

Physician Assisted Dying in Washington State: A primer for participating physicians and pharmacists

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Summary

Medical Aid in Dying (MAID), also known as Death with Dignity, is now legal in nine states and the District of Columbia. Though patients have been using the Death with Dignity laws since 1998, very little information is published for physicians, pharmacists, and patients who are trying to learn more about actual requirements, protocols, or patient instructions. We present current drug regimens and practice recommendations.

Background

Medical Aid in Dying (MAID) was first approved by Oregon voters in 1997. Since that time, Death with Dignity (DWD) has become law in Washington, California, Colorado and Hawaii by popular vote; in Vermont, New Jersey, Maine and New Mexico by legislative vote; in Montana by State Supreme Court decision; and in Washington, D.C. by City Council vote. The idea that a dying person be allowed lethal medicines to expedite his or her own death is being embraced by more people throughout the United States and MAID is now available to 22 percent of US residents. Since mid-2016, MAID has been available to terminally ill persons in Canada, usually by injection.

In 2008, Washington State voters passed its Death with Dignity Act; the law was implemented in March 2009. By the end of 2018, prescriptions were dispensed to 1663 participants who had qualified under the act. There have been 1210 documented deaths from taking the MAID medications; the other 27 percent of the qualified participants died without taking the prescribed medications, or their status is unknown.¹

Physicians and pharmacists are not required to participate in DWD; they often decline for personal or religious convictions, or because of employer-imposed restrictions. Patients who pursue DWD are usually reasonably well informed and determined. They (or their families) ask doctors or hospice personnel, or search the internet, for information and help. Patients get discouraged and become anxious when their doctors refuse or delay granting them this option, which forces them to find new doctors.

Very little has been written on how medical aid in dying has actually been accomplished,^{2 3 4} partly because of concern that technical information might arm opponents or be used by persons seeking to commit suicide. However, in the interest of providing safe, consistent, quality options to patients who qualify for DWD and choose to use that option, we are presenting this information to interested physicians and pharmacists.

The Process of Qualifying⁵

The MAID laws in Oregon, Washington, California, Vermont, Colorado, Hawaii, Maine, New Jersey, New Mexico and Washington DC are very similar.⁶ In all states, a patient who has a medical diagnosis that is expected to lead to death within six months is required to qualify in accord with the following criteria:

1. The patient must be a legal resident of the jurisdiction where MAID is available.
2. The patient must be of sound decision-making capacity. A psychiatric/ psychological consult is required for any patient who the attending or consulting physician questions being of sound mind.*
3. Two independent, licensed, participating physicians must confirm that the patient is terminal; i.e., that life expectancy is six months or less. (Most jurisdictions require both doctors to complete a Physician Compliance form, which the prescribing physician sends to the jurisdiction's department of

* New Jersey requires a psychological assessment completed on every MAID patient.

health, DOH.)[†] The patient must also be able to self-administer/ingest the lethal medicine orally or by feeding or other tube.

4. The patient must make two oral requests to a physician, at least 15 days apart[‡], requesting the option to use MAID, and these requests must be documented in the patient's medical record. In Washington State, the second oral request must be made to the prescribing (attending) physician but can be made by phone.
5. After meeting with[§] both physicians, the patient must sign a Written Request for Medication, which is witnessed by two individuals, at least one of whom is not related or entitled to any portion of the patient's estate. In Washington, this form, together with the two compliance forms, is sent to the state DOH when life-ending prescriptions are written. California and Hawaii also require that those wishing to take the medication prescribed in accordance with the act must complete a Final Attestation Form 48 hours prior to taking the medication.
6. The patient must be counseled about all end of life options and told that the request for MAID can be canceled at any time.
7. In Hawaii, MAID prescriptions expire in 30 days of being written. In all other states, the prescription is valid for 6 months after it is written.
8. Oregon and New Mexico offer options to decrease the time between first and second oral requests if it is likely that the patient will not survive the 15 days required to qualify for medical aid in dying.

Once both oral requests have been made, and the written request has been signed (at least 48 hours earlier in Washington), the attending physician may write a prescription for life-ending medication and send it to a participating pharmacy.

In Oregon, the median time between a patient's first request and death was noted to be 46 days.⁷ If time is of the essence, the process of qualifying and obtaining prescriptions can be completed in 15 days minimum in most jurisdictions except Hawaii. Oregon has recently made it possible for the 15 day and 48 hour waiting periods to be shortened in certain circumstances.

