Chapter 246-978 WAC

DEATH WITH DIGNITY ACT REQUIREMENTS

NEW SECTION

WAC 246-978-001 Purpose and authority. This chapter is adopted by the Washington state department of health to implement the provisions of Initiative Measure No. 1000, the Washington Death with Dignity Act.

NEW SECTION

WAC 246-978-010 Definitions. For the purpose of this chapter, the following definitions apply:

(1) "Act" means the "Washington Death with Dignity Act" or Initiative Measure No. 1000 as adopted by the voters on November 4, 2008.

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

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

(4) "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.

(5) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(6) "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.

(7) "Department" means the department of health.

(8) "Dispensing record" means a copy of the Pharmacy Dispensing Record form, DOH 422-067.

(9) "Health care facility" means a facility licensed under chapter 70.41, 18.51, or 72.36 RCW.

(10) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the 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.

(11) "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.

(12) "Long-term care facility" means a facility licensed under chapter 18.51 or 72.36 RCW.

(13) "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.

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

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

(16) "Qualified patient" means a competent adult who is a resident of Washington state and has satisfied the requirements of this act 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.

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

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

NEW SECTION

WAC 246-978-020 Reporting. (1) To comply with the act, within thirty calendar days after the date of death of the patient, the attending physician shall send the following completed, signed, and dated documentation by mail to the State Registrar, Center for Health Statistics, P.O. Box 47814, Olympia, WA 98504:

(a) The patient's completed written request for medication to end life, either using the Written Request for Medication to End My Life in a Humane and Dignified Manner form, DOH 422-063, or in substantially the same form as described in the act;

(b) Attending Physician's Compliance form, DOH 422-064;

(c) Consulting Physician's Compliance form, DOH 422-065; and

(d) Psychiatric/Psychological Consultant's Compliance form, DOH 422-066, if an evaluation was performed.

(2) Within thirty calendar days of a qualified patient's ingestion of lethal medication obtained pursuant to the act, or death from any other cause, whichever comes first, the attending physician shall complete the Attending Physician's After Death Reporting form, DOH 422-068.

(3) To comply with the act, within thirty calendar days of dispensing medication, the dispensing health care provider shall file a copy of the Pharmacy Dispensing Record form, DOH 422-067, with the State Registrar, Center for Health Statistics, P.O. Box 47814, Olympia, WA 98504. Information to be reported to the department shall include:

(a) Patient's name and date of birth;

(b) Patient's address;

(c) Prescribing physician's name and phone number;

(d) Dispensing health care provider's name, address and phone number;

(e) Medication dispensed and quantity;

(f) Date the prescription was written; and

(g) Date the medication was dispensed.

NEW SECTION

WAC 246-978-030 Confidentiality--Liability. All information collected by the department under the act shall not be a public record and may not be available for inspection by the public under chapter 42.56 RCW. This information includes, but is not limited to, the identity of patients, health care providers, and health care facilities.

NEW SECTION

WAC 246-978-040 Qualifications of witness in a long-term care facility. If the patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses must be designated by the facility. The witness designated by the facility shall be a person who is not:

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

(2) 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

(3) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident. This witness may be, but is not limited to, an ombudsman, chaplain, or social worker.

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

I, ____, am an adult of sound mind.
First Middle Last

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 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.

Signature:	County of Residence:	Date:

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	
[ ]	[ ]	1. Is personally known to us or has provided proof of identity;
[ ]	[ ]	2. Signed this request in our presence on the date following 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:	Signature:	Date:
Printed Name: Witness 1	Signature:	Date:
Printed Name: Witness 2	Signature:	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 long-term health care facility, one of the witnesses shall be an individual designated by the facility.

ATTENDING PHYSICIAN'S COMPLIANCE FORM

MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47814, Olympia, WA 98504

A PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH:
MEDICAL DIAGNOSIS	

B PHYSICIAN INFORMATION

NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
MAILING ADDRESS	
CITY, STATE AND ZIP CODE	

C ACTION TAKEN TO COMPLY WITH LAW

1. FIRST ORAL REQUEST

First oral request for medication to end life.	DATE

Comments:

Indicate compliance by checking the boxes. (Both the attending and consulting physicians must make these determinations.)

