HOUSE BILL REPORT
HB 1281

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to increasing access to the provisions of the Washington death with dignity act.

Brief Description: Increasing access to the provisions of the Washington death with dignity act.

Sponsors: Representatives Rude, Peterson, Harris, Macri, Riccelli, Stonier, Fitzgibbon, Senn, Simmons, Tharinger, Kloba, Reeves, Reed, Walen, Gregerson, Ormsby, Bateman, Doglio, Alvarado, Ramel, Santos and Pollet.

Brief History:
Committee Activity:
Health Care & Wellness: 1/25/23, 2/3/23 [DPS].

Brief Summary of Substitute Bill

- Expands the health care providers authorized to perform the duties of the Death with Dignity Act (Act) to include advanced registered nurse practitioners and physician assistants.
- Reduces the required 15-day waiting period between the first and second oral requests for medications to seven days and eliminates the 48-hour waiting period for the written request.
- Permits medications dispensed under the Act to be delivered or mailed.
- Prohibits health care providers from contractually prohibiting an employee from participating in the Act while outside of the scope of employment and not on the employing health care provider's premises.
- Requires hospitals and hospices to submit their policies regarding access to end-of-life care and the Act to the Department of Health.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

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

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Bronoske, Davis, Harris, Macri, Orwall, Simmons, Stonier, Thai and Tharinger.

Minority Report: Do not pass. Signed by 6 members: Representatives Schmick, Ranking Minority Member; Hutchins, Assistant Ranking Minority Member; Barnard, Graham, Maycumber and Mosbrucker.

Staff: Ingrid Lewis (786-7293).

Background:

Death with Dignity Act.

The Death with Dignity Act (Act) allows a qualified patient with a terminal illness with six months or less to live to request medication that the patient may self-administer to end his or her life. A qualified patient must meet the following requirements:

- be a competent adult and a resident of Washington;
- the attending physician and a consulting physician have determined that the patient suffers from a terminal disease and the patient has voluntarily expressed the wish to die;
- the patient has made a request for medication on a form provided in statute; and
- the form is signed and dated by the patient and at least two witnesses who attest to their belief that the patient is competent, acting voluntarily, and not being coerced to sign the request.

The health care providers authorized to perform the duties of the Act are physicians or osteopathic physicians. The patient's attending physician is responsible for determining that the patient has a terminal condition, is competent, is making an informed decision, and is voluntarily making the request. These determinations must be confirmed by a consulting physician. If either physician determines that the patient may have a psychiatric or psychological disorder or depression that impairs the patient's judgment, the patient must be referred for counseling with a psychiatrist or psychologist.

Under the Act, to receive the medication to end his or her life, the patient must make an oral request and a written request to an attending physician, followed by a subsequent second oral request. A waiting period of 15 days is required between the time of the first oral request and the second request. At least 48 hours must pass between the patient's written request and the writing of the prescription. The patient can rescind the request at any time.

The attending physician must deliver the prescription for the medication to a pharmacist either personally or by mail or fax. A pharmacy is prohibited from dispensing medication by mail or courier.

The Act requires the Department of Health (DOH) to collect and report on certain information about participation in the Act.

Health care providers are not required to participate in the provisions of the Act, and health care providers may prohibit others from participating on their premises. Health care providers may sanction other health care providers for participating, unless the participation occurs outside of the course of employment or involves a provider with independent contractor status. Physicians and other health care providers who participate in good faith may not be subject to criminal or civil liability or professional disciplinary action.

Access to Care Policies.

Hospitals must submit to the DOH their policies related to access to care regarding admissions, nondiscrimination, and reproductive health care, along with a form that provides the public with specific information about which reproductive health care services are and are not performed at each hospital. Submitted policies and the form must be posted on the hospital's website.

Summary of Substitute Bill:

The health care providers authorized to perform the duties of the Death with Dignity Act (Act) are expanded to include advanced registered nurse practitioners and physician assistants. Authorized healthcare providers are defined as "qualified medical providers." Patients may select the attending or consulting health care provider of their choosing, as long as a physician or osteopathic physician serves in one of the roles. The attending and consulting qualified medical providers chosen by the patient may not have a supervisory relationship with each other.

A prescription from an attending qualified medical provider may be submitted to a pharmacist electronically and the prohibition on dispensing medications by mail or courier is eliminated. Medications may be delivered by personal delivery, messenger service, or the United States Postal Service or a similar private parcel delivery entity. The addressee or an authorized person must sign for the medications upon receipt.

In the event either an attending or consulting qualified medical provider refers the patient to counseling, the types of providers who may provide counseling to patients under the Act are expanded to include independent clinical social workers, advanced social workers, mental health counselors, and psychiatric advanced registered nurse practitioners.

The timeframe in which a qualified patient must wait to make a second oral request is reduced from 15 days to seven days. If at the time of the initial oral request an attending qualified medical provider determines that a qualified patient is either not expected to survive for seven days or is experiencing intractable suffering, the patient may receive the

prescription upon making a second request sooner than seven days. Intractable suffering is defined as pain or other physical symptoms related to a person's terminal disease that cannot be reasonably managed by palliative care. The 48-hour waiting period between the written request and the writing of a prescription is removed. Transfer of care or medical records does not restart a waiting period.

In addition to filing by mail, the prescribing qualified medical provider may file all required documentation with the Department of Health (DOH) by fax or email no later than 30 days after the death of the patient.

An employing health care provider may not contractually prohibit an employee health care provider from participating in the Act while outside of the employment relationship and not on the employing health care provider's premises or on property that is owned by, leased by, or under the direct control of the employing health care provider. A health care provider who does participate in the Act outside the course and scope of an employment relationship with a health care provider who prohibits participation is required to be at a location not on the employer's premises or on property that is owned by, leased by, or under the direct control of the employing health care provider.