Non-Washington physicians should review their appropriate jurisdiction's laws.

Hospice participation

Most hospices have policies defining whether their physicians are permitted to participate as either Attending or Consulting Physicians for MAID. When hospice allows physician participation, it is usually as Consulting Physician, though an occasional hospice physician will serve as Attending Physician for DWD patients. Though many hospice employees (e.g., social workers, nurses, and chaplains) are personally supportive of DWD, hospice organizations can request that their employees do not attend DWD deaths.

Life-Ending Medications

Existing Death with Dignity laws do not specify what medicine(s) physicians must prescribe for patient self-ingestion to peacefully end life, assuming physicians know best. Patients ask for the magic pill that has always been shown in old spy movies, but the FDA has worked diligently to make prescription drugs as non-toxic as possible. When the first Death with Dignity law was passed in 1998, doctors in Oregon searched to find FDA-approved drugs that would work.

[†] "**Attending Physician**" (AP) is the physician who agrees to write the prescriptions for DWDA. The AP also takes primary responsibility for counseling the patient, ensuring compliance with the law, and submitting physician documents to the DOH. The "**Consulting Physician**" (CP) examines the patient and makes a written confirmation of the patient's diagnosis, prognosis, ability to make an informed decision, and voluntary decision-making.

[‡] Hawaii requires that the two oral requests be 20 or more days apart.

[§] "Seeing" patients, especially during the prolonged coronavirus pandemic, must often be done via telemedicine. Attending and consulting physicians agree that the visual examinations and discussions during the clinical 'visit', combined with records and communications from treating physicians, are totally adequate to carefully evaluate, and qualify a patient for DWD.

For the first decade or two the clear drug choices for DWD prescriptions were the short-acting barbiturates, since these drugs were rapidly absorbed, promptly resulted in sleep, and overdoses uniformly caused death. Secobarbital and pentobarbital became the drugs of choice, until the cost became prohibitive or they were no longer available to US patients. A combination of chloral hydrate, phenobarbital and morphine sulfate was also tried for a short time before it was deemed unacceptable by patients and families; all of these choices depended on respiratory depression to cause death.

In 2016, the first attempt was made to design a drug regimen that included both respiratory- and cardiac-depressive components, which ushered in a new era in medical aid in dying. A group of Washington State physicians sought to find a combination of drugs which would produce quick sedation and coma, followed by a quick cessation of breathing and/or effective heart function. The drugs also needed to be affordable, available, predictable, comfortable, safe to non-medical helpers (as health care professionals are usually not present) and composed of FDA approved compounds. We consulted pharmacists and a toxicologist. The first widely used regimen was called DDMP2 (digoxin 50 mg, diazepam 1 gram, morphine sulfate 15 grams, propranolol 2 grams). 68% of patients using this regimen died in less than 2 hours but, unfortunately, 5% of deaths took longer than 12 hours, with the maximum of 39 hours. All patients slept peacefully throughout. DDMP2. To be consistent with California practices, WA now offers the choice of D₁₀₀DMP (digoxin 100 mg, diazepam 1 gram, morphine sulfate 15 grams, propranolol 2 grams) but it is now rarely prescribed, as newer regimens offer shorter times-to-death (DDMAPh, see just below).

The science of medical aid in dying took another leap as MAID became legal in California in 2016, where one motivated MAID physician, Dr. Lonny Shavelson, attended every one of his patient's death, and monitored each patient throughout the entire process. Monitoring documented that faster MAID deaths (less than 1 hour) were primarily respiratory in origin, and those occurring after about 2 hours were primarily from cardiac causes (resulting from digoxin/amitriptyline or digoxin/propranolol toxicity).

Dr. Shavelson introduced changes in drug choice, dose and timing, resulting in D-DMA (digoxin 100 mg which is given 30 minutes before diazepam 1 gram, morphine sulfate 15 grams, amitriptyline 8 grams). Combined data from patients in Oregon and California showed that 88% of D-DMA patients die in less than 2 hours (n=104) with the longest death at 6 hours.** This drug regimen makes the ingestion a 2-part process, requiring more family participation when there is no trained support person at bedside to prepare the medications.

