concluded that physicians do seem to be screening such individuals out, but recommend including mental health professionals as part of regular treatment teams, integrated into the care of all terminally ill persons, independent of whether PAD requests are involved.

Where Death Occurred

-94% died at home
-4% died in long term care, assisted living, or foster care facility
-<1% died in hospital

These figures are significant because they show the high frequency of home deaths, which is what most Americans say they would want.

Notification of Family Members: Was Family Informed of Patient's Decision to Take Lethal Medication?

Age of patients 20-64   96%
Age of patients 65-95   97%
Married patients   98%
Widowed patients   95%
Divorced patients   90%
Never married patients   91%

Except for minors, no medical act, including stopping life supporting treatment or medications, requires mandatory notification of family members; it would be against the rules of medical ethics to require a patient to do so because of confidentiality and patient autonomy. Patients requesting PAD in Oregon are asked on reporting forms if they have notified a family member but are not required to do so. However the vast majority of the DWDA patients do notify at least one family member of their decision. This may be seen as further support for the argument that distinguishes PAD from suicide, which tends to be carried out in secret and certainly without support of loved ones.

Improvements in Quality of End-of-Life Care in Oregon and the U.S. Since Implementation of ODWDA

Several significant increases in the quality of end-of-life care in general in Oregon that correlate with the implementation of the Oregon Death With Dignity Act have been identified:

> Although physician-assisted death accounts for only 1 in 1000 deaths in Oregon, 1 in 50 dying Oregonians now talk with their physician about the possibility and 1 in 6 talk to family members about it…legalization has resulted in more open conversation and careful evaluation of end-of-life options. Rather than undermining other aspects of palliative care, legalization in Oregon has been associated with national leadership in terms of opioid prescriptions per capita, hospice referral rates, numbers of deaths occurring at home rather than in medical facilities, the training of physicians in palliative care, and organized statewide approaches to a protocol called Physician Orders for Life-Sustaining Treatment (Quill, 2007).

Quill (2007) reports the same findings for the Netherlands, where even though the laws and social context are different from those in Oregon, the use of PAD has remained stable over the last 17 years, finding

> no evidence of “slippery slope” deterioration in terms of increased numbers of assisted deaths in the face of open acceptance and, now, explicit legalization of these practices. There is also evidence that during this period palliative care and hospice care have simultaneously grown stronger in the Netherlands, so the possibility that these last-resort practices are being chosen because of inadequate palliative care is lessening.

Finally, Quill (2007) points to the dramatic growth of the palliative care movement throughout the U.S. during the same time period that the ODWDA has been in effect and the issue of PAD has come to the forefront. Most academic medical centers now have palliative care consultation services, palliative care is now a recognized subspecialty, and there is increasing acceptance of a variety of last-resort options to help dying patients with intractable suffering.

Battin et al. (2007) found no evidence of abuse of vulnerable populations in Oregon for the elderly, women, uninsured people, people with low educational status, the poor (recipients of PAD were likely to have higher educational status and were less likely than the background population to be poor), racial and ethnic minorities (the vast majority using the ODWDA are white), people with non-terminal physical disabilities or chronic non-terminal illness, minors, or people with psychiatric illness including depression and Alzheimer’s. “…there is no evidence of heightened risk of physician-assisted dying to vulnerable patients…”(597) These researchers found a similar absence of evidence of abuse of vulnerable populations in the Netherlands.

Conclusions About ODWDA Implementation

Under intense scrutiny and in the face of numerous legal challenges, extensive empirical data on PAD have been collected and reported by the Oregon

Department of Health since 1998. These data do not show evidence of misuse, abuse, lack of protection of vulnerable populations, increasing use, overall declines in palliative care, or a slippery slope toward loosening requirements, all of which have been the subject of concerns about legalizing PAD. To the contrary the data in fact indicate improvements in palliative care that have benefited all Oregonians at the end of life.

-PAD is rarely requested and used even less often.

-Vulnerable or underserved populations do not appear to seek or utilize PAD: the vast majority of Oregonians requesting and using PAD are white, educated, and have insurance. The law mandates that all be offered hospice and palliative care and most do receive it.

-The law excludes chronic physical or mental disabilities or chronic non-terminal illness as a reason to receive PAD, and no such cases have been identified or reported.

-The screening process for depression appears to be working, although it is not known, since recordkeeping is not required, how many requests are turned down prior to formal evaluation.

