Medical Aid in Dying in Washington State: A primer for participating providers and pharmacists

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Summary

Medical Aid in Dying (MAID) is now legal in ten states and the District of Columbia. Though Washington patients have had access to this legal right since the passage of the Washington State Death with Dignity Act (DWDA) in 2008, providers and pharmacists have often struggled to navigate the process of assessing, certifying, prescribing and dispensing MAID. Below, the most current drug regimen and practice recommendations are discussed.

Background

Within the United States, Medical Aid in Dying (MAID), also referred to Death with Dignity (DWD), was first approved by Oregon voters in 1997. Since that time, MAID has become legalized in Washington, Vermont, California, Colorado, Washington D.C., Hawaii, New Jersey, Maine and New Mexico. Additionally, MAID was legalized by court order in Montana in 2009. MAID is now available to 22 percent of US residents. All United States MAID laws require that **patients self-ingest the life-ending medications**. The legal definition of "ingest" is to administer into the GI tract, thus allowable administration routes include oral, via NG/GJ/PEG/etc., or via rectal catheter. Intravenous administration is not allowed in any US jurisdiction.

In 2008, Washington State voters passed its Death with Dignity Act (DWDA); the law was implemented in March 2009. As of end of 2021, 2702 participants had qualified under the act and had lethal prescriptions dispensed; of those 1,978 died via ingesting their lethal medications. For updated statistics about the use of the DWDA, please review the WA Department of Health (DOH) annual reports (HERE).

Providers and pharmacists may choose to but are not required to participate in MAID; some choose to opt out of participating due to personal or religious convictions, or because of employer-imposed restrictions. Others may be supportive of a patient's choice of MAID, but due to lack of training or experience, may be hesitant to participate.

Patients who wish to have the option of MAID have variable knowledge about the law, how it works, and how to get help accessing this option from their medical team. Many patients and their families are only vaguely aware that there is a legal option for medically assisted dying in Washington but are unclear on the details of how it works or how to access this option. They typically ask their doctors, hospice team, or even search the internet to try to find information. They are already facing a terminal illness, and trying to navigate the process of the DWDA is often confusing and can cause anxiety or discouragement. End of Life Washington's (EOLWA) mission is to help Washingtonians have access to their full range of end-of-life choices, and one of the things that we do is train community volunteers (Volunteer Client Advisors, or VCAs) who can help to support a person as they navigate the process.

The purpose of this guide is to provide current and accurate information about the WA DWDA and to interested providers and pharmacists might participate.

Eligibility Criteria and the Qualification Process

The MAID laws throughout the US are similar, but there are important differences in each jurisdiction. If you plan to provide MAID services in another legal jurisdiction, please be sure to educate yourself on all of the elements of the law that governs that place. The Compassion and Choices website (HERE) is a good resource for this. Additionally, the American Clinicians Academy on Medical Aid in Dying (ACAMAID) is the nationally recognized organization providing expertise and support for MAID across all US areas where it has been legalized. Please review the ACAMAID website (https://www.acamaid.org/) and familiarize yourself with the materials. Helpful educational documents and videos are available, as well as presentation of available evidence for the recommended MAID cocktail and many other helpful resources.

Here we will focus on the legal criteria for MAID eligibility in WA state, which are:

1. The person must be an adult, 18 years old or older
2. The person must be a resident of Washington state (residency requirements found HERE)
3. The person must have a terminal diagnosis documented by a qualified medical professional (MD/DO, ANRP, or PA) who has an active WA medical license, with a documented life-expectancy/prognosis of 6 months or less.

   If a patient is on hospice, they have been certified to have a 6-month prognosis, so by default, a patient on hospice meets this prognostic criterion.

4. The person must be found mentally competent to make an informed medical decision to pursue MAID, despite any existing psychiatric or psychological disorder.
   - "Competency" is legally defined as having "the ability to make and to communicate an informed decision to health care providers"
   - "Informed decision" is legally defined as being fully informed of:
     - (a) their medical diagnosis
     - (b) their prognosis
     - (c) potential risks associated with taking the medications to be prescribed (nausea/vomiting, long time to sleep, long time to death, failure to die, etc)
     - (d) the expected result of taking the medication to be prescribed (death)
     - (e) the feasible alternatives including comfort care, hospice or palliative care, pain control, etc.
   - *This is an important distinction, the law does* ***not*** *say that the person has to be found free of having a psychiatric or psychological disorder, only that they must be certified has having intact ability to make an informed decision to pursue MAID.*
5. The person must be able to ingest (legally defined via the GI tract) via self-administration the life-ending medications.