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination the patient has six months or less to live.
- ☐ 3. Determination that patient is competent.*
- ☐ 4. Determination that patient is a Washington state resident.**
- ☐ 5. Determination that patient is acting voluntarily.
- 6. Determination that patient has made his/her decision after being fully informed of:
  - ☐ a) His or her medical diagnosis; and
  - ☐ b) His or her prognosis; and
  - ☐ c) The potential risks associated with taking the medication to be prescribed; and
  - ☐ d) The potential 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.

Indicate compliance by checking the boxes. DATE:

- ☐ 1. Patient informed of his or her right to rescind the request at any time.
- ☐ 2. Patient recommended to inform next of kin.
- ☐ 3. Patient counseled about the importance of having another person present when the patient takes the medication(s).
- ☐ 4. Patient counseled about the importance of not taking the medication in a public place.

2. SECOND ORAL REQUEST (*Must be made **15 days** or more after the first oral request.*)

Indicate compliance by checking the boxes. DATE:

- ☐ 1. Second oral request for medication to end life.
- ☐ 2. Patient informed of the right to rescind the request at any time.

Comments:

ATTENDING PHYSICIAN'S COMPLIANCE FORM (continued)

PATIENT INFORMATION	
PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

C	ACTION TAKEN TO COMPLY WITH THE LAW – continued	
	3. PATIENT'S WRITTEN REQUEST	
	☐ Written request for medication to end life received. Please attach request. (*No less than* ***48 hours*** *shall elapse between the written request and writing the prescription.*)	DATE
	Comments:	

D	MEDICAL CONSULTATION (Attach consultant's form.)		
	Medical consultation and second opinion requested from:		
	MEDICAL CONSULTANT'S NAME	TELEPHONE NUMBER ( ) —	DATE

E	PSYCHIATRIC/PSYCHOLOGICAL EVALUATION		
	Check one of the following ***(required)****:* ☐ I have determined that the patient is not suffering from a psychiatric or psychological disorder, or depression, causing impaired judgment, in accordance with Initiative Measure No. 1000 (codified as RCW XXX). ☐ I have referred the patient to the provider listed below for evaluation and counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment, **and attached the consultant's form**.		
	PSYCHIATRIC CONSULTANT'S NAME	TELEPHONE NUMBER ( ) —	DATE

F	MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT (*To be prescribed no sooner than* ***48 hours*** *after patient's written request has been signed.*)		
	LETHAL MEDICATION PRESCRIBED AND DOSE		DATE PRESCRIBED
	Please check one of the following: ☐ Dispensed medication directly. Date ____/____/____ ☐ Contacted pharmacist and delivered prescription personally or by mail to the pharmacist. Pharmacy Name City Phone # ( ) -		
	Immediately prior to writing the prescription, the patient was fully informed of: (*check boxes*) ☐ (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; ☐ (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.		
	To the best of my knowledge, all of the requirements under the Washington Death with Dignity Act have been met.		
	✗	PHYSICIAN'S SIGNATURE	DATE

* "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.

** Factors demonstrating residency include, but are not limited to: 1) Possession of a Washington state driver's license; 2) Registration to vote in Washington state; 3) Evidence that a person owns or leases property in Washington state.

CONSULTING PHYSICIAN'S COMPLIANCE FORM

Deliver this form to the attending physician who will mail it to:
State Registrar, Center for Health Statistics,
P.O. Box 47814, Olympia, WA 98504

A — PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

B — REFERRING/PRESCRIBING PHYSICIAN

REFERRING/PRESCRIBING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER
	( ) —

C — CONSULTANT'S REPORT

1. MEDICAL DIAGNOSIS	DATE OF EXAMINATION(S)

2. Check boxes for compliance. *(Both the attending and consulting physicians must make these determinations.)*

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination the patient has 6 months or less to live.
- ☐ 3. Determination that patient is competent.*
- ☐ 4. Determination that patient is acting voluntarily.
- 5. Determination that patient has made his/her decision after being fully informed of:
  - ☐ a. His or her medical diagnosis; and
  - ☐ b. His or her prognosis; and
  - ☐ c. The potential risks associated with taking the medication to be prescribed; and
  - ☐ d. The potential 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.