-Regarding the question of whether women are vulnerable to being manipulated or coerced into requesting PAD because of lower social status and internalized low self-worth, fewer women than men in Oregon chose PAD. Some argue (Bergner, 2007) that this does not settle the concern of increased vulnerability to coercion of women because traditional psychiatric suicide rates among women are about four times less than rates for men, so even the male-female ratio of 54-46 reported among the Oregon PAD deaths might indicate a higher than usual rate of an action ending life among women who are terminally ill. But the two populations, terminally ill women choosing PAD and physically well women choosing suicide for reasons of emotional distress or illness, are not comparable – one is a dying population and the other is not – so it is erroneous to attribute patterns found in either group to the other. It also seems demeaning to assume that terminally ill women choosing PAD are not capable of making sound, informed decisions about how they want to die because of internalized low self-worth.

There are no data demonstrating that patients with psychiatric illness, including depression and Alzheimer's, are at heightened risk for receiving PAD, though it is possible that physicians may sometimes under-diagnose depression. However, the deaths occurring under the ODWDA have been monitored closely, and the only accusation of a misdiagnosis of depression was based on newspaper articles rather on substantive data (see Hamilton, 2005 and response by Ganzini, 2006). To address the potential for and risks of under-diagnosis of depression, Oregon doctors report that since the passage of the ODWDA,

> efforts have been made to improve their ability to provide adequate end-of-life care [including] improving their knowledge of the use of pain medications for the terminally ill, improving their ability to recognize depression and other psychiatric disorders, and more frequently referring their patients to hospice programs (Tucker, 2008).

Regarding concerns that the availability of PAD will be a disincentive to improving end-of-life health care in general and to making alternative palliative care more widely available to people who are dying, the opposite seems in fact to have occurred in Oregon. The implementation of the ODWDA has galvanized improvements in end-of-life care and promoted dignity for all terminally ill patients in Oregon in concrete, measurable ways, making Oregon a national leader in quality end-of-life care.

In their comprehensive review of the Oregon data addressing multiple areas of concern, Werth & Wineberg (2004) ”find criticisms [of the ODWDA] to be unfounded given the research and analyses conducted to date,” abstract). They noted at the time of publication that because of limited number of years and low numbers of persons using the law at the time of their study, these findings are preliminary; however later data published since their study have been consistent with the data they examined. They conclude with the recommendation that everyone concerned about end-of-life care, including proponents and opponents of PAD, will focus attention on improving the quality of care, such as continued barriers to adequate pain medication, use of advance directives, culturally appropriate approaches to end-of-life discussions and care, timely referrals to hospice, and an emphasis on psychosocial and spiritual issues.

Caution needs to be exercised in generalizing the Oregon experience to other states, which may have different population mixes and different health care systems.

THE PUBLIC: OPINION POLLS, SURVEYS, AND EDITORIALS

PAD is a controversial issue, but there is consistent evidence that the majority of Americans support it under certain circumstances.

Public Opinion Polls and Surveys

Thus far, no current polls of Washington State residents are available. Following is a listing of some of the more recent national polls:

A 2005 Harris Poll (April) showed that “two-thirds of the public (67% to 32%) would like their states to allow ‘physician-assisted suicide’ as it is currently allowed in Oregon.” 64% to 32% disagree with the 1997 U.S. Supreme Court ruling that individuals don’t have a constitutional right to doctor-assisted suicide.

A 2005 Gallup Poll (May) showed that 75% of Americans said "doctors should be allowed to help a terminally ill person die… Even when pollsters used [the term] 'suicide' 58% said yes."

A 2005 Fox News Poll (October) found "assisted suicide" was backed 48% with 39% opposed; when the language was changed to whether "states should have the right to let doctors prescribe medications that would help mentally competent, terminally ill patients end their lives," support went up to 57% with 37% opposed.

A 2005 Field Poll (March) reported 70% of Californians agree that "incurably ill patients have the right to ask for and get life-ending medication." Majorities of every major religion including Catholics (65%) supported this choice.

The AMA newsletter, AMNews (11/21/05), reported that "nearly 6/10 (59%) physicians believe doctors should be legally permitted to dispense prescriptions for life-ending drugs to terminally ill patients who request them." HCD Research, which conducted the survey of 677 doctors randomly selected from their marketing list of about 50,000 doctors, also polled the public and found 64% favor PAD.

A survey that may be of particular interest to psychologists is a Wake Forest University Baptist Medical Center study (Hall et al, 2005). It found that, contrary to the fears of some members of the medical profession, the majority of patients would not lose trust in their doctors if it were legal for them to provide PAD. Overall, almost 3 times as many participants (N = 956) disagreed (58%) as agreed (20%) that legalizing euthanasia (a far more controversial option than PAD and one that is completely excluded by the Oregon or Washington Acts) would cause them to trust their personal physician less. The authors discuss the importance of questioning the common assumption that legalizing PAD would seriously threaten or undermine trust in physicians, and conclude that this is not supported empirically, citing other studies with similar findings.