The process for MAID qualification

- ✓ The patient must make two verbal (oral) requests (referred to as the first oral request [FOR] and second oral request [SOR]) which must be documented in their medical record at least 7 days apart.
  - *The FOR date is counted as day 0, and then 7 days must elapse before the SOR can be documented, thus the total number of days is 8 days.*
  - Any records kept by a licensed medical provider in the context of providing care to a consenting patient are considered legal medical records, whether the records are kept within a health system EHR or kept privately by the documenting provider.

    - The AP must both conduct and document an informed decision-making discussion of MAID and inform the patient of their right to rescind the request
- ✓ Two independent, qualified providers (AP and CP) must certify that a patient meets all the above eligibility criteria, and each must inform the patient of the right to rescind the request. The CP will complete the Consulting Provider Compliance Form (found HERE) and send this (can fax, email, mail, or hand deliver) to the AP.
- ✓ If there is concern from either the AP or CP about the patient's decision-making capacity, especially regarding underlying mental health issues, either provider can request a psychiatric/psychological consultation. The psychiatric provider will assess the patient and then complete the Psychiatric/Psychological Provider Compliance Form (found HERE).
    - *As of the 2023 law update, the psychiatric consult can be performed by the following providers: state licensed psychiatrist ((or)), psychologist, independent clinical social worker, advanced social worker, mental health counselor, or psychiatric advanced registered nurse practitioner. Given the nature of the request, it is helpful to use a provider who has experience in assessing capacity within the context of the WA Death with Dignity Act. Please see the list of pharmacies HERE consult with End of Life Washington staff for names of experienced assessors.*
- ✓ After having been evaluated by the AP at least once (includes virtual/telemedicine visits), the patient must initial, sign, and date the *Written Request to End my Life in a Humane and Dignified Manner* (aka WR) form (found HERE). They also must have the form witnessed, initialed, signed, and dated by two witnesses who attest to their belief that the patient is competent, acting voluntarily, and not being coerced to sign the request. This form should then be sent to the AP (email, fax, mail, or hand delivery are ok).
    - *Note, only 1 of the 2 witnesses can be a relative (by blood, marriage, or adoption) to the person signing the request. The other witness should be someone unrelated and who will not be a beneficiary of the signer's estate. 1 of the 2 witnesses can be the owner, operator, or employee of a health care facility where the signer resides. Other examples of who may sign this form include the hospice nurse, social worker, or other staff, friends, neighbors, or an EOLWA VCA. The AP cannot be a witness.*
- ✓ Once all the elements described above have been completed, the AP can then write and send (via fax, electronic submission, mail, or hand delivery) the MAID prescription to a participating pharmacy (contact EOLWA for a list of currently participating pharmacies). The written prescription is usually held at the pharmacy until the patient notifies them that they are within a few days from wanting to ingest the meds, and then the medicine mixture will be compounded by the pharmacy.
    - *We encourage patients to leave the prescription at the pharmacy without mixing it until they are almost ready for a couple of reasons:*

        1. The patient does not have to pay for the medications until they are compounded; and

        2. It is dangerous to have lethal medications stored in someone's home. If they choose to have the medications compounded and stored in their home, the AP should inquire how they plan to store

the medications and encourage them to keep them in a locked unit (e.g. safe, lock box), which will be cool, dark, and dry. It is up to the AP whether they will allow the patient to have the medications compounded as soon as the prescription is written or if they ask the pharmacy to hold the prescription and then contact the prescriber before compounding the meds.

- The written prescription is valid for 6 months. After 6 months, a new prescription with an updated date will need to be re-sent.
    - *It is best practice for the AP to re-verify that the patient continues to meet all eligibility criteria for MAID in WA before resending a prescription, including verifying that they still have a 6 month or less life expectancy and are competent to make this request.*
    - *The AP should also assess whether the medical facts of the case have substantially changed such that the AP would prescribe an alternative route of administration, a change to the prescription, or even a re-evaluation of whethjer MAID is still a medically valid option for the patient. Things that can impact this include GI tract obstruction, uncontrolled nausea/vomiting, or constipation. Please see the Red Flags Checklist published by ACAMAID (found* HERE*) for a more comprehensive list of considerations prior to prescribing MAID meds.*
- Once the MAID medication cocktail is compounded, expert pharmacists recommend a 6-month shelf life. It is recommended that a new prescription be obtained/filled if the medications have been sitting for 6 months, to ensure optimal effectiveness. However, there are reports of patients using a legally obtained MAID prescription more than 6 months from the date of compounding, *and to our knowledge,* they have all died as a result of taking the outdated MAID meds, without any significant complications. A patient may choose to take outdated medications, as long as there is a documented informed consent discussion regarding this decision.