Physicians working with End of Life Washington (EOLWA) modified the D-DMA regimen into DDMA for simplicity,** ordering the powders in the same doses but dispensed together in one glass bottle as DDMA, to be ingested all at once. DDMA was first prescribed in early 2019 and is currently used, along with D-DMA, in every legal jurisdiction. The first 12 months of combined data from DDMA patients in Washington, Oregon and Colorado show that 81% DDMA of patients die in less than 2 hours (n=101), with the longest death at 12 hours.** It is also notable that there were 5 patient deaths where observers noted the patients exhibited seizures in last while just before death while sleeping throughout.

Phenobarbital was first added to both D-DMA and DDMA regimens in summer 2020, in an attempt to augment the respiratory deaths (by adding a 3rd class of sedative) and help prevent any seizure activity that might occur in at-risk patients. Early results of these D-DMAPh and DDMAPh regimens are encouraging;

** Patients with gastroparesis or other significant risk factors may have been offered other modes of self-ingestion.

** In, Washington, non-medical, experienced volunteers are usually present to support the patient and family at non-monitored DWD deaths.

** The 12-hr patient had severe gastroparesis, nausea and vomiting, and cachexia.

these phenobarbital-containing regimens are now being recommended for MAID patients, as the data show faster times to death when compared to DDMA or D-DMA patients, Data from the first 6 months of use the phenobarbital-containing regimens show a marked improvement in shortening times to death in the long, outlying patients, with almost identical data profiles for D-DMAPH and DDMAPH.

Table 1: Washington patient Time-to-Death by Life-Ending Medications (2009-2020)*

As of 6/1/21	cases	Cost	Sleep				Death				% < / = 2 hr
			Med	Avg	Min	Max	Med	Avg	Min	Max	
Pentobarbital (up to 2017)	180	\$500	5	5	1	20	20	66	2	2490	
Secobarbital (up to 2019)	380	\$3,000	5	6	1	130	25	76	4	2400	
Secobarbital + Propranolol (up to 2019)	32	\$3,000	5	1	1	20	26	55	5	510	
Chloral Hydrate Mixture	77	\$500	7	7			51	205	8	4280	
DDMP (diazepam, dig, MS, propranolol)	71	\$600	8	9	2	30	67	185	9	1860	
DDMP2 (Higher dose)	338	\$700-850	7	9	2	123	61	209	5	3710	67%
DDMA (dig 50mg)	102	\$700	5	6	1	28	53	106	10	956	77%
DDMA (dig 100ma)	99	\$750-900	5	7	1	31	50	111	6	802	71%
DDMAPh	108	\$550-1400	5	7	2	30	43	73	5	375	81%

Notes on unexpected occurrences: Over the years there have been rare patients who have not died for 10 or more hours (60 hours is the max). In the over 1200 patients who have taken legal life-ending medications in Washington State over the first 10 years, we know of a handful who have regurgitated the medicine; all of these patients died within 9 hours post regurgitation. One patient who took DDMP2 stayed semi-conscious for nearly an hour, but finally became comatose and died. Another patient took DDMP2 rectally about a year after most of his colon had been removed for colon cancer and tumor recurrence obstructed his upper intestine. He did not fall asleep for more than 30 minutes, and then awoke about 17 hours later, confused but comfortable. At that point, he was admitted to in-patient hospice and died suddenly 3 days later (perhaps when toxic digoxin serum levels were achieved).

The times to death depend on the agent ingested, as can be seen in Table 1



DDMAPh is currently recommended life-ending medication regimens for use in Washington State, though DDMA is also acceptable though slower:^{§§}

- **DDMAPh (digoxin 100 mg, diazepam 1 gram, morphine sulfate 15 grams, amitriptyline 8 grams), phenobarbital 5 grams) OR**
- **DDMA (digoxin 100 mg, diazepam 1 gram, morphine sulfate 15 grams, amitriptyline 8 grams)**

IMPORTANT: For every drugs regimen, prophylactic antiemetics are recommended an hour prior to the life-ending medication (unless life-ending meds will be administered by jejunal feeding tube or rectal catheter). In Washington, we recommend that all patients who are prescribed any life-ending medication receive metoclopramide 20 mg and haloperidol*** 2 mg for anti-emesis, as haloperidol is an excellent antiemetic and promotes additional relaxation.^{8 9} *Ondansetron 8 mg can be used as an alternative to the haloperidol, especially in a very weak or somnolent patient.*

^{§§} In some locations, Kaiser may still be using DDMP2, the older regimen containing propranolol.