A Washington State public opinion poll will be taken in the next couple of months. The last baseline poll was conducted was in April 2007, with a 600 person sample of 2008 general election voters, by Goodwin Simon Victoria Research. Although a ballot title was not yet available, the pollsters tested the basic Oregon approach and the result was 64% yes, 29% no, and 7% undecided.

There are no data regarding the attitudes of Washington State psychologists.

In the U.S. overall, public and professional support for PAD has tended to remain stable between 60-75% for over a decade.

Newspaper Editorials Supporting PAD

On 1/10/08, the Seattle Times published an editorial saying

> The "death with dignity" ballot measure…deserves public support…there have been no big scandals under [the Oregon] law, which has been used by a small and steady number of patients. In a population of 3.7 million, of which 30,000 die each year, deaths under the law have been running at about 40 per year. That suggests a death rate for Washington of about 70 per year. [This] law will not affect many people. But those it does affect, and their families, will be thankful for its passage.

On 1/25/08, an editorial in the Everett Herald stated:

> Dignity is a fundamental human right. Being on death's doorstep shouldn't change that. That's why we support [the] initiative…. Oregon's experience has disproven predictions that even a carefully crafted law with sensible safeguards would be abused. In 10 years, fewer than 300 people have used the law…and far more people request a lethal prescription than use it – evidence that just having such control is comforting to many…

On 1/13/08, an editorial in the Oregonian announced the Washington DWD initiative that

> could foster discussion of end-of-life care, which will benefit all Washingtonians…Oregonians have been engaged for years in the same emotional conversation, and it has produced much positive change. Today, as a result of white-hot focus on end-of-life care, Oregon leads the nation in providing access to palliative medicine and pain treatment…Years of fierce debate over Oregon's physician-assisted suicide law helped elevate end-of-life care in this state. Relentless legal battles and public discussion helped physicians to recognize the importance of humane pain management. It spurred them to refer more and more patients to hospice, and it led them to get much better at diagnosing depression among the terminally ill… A good share of the credit goes to a hefty set of safeguards built into the Oregon act. Wisely, in drafting the Washington proposal, Gardner's coalition borrowed almost all of them and added some of their own.

The New York Times wrote in a 6/5/05 editorial:

> The fundamental flaw in Dr. Kevorkian's crusade was his cavalier, indeed reckless, approach. He was happy to hook up patients without long-term knowledge of their cases or any corroborating medical judgment that they were terminally ill or suffering beyond hope of relief with aggressive palliative care…
>
> By contrast, Oregon, which has the only law allowing terminally ill

> adults to request a lethal dose of drugs from a physician, requires two physicians to agree that the patient is of sound mind and has less than six months to live. Now California is about to vote on a similarly careful measure. One of its sponsors cites Dr. Kevorkian as "the perfect reason we need this law in California. We don't want there to be more Dr. Kevorkians."

On 1/19/06, in response to the U.S. Supreme Court decision to uphold the ODWDA in the challenge brought by Attorney General John Ashcroft, the New York Times commented: "…our own sense is that Oregon has acted with exquisite care by requiring that two doctors agree that a patient is likely to die within six months, and is well informed and acting voluntarily, before lethal drugs can be prescribed. Congress would be wise not to meddle in a sensitive issue that Oregon has clearly studied far more closely."

On 1/17/06, commenting on the same Supreme Court decision, USA Today said that the ODWDA "provides a common-sense alternative for those who might otherwise have been tempted to shoot themselves or leap off a high bridge, the sort of tragic incidents that prompted enactments of the law by popular referendum."

The Seattle Post-Intelligencer published a guest editorial on 3/25/08 strongly advocating for legalized PAD (see http://seattlepi.nwsource.com/opinion/356404_dignity26.html),
and an opinion column on 3/31/08 that was strongly opposed to the WDWD1000 (see http://seattlepi.nwsource.com/connelly/357023_joel31.html).

POSITIONS ON PHYSICIAN AID-IN-DYING TAKEN BY SELECTED HEALTH CARE ASSOCIATIONS

The American Medical Association is opposed to PAD (for long periods in the past they have also opposed mandatory warnings on cigarette labels; giving contraceptive advice to patients, married or unmarried; and most forms of insurance and group health plans, including Medicare). As of 2004 the AMA represented 26% of the nation's doctors. The majority of the nation's doctors support PAD.

