Checklist for Health Care Providers' Compliance with Maine's Death with Dignity Law

Attending Physician: Physician with the primary responsibility for the care of a patient and the treatment of that patient's terminal disease.

- ☐ Determines the patient has an incurable and irreversible disease that will likely result in death within six months.
- ☐ Requests that the patient demonstrate residency.
- ☐ Determines whether the patient is competent, which the law defines as the ability to make and communicate an informed decision.
- ☐ Meets alone with the patient (with an unrelated qualified interpreter, if needed, who must complete a state form) to confirm the patient is making the oral and written requests voluntarily without coercion or undue influence.
- ☐ Informs the patient of their diagnosis and prognosis, the risks and expected result of taking the medication and the alternatives to taking the medication.
- ☐ Confirms that the written request is in the proper form with two qualified witnesses and signed at least 15 days after the initial oral request and gives a copy of the completed form to the patient.
- ☐ At the time of the patient's second oral request at least 15 days following the first oral request, the attending physician must offer the patient an opportunity to rescind the request.
- ☐ Refers the patient to a consulting physician for confirmation of the attending physician's findings.
- ☐ If necessary, refers the patient for counseling.
- ☐ Obtains the patient's informed consent.
- ☐ Recommends that the patient notify his/her next of kin.
- ☐ Counsels the patient about the importance of having another person present when taking the medication and to not self-ingest the medication in a public place. Consider the patient's ability to self-ingest the medication.
- ☐ No sooner than 48 hours following the written request, the attending physician ensures that all appropriate steps have been completed before writing a prescription, including verifying that the patient is making an informed decision immediately before writing the prescription. Completes the state's End-of Life Reporting Form.
- ☐ Prescribes or dispenses life-ending medication directly to the patient to voluntarily self-ingest or delivers that prescription to a pharmacist, and files a copy of the prescription or the dispensing record with the State.
- ☐ Fulfills the required medical record documentation in the patient record: all oral and written patient requests; diagnosis/prognosis; determination that patient is competent, acting voluntarily and with informed consent; counseling report(s), if any; offer to rescind, medication(s) prescribed and a note that all requirements in this law have been met. All required state forms must be part of patient's medical record.
- ☐ Completes the state End-of-Life Closure Form, files it in the medical record and sends a copy of it with copies of all of the required completed official state forms to the State Registrar within 30 days following the patient's death.

Consulting Physician: Physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's disease.

- ☐ Examines the patient and reviews the patient's medical records.
- ☐ Confirms, in writing, the attending physician's medical diagnosis.
- ☐ Verifies that the patient is competent.
- ☐ Verifies that the patient is acting voluntarily.
- ☐ Verifies that the patient is making an informed decision.
- ☐ If necessary, refers the patient for counseling.
- ☐ Completes the same medical record documentation requirements as the attending physician **except** the attending physician's offer to rescind, note that all requirements of the Act are met, and the specific medication(s) prescribed.
- ☐ Completes the state form for consulting physicians and sends it to the attending physician to file with the state.

Psychiatrist, Psychologist, Clinical Social Worker or Clinical Professional Counselor: State-licensed professional conducts counseling consultation(s) if either physician finds the patient may have impaired judgment due a psychiatric or psychological disorder or depression.

Pharmacist: Dispenses the end-of-life medication to the patient, the attending physician or an expressly identified agent of the patient, provided that the pharmacist/pharmacy has opted to be a participating provider under this Act.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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Maine Center for Disease Control and Prevention
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TTY: Dial 711 (Maine Relay); Fax (207) 287-5470

Attending Physician End-of-Life Reporting Form

PLEASE PRINT

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH
	MEDICAL DIAGNOSIS AND PROGNOSIS	
B	**PHYSICIAN INFORMATION**	
	NAME (LAST, FIRST, MI)	TELEPHONE
	MAILING ADDRESS	
	CITY, STATE, ZIP	
	CONSULTING PHYSICIAN NAME	TELEPHONE
C	**ACTION TAKEN TO COMPLY WITH LAW**	
	1. FIRST ORAL REQUEST	
	☐ The patient made an oral request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner.	DATE
	Comments:	
	2. SECOND ORAL REQUEST (Must be made 15 days or more after the first oral request.)	
	Indicate compliance by checking the boxes. ☐ 1. The patient made a second oral request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner. ☐ 2. Attending physician has offered the patient an opportunity to rescind the request.	DATE
	Comments:	
	3. WRITTEN REQUEST (Must be made 15 days or more after the first oral request.)	
	☐ The patient made a written request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner.	DATE
	Comments:	

4. ATTENDING PHYSICIAN DETERMINATIONS AND ACTIONS

Indicate compliance by checking the boxes.