✓ Within 30 days of sending the MAID prescription to the pharmacy, the AP must complete the AP Compliance form (found HERE), and is responsible for submitting (via electronic portal found HERE, fax to 360-200-7408, or mail- see first page of form for address) the following completed forms to the DOH: AP compliance form, CP compliance form, WR signed by patient and initialed/signed by witnesses, and the psychiatric assessment form if applicable. *If submitted electronically, the submitter will receive an email to confirm the submission, but if submitted by fax or mail, a confirmation will not be sent.*

✓ Within 30 days of death **by any cause**, the AP is responsible to submit (electronically, by fax, or by mail) the AP After-Death Reporting form (found HERE) to the DOH.

- *Our VCAs are trained to check in on each case periodically once a prescription is written and then report back to the AP once they have died, and from what cause. If the patient dies from taking the prescribed MAID meds, the VCA will report the necessary details (time to sleep, time to death, any complications) so the AP can complete the After Death Reporting Form.*

✓ In addition to filing the required forms with the DOH, the ACAMAID would like providers to submit detailed data on MAID deaths on their website (found HERE). While EOLWA does submit aggregated data to ACAMAID a couple of times a year, the form found on their

website asks more detail about each case, and they use this to continue to shape recommendations for the pharmacology, red flags, and outcomes for MAID in the US. We encourage providers to submit this information to ACAMAID, but it is voluntary.

The DOH has a FAQ page that also contains helpful information (found HERE), we encourage providers to review this.

Providers who want to support their patients seeking MAID outside of Washington state should review their appropriate jurisdiction's laws.

Hospice participation

EOLWA recognizes the importance and potential benefit that a comprehensive hospice support team can provide to terminally ill patients, and we strongly encourage hospice enrollment by all MAID-eligible patients, as the prognostic eligibility criterion (6-mo or less prognosis) makes any MAID-eligible patient also hospice-eligible, and vice versa. If the patient is expressing fear that symptoms such as pain or nausea will be uncontrolled, providers should educate patients that hospice has expertise in how to help control and reduce these symptoms and they should avail themselves of this benefit which comes at no cost to them (Medicare benefit). Some APs require that a patient be enrolled in hospice before they will prescribe the MAID medications; this is left to the discretion of each AP, as individual circumstances should be considered for each case. We encourage strong relationships between hospices and EOLWA staff, volunteers, and associated providers. We recommend communication with the hospice team directly or indirectly via the VCA regarding all aspects of the MAID case. Open communication between all involved healthcare providers will provide the best support for the patient and the best outcomes for MAID if this is what the patient chooses to pursue. Many patients find great relief from suffering just knowing that they will be supported in the option of MAID if they find their suffering due to their terminal illness too great. A substantial subset of patients who undergo the MAID qualification process and have a prescription for MAID written (historically about a third) ultimately choose not to take their medications or lose the opportunity (e.g., losing competency) and instead pass naturally. Just knowing they have the option of MAID is palliative for these patients, and we often hear patients and their families expressing this sentiment. Having a MAID-supportive hospice team helps to reassure these patients that their autonomy will be respected.

Recognizing the complexity of care required for terminally ill patients seeking MAID, it is the opinion of both ACAMAID and EOLWA that MAID is best delivered in the context of a comprehensive hospice program, with the hospice providers acting as the AP, and the hospice team supporting the patient longitudinally until death to assess for continued desire for and appropriateness of MAID, and to ensure that medical issues which may impact the effectiveness of the MAID medications are addressed as best as possible, or even that the use of MAID be discouraged in certain circumstances where there are medical issues which increase the likelihood of a poor outcome (prolonged death or even failure to die after ingesting the MAID meds). EOLWA has been and will continue to work with WA hospices to encourage full participation and support for MAID within their organizations. We encourage hospices to update their MAID policies to allow their staff to properly mix the MAID medications, be present on the day of ingestion to support the patient and their families/friends and to stay with the patient during the act of self-ingestion, and to allow their providers to participate (on a voluntary basis, of course) as AP and CP. EOLWA is gathering information regarding the level of MAID support that each hospice offers, and will be