The Washington Medical Association is opposed to PAD. In a recent poll of its membership, which represents a minority of doctors in the State, members were split 50/42, with 50% in support of legalized PAD.

The Washington Academy of Family Practice recently adopted a position of "neutrality" on PAD, based on a similar resolution passed by the King County Medical Society (personal correspondence, Tom Preston MD, 2/22/08). The resolution includes the following statements:

> WHEREAS any position other than one of strict neutrality may jeopardize the reputation of the WAFP by allowing partisan interests on either side of the issue to use the stance for their own political advantage, and
>
> WHEREAS, strict neutrality is the only position the WAFP could adopt that would not misrepresent the collective view of Washington family physicians while taking into account that the views of individual physicians may vary widely on the subject of physician-assisted dying, THEREFORE BE IT
>
> RESOLVED, with regard to a citizen initiative relating to physician aid in dying, the WAFP adopt an organizational position of strict neutrality, and BE IT FURTHER
>
> RESOLVED, that the WAFP continue to support the further extension of Hospice Care, Palliative Care and Pain Management plus other techniques that further optimize end-of-life care for the terminally ill, and BE IT FURTHER
>
> RESOLVED, that the WAFP encourage all physicians to speak out on the issue and express their honest personal opinions on the subject with patients who seek to discuss it.

The American Medical Women's Association (AMWA, 2007) endorsed advocating PAD on 9/9/07: "The AMWA supports patient autonomy and the right of terminally ill patients to hasten death. AMWA also believes the physician should have the right to engage in physician assisted dying. In addition, AMWA strongly supports the use of palliative care measures and hospice care for terminally ill patients." The AMWA supports referral for psychiatric evaluation for all patients seeking aid in dying to evaluate mental competency and assess for depression. The AMWA supports the passage of aid-in-dying laws such as the ODWDA.

The American Medical Students Association (AMSA, 2008) endorsed PAD in Resolution D 01 at its House of Delegates meeting in March 2008, which "supports passage of aid in dying laws that empower mentally competent, terminally ill patients to hasten what might otherwise be a protracted, undignified, or extremely painful death. Aid in dying should be a last resort option in patient care if the following criteria are met…" These criteria include all the requirements in the ODWDA and the WDWD 1000 as well as thorough exploration by the patient of the following:

1. All appropriate standard and experimental allopathic and osteopathic therapies.
2. All relevant culturally sensitive alternative therapies.
3. All palliative care options, such as hospice.
4. Comprehensive pain management.

5. Comprehensive psychiatric, psychosocial and spiritual support.

On 2/14/07 the American Academy of Hospice and Palliative Medicine (AAHPM), the largest palliative care association in the country, approved a position statement of “studied neutrality” regarding PAD that addresses requests for PAD for physicians and other healthcare professionals and the significant clinical, ethical, and legal challenges involved. The statement identifies cautionary steps providers need to take in states where PAD is legal to ensure that “no patient be indirectly coerced to hasten his death because he lacks the best possible medical care.” The AAHMP further

> recognizes that deep disagreement persists regarding the morality of PAD. Sincere, compassionate, morally conscientious individuals stand on either side of this debate. AAHPM takes a position of “studied neutrality” on the subject of whether PAD should be legally regulated or prohibited, believing its members should instead continue to strive to find the proper response to those patients whose suffering becomes intolerable despite the best possible palliative care. (AAHPM, 2007)

The Oregon Psychological (OPA) position (personal correspondence, Tony Farrenkopf, PhD, OPA member, 2/13/08):

1. An OPA press release, dated Sept. 11, 1997, consistent with APA's position, stated: "At this time, the Oregon Psychological Association does not advocate for or against assisted suicide or for or against Measure 51." OPA advocated protecting client rights, preventing inappropriate diagnoses, evaluating patient capacity, supporting family members. "As psychologists, we want to attempt to ensure that the end-of-life decision making process includes a complete assessment of the patient's ability to make a rational judgment, and we want to help protect the patient's right to self-determination."

2. On March 9, 2007, the OPA board approved that OPA support using value-neutral language when referring to PAD.

CONCLUDING SUMMARY AND RECOMMENDATIONS REGARDING WSPA'S POSITION ON WDWD 1000

The Oregon Death With Dignity Act, comparable in virtually every way to the Washington Death With Dignity Initiative 1000, has been operationalized, implemented, reported on in great depth and detail, and rigorously scrutinized in Oregon since 1998. The data show no evidence of abuse, though admittedly that does not prove conclusively that no abuse exists. Some information of interest to psychologists is not available because it is not mandated in the reporting guidelines: i.e. how many terminally ill Oregonians have requested PAD but been deemed ineligible for psychological reasons and therefore never got to a formal assessment referral. However, implementation, protections, and reporting protocols appear to be solidly in place. Finally, contrary to the serious concerns about deleterious effects the ODWDA would have on overall end-of-life care in Oregon, unexpected and very broad improvements have ensued as a direct result of the ODWDA, e.g. greater utilization of hospice care, advanced pain management, more home deaths, improved physician education and training in end-of-life care and the detection of depression, and more open discussions between patients and doctors and families about death and dying.