^{***} Haloperidol is often used in hospice patients as an antiemetic for nausea and vomiting refractory to ondansetron.

The Challenging Patient: red flags

The table above illustrates that a small minority of patients take a significantly longer to die than expected, for every life-ending drug regimen ever utilized.

The most important factor in prolonged time-to-death is impaired gut motility and/or absorptive capacity:

Life-ending medications are absorbed primarily in the small intestine, not the stomach.^{10 11 12 13}, though there is some absorption of phenobarbital by gastric mucosa.^{††† 14 15} In addition, the rate of drug absorption is influenced by the solution or suspension in which the drugs are administered, how far the drugs actually travel within stomach and numerous small intestine absorptive compartments, available surface area, blood flow, and the patient's specific disease processes.¹⁶

*Any patient who has **gastroparesis (from pancreatic or other upper GI cancers, diabetes, etc.) or significant obstruction of the upper GI tract will be at risk for a longer time to death.*** DDMA medications cannot be absorbed until they get to the villi. DDMAPh may be advantageous to this patient population, as there will be some phenobarbital absorption if the meds do not move through the stomach quickly.

The intestinal villi must be functioning well, with good blood supply, for the medications to be absorbed; patients who are **status-post small bowel resection** or who have **malabsorptive syndromes** will have a longer time-to-death. Patients with gastroparesis, bowel obstruction or malabsorption might be good candidates for rectal self-administration of life-ending medication (unless the rectum has epithelialized from disuse or surgical isolation.)

Other factors influencing prolonged time-to-death:

Certain groups of patients are now recognized as likely to exhibit longer times to sleep and death. Patients who are very tolerant or **addicted to opiates/sedative drugs/alcohol** should be considered to have a cross-tolerance to the morphine-diazepam components of the DDMA and DDMP drug regimens. Additional characteristics that predispose to longer times to death include: **young and healthy** patients (especially athletes), **large patients** (over 300 lb.), patients with intractable pain or who require **IV pain pumps, or IV drug addicts** (yes, some request MAID).

These patients and their helpers should be counseled that the time-to-death might be longer than for most other MAID patients. The use of a phenobarbital-containing drug regimen is also recommended for these known challenging patients in order to potentially shorten the time-to-death.

Seizures:

Rarely, a patient may exhibit seizures after being asleep for several hours. Terminal seizures are more likely in patients with a history of **brain insult (tumor, trauma or stroke) or history of seizure disorder**. Persons attending the death of a patient should be advised of this possibility and assured that, if a seizure does occur, it will not awaken the patient or cause him any discomfort.

Writing the prescription

The most recent updates on recommendations for life-ending medications are available on:
End of Life Washington's Website: <https://endoflifewa.org> OR
End of Life WA Providers' Network: <https://endoflifewa.ning.com/?xgi=wHU1wwSPRBVWg1>

††† Barbiturates and aspirin are some of the few drugs absorbed in the acidic pH of the stomach.

Attending and Consulting Physicians information packets, a list of participating compounding pharmacies, and family information documents are available for download from EOLWA. Instructions for feeding tube and rectal catheter self-administration are also available for patients and families.^{†††}

Though not required, it is helpful for the attending physician to call the pharmacist to introduce him or herself and to let the pharmacist know that the prescription is coming. Pharmacists often have specific questions or suggestions. Because the quantities of medications dispensed are not always in stock in sufficient quantity, one or two days of lead time is recommended when requesting that prescriptions be filled. Prescriptions are valid for six months; if a patient survives longer than six months, prescribing physicians can simply reissue the expired prescription without having to restart the qualifying process.

When writing the prescription, the name of the person(s) who will be picking up the medication should be included on the prescription. Including this information allows the pharmacist to dispense the medications to family members or a designee, since it is rare that a dying patient is able to pick up his own medications.

In Washington State, prescriptions may be faxed to the compounding pharmacy for HOSPICE PATIENTS^{§§§} and those in long-term care facilities only. For all other patients, the original MAID prescription must be hand delivered to the pharmacist by the prescribing doctor or courier, or received by mail before it can be filled.