I have determined that the patient:

- ☐ is at least 18 years of age;
- ☐ is suffering with a terminal disease;
- ☐ is competent; and
- ☐ has made a voluntary request for medication to self-administer for the purpose of ending the patient's life in a humane and dignified manner.

I have requested that the patient:

- ☐ demonstrate he/she is a Maine state resident, and I am satisfied the patient is a Maine state resident.

To ensure the patient is making an informed decision, I have informed the patient of the following:

- ☐ the patient's medical diagnosis;
- ☐ the patient's prognosis;
- ☐ the potential risks associated with taking the medication to be prescribed;
- ☐ the probable result of taking the medication to be prescribed; and
- ☐ the feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options.

I have taken the additional following steps:

- ☐ Referred the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is competent and acting voluntarily;
- ☐ Confirmed that the patient's request does not arise from coercion or undue influence by another individual by discussing with the patient, outside the presence of any other individual, except for an interpreter, whether the patient is making an informed decision;
- ☐ Verified that the patient, based on my evaluation or following a referral for counseling, is not suffering from a psychiatric or psychological disorder or depression causing impaired judgement;
- ☐ Recommended that the patient notify the patient's next of kin;
- ☐ Counseled the patient about the importance of having another person present when the patient takes the medication prescribed, and counseled the patient about not taking the medication prescribed in a public place;
- ☐ Informed the patient that the patient has the opportunity to rescind the request at any time and in any manner; and
- ☐ Verified immediately before writing a prescription for life-ending medication that the patient is making an informed decision.

D MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT

To be prescribed no sooner than **48 hours after** the date of the written request.

MEDICATION PRESCRIBED AND DOSAGE:	DATE PRESCRIBED

NAME OF PHARMACIST AND ADDRESS (if applicable)

DATE DISPENSED AND TO WHOM	DATE DISPENSED

E MEDICAL COVERAGE/PATIENT INSURANCE

What is the principal source of medical coverage for the patient?

- ☐ a) Private Insurance
- ☐ b) Government Payor includes Medicare, Indian Health Service, or CHAMPUS
- ☐ c) Mainecare or Medicaid
- ☐ d) Self Pay
- ☐ e) None
- ☐ f) Unknown

To the best of my knowledge, all of the requirements of the Death with Dignity Act, 22 M.R.S. chapter 418, have been met.	
PHYSICIAN'S SIGNATURE	DATE

If comments in any section exceed the space provided, please use an attached page. Supplemental comments should be identified using the appropriate alphanumeric notation (e.g., C3). **Retain the original form in the patient's medical record. Provide a copy of the completed form to the State Registrar, Office of Data, Research, and Vital Statistics within 30 days of writing the prescription.**

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Death with Dignity Frequently Asked Questions

We recommend reading all the questions and answers.

This information is provided as a courtesy and not intended as legal advice. Consult your physician and attorney.

What is the Death with Dignity act?

The Maine Death with Dignity Act, provides eligible Maine residents with terminal diseases the option to be prescribed a dose of medication that, if taken, will hasten the end of their life. This option requires the participation of a Maine-licensed physician.

Who is eligible to participate?

Maine residents who are suffering from an incurable and irreversible disease that would, within reasonable medical judgment, result in death within six months. The patient must be capable of making a voluntary, informed health care decision, and can self-administer the prescribed dose. *See the text of the law for more detail*

How does the law work?

The Act lays out a step-by-step process for a patient and doctor to follow. It begins with a diagnoses and prognosis of a terminal and incurable illness that will, within medical judgment, take place within six months. Once that determination has been made, a patient may make an oral request of his or her physician to be prescribed a dose of medication that, if taken, would hasten death. The process requires, among other things, both oral and written requests, witnesses, and the second opinion of a physician. Every step must be voluntary by both the patient and the physician.

What makes someone a Maine resident?

The Act does not specify what qualifies a person as a resident: it is up to the patient's physician to make that determination. Factors demonstrating residency include but are not limited to 1) Possession of a Maine driver's license; 2) Registration to vote in Maine; 3) Evidence that a person leases/owns property in Maine; or 4) Filing of a Maine tax return for the most recent tax year.

Is there a standard form for the written request?

There is a Patient Request for End-of-Life Care Medication form. You can get that form from your doctor or at the Department of Health and Human Service website below.

http://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/forms/index.shtml

What does a patient do if he or she chooses not to use the prescribed dose?

Patients may choose to rescind their request at any time. If the medication has been dispensed and the patient chooses not to use the medication, it should be delivered in person to a facility qualified to dispose of controlled substance. Consult your pharmacist for information about disposal facilities.

Are all doctors, nurses and pharmacists required to participate?

No. Participation by any health care professional is completely voluntary.

Are doctors required to tell patients about this medical aid in dying?

Patients have a right to receive relevant information regarding all treatment options reasonably available for the care of the patient. A doctor may choose not to participate in the Act . If they are unable or unwilling to carry out a qualified patients request, they will transfer any relevant medical records for the patient to a new physician if the patient requests.

How do you know if your doctor will participate?

Make an appointment to talk to your doctor about your end-of-life goals and concerns, including the Death with Dignity option. During your visit the physician will provide you will all the information you need to make an informed decision.

Who will be providing accountability and oversight for implementation of Act?

The legislature did not vest any government Agency with oversight of the Act. The Department of Health and Human Services is charged with collecting forms provided by participating physicians. Alleged abuses under the law would be investigated by the relevant licensing board, and/or the Maine Attorney General's Office.

How will this impact life insurance policies?

The Act prohibits a life insurance company from denying benefits to individuals who act in accordance with Act.

What are the reporting requirements and what will be done with the information?

The Act requires only that the physician, who prescribes the medication, provides documentation to the Department of Health and Human Services as required by rule. This information is confidential, is not a public record and not open to public inspection. It will be protected under state and federal privacy laws.

Who can prescribe this medication?

Any physician who is licensed to practice medicine in Maine, that includes physicians with MD and DO degrees. It does not extend to other prescribers such as advanced-practice registered nurses and physician assistants.

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Consulting Physician End-of-Life Care

PLEASE PRINT

A	**PATIENT INFORMATION**	
	PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH
B	**REFERRING/ATTENDING PHYSICIAN INFORMATION**	
	NAME	TELEPHONE NUMBER
C	**CONSULTING PHYSICIAN DETERMINATIONS**	
	I examined the above-named patient on _____ (date) at _____ (time). I have also reviewed the patient's relevant medical records. By checking below, I confirm the attending physician's diagnosis that the patient is suffering from a terminal disease, specifically _____ (list diagnosis), and verify that the patient is competent, is acting voluntarily, and had made an informed decision: ☐ a) diagnosis that patient is suffering from a terminal disease; ☐ b) patient is competent; ☐ c) patient is making an informed decision; ☐ d) patient is acting voluntarily in his/her request for medication to end his/her life in a humane and dignified manner.	
D	**CONSULTING PHYSICIAN'S INFORMATION**	
	NAME (please print)	LICENSE NUMBER
	MAILING ADDRESS	
	CITY, STATE, ZIP	TELEPHONE NUMBER
	PHYSICIAN'S SIGNATURE	DATE

To the consulting physician: Provide the completed form to the attending physician.
To the attending physician: Provide a copy of the completed form to the State Registrar, Office of Data, Research, and Vital Statistics. Retain the original in the patient's medical record.

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End-of-Life Closure Form

Dear Physician:

Pursuant to the Department of Health and Human Services' authority to collect information under **the Death with Dignity Act**, 22 M.R.S. chapter 418, the Department requires physicians who write a prescription for medication for a patient to self-administer for the purpose of ending the patient's life in a humane and dignified manner to complete this follow-up form within **30 calendar days** of a patient's death, if known to the physician.