The APA 2001 End-of-Life Resolutions on end-of-life care and "assisted suicide" committed psychology to gathering and reviewing emerging empirical knowledge and to working to improve end-of-life care and concludes

> …WHEREAS the empirical database, legal developments, and policy discourse related to assisted suicide are evolving rapidly;
>
> THEREFORE, be it resolved that the American Psychological Association take a position that neither endorses nor opposes assisted suicide at this time…
>
> LET IT BE FURTHER RESOLVED that the American Psychological Association will assist in preparing the profession to address the issue of assisted suicide by taking the following actions:
> …Advocate for quality end-of-life care for all individuals; and
> …Monitor legal, policy, and research developments that may require or encourage psychologists to involve themselves in assisted suicide cases… (http://www.apa.org/ppo/issues/asresolu.html)

The WSPA Council has concluded that the ten years of empirical data on DWD in Oregon now available justify participation of WSPA in the WDWD1000 debate.

Discussion

The issues and ramifications of WSPA taking a position regarding WDWD1000 as an organization are very complex. Passage of this Initiative would mean that residents of Washington State wishing to have the choice of physician aid-in-dying but for whom it is currently illegal would not have to resort to violent means to hasten their death or to put supportive physicians at risk for helping them in an illegal environment. Implemented properly, with the safeguards and protections built into the Initiative, people with treatable depression or other needs best addressed by other treatment and palliative care options could be identified and offered appropriate care. Possibly the impressive improvements in end-of-life care in Oregon might similarly develop in Washington State. However, PAD is deeply controversial not only as a public policy issue but because of the diversity of individual, deeply held personal beliefs and values, and of cultural, religious, and spiritual attitudes and values.

The unique strength of psychology is its commitment to empirical science and evidence-based treatment. We are standing on strong ground when we comment on the empirically based scientific aspects of physician aid-in-dying rather than arguing for a particular moral position.

Psychological knowledge relevant to end-of-life issues and care and the physician aid-in-dying debate includes critical analyses of empirical data and identification of specific assessment skills psychologists have the training and experience to provide. Contributing information in these areas is a responsible and meaningful way to participate in end-of-life care in Washington State and supports the mission statement of WSPA.

Recommendations and action steps related to WDWD1000 were presented to the Executive Board of WSPA on March 17, 2008, which unanimously approved them. They were then reviewed, refined, and finalized by Council, as summarized below.

RECOMMENDATION

WSPA Council Vote: On May 25, 2008, Council voted that WSPA should contribute to the public debate on physician aid-in-dying by providing information from a data-based perspective, as educators and informed experts on the psychological issues. The unique strength of psychology as a mental health profession is its commitment to empirical science and evidence-based treatment. WSPA upholds the right of all individuals to act according to their conscience and values, and WSPA is committed to supporting informed choices through education and facilitating respectful dialogue among people with diverse views. Therefore WSPA does not advocate any particular position on the Initiative but comments on the issues psychology is best qualified to speak to: (1) assessment of mental status and capacity particularly with regard to capacity for informed consent in end-of-life decisionmaking; (2) distinguishing between (a) suicide based on acute or chronic mental disorders, emotional distress, or substance abuse and (b) requests by terminally ill people to hasten a death that is inevitable for medical reasons; and (3) analysis and assessment of social science data such as the Oregon annual reports and related research and peer-reviewed journal articles.

WSPA would like to inform the public on the following scientific aspects of WDWD1000:

1. Established psychological assessment tools and methods are available to assess for mental states such as dementia or Alzheimer’s and psychiatric conditions such as major depression that could impair judgment and decision-making capacity in PAD requests.

2. Psychology has the expertise to assess whether a request for PAD is based on informed consent and being made voluntarily.

3. The APA and WSPA distinguish a terminally ill mentally competent individual's request for physician aid-in-dying from suicide motivated by emotional distress or psychiatric illness.

