

SENATE BILL REPORT

SB 5433

As Passed Senate, March 7, 2017

Title: An act relating to informed decision making for death with dignity decisions.

Brief Description: Concerning informed decision making for death with dignity decisions.

Sponsors: Senators Miloscia, Angel, Sheldon, Padden and Fortunato.

Brief History:

Committee Activity: Law & Justice: 2/07/17, 2/14/17 [DP].

Floor Activity:

Passed Senate: 3/07/17, 26-23.

Brief Summary of Bill

- Preserves the option for a terminally ill patient to request a lethal dose of medication to end their life.
- Requires the treating physician to inform a terminally ill patient about all feasible alternatives to life ending medication.
- Requires the treating physician to comply with Washington State's standard of care when counseling a terminally ill patient who requests a life-ending dose of medication.

SENATE COMMITTEE ON LAW & JUSTICE

Majority Report: Do pass.

Signed by Senators Padden, Chair; O'Ban, Vice Chair; Pedersen, Ranking Minority Member; Angel, Darneille, Frockt and Wilson.

Staff: Melissa Burke-Cain (786-7755)

Background: Washington enacted its Death with Dignity law by initiative in 2008. Under current law, terminally ill adults who want to end their life may request a prescription for a lethal dose of medication. Terminally ill means the patient has an incurable and irreversible disease that will result in death within the next six months, in the physician's reasonable medical judgment.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

The law does not change the physician's obligation to meet the standard of care for Washington physicians when providing care under the Death with Dignity law. To ensure the patient makes an informed decision, the treating physician must:

- make sure that the patient's request for lethal medication is voluntary;
- confirm the patient has a terminal disease;
- verify the patient is competent to make treatment decisions;
- inform the patient of the medical diagnosis, the prognosis, and the risks of taking the lethal dose of medication; and
- inform the patient of the feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.

For each lethal medication prescribed and dispensed, the physician and pharmacist must report the patient circumstances and treatment to the Department of Health. The Department of Health ensures compliance with the law and issues an annual Death with Dignity Act report.

Summary of Bill: When patients request a prescription for a lethal dose of medication, physicians must inform patients of feasible alternatives including, but not limited to, comfort care, hospice care, pain control, treatment for the purpose of cure, and treatment for the purpose of extending the patient's life.

Appropriation: None

Fiscal Note: Not requested.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which the bill is passed.

Staff Summary of Public Testimony: PRO: The updated language is only a few words, but they are critical because it ensures that the doctor gives the patient full information as he or she makes such a difficult decision. Predicting life expectancy is not a precise science. A person with a chronic condition who may meet the definition of terminally ill, may also live for years with treatment. The bill ensures the patient receives full informed consent. A patient may not understand the diagnosis that is given, and may not fully understand his or her treatment choices. It may be the case that a patient's prognosis with treatment was good, but the patient did not understand that treatment could be a reasonable option. It is important to make sure that the physician takes sufficient time to make sure the patient's understanding of all available options for care is full and complete. The patient has a right to know and understand all the choices available to him or her.

Safeguards for patients need to be strengthened. We are concerned that the current assisted suicide laws do not have sufficient patient safeguards. A patient may be despondent or depressed and temporarily seek assisted suicide, but if the depression is treated, the patient may decide against suicide. There are a number of ways a patient may not receive sufficient informed consent. Without adequate regulation, patients may experience duress or coercion to accept assisted suicide.

Individual choice and autonomy is most important. The current law's language could be interpreted as limiting the information a patient receives. The finding that a patient has only six months to live is made based on life expectancy without treatment. What might appear as a dismal situation without treatment might not be as bad with the right treatment. Discussion of potential treatment has been characterized as a burden on the patient; it is not a burden on the patient but on the treating health care provider. Yet, it is the physician's ethical responsibility to ensure informed consent. Assisted suicide has lethal consequences with no do-over.

Fights among families over money in an estate are common in probate and estate practice. It is easy to exert undue influence over someone who is vulnerable. It is easy and relatively common in practice to see vulnerable persons near the end of life who are induced to sign Powers of Attorney, change beneficiaries on life insurance policies, change a will, or turn over control of banking and investment accounts to unscrupulous persons. The current law's process for assisted suicide lacks the safeguards of sufficient objective witnesses. When estate and property changes are made near death, the assisted suicide law does not allow suspicions to be investigated because the true circumstances of state of mind and assisted suicide are not required to be on the death certificate.

CON: The bill creates an unnecessary burden for terminally ill patients on hospice care. Once a patient is in hospice care, curative treatment is not covered by Medicare. Nearly no one in hospice care has a curative treatment option. Even for life prolonging treatment, the burden may outweigh the benefit. The additional discussion of potential treatments is contradictory to the mission of hospice care. By deciding to accept hospice care, the patient has already gone through the difficult process of grappling with the illness they have. The requirement to go over treatment options at the time when the patient is in hospice care adds suffering to patients and an additional burden to the patient's loved ones.

Hospice care is a wrap around service. Some patients in hospice do not pass away. A patient can withdraw from hospice at any time or can elect the death with dignity option. But concurrent curative care with hospice services is not covered or paid for by Medicare and Medicaid. When patients are followed through the death with dignity process, they are exercising the right to forego more treatment. More discussions about treatment are unnecessary, including alternatives. It makes no sense to require a physician to discuss cure when there is no cure. A patient may have already taken every step reasonably available for cure such as complex surgeries, multiple surgeries, multiple rounds of chemotherapy, radiation therapy. Their tumor may be too big for effective treatment and the pain may be too intense.

Even if a patient has an long-term chronic disease instead of an acute aggressive cancer, the patient may have done everything possible to keep living, used all the assisting equipment such as becoming respirator dependent, but may not be able to continue in the present state. The present state may be sheer misery—ventilator-dependent, tube fed, unable to speak, or take care of his or her own most basic daily living activities. It is just another indignity for a person who has decided to exercise their death with dignity option to be forced to travel to a physician while in pain to have an irrelevant treatment conversation. All this bill would do is force a conversation after the patient has made a choice and has hope for death in the way

that they choose. Patients are generally not in a hurry to end their life, they have no new treatment option.

The cure discussion is not logical; there is no treatment option. The process of approval under the current death with dignity law takes time. Approximately one-third of the patients who begin the process to obtain the lethal dose of medication die before they ever get far enough in the process to obtain the prescription. Predicting death within six months is not exact, because there are always outliers to any situation. Persons may not use the medication, but want to have the option to control the situation they are in; including the option to take the prescription at the time they choose. The discussion of treatment for cure or prolonging life could be a discussion for the purpose of prolonging misery. There are worse things than death, and the law already has many steps that must occur before a patient receives the prescription under the law.

Persons Testifying: PRO: Senator Mark Miloscia, Prime Sponsor; Dr. Kenneth Stevens, Physicians for Compassionate Care Marilyn Golden, Senior Policy Analyst, Disability Rights Education and Defense Fund; Chris Plante, Policy Director, Family Policy Institute; Luke Esser, Washington State Catholic Conference; Michael Pauley, Human Life of Washington; Theresa Schrempf, citizen.

CON: Leslie Emerick, WA State Hospice and Care Org., Home Care Association of Washington, ARNP's of Washington; Arline Hinckley, Board Member, End of Life WA; Therese Law, MD, Medical Director, End of Life WA; Lee Chambers, citizen.

Persons Signed In To Testify But Not Testifying: No one.