making this available on our website for patients to be able to access and choose the most supportive hospice in their local area.
Historically, however, many hospices have had policies which limit their staff and providers participation in MAID. Even if a hospice or other healthcare entity prohibits an employee's participation in MAID as a part of their employment, according to the 2023 DWDA update (full text can be found HERE), a healthcare entity, including hospital system or hospice, **cannot** prohibit healthcare providers (including clinicians such as MD/DO/ARNP/PA, nurses, or social workers) from participating in providing MAID services on a volunteer basis, on their own time, off premises, not using property belonging to the healthcare entity (such as computer or phone) and outside work hours. Providers who choose to participate in a MAID request as a volunteer are legally protected from being sanctioned, disciplined, or otherwise retaliated against by their employer for their volunteer services. Therefore, any provider may choose to participate as a volunteer on their own time and outside their place of employment.

Issues regarding providers with direct supervisory relationships

The following statement was part of the updates to the WA DWDA that passed in 2023. "The attending and consulting qualified medical providers chosen by the patient may not have a direct supervisory relationship with each other." As the bill was being discussed and crafted by lawmakers, this prohibition was meant to be in effect for APPs (esp. PAs) and their supervising physicians (as per their delegation agreements filed with the state). Unfortunately, the language that was ultimately chosen was broader than what they had intended. We plan to ask for a clarification/modification to that language during the next legislative session, but until then, we have, in conjunction with our legal advisors and input from the WA Department of Health, formulated guidelines for APPs who wish to participate as providers within the DWDA context:

1. a) If an APP will be acting as Attending Qualified Medical Provider (AP) or Consulting Qualified Medical Provider (CP):
2. If an APP is directly employed by a MD/DO, in a private practice, the APP and MD/DO cannot both serve in AP/CP roles for the same patient.
3. If a PA-C has a Delegation Agreement filed with the state, which names a MD/DO as a supervising physician, the PA-C and MD/DO cannot both serve in AP/CP roles for the same patient.
4. In an institution where APP charts must be co-signed, both APP and co-signer (MD/DO) cannot serve in AP/CP roles for the same patient.
5. If a PA-C wishes to provide End of Life care as a volunteer, outside of their primary institution / role, then a supervising physician (MD/DO) must be found, and a Delegation Agreement must be filed with the state for the PA-C to provide such care.
6. If such a Delegation Agreement is created, a.2 will apply.
7. A copy of this Delegation Agreement should be retained by both PA-C and MD/DO; if a supervising relationship is terminated, then another MD/DO should be found to serve in the supervising role, and a new Delegation Agreement should be filed with the state.

Aid in Dying Medications

Although the existing Death with Dignity laws do not specify what drugs providers must prescribe for patient self-ingestion to peacefully end life, ACAMAID has now published recommendations for the MAID cocktail, based on data that is continuously being collected across all US jurisdictions where MAID is legal. You can find these recommendations on the ACAMAID website, HERE. Rational for the current MAID cocktail is available to review on that website. If you have any questions about the currently recommended MAID cocktail, please reach out to the medical director or to ACAMAID directly (ACAMAID@ACAMAID.org). There is also an Aid in Dying Clinicians Hotline (510-298-1135) available to clinicians/providers (not for patients or families) to answer urgent or non-urgent clinical questions regarding MAID. This hotline is staffed by experienced MAID providers across the US. For WA-specific questions, please reach out to staff (clientservices@endoflifewa.org) and/or the medical director at EOLWA (providers@endoflifewa.org).*5.10 298 1135*

For historical context, when the first Death with Dignity law was passed in 1998 in Oregon, doctors searched to find FDA-approved drugs that would work. For the next 18 years, Oregon and Washington providers prescribed short-acting barbiturates, since these drugs were rapidly absorbed, promptly resulted in sleep, and overdoses almost uniformly caused death (there were a few documented cases of failure to die). Secobarbital and pentobarbital remained 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 brief time but was deemed unacceptable. All 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 MAID. A group of Washington State providers 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. A pharmacist and a toxicologist were included in the design team. 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.

The science of medical aid in dying took another leap as MAID became legal in California in 2016, with the introduction of physiologic monitoring. Dr. Lonny Shavelson not only prescribed MAID meds but also attended every patient's death, monitoring each patient throughout the entire process with ECG and pulse ox. Monitoring documented that faster MAID deaths (less than 1 hour) were primarily respiratory in origin, where those occurring after 1.5-2 hours confirmed significanacnet cardiac causality.

Dr. Shavelson introduced changes in drug choice, dose and timing, resulting in D-DMA (requiring the digoxin 100 mg to *be ingested 30 minutes before* diazepam 1 gram, morphine sulfate 15 grams, amitriptyline 8 grams). Combined data from patients in Oregon and California showed that 85% of D-DMA patients died in less than 2 hours (n=104) with the longest death at 6 hours.* However, this

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

drug regimen made the ingestion a 2-part process, with the potential for death from un-sedated digoxin toxicity if the protocol was not followed correctly by an already anxious family.

Providers 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 dark glass bottle as DDMA, to be ingested all at once, eliminating the possibility of digoxin toxicity without sedation.

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 that was well absorbed in the stomach), hoping to pull in the long-death outliers. Washington had also experienced seizures in several cases after amitriptyline was added, despite the valium in the mixture, so it was hoped phenobarbital might add additional protection._Data from the first 6 months of use the phenobarbital-containing regimens show a marked improvement in shortening times to death in the group of patients most at risk for longer death. In addition, the data profiles for D-DMAPh and DDMAPh were almost identical. At that point, DDMAPh became the only recommended drug regimen for all legal jurisdictions. Washington data (see Table 1) illustrate the improvement over all previous regimens: to date, ~80% percent of patients ingesting DDMAPh have died in less than 2 hours; and ~95% have died in less than 4 hours. Most of the deaths which are considered “prolonged deaths” have occurred in a subset of patients who have recognized “red flags” which may predict a prolonged death after MAID med ingestion. For this reason, it is important to review each patient’s case carefully to identify any “red flags” (see checklist, HERE) and to have an informed, shared decision making discussion with the patient about their risk for a prolonged death, as well as working with the patient care team (ideally hospice team) to mitigate any of the modifiable red flags prior to MAID ingestion (I.e. work to control nausea, give aggressive bowel regimen to treat/prevent constipation, palliative paracentesis, etc).

Prophylactic antiemetics are always recommended ~~an hour~~ 30 to 60 minutes prior to the ingestion of the MAID medications, unless the meds ~~life-ending medication unless life-ending meds~~ will be administered by jejunal feeding tube or rectal catheter. In Washington, recommended antiemetics are metoclopramide 20 mg and haloperidol 2 mg, as haloperidol often works in patients with ondansetron failures and promotes additional relaxation in an anxious patient on the day of death.[1,2] Ondansetron 8 mg can be used as an alternative to the haloperidol, especially in a very weak or somnolent patient.

The Challenging Patient and Red Flags: factors recognized to prolong time to death

Sometimes a patient can take significantly longer to die than expected, and this has been shown for every life-ending drug regimen ever utilized. (Table 1)

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.[3,4,5,6], though there is some absorption of phenobarbital by gastric mucosa.[‡][7,8] The rate of drug absorption is influenced by the solution in which the powdered drugs are mixed, how quickly the

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

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

drugs travel through the stomach and reach the numerous small intestine absorptive compartments, available surface area, blood flow, and the patient's specific disease processes.[9]

Any patient who has **gastroparesis** (from pancreatic or other upper GI cancers, diabetes, etc.), **significant obstruction of the GI tract, or uncontrolled nausea/vomiting or constipation** will be at risk for delayed gastric emptying**.** The meds cannot work until they get into the intestine where they are absorbed.

In addition, for the medications to be absorbed, the intestinal villi must be functioning well, with good blood supply. Patients who are **status-post small bowel resection** or who have **malabsorptive syndromes** will have a longer time-to-death. Any patient with gastroparesis, bowel obstruction or malabsorption should be considered candidates for rectal self-administration of life-ending medication (unless the rectum has been surgically isolated months to years previously).