4. The quality and specificity of 10 years of comprehensive annual reports from the Oregon Department of Health on the implementation and regulation of the Oregon Death With Dignity Act and related research and data analyses do not show evidence of abuse, neglect, manipulation of, or pressure on patients in vulnerable groups in the state of Oregon. The data do not show evidence of a slippery slope toward less stringent guidelines and regulation. Reasons patients chose aid in dying were based on quality of life concerns, desire for autonomy, and the wish to avoid loss of dignity and control, not lack of resources or social support. Furthermore there is evidence that the law has had a positive effect in terms of significant improvements in palliative care for all Oregonians, e.g. increased hospice referrals, advanced pain management, more home deaths, improved physician education and training in end-of-life care and detection of depression, and more open discussions among patients, doctors, and families about dying.

In conclusion, WSPA supports excellent palliative care for all people at the end of life, and upholds that all end-of-life treatment should be based on dignity, compassion, and respect for individual differences whether based on religion, spirituality, culture, ethnicity, or personal values.

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Appendix 1: Washington Death With Dignity Act

WASHINGTON DEATH WITH DIGNITY ACT

The Washington Death with Dignity Act
Section Outline

Section 1. Definitions
Adult
Attending physician
Competent
Consulting physician
Counseling
Health care provider
Informed decision
Medically confirmed
Patient
Physician
Qualified patient
Self-administer
Terminal disease
Written Request for Medication to End Life in a Humane and Dignified Manner
Section 2. Who may initiate a written request for medication
Section 3. Form of the written request
Safeguards
Section 4. Attending physician responsibilities
Section 5. Consulting physician confirmation
Section 6. Counseling referral
Section 7. Informed decision
Section 8. Family notification
Section 9. Written and oral requests
Section 10. Right to rescind request
Section 11. Waiting periods
Section 12. Medical record documentation requirements
Section 13. Residency requirement
Section 14. Disposal of unused medications
Section 15. Reporting requirements
Section 16. Effect on construction of wills, contracts, and statutes
Section 17. Insurance or annuity policies
Section 18. Construction of Act
Immunities and Liabilities
Section 19. Immunities–basis for prohibiting health care provider from participation–
notification–permissible sanctions
Section 20. Liabilities
Section 21. Claims by governmental entity for costs incurred
Additional Provisions
Section 22. Form of the request
Section 23. Amendments
Section 24. Amendments
Section 25. Amendments
Section 26. Short title
Section 27. Severability
Section 28. Effective date
Section 29. New chapter in Title 70
Section 30. Captions, part headings, and subpart headings not law
Section 31. Expiration date

AN ACT Relating to death with dignity; amending RCW 70.122.100; reenacting and amending RCW 42.56.360 and 42.56.360; adding a new chapter to Title 70 RCW; prescribing penalties; providing an effective date; and providing an expiration date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

THE WASHINGTON DEATH WITH DIGNITY ACT

General Provisions

NEW SECTION. **Sec. 1.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Adult" means an individual who is eighteen years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "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 the patient's disease.

(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

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

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

(e) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in the state of Washington.

(11) "Qualified patient" means a competent adult who is a resident of Washington state and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.

(12) "Self-administer" means a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner.

(13) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

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

NEW SECTION. **Sec. 2.** WHO MAY INITIATE A WRITTEN REQUEST FOR MEDICATION. (1) An adult who is competent, is a resident of Washington state, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication that the patient may self-administer to end his or her life in a humane and dignified manner in accordance with this chapter.

(2) A person does not qualify under this chapter solely because of age or disability.

NEW SECTION. **Sec. 3.** FORM OF THE WRITTEN REQUEST. (1) A valid request for medication under this chapter shall be in substantially the form described in section 22 of this act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage, or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the department of health by rule.

Safeguards

NEW SECTION. **Sec. 4.** ATTENDING PHYSICIAN RESPONSIBILITIES. (1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is competent, and has made the request voluntarily;

(b) Request that the patient demonstrate Washington state residency under section 13 of this act;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(i) His or her medical diagnosis;

(ii) His or her prognosis;

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

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

(v) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily;

(e) Refer the patient for counseling if appropriate under section 6 of this act;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this chapter and of not taking the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the fifteen-day waiting period under section 9 of this act;

(i) Verify, immediately before writing the prescription for medication under this chapter, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of section 12 of this act;

(k) Ensure that all appropriate steps are carried out in accordance with this chapter before writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(l)(i) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under statute and rule to dispense and has a current drug enforcement administration certificate; or

(ii) With the patient's written consent:

(A) Contact a pharmacist and inform the pharmacist of the prescription; and

(B) Deliver the written prescription personally, by mail or facsimile to the pharmacist, who will dispense the medications directly to either the patient, the attending physician, or an expressly identified agent of the patient. Medications dispensed pursuant to this subsection shall not be dispensed by mail or other form of courier.