Pharmacists have a vital role in the preparation, dispensing and use of the medication:¹⁷

A compounding pharmacist must prepare DDMA and DDMPH mixtures. **Concentrated powder forms** of these component drugs should be used, instead of grinding tablets.^{****} The compounded mixture is best **dispensed in powdered form, in an amber colored glass bottle.**^{†††} Immediately before ingesting, the powdered mixture can easily be mixed with 2-3 oz. water or clear juice, or a favorite clear drinking alcohol (though this may increase the incidence of a burning sensation on ingestion).^{****} **Shelf-life of the undiluted powdered life-ending medication is considered to be 6 months; once the powders have been mixed with a liquid of choice, the medications must be used within 2 weeks.** Cost to the patient is \$700-\$850, as these are rarely covered by insurance.

Additional considerations for providing the best patient care:

If not already enrolled, patients should be encouraged to **enroll in hospice**, as soon as they bring up the option of physician assisted dying. Hospice provides additional medical, physical, emotional, and spiritual support to the patient and his family, in the last days, weeks, and months of the patient's life. Enrollment in hospice also facilitates disposition of the body after death, as it indicates to local coroners and medical examiners that the death was expected.

If a patient has a functioning pacemaker there is no need to be concerned, but if the patient has a defibrillator the patient's cardiologist should arrange to have it turned off.

^{†††} EOLWA has also specifically developed instructions during periods when volunteers cannot be present with terminal patients for education, hand-holding, or even preparing the final cocktail, during the time of the COVID 19 restrictions.

^{§§§} "HOSPICE PATIENT" must be clearly noted on the faxed prescriptions.

^{****} When pills are pulverized, the filler from the tablets adds a large volume of inert powder, which has been shown to result in longer deaths.

^{†††} Diazepam is absorbed into plastic and degraded in light; thus, it should only be dispensed in amber glass bottles.

^{****} Clear liquids are recommended to suspend the powder into a drinkable form. **Mixing the medication in soft food, particulate juices or fatty or dairy products can result in delayed gastric emptying and will prolong the time to death.**

Counseling the patient and family

Written instructions are invaluable to the patients and families. Family members often become anxious as the day of death approaches, and really appreciate something in writing for reference. Written instructions should confirm the information that they hear during the counseling session with the attending physician, concerning mixing the medication, positioning the patient, and what to expect. **Instruction documents are available through End-of-Life Washington.**

There is a limited 'window' of opportunity for terminally ill patients to use the DWD laws. Because of the decline of dying persons, they may gradually or suddenly (e.g., those with brain tumors) lose competence and become ineligible to use the law. The 'window' concept should be reviewed in advance with the patient and family, as it may influence the timing of the patient's decision to use or not use life-ending medicine.

One in three qualified patients die without using available MAID medications. **Physicians should advise patients to leave the prescription on file at the pharmacy until they decide that the time has come to use the medication and fill it shortly before expected use.** This saves on the cost of filling a never used prescription and eliminates the need for disposal.

Family information: *Oral self-ingestion*

The life-ending medications should be taken on a fairly empty stomach.

- Routine medications should be discontinued 12 hours prior to taking the medication, with the exception of pain medications, which should be continued as needed (and potentially even be increased) just before the life-ending medicine.
- **The patient should not eat solid food or dairy products for 5 hours** before the medications are planned. He may have a light meal the night before, or up to five hours before the chosen time, and then just some clear juice or water. Carbonated beverages and stomach coating medicines (e.g., Pepto-Bismol, Sucralfate) are not recommended.

On the day chosen to take the medications, a patient may choose to be surrounded by friends and family, or to be alone with just one person in attendance. It is usually easiest for everyone concerned if the patient plans to take the medications in mid-to-late morning, as the dying process may take a number of hours. At least one person should be present to mix the medications, to help position the patient, and to gather the information required by the attending physician for the state compliance forms.

The patient must have the ability to drink 2-4 ounces of volume within a minute or two, so that she ingests the entire amount of drug before becoming unconscious. An additional cup of clear juice or water, a popsicle, or spoonfuls of sorbet (which contains no dairy) should be immediately available before and after ingesting the medication. These options may clear the palate and, more importantly, stimulating gastric emptying¹⁸ and hasten movement of the medication into the small intestine where it is absorbed. A final glass of wine or clear liquor may make the experience more pleasant for patients who still have a taste for it. Most patients fall asleep in about 5-10 minutes, and sleep very comfortably thereafter, peacefully and without pain, until they die.

When it is time to take the medications, the patient should position herself sitting comfortably in an adjustable bed or recliner, or prop himself up in bed with pillows, as it is easier to swallow the meds quickly in the sitting position. A volunteer from EOLWA, or a family member or friend should pour 2-3 ounces of water or clear juice into the bottle of powder, recap it, and shake vigorously for 30 seconds. The medication should be ingested immediately, chugged from right the bottle, or poured into a small glass, or sipped through a straw.

IMPORTANT: *No matter which drug regimen the patient has been prescribed, or what juice or alcohol it is mixed in, the orally -ingested life-ending medication which the patient ingests has a **distinctly BITTER taste** (unless administered by feeding or rectal tube).* The DDMA or DDMAPh mixtures may cause some burning upon ingestion, but this is usually eliminated by drinking a pre-prepared glass of water or a popsicle immediately afterward. It is a good idea to discuss these plans beforehand, and even suggest that a weakened patient practice drinking 4 ounces of liquid in less than 2 minutes, as a **prepared patient does a much better job of getting all the medication ingested in the suggested time frame.**

If a patient has been on oxygen for comfort, it should be discontinued after the patient falls asleep.

Family information: Rectal or feeding tube self-ingestion/administration

In US jurisdictions that permit MAID, patients must self-administer the life-ending medication, but not all terminally ill persons in the process of dying retain the ability to ingest in the usual way. Some patients develop progressive weakness (e.g., those with neuromuscular diseases) or obstruction (e.g., from esophageal cancer) making them unable to swallow a half-cup of medicine. NOTE: Attorneys have advised physicians that 'ingestion' may include administration by feeding tubes. For patients who have been eating through a feeding tube, the medication must be self-administered into the feeding tube **by the patient**. When no feeding tube is present, patients with significant gastroparesis or obstructions of the upper GI tract may rectally self-administer any of the available agents by means of a rectal tube. For tube self-ingestion, the patient must either push the plunger on 1-2 syringe(s) containing the suspended medicine for ingestion, or open a clamp or valve to allow the medicine to flow from a gravity bag into the feeding tube or rectal catheter.

Patient positioning after sleep ensues

Patient positioning has been a long-discussed issue. The **patient should be sitting to take the medication and remain in that position for at least the next twenty minutes** to reduce the risk of regurgitation as he falls asleep. After 20-30 minutes, patients may be left in a sitting position or lowered to a semi-recumbent position. Some physicians believe that the patient should then be placed in right lateral decubitus (RLD) position to enhance gastric emptying. However, unless the patient is very small or the family/friends present are well-muscled, positioning the sleeping patient in the RLD position can cause injury to the positioner. Basically, any position will result in death, and all these factors must be considered before moving sleeping patients to a more favorable position.

Reviewing the literature which examines the influence of different body positions (sitting, supine, right lateral decubitus, and left lateral decubitus) on gastric emptying in healthy volunteers, two studies have shown no statistically significant difference between positions;^{19 20} others have found gastric emptying to occur faster in sitting position than supine.^{21 22} Sanka et al. found that 100 ml of plain water flowed passively (without peristalsis) into the small bowel faster when the patient was positioned in RLD,²³ but no thicker liquids were studied. In their excellent review of the effect of postural influence on the physiology and pharmacokinetics of drug absorption, Quackenbarg and Fuhr summarize "... because for most of the drug's total [exposure in the patient] is not affected by posture, the clinical impact for mobile patients would seem to be quite limited. In bedridden patients, particularly those with severe illness and/or those taking drugs with a narrow therapeutic range, the situation may be different: to position a patient in right lateral posture may accelerate the onset of therapeutic effects."²⁴ A study in children found that delayed gastric emptying shows significant improvement with change of position.²⁵ Interestingly, it is not uncommon for us to get reports from friends or family witnessing a Death with Dignity that the patient died within a short time after position change.

As death occurs...

After the patient has ceased breathing (no breaths in 5 minutes) and no longer has a pulse, hospice should be called. NOTE: For patients not enrolled in hospice, the medical examiner or the funeral parlor should be

called. The prescribing physician should also be notified and may need to intercede with the local medical examiner to avoid emergency response protocols.

In Washington State the attending physician must submit the After-Death Form to the Department of Health within 30 days after the death.

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