Hospitals must submit policies related to end-of-life care and the Act to the DOH. By November 1, 2023, the DOH is required to develop an additional form for hospitals to submit which must provide the public with information about which end-of-life services are and are not available at each hospital. Hospitals must submit completed forms to the DOH within 60 days of the form being provided.

Agencies and facilities providing hospice services must submit their policies related to end-of-life care to the DOH and must include information for the public about which end-of-life services are and are not available at each agency or facility. A copy of the policies must be posted to the agency or facility's website and the DOH website. An agency or facility providing hospice services must submit changes to any of the policies to the DOH within 30 days of the approval of the change.

Substitute Bill Compared to Original Bill:

The substitute bill provides a timeframe in which a hospital must submit forms related to end-of-life care and the Death with Dignity Act (Act). The hospitals must submit completed forms to the Department of Health (DOH) within 60 days of the form being provided. In addition, references to hospice and hospice care agencies and facilities regulated by the DOH are corrected by removing references to the Department of Social and Health Services and clarifying that the submission of end-of-life care and the Act policies applies to the agencies and facilities providing hospice services.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) Many people approach end of life confident that they will have access to Death with Dignity laws, but the law is in need of updating. There has been a steady increase in requests for medical aid in dying in the last four years. One in four eligible patients do not make it through the 15-day waiting period. Many patients lose the mental capacity and the ability to self-administer during that time. The current process is too inaccessible, too onerous, and it takes too long.

Nurses and physician assistants (PAs) are desperate to support their patients. People cannot access this law because of who their primary care providers are and where they live in the state. When caring for people at end of life, advanced registered nurse practitioners (ARNPs) can serve as the attending provider on record, admit a patient to hospice, sign do not resuscitate orders and death certificates, and prescribe opioids. Despite all of these lawful abilities, patients cared for by ARNPs continue to be discriminated against because ARNPs are excluded in this law. Allowing ARNPs and PAs to perform the duties would alleviate some of the difficulty that people in rural areas have in accessing care. Current prescription and delivery restrictions are a barrier to people who live in areas where there is no local compounding pharmacy willing to participate.

The changes in the bill do not expand eligibility. The core safeguards remain in place and there continues to be over a dozen steps before a patient can access a prescription, including the requirement that two providers need to confirm the patient's eligibility. Participation by providers continues to be voluntary. Patients will continue to be given reminders that this is a voluntary choice. Many will choose not to pick up prescriptions at the pharmacy or use the prescriptions once received. Advanced age, disability, and chronic health conditions are not conditions or qualifying factors for eligibility. Both Oregon and California have shortened their wait times. Death with Dignity has resulted in a more compassionate experience for the residents of the state and this bill expands access while protecting the more vulnerable population in the state. The best palliative care cannot alleviate end-of-life suffering. The Death with Dignity Act allows mentally competent terminally ill patients to die calmly, when, where, and with whom they choose.

(Opposed) The current law is not too restrictive. The number of prescriptions and overdose deaths has dramatically increased. The percentage of people choosing to end their life is three times higher than in California which has a broader law. Caregivers are more likely than patients to claim there are barriers to access. The bill would allow the drugs to be sent by mail or messenger to a family member who has their own agenda. The waiting period is cut in half from 15 days to seven days. The wait time is there to allow antidepressants to

take effect. An acute but treatable medical emergency can mean a death sentence hours later because a provider believes that the patient will not live seven days. Physicians are poor at predicting life expectancy and patients have lived far past their prognosis. Specialists are often wrong when a patient is close to death. There is no time for a patient to reconsider or consult loved ones. This bill is a part of a national campaign to increase assisted suicide.

The safeguards voters asked for are ignored and the right that a patient has to change their mind is removed. The bill fails to account for how often the terminally ill have compromised decision-making abilities and depression which go unrecognized by physicians. Brain function declines close to death making this a legal and ethical challenge because getting consent during this time is unethical due to patient choice being compromised.

Patients often change their mind once pain is treated. No dying patient should have excessive pain. Physicians can support life to the end and allow patients to retain their full dignity with palliative care by facilitating the visitation of family and friends; getting patients to visit familiar places; and making them more comfortable in bed. Doctors may lack knowledge about palliative care possibilities; lethal drugs should not be a solution for lack of education.

Many people chose to take these drugs because they do not want to be a burden to their family. Vulnerable patients make rash decisions out of fear, depression, or the pressures of feeling like a burden.

Physicians are ignoring the safeguards; they are not filing reports claiming any terminal diagnosis. This is a felony, and nothing is being done about it.

Offering assisted suicide to people with disabilities and resources for services to those who are not disabled is ableism.

Persons Testifying: (In support) Representative Skyler Rude, prime sponsor; Cassa Sutherland, End of Life Washington; Susan Powell; George Hendrickson; Darrell Owens, Advanced Registered Nurse Practitioners United of Washington State; Dick Gibson; Mary Rivkin; and Representative Strom Peterson.

(Opposed) Conrad Reynoldson; Richard Doerflinger; Sharon Quick and Shane Macaulay, Physicians for Compassionate Care Education Foundation; Arthur Coday; and Alec Rowlands, Westgate Chapel.

Persons Signed In To Testify But Not Testifying: Nat Dean, Us for Autonomy; Angela Ross, Washington Association of Naturopathic Physicians; Kelly Thompson; Cynthia Potts; Judy Kinney, End of Life Washington; Kathryn Lewandowsky; Rebecca Faust; Mary Long, Conservative Ladies of Washington; and Ivanova Smith.