(2) The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death.

NEW SECTION. **Sec. 5.** CONSULTING PHYSICIAN CONFIRMATION. Before a patient is qualified under this chapter, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is competent, is acting voluntarily, and has made an informed decision.

NEW SECTION. **Sec. 6.** COUNSELING REFERRAL. If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. Medication to end a patient's life in a humane and dignified manner shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

NEW SECTION. **Sec. 7.** INFORMED DECISION. A person shall not receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision. Immediately before writing a prescription for medication under this chapter, the attending physician shall verify that the qualified patient is making an informed decision.

NEW SECTION. **Sec. 8.** FAMILY NOTIFICATION. The attending physician shall recommend that the patient notify the next of kin of his or her request for medication under this chapter. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

NEW SECTION. **Sec. 9.** WRITTEN AND ORAL REQUESTS. To receive a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician at least fifteen days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the qualified patient an opportunity to rescind the request.

NEW SECTION. **Sec. 10.** RIGHT TO RESCIND REQUEST. A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this chapter may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

NEW SECTION. **Sec. 11.** WAITING PERIODS. (1) At least fifteen days shall elapse between the patient's initial oral request and the writing of a prescription under this chapter.

(2) At least forty-eight hours shall elapse between the date the patient signs the written request and the writing of a prescription under this chapter.

NEW SECTION. **Sec. 12.** MEDICAL RECORD DOCUMENTATION REQUIREMENTS. The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is competent, is acting voluntarily, and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request under section 9 of this act; and

(7) A note by the attending physician indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

NEW SECTION. **Sec. 13.** RESIDENCY REQUIREMENT. Only requests made by Washington state residents under this chapter may be granted. Factors demonstrating Washington state residency include but are not limited to:

(1) Possession of a Washington state driver's license;

(2) Registration to vote in Washington state; or

(3) Evidence that the person owns or leases property in Washington state.

NEW SECTION. **Sec. 14.** DISPOSAL OF UNUSED MEDICATIONS. Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means.

NEW SECTION. **Sec. 15.** REPORTING REQUIREMENTS. (1)(a) The department of health shall annually review all records maintained under this chapter.

(b) The department of health shall require any health care provider upon writing a prescription or dispensing medication under this chapter to file a copy of the dispensing record and such other administratively required documentation with the department. All administratively required documentation shall be mailed or otherwise transmitted as allowed by department of health rule to the department no later than thirty calendar days after the writing of a prescription and dispensing of medication under this chapter, except that all documents required to be filed with the department by the prescribing physician after the death of the patient shall be mailed no later than thirty calendar days after the date of death of the patient. In the event that anyone required under this chapter to report information to the department of health provides an inadequate or incomplete report, the department shall contact the person to request a complete report.

(2) The department of health shall adopt rules to facilitate the collection of information regarding compliance with this chapter. Except as otherwise required by law, the information collected is not a public record and may not be made available for inspection by the public.

(3) The department of health shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section.

NEW SECTION. **Sec. 16.** EFFECT ON CONSTRUCTION OF WILLS, CONTRACTS, AND STATUTES. (1) Any provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, is not valid.

(2) Any obligation owing under any currently existing contract shall not be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner.

NEW SECTION. **Sec. 17.** INSURANCE OR ANNUITY POLICIES. The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication that the patient may self-administer to end his or her life in a humane and dignified manner. A qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner shall not have an effect upon a life, health, or accident insurance or annuity policy.

NEW SECTION. **Sec. 18.** CONSTRUCTION OF ACT. (1) Nothing in this chapter authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide." Consistent with sections 1 (7), (11), and (12), 2(1), 4(1)(k), 6, 7, 9, 12 (1) and (2), 16 (1) and (2), 17, 19(1) (a) and (d), and 20(2) of this act, state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication.

(2) Nothing contained in this chapter shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist or psychologist, or other health care provider participating under this chapter.

Immunities and Liabilities

NEW SECTION. **Sec. 19.** IMMUNITIES–BASIS FOR PROHIBITING HEALTH CARE PROVIDER FROM PARTICIPATION–NOTIFICATION–PERMISSIBLE SANCTIONS. (1) Except as provided in section 20 of this act and subsection (2) of this section:

(a) A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner;

(b) A professional organization or association, or health care provider, may not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter;

(c) A patient's request for or provision by an attending physician of medication in good faith compliance with this chapter does not constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator; and

(d) Only willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(2)(a) A health care provider may prohibit another health care provider from participating under this act on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under this act. This subsection does not prevent a health care provider from providing health care services to a patient that do not constitute participation under this act.