Comments:

D — PATIENT'S MENTAL STATUS

Check one of the following ***(required)***:

- ☐ I have determined that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, in conformance with Initiative Measure No. 1000 (codified as RCW XXX).
- ☐ I have referred the patient to the provider listed below for evaluation and counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment.

PSYCHIATRIC CONSULTANT'S NAME	TELEPHONE NUMBER	DATE
	( ) —	

E — CONSULTANT'S INFORMATION

✗	PHYSICIAN'S SIGNATURE	DATE
	NAME (PLEASE PRINT)	
MAILING ADDRESS		
CITY, STATE AND ZIP CODE		TELEPHONE NUMBER ( ) —

* "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.

PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM

MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47814, Olympia, WA 98504

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:

B	REFERRING/PRESCRIBING PHYSICIAN	
	REFERRING PHYSICIAN'S NAME (LAST, FIRST, M.I.):	TELEPHONE NUMBER: ( ) —

C	PSYCHIATRIC / PSYCHOLOGICAL EVALUATION	
	1. MEDICAL DIAGNOSIS	DATE(S) OF EXAMINATION(S):
	2. PSYCHIATRIC / PSYCHOLOGICAL EVALUATION	

D	PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S INFORMATION		
	I have determined through evaluation that the above-named patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment, in conformance with Initiative Measure No. 1000 (codified as RCW XXX).		
	✗	CONSULTANT'S SIGNATURE AND TITLE (e.g., M.D., Ph.D., etc.):	
		CONSULTANT'S NAME (PRINTED):	DATE:
	MAILING ADDRESS:		
	CITY, STATE AND ZIP CODE:		TELEPHONE NUMBER: ( ) —

PHARMACY DISPENSING RECORD

**MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47814, Olympia, WA 98504**

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:

B	PHYSICIAN INFORMATION	
	NAME (LAST, FIRST, M.I.):	TELEPHONE NUMBER: ( ) —
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	

C	DISPENSING HEALTH CARE PROVIDER INFORMATION	
	NAME (LAST, FIRST, M.I.) AND TITLE:	TELEPHONE NUMBER: ( ) —
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	DATE OF THIS REPORT:

D MEDICATIONS DISPENSED

MEDICATIONS	QUANTITY	DATE PRESCRIBED	DATE DISPENSED
#1			
#2			
#3			
#4			

E	SIGNATURE		
	DISPENSING HEALTH CARE PROVIDER'S SIGNATURE	TELEPHONE NUMBER ( ) —	DATE

ATTENDING PHYSICIAN'S AFTER DEATH REPORTING FORM

**MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47814, Olympia, WA 98504**

Dear Physician:

The Washington Death with Dignity Act requires physicians who write a prescription for lethal medications under the Act to report to the Department of Health information that documents compliance with the law. The attending physician shall complete this form within thirty calendar days of a patient's ingestion of lethal medication obtained pursuant to the act or death from any other cause, whichever comes first. If you do not know the answers to any of the following questions, please contact the family or patient's representative.

All information will be kept strictly confidential. Please do not write your name or the patient's name on this form. Instead, write both on a slip of paper and attach it to this page. If you have questions about these instructions, please call 360-236-4369.

Date: ___/___/___

Date of Death: __/___/___

1. Did the patient die from the ingestion of lethal medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink?

If the patient died from ingestion of a lethal medication complete questions 2-23.

If the patient died from their underlying illness or other causes do not complete questions 2-23. Mail this page, along with a separate slip of paper with your name and the patient's name to the address listed above. Any medication dispensed that was not self-administered shall be disposed of by lawful means.