Severe cachexia, which is commonly seen in terminally ill patients, is also a major risk factor for a prolonged death, because the intestinal lining needs to have at least a minimal amount of nutrients to continue with its absorptive function. Patients should be advised that, if at all possible, they should try to ingest at least some nutrient dense liquids (for example, high calorie Ensure, at least 1/3 container 2-3 times per day) in the days or weeks before they plan to ingest MAID medications to prepare their intestines to absorb the medications as best as possible. All cachectic patients should be advised about the risk for prolonged death, or even failure to die, although that is an exceedingly rare outcome.

Other factors influencing prolonged time-to-death: these have been identified as potential outliers through data analysis (for full list, please see the ACAMAID website HERE).

- Patients who are very tolerant or **addicted to opiates/sedative drugs/alcohol** should be considered to have a cross-tolerance to the morphine-diazepam-phenobarbital components of the life-ending drug regimens.
- Patients with intractable pain or who require **IV pain pumps**
- **Young and healthy** patients (especially athletes)
- **Large patients** (over 300 lb. regardless of BMI)

These patients and their helpers should be counseled that the time-to-death might be longer than for most other MAID patients.

Seizures:

Rarely, a patient may exhibit ~~seizures~~ seizure-like activity 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, but can also occur from hypoxia immediately preceding death. The incidence of seizures is not statistically increased in patients who choose to ingest the currently recommended MAID cocktail, DDMAPh. However**,** persons attending the death of a patient should be advised of the possibility of terminal seizure (as it is often upsetting when witnessed) and be 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 the ACAMAID website, HERE. Please check for any updates to the recommended prescription on this site. Instructions for non-oral (feeding tube and rectal catheter) self-administration are also available for patients and families on the ACAMAID website, HERE. Attending and Consulting Providers information packets, a list of participating compounding pharmacies, and family information documents are available for download from EOLWA's website, HERE.

Though not required, it is helpful for the AP 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. The time needed to obtain needed medications and compound the MAID cocktail is variable, but typically the pharmacy "turn around" time is 24-72 hours after receiving the prescription. Written prescriptions are valid for six months; if a patient survives longer than six months, prescribing providers can simply reissue the expired prescription without having to restart the qualifying process. *t is best practice for the AP to re-verify that the patient continues to meet all eligibility criteria for MAID in WA before resending a prescription, including verifying that they still have a 6 month or less life expectancy and are competent to make this request. The AP should also assess whether the medical facts of the case have substantially changed in a way that would make an alternative route of administration, a change to the prescription, or even a re-evaluation of whether MAID is still a medically valid option for the patient. Things that can impact this include GI tract obstruction, uncontrolled nausea/vomiting, or constipation. Please see the Red Flags Checklist published by ACAMAID (found HERE) for a more comprehensive list of considerations prior to prescribing MAID meds.* Once the MAID medication cocktail is compounded, expert pharmacists recommend a 6-month shelf life. It is recommended that a new prescription be obtained/filled if the medications have been sitting for 6 months, to ensure optimal effectiveness. However, there are reports of patients using a legally obtained MAID prescription more than 6 months from the date of compounding, *and to our knowledge,* they have all died as a result of taking the outdated MAID meds, without any significant complications. A patient may choose to take outdated medications, as long as there is a documented informed consent discussion regarding this decision.

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, e-submitted, mailed, or hand-delivered to the compounding pharmacy. Make sure that all prescriptions have the prescriber's full information including name, address, phone number, NPI number, and DEA number. If faxing a prescription, expert pharmacists have told us that it is preferrable to fax the prescription on plain white paper, rather than a watermarked prescription page. This is because when a watermarked prescription is faxed, it says "void" in the background and thus the original will need to be sent in for confirmation. They are able to accept a valid prescription on faxed plain paper as long as it contains all the required information for the provider and has a number they can call to verify the prescription. It is also recommended that "For hospice patient care" be written at the bottom of the MAID prescription (if the patient is indeed on hospice, of course), as this helps with the DEA monitoring process for these substantial amounts of controlled substances used for the prescription. ~~for~~

~~HOSPICE PATIENTS[§] and those in long-term care facilities only. For all other Washington 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.~~ o

Pharmacists have a vital role in the preparation, dispensing and use of the medication:
A compounding pharmacist must prepare DDMPh mixtures. **Concentrated powder forms** of these component drugs should be used, instead of grinding tablets.[**] The compounded mixture should be **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**. Mixing the powdered mixture with a favorite clear drinking alcohol is not recommended: the powders are no more soluble in alcohol and will causes the favorite liquor to taste horrible, and the liquor may increase the incidence of a burning sensation on ingestion. 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 . **Shelf-life of the unsuspended/dissolved powdered life-ending medication is considered to be 6 months; once the powders have been mixed with a liquid of choice, the medications should be used within 2 weeks**. Cost to the patient typically runs $700-900, and these medications are not paid by insurance, so the patient will need to pay for this out of pocket. We do not want lack of funds to be a reason that someone cannot access the option of MAID, so we have partnered with the Costigan foundation to provide a small fund (and needing more funding if you're looking for somewhere worthy to donate!) that VCAs can help a patient apply for if they are truly unable to afford the cost of their MAID prescriptions.
A dispensing pharmacy must complete the Pharmacy Dispensing Record form (found HERE), and submit it to the DOH within 30 days. Forms may be submitted electronically via the DOH RedCap site (found HERE), by fax (360-200-7408), or by mail (Center for Health Statistics, PO Box 47856, Olympia, WA 98504-7856).

Additional considerations for providing the best patient care:
If a patient has a functioning pacemaker there is no need to do anything, but if the patient has a AICD (pacemaker/defibrillator), the patient should ideally arrange with their hospice team or cardiologist to have the defibrillator function turned off shortly before ingestion. Please see further guidance about this issue on the ACAMAID website, HERE.

As discussed above, we encourage all terminally ill patients to enroll in hospice to have the most support and expertise involved in helping to manage their symptoms, as well as provide support to their friends and families who are helping to care for them. There are now several hospices who are fully supportive of MAID, and EOLWA encourages patients to choose the most MAID-supportive hospice in their area. A full list of hospices and their level of support will be available on the EOLWA website, so please check there or tell patients to check there for information about which hospices are most supportive.
There are many reasons to encourage hospice enrollment, including the medical, emotional, and spiritual support that a hospice team can provide; having a "safety net" on the day of ingestion in case of complication, which if were to occur, would necessitate hospice to step in and provide

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[§] "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.

palliative sedation or other support; and lastly, easier disposition of the body after death, as the family or VCA can call hospice instead of having to call the medical examiner office. *Some APs will choose to have personal policies which require that the patient be enrolled in hospice at the time of writing the prescription, and this is left to each individual prescriber's discretion.*

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 written instructions for reference. This material should confirm the information that they hear during the counseling session with the attending provider, and cover mixing the medication, positioning the patient, and what to expect after the meds are ingested. **Instruction documents are available on ACAMAID's website (HERE) EOLWA's website, (HERE).**

There is a limited 'window of opportunity' for terminally ill patients to use the DWD laws. Because of the decline of dying persons, some may suddenly (e.g., those with brain tumors) lose competency and become ineligible to use the law. Other patients, such as those with neurodegenerative conditions, may lose the ability to self-administer the medications. The 'window' concept should be reviewed in advance with the patient and family, as it may influence the timing of the patient's decision on whether to use life-ending medicine. We never want a patient to feel pressured to take their MAID medications, but we also want to be sure that they have the opportunity to take them if they choose to.

Every year, 20-30% of ~~One in four~~ qualified patients dies without using available MAID medications. Many times, this is because the patient ultimately did chose not to take the medicines to end their life, which is an outcome we fully support, other times it is because they lost the ability to take their medications, either because of losing mental capacity during their dying process, or losing the physical capacity. We recommend telling patients that we fully support them to decide to or not to take their medications once they have them available, and as much as we want them to have the option of MAID, we also want them to feel supported to change their mind at any time, and not use their medications. ***Providers 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 (recommend 2-5 days in advance) expected use.*** This saves on the significant cost of filling a never-used prescription and eliminates the need for storage and disposal of a lethal substance.

Family information*: Oral self-ingestion*

Please refer to the ACAMAID patient information website (HERE) for current documents, videos, and checklists that can provide helpful information to the patient and their families about the day of death. Step-by-step instructions are available on the EOLWA website, HERE.

Here are some helpful tips that the AP may wish to include in their discussion of the MAID process during their visit with the patient.

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

- Pain medications should be continued as needed just before the life-ending medicine. Laxatives or stomach-coating medications (e.g., Pepto-Bismol, Sucrafrate, Maalox) are not recommended on the day of ingestion.

- **The patient should not eat solid food or dairy products or drink particulate (non-clear) juices for 5 hours** before the medications are planned**.** They may have a light meal the night before, or up to five hours before the chosen time, and then 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 provider for the state compliance forms. Typically the EOLWA VCA that is assigned to the case can fulfill this role, if the patient chooses to have them present. If the AP or CP wants to attend the death, they can also let the patient know this, but ultimately it is up to the patient to decide who they want to have present for this very personal and deeply intimate day.

When self-administering orally, **the patient must have the ability to drink 2-3 ounces of liquid within a minute or two**, so that they ingest the entire amount of drug before becoming unconscious. We recommend that a strongly flavored (raspberry is usually a good choice for most) softened sorbet (non-dairy) or popsicle be available to be given right before and then again right after ingestion of the MAID medications, to cool the mouth and throat and to wash down the chemical flavor and any burn associated with the medications. A final glass of wine or clear liquor is fine for patients who still have a taste for it. Patients fall asleep in about 5-20 minutes, and sleep very comfortably thereafter, peacefully and without pain, until they die. It's helpful to have a DWD-experienced provider or VCA present to oversee the process, and coach the patient to swallow quickly; and if swallowing is impaired the patient should practice quickly swallowing 2-3 ounces of liquid a day or so ahead of the 'final act'.

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 easiest to swallow the meds quickly in the sitting position. A volunteer from EOLWA, a family member or a friend should pour 2-3 ounces of water or clear juice into the bottle of powdered meds, 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.

No matter which drug regimen the patient has been prescribed, or what liquid it is mixed in, the life-ending medication which the patient orally ingests has a distinctly BITTER taste that cannot be blocked*.* In addition, about half of DDMAPh patients notice some burning upon ingestion (similar to a shot of whiskey), but this is usually eliminated by drinking a pre-prepared glass of water, or eating a popsicle or sorbet immediately before and after swallowing the medications. It is a good idea to discuss these issues beforehand. We recommend that patients practice drinking this quantity of thick liquids (such as Ensure, V8, smoothie, etc.) in the days prior to planned ingestion, so they feel confident that they will be able to ingest the medications fully. A prepared patient does a much better job of getting all the medication comfortably ingested in the suggested time frame, and if they are

advised to expect the burning sensation, they usually react less to this, knowing that it will be brief and can be ameliorated by having sorbet, popsicle, or more clear liquid after they have swallowed the medications.

If a patient has been on oxygen for comfort, it should be discontinued after the patient falls asleep. Let the family know this in advance, as it seems cruel to some. If there is a major objection from the patient or family to turning off the oxygen, it is ok to keep it on, but let the family know that it may prolong the death to continue giving oxygen.

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 the required amount. Intractable nausea and vomiting may make it impossible for the patient to keep the life-ending medications down. Legal opinion defines 'ingestion' to include self-administration of food or medications anywhere within the alimentary canal. For patients who eat or take their medications through a feeding tube, the medication can be **self-administered into the feeding tube by the patient using a syringe.** When no upper GI feeding tube is present, patients who are unable to swallow or keep food down 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 a syringe (60 to 100ml) which is connected to a catheter (28-30 Fr Foley is recommended, **not Macy catheter**, due to the smaller diameter and increased risk for clogging). It is very important that the patient is prepared for a rectal administration by clearing the rectum of any stool via enema a shortly before planned rectal self-administration. Rectal deaths are more prone to complication due to the equiptment and expertise needed, and are also often associated with longer times to death. EOLWA strongly recommends that a medical professional be present at the time of a rectal self-administration death, so they can help to manage any complications that might arise, such as clogging of the tube, need to quickly exchange the rectal tube, or other issues. Please refer to the ACAMAID guidance regarding rectal deaths (found HERE)

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** for optimal gastric emptying. After 20-30 minutes, patients may be left in a sitting position or lowered to a semi-recumbent position. Some providers 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 concerning 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;[10] [11] others have found gastric emptying to occur faster in sitting position than supine.[12] [13] 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 right lateral decubitus,[14] but no thicker liquids were studied. In their excellent review of the effect of postural influence on the physiology and pharmacokinetics of drug absorption, Quackenberg 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."[15] A study in children found that delayed gastric emptying shows significant improvement with change of position.[16] 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 10 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. In addition, the prescribing provider or VCA can sometimes preemptively arrange with the local medical examiner or coroner that emergency response protocols not be activated for a planned DWD death, depending on the jurisdiction's policy, which will vary. Again, it is much easier and smoother for everyone if the patient is on hospice at the time of death.

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