For the Department of Health and Human Services to accept this form, it must be signed by the Attending Physician, whether or not he or she was present at the patient's time of death.

This form should be mailed to the attention of the State Registrar at: 220 Capitol Street, 11 State House Station, Augusta, Maine, 04330. *All information is kept strictly confidential.* If you have any questions, call: 207-287-5459.

Patient's Name:_____**DOB:**_____/_____/_____

Name of Attending Physician**:** _____

Prescription Record

Did the patient die from ingesting the lethal dose of medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink? **If unknown, please mark the form indicating that.**

- ☐ 1. **Patient Choice** (self-administered medication)
- ☐ 2. **Underlying illness**
- ☐ 3. **Unknown**
- ☐ 4. **Other** (please specify):

  _____
- ☐ 5. **It has been six months since the prescription was written on _____(date) and the death has not occurred or confirmed.**

How was the unused medication disposed of? If unknown, please indicate the same.

_____

Attending Physician Signature: _____

Date:_____/_____/_____

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Form of Interpreter Attachment

I, _____, am fluent in English and _____

(language of patient)

On _____ (date) at approximately _____ (time) I read the "REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER" to _____ (name of patient) in _____ (language of patient).

Mr./Ms. _____ (name of patient) affirmed to me that he/she understands the content of this form, that he/she desires to sign this form under his/her own power and volition and that he/she requested to sign the form after consultations with an attending physician and a consulting physician.

Under penalty of perjury, I declare that I am fluent in English and _____ (language of the patient) and that the contents of this form, to the best of my knowledge, are true and correct.

Executed at _____ (city, county, and state) on _____ (date).

Interpreter's signature: _____
Interpreter's printed name: _____
Interpreter's address: _____
_____

NOTE: The interpreter must be a person who is not a relative of the patient by blood, marriage or adoption; a person who at the time the patient signs the *Request for Medication to End My Life in a Humane and Dignified Manner* would be entitled to any portion of the estate of the patient upon death, under any will or by operation of any law; or an owner, operator or employee of a health care facility where the patient is receiving medical treatment or is a resident.

To the interpreter: Give this completed form to the attending physician.

To the attending physician: Retain the original form in the patient's medical record. Mail a copy to the attention of the State Registrar, Office of Data, Research, and Vital Statistics.

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Request for Medication to End My Life in a Humane and Dignified Manner

Part One: Declaration of Patient

I, _____, am an adult of sound mind and am a resident of the State of Maine and have been since _____ (month) of _____ (year) and 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 and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result and feasible alternatives, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and contact any pharmacist to fill the prescription.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions 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 3 hours, 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.

Signature	Date

Part Two: Declaration of Witnesses

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing above request:

Initials of Witness 1:

_____ 1. Is personally known to us or has provided proof of identity;

_____ 2. Signed this request in our presence on the date of the person's signature;

_____ 3. Appears to be of sound mind and not under duress, fraud, or undue influence; and

_____ 4. Is not a patient for whom either of us is the attending physician.

Witness 1 Print name	Signature	Date

Initials of Witness 2:

_____ 1. Is personally known to us or has provided proof of identity;

_____ 2. Signed this request in our presence on the date of the person's signature;

_____ 3. Appears to be of sound mind and not under duress, fraud, or undue influence; and

_____ 4. Is not a patient for whom either of us is the attending physician.

Witness 2 Print name	Signature	Date

NOTE: One witness must be a person who is not a relative by blood, marriage, or adoption of the person signing this request, is not entitled to any portion of the person's estate upon death and does not own or operate or is not employed at a health care facility where the person is a patient or resident. The person's attending physician at the time of the request is signed may not be a witness. If the person is an inpatient at a long-term care facility, one of the witnesses must be a licensed healthcare provider designated by the facility; the facility's designee may be an owner, operator, or employee of the health care facility.

To the person signing this request:

Give this completed form to your attending physician. Request a copy to keep for yourself.

To the attending physician:

Retain this completed original form in the patient's medical record. Provide a copy to the State Registrar, Office of Data, Research, and Vital Statistics.