☐ 1 Ingestion of lethal medication

☐ 2 Underlying illness

☐ 3 Other (specify):____

2. On what date did you begin caring for this patient?

___/___/___ (Mo/Da/Yr)

3. On what date was the patient first told about their underlying medical condition?

___/___/___ (Mo/Da/Yr)

4. On what date was the patient told that this condition was terminal -- that is, that they would die from this illness despite medical therapy?

___/___/___ (Mo/Da/Yr)

5. On what date was the lethal prescription written or phoned in?

___/___/___ (Mo/Da/Yr)

6. And, on what date were the lethal medications dispensed to the patient?

___/___/___ (Mo/Da/Yr) . ☐ Not Dispensed ☐ Unknown

7. Were you at the patient's bedside when the patient took the lethal medication?

☐ 1 Yes
☐ 2 No, did not offer to be present at the time of ingestion
☐ 3 No, offered to be present, but the patient declined
☐ 8 No, other (specify):______________________________
☐ 9 Unknown

<u>If no:</u> Was another physician or trained health care provider or volunteer present when the patient ingested medication?

☐ 1 Yes, another physician
☐ 2 Yes, a trained health-care provider/volunteer
☐ 3 No
☐ 9 Unknown

8. Were you at the patient's bedside at the time of death?

☐ 1 Yes
☐ 2 No

<u>If no:</u> Was another physician or trained health care provider or volunteer present at the patient's time of death?

☐ 1 Yes, another physician
☐ 2 Yes, a trained health-care provider/volunteer
☐ 3 No
☐ 9 Unknown

<u>If no:</u> How were you informed of the patient's death?

☐ 1 Family member called M.D.
☐ 2 Friend of patient called M.D.
☐ 3 Another physician
☐ 4 Hospice R.N.
☐ 5 Hospital R.N.
☐ 6 Nursing home/Assisted-living staff
☐ 7 Funeral home
☐ 8 Medical Examiner
☐ 9 Other (specify):______________________________

9. What lethal medication was prescribed and what was the dosage?

____

____

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

☐ 1 Yes
☐ 2 No

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

____

____

____

____

☐ 9 Unknown

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

☐ 1 Yes

Please Describe:

____

____

____

☐ 2 No

☐ 9 Unknown

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

☐ 1 Yes

Please describe:

____

____

____

☐ 2 No

☐ 9 Unknown

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

Minutes: _____ or Hours: _____ ☐ Unknown

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

Minutes: _____ or Hours: _____ ☐ Unknown

If the patient lived longer than six hours:

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

____

____

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

A concern about:

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

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

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

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

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

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

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

16. *Immediately* prior to ingestion of lethal medication, what was the patient's mobility? (ECOG scale)

☐ 0 Fully active, no restrictions on pre-disease performance.
☐ 1 Restricted in strenuous activity, but ambulatory and able to carry out work.
☐ 2 Ambulatory and capable of all self-care, but no work activities; up and about more than 50% of waking hours.
☐ 3 Capable of only limited self-care; in bed or chair more than 50% of waking hours.
☐ 4 Completely disabled, no self-care, totally confined to bed or chair.
☐ 9 Unknown

17. Where did the patient ingest the medication?

☐ 1 Private home
☐ 2 Assisted-living residence (including foster care)
☐ 3 Nursing home
☐ 4 Acute care hospital in-patient
☐ 5 In-patient hospice resident
☐ 6 Other (specify) ____________________
☐ 9 Unknown

18. When the patient initially requested a prescription for the lethal medication, was the patient receiving hospice care?

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

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

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

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

- ☐ 1 Medicare
- ☐ 2 Medicaid
- ☐ 3 Military/CHAMPUS
- ☐ 4 V.A.
- ☐ 5 Indian Health Service
- ☐ 6 Private insurance
- ☐ 7 No insurance
- ☐ 8 Had insurance, don't know type
- ☐ 9 Unknown

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

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

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

Years: ____

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

____

____

____

FOR OFFICIAL USE ONLY
CASE ID NUMBER:

☐ DWDA ☐ ILLNESS

PHYSICIAN ID NUMBER: