GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

WE ARE WASHINGTON DC

DEATH WITH DIGNITY

Patient Education Module

July 17, 2017

What is Death with Dignity?

- The District of Columbia passed the "Death with Dignity Act of 2016".
- The Death with Dignity law establishes a process by which competent, terminally ill residents of DC can legally obtain a physician's prescription for drugs to end their lives in a humane and peaceful manner.
- The District of Columbia Department of Health (DOH) will regulate and oversee the Death with Dignity process. DOH's primary responsibilities include:
    - Providing educational resources on how the Death with Dignity process works;
    - Clarifying the requirements that must be followed by both physicians and patients; and
    - Ensuring residents are not taken advantage of during a vulnerable period of their lives.
- Any patient wishing to utilize this process is required to review these modules before any covered medication is prescribed.

Who Can Participate?

- In order to participate in the Death with Dignity program, a patient must:
  1. Be eighteen (18) years of age or older;
  2. Reside in the District of Columbia;
  3. Be under the care of a physician licensed in the District of Columbia; and
  4. Have a terminal disease which is expected to result in death within six (6) months.

Establishing Residency

- A patient may establish residency by submitting any two (2) of the following original documents that include a valid address in the District of Columbia:

1. A utility bill or computer printout (water, gas, electric, oil or cable), with name and address, issued within the last sixty (60) days (disconnect notices are not acceptable);
2. A telephone bill or computer printout (cell phone, wireless, or pager bills acceptable), reflecting patient's name and current address, issued within the last sixty (60) days (disconnect notices not accepted);
3. A deed, mortgage, or settlement agreement reflecting the patient's name and property address;
4. An unexpired lease or rental agreement with the name of the patient listed as the lessee, permitted resident, or renter (may be a photocopy). The unexpired lease or rental agreement shall be signed by all parties;
5. A District property tax bill or tax assessment issued within the last twelve (12) months reflecting the applicant's name and property address;
6. An unexpired homeowner's or renter's insurance policy reflecting the patient's name and address;
7. A letter with picture from the Court Services and Offender Supervision Agency or DC Department of Corrections certifying the patient's name and District residency issued within the last sixty (60) days;
8. A Department of Motor Vehicles proof of residency form signed by the certifier residing at the residence and a copy of the certifier's unexpired DC Driver license or DC identification card;
9. A bank, credit union, credit card, or investment account statement issued within the last sixty (60) days reflecting the patient's name and address;
10. A piece of official mail – received from any government agency (with the patient's full name and address) to include contents and envelope received within the last sixty (60) days;
11. A form from a social service provider that includes the patient's name and address issued within the last sixty (60) days;
12. A medical bill issued within the last sixty (60) days reflecting the patient's name and address;
13. A student loan statement issued within the last sixty (60) days reflecting the patient's name and address;
14. A home line of equity statement issued within the last sixty (60) days reflecting the patient's name and address;
15. A car or personal loan statement (no coupon books/vouchers accepted) issued within the last sixty (60) days reflecting the patient's name and address; or
16. A home security system bill issued within the last sixty (60) days reflecting the patient's name and address.

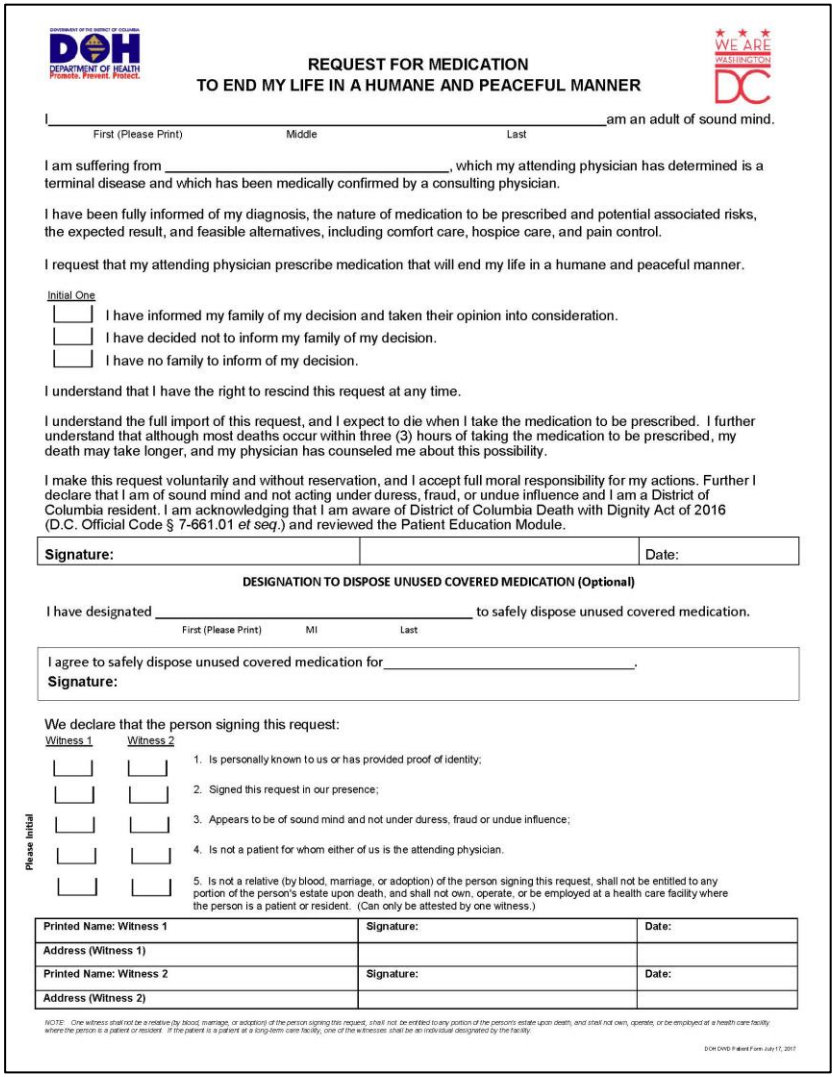
Obtaining the Medication

- In order to obtain the covered medication from your treating physician, you must:
    1. Make two (2) oral requests to your treating physician, separated by a minimum of fifteen (15) calendar days; and
    2. Make a written request **before** the second oral request, and at least forty eight (48) hours before any medication is dispensed or prescribed.
- Once the necessary requests are made, your treating physician can either dispense the medication directly to you, or submit a prescription directly to a pharmacy for you or a designee to pick up.

The Oral and Written Requests

- The requests must be made voluntarily;
- You must be capable of making and communicating the requests to your treating physician;
- The written request must be submitted on the DOH approved form, which can be located online at **https://doh.dc.gov/page/death-dignity-act-2016**.
- The written request must be sent to, and received by, your treating physician **between** the first and second oral requests;
- There must be two (2) witnesses to the written request.

Patient Written Request Form



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

I _____ am an adult of sound mind.
First (Please Print) Middle Last

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, the nature of medication to be prescribed and potential associated risks, the expected result, and feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and peaceful manner.

Initial One

☐ I have informed my family of my decision and taken their opinion into consideration.
☐ I have decided not to inform my family of my decision.
☐ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request, and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three (3) hours of taking the medication to be prescribed, my death may take longer, and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions. Further I declare that I am of sound mind and not acting under duress, fraud, or undue influence and I am a District of Columbia resident. I am acknowledging that I am aware of District of Columbia Death with Dignity Act of 2016 (D.C. Official Code § 7-661.01 *et seq.*) and reviewed the Patient Education Module.

Signature:		Date:

DESIGNATION TO DISPOSE UNUSED COVERED MEDICATION (Optional)

I have designated _____ to safely dispose unused covered medication.
First (Please Print) MI Last

I agree to safely dispose unused covered medication for _____.
Signature:

We declare that the person signing this request:

Please Initial

Witness 1	Witness 2	
☐	☐	1. Is personally known to us or has provided proof of identity;
☐	☐	2. Signed this request in our presence;
☐	☐	3. Appears to be of sound mind and not under duress, fraud or undue influence;
☐	☐	4. Is not a patient for whom either of us is the attending physician.
☐	☐	5. Is not a relative (by blood, marriage, or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. (Can only be attested by one witness.)

Printed Name: Witness 1	**Signature:**	**Date:**
Address (Witness 1)		
Printed Name: Witness 2	**Signature:**	**Date:**
Address (Witness 2)		

NOTE: One witness shall not be a relative (by blood, marriage, or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. If the patient is a patient at a long-term care facility, one of the witnesses shall be an individual designated by the facility.

DOH DWD Patient Form July 17, 2017

Acceptable Witnesses

- Your treating physician is **never** an acceptable witness.
- One witness can be anyone you choose other than your treating physician.
- The other witness can be anyone you choose **who is not**:
  - A relative by blood, marriage, or adoption;
  - A recipient of your estate;
  - An owner, operator, or employee of the health care facility where you are receiving treatment or are a resident.
- If the patient is in a health care facility (e.g., a nursing home, community residence facility or assisted living facility), one witness shall be a person designated by the facility except the owner, operator, or employee of the facility.

Physician Requirements

- After you have made the required oral and written requests, your treating physician must determine:
  1. You have a terminal disease that will result in death within six (6) months;
  2. You are capable of making and communicating your health care decisions;
  3. The request was made voluntarily; and
  4. You are a resident of the District of Columbia.
- Your treating physician must provide you with information that will allow you to make an informed decision. This includes informing you of:
  - Your medical diagnosis and prognosis;
  - The potential risks and probable results of taking the covered medication; and
  - Feasible alternatives to taking the covered medication (e.g., comfort care, hospice care and pain control).

Physician Requirements (cont.)

- Your treating physician must also inform you of:
  - The availability of supportive counseling services;
  - Recommend that you notify next of kin, friends, and spiritual advisor, if applicable, of your decision;
  - The importance of having another person present when taking the medication;
  - The importance of not taking the medication in a public place; and
  - The opportunity to cancel your request for covered medication at any time.
- Next, your treating physician will refer you to a consulting physician.

Role of Consulting Physician

- A consulting physician is a doctor that is qualified to make a professional diagnosis and prognosis **regarding your specific disease**, and is willing to participate in the Death with Dignity process.
- The consulting physician's responsibilities include:
  - Examining you and your medical records to confirm, in writing to your treating physician, the diagnosis of a terminal disease; and
  - Verifying, in writing to your treating physician, that you are capable of making and communicating health care decisions, are acting voluntarily, and have made an informed decision.

Counseling Referral

- If either your treating physician or consulting physician believes that you may have impaired judgment due to a mental health disorder or depression, they **must** refer you for counseling to a psychiatrist or psychologist that is licensed in the District of Columbia.
- If you are referred for counseling, you **must** see a psychiatrist or psychologist that is licensed in the District of Columbia, before any covered medication can be prescribed.
- The psychologist or psychiatrist must determine that you do not have impaired judgment due to a mental health disorder or depression, and must submit this information to DOH before any covered medication can be dispensed.

Dispensing or Prescribing the Drug

- Immediately before any covered medication is prescribed or dispensed, your treating physician must offer you an opportunity to change your mind and ensure you are making an informed decision.
- The covered medication will either be:
    1. Dispensed to you directly from your treating physician; or
    2. Your treating physician will submit a prescription for the covered medication to a pharmacy located and licensed in the District of Columbia.
- A prescription for a covered medication **shall never** be given to you to be filled at a pharmacy.

Dispensing or Prescribing the Drug (cont.)

- If your treating physician **dispenses** the covered medication, it can be dispensed directly to you at his or her office.
- If your treating physician **prescribes** you the covered medication, he or she is responsible for delivering that prescription to a pharmacy located and licensed in the District of Columbia. Your physician **cannot** give you the prescription for you to take to a pharmacy to be filled.
- Once the covered medication is transmitted to the pharmacy, it must be picked up at the pharmacy by you, your treating physician, or another individual designated by you that has been **previously communicated** to the pharmacy, either orally or in writing.

Taking the Covered Medication

- You **do not** have to take the covered medication in a hospital or health care facility.
- You can take the covered medication in your home, or any other location you have permission to take the medication, **except** in a public location. Your estate or family will be responsible to the District of Columbia for any costs associated with taking the medication in a public place.
- It is recommended you take the medication with another person present.

Taking the Covered Medication

- It is recommended you have on your person, or in plain sight, a written Do Not Resuscitate Order (DNR) when taking the covered medication.
- It is recommended that you contact emergency responders by registering with SMART 911 to inform them that you intend to take the covered medication pursuant to the Death with Dignity law.

Rescinding Your Request

- You can change your mind regarding the use of covered medication at anytime.
- It is recommended that you consult with your treating physician prior to making any decisions about rescinding your request to participate in the Death with Dignity process.
- If you do change your mind and decide to no longer utilize the Death with Dignity process, you will need to inform your physician of your decision.
- If you rescind from the Death with Dignity Program, notify DC Department of Health via email at deathwithdignitydc@dc.gov.
- If you decide in the future to utilize the Death with Dignity process, you will be required to restart the application all over again.

Additional Helpful Information

- A request for covered medication **cannot** be used as a basis for the appointment of a guardian or conservator.
- It is recommended that you designate a person to safely dispose of any unused covered medication.
- Resources for safe disposal of covered medications can be found online at **https://doh.dc.gov/page/death-dignity-act-2016.**
- If you take the covered medication, the cause of death listed on your death certificate will identify your underlying medical condition leading to your death, and **will not** include information about your use of covered medication.

Additional Helpful Information (cont.)

- The Death with Dignity law does not authorize anyone to end his or her life by lethal injection, mercy killing, active euthanasia, or any other method or medication that is not allowed by the law.
- Actions taken in accordance with the Death with Dignity law **do not** constitute suicide, assisted suicide, mercy killing or homicide.
- Pursuant to District of Columbia law, the use of covered medication will not have an effect on life insurance, health insurance, accident insurance, annuity policies, or employment benefits.

- Any person who willfully alters or forges a request for a covered medication or conceals or destroys rescission of a request for a covered medication with the intent or effect of causing your death, is punishable as a Class A felony.
- Any person who willfully coerces or exerts undue influence on you to request or ingest a covered medication with the intent or effect of causing your death, is punishable as a Class A felony.

Questions?

DEATH WITH DIGNITY
CONTACT INFORMATION

Department of Health
Death with Dignity
Health Regulation and Licensing Administration
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

Phone: (202) 724-8800
Email: deathwithdignitydc@dc.gov
Website: https://doh.dc.gov/page/death-dignity-act-2016