(b) A health care provider may subject another health care provider to the sanctions stated in this subsection if the sanctioning health care provider has notified the sanctioned provider before participation in this act that it prohibits participation in this act:

(i) Loss of privileges, loss of membership, or other sanctions provided under the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in this act while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(ii) Termination of a lease or other property contract or other nonmonetary remedies provided by a lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in this act while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(iii) Termination of a contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in this act while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subsection (2)(b)(iii) prevents:

(A) A health care provider from participating in this act while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(B) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions under (b) of this subsection shall follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For the purposes of this subsection:

(i) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider before the provider's participation in this act of the sanctioning health care provider's policy about participation in activities covered by this chapter.

(ii) "Participate in this act" means to perform the duties of an attending physician under section 4 of this act, the consulting physician function under section 5 of this act, or the counseling function under section 6 of this act. "Participate in this act" does not include:

(A) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(B) Providing information about the Washington death with dignity act to a patient upon the request of the patient;

(C) Providing a patient, upon the request of the patient, with a referral to another physician; or

(D) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(3) Suspension or termination of staff membership or privileges under subsection (2) of this section is not reportable under RCW 18.130.070. Action taken under section 3, 4, 5, or 6 of this act may not be the sole basis for a report of unprofessional conduct under RCW 18.130.180.

(4) References to "good faith" in subsection (1)(a), (b), and (c) of this section do not allow a lower standard of care for health care providers in the state of Washington.

NEW SECTION. **Sec. 20.** LIABILITIES. (1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death is guilty of a class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication to end the patient's life, or to destroy a rescission of a request, is guilty of a class A felony.

(3) This chapter does not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct that is inconsistent with this chapter.

NEW SECTION. **Sec. 21.** CLAIMS BY GOVERNMENTAL ENTITY FOR COSTS INCURRED. Any governmental entity that incurs costs resulting from a person terminating his or her life under this chapter in a public place has a claim against the estate of the person to recover such costs and reasonable attorneys' fees related to enforcing the claim.

Additional Provisions

NEW SECTION. **Sec. 22.** FORM OF THE REQUEST. A request for a medication as authorized by this chapter shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMAN AND DIGNIFIED MANNER

I, ..., am an adult of sound mind.

I am suffering from . . . ., which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and to 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 three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: . . . .
Dated: . . . .

DECLARATION OF WITNESSES

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

Witness 1 Witness 2
Initials Initials
. . . . 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;
. . . . 4. Is not a patient for whom either of us is the attending physician.

Printed Name of Witness 1: . . . .
Signature of Witness 1/Date: . . . .
Printed Name of Witness 2: . . . .
Signature of Witness 2/Date: . . . .

NOTE: One witness shall not be a relative by blood, marriage, or adoption of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

Sec. 23. RCW 42.56.360 and 2007 c 261 s 4 and 2007 c 259 s 49 are each reenacted and amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;

(b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, and notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170;

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1); ((~~and~~))

(h) Information obtained by the department of health under chapter 70.225 RCW; and

(i) Information collected by the department of health under chapter 70.– RCW (sections 1 through 22, 26 through 28, and 30 of this act) except as provided in section 15 of this act.

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

Sec. 24. RCW 42.56.360 and 2007 c 273 s 25, 2007 c 261 s 4, and 2007 c 259 s 49 are each reenacted and amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;

(b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, and notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170;

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1); ((~~and~~))

(h) Information obtained by the department of health under chapter 70.225 RCW; and

(i) Information collected by the department of health under chapter 70.– RCW (sections 1 through 22, 26 through 28, and 30 of this act) except as provided in section 15 of this act.

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

Sec. 25. RCW 70.122.100 and 1992 c 98 s 10 are each amended to read as follows:

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing ((~~or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying~~)), lethal injection, or active euthanasia.

NEW SECTION. **Sec. 26.** SHORT TITLE. This act may be known and cited as the Washington death with dignity act.

NEW SECTION. **Sec. 27.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 28.** EFFECTIVE DATE. This act takes effect one hundred twenty days after the election at which it is approved, except for section 24 of this act which takes effect July 1, 2009.

NEW SECTION. **Sec. 29.** Sections 1 through 22, 26 through 28, and 30 of this act constitute a new chapter in Title 70 RCW.

NEW SECTION. **Sec. 30.** CAPTIONS, PART HEADINGS, AND SUBPART HEADINGS NOT LAW. Captions, part headings, and subpart headings used in this act are not any part of the law.

NEW SECTION. **Sec. 31.** Section 23 of this act expires July 1, 2009.