Death with Dignity

A Study of Washington State's Medical Aid in Dying Laws

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Chapter 1

Purpose of Study:

The purpose of this study is to examine if Washington State medical professionals believe medical aid in dying (MAID) laws in Washington State are adequate for patients during their end-of-life process. Legally, medical aid in dying can be defined as “a method by which a physician will provide medical supplies and prescription medications to a terminally ill individual as a means for that individual to end their life” (Cornell Law School). In 2023, Washington State passed an expansion on its Death with Dignity law. Washington historically has taken influence from its neighboring governments of Oregon and Canada when it comes to medical aid in dying. With the neighboring governments becoming more progressive in their laws, many have come to worry we’ll run into the same issues they’re running into. My study examines how physicians feel about the current state of Washington’s MAID laws by asking them a series of survey questions where they rate their answers on a scale of 1-5. Every physician would be asked the same questions using the same scale, but the changing variable would be the profession and care they provide to a patient. The goal is to see not only if the law should be expanded/cut, but also to see if different professions of physicians have varying opinions on these laws' impact on their patients.

There have been several opinion poll surveys that have gathered data on the general public’s view on assisted suicide and how it’s progressing in our country. However, limited studies have shown medical professionals' opinions of the matter exclusively though. By surveying just the medical professionals, you’re able to get a view of what the more educated and qualified feel about the issue.

I hypothesize that the more involved a physician is in end-of-life care, the more skeptical they will be about the current law. The data will represent this by higher numbers on survey question 4 and lower numbers on survey questions 5-9 when they're more skeptical. I hypothesize that physicians being more involved in a patient's end-of-life care will make them more empathetic with their patients, resulting in lower numbers on questions 4-10, and higher numbers on question 11.

When policy is made, it should be informed by the people educated in the problem as well as the opinions of the general public. It's important to have a balance between the two. My study aims to address the gap in knowledge between the general public and the medical professionals of Washington State. Policymakers can use this data to go on and make an educated decision if Death with Dignity should be expanded or not.

Chapter 2

Review of Literature:

The purpose of my study is to determine if Washington State's assisted suicide laws are adequate to support dying people who wish to use it. The law was initially passed in 2008 but was recently updated in 2023. My study aims to see if the new changes met the needs of patients that the previous law missed. When doing a literature review, it is important to note that the importance of my research stems from the recency of the changed law. There have not been many articles written about the new law, so the research I will reference will be mostly about the original law and the general concept of MAID..

One aspect of my research is to determine if the law is progressive enough to support Washington State patients. In my study, I will define progressive as the act of development or making a law more encompassing (Oxford Languages). A more progressive assisted suicide law leads to physician-assisted euthanasia. Physician-assisted euthanasia is different from MAID because, with euthanasia, the doctor administers the life-ending medication to you directly. With Washington's current law, the patient must be the one to take the medication. A qualified medical professional can prescribe it, but cannot be the one to actively give it. A study done in 2016 examined support for euthanasia in the United States. The conclusion from their research stated that "Euthanasia and physician-assisted suicide are increasingly being legalized, remain relatively rare, and primarily involve patients with cancer" (Ezekiel et al, 2016). This study shows that a couple of years back in 2016, support for euthanasia in the United States was lower. During this study, though, only five states in the United States had MAID legalized. Now, in 2024, an additional six have been added.

In Ezekiel et al's, they analyzed the General Social Survey (GSS) and Gallup. Gallup had 1028 responses and GSS had 1664. The respondents to Gallups were asked, "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it"? The response to this was 67% saying yes.

In 2024, Gallup produced a new survey asking people new questions about assisted suicide and euthanasia. Gallup showed results that said euthanasia is more widely supported than physician-assisted death, "At the same time, doctor-assisted suicide (...) garners slightly less but still majority support. Sixty-six percent of Americans believe doctors should 'be allowed by law to assist the patient to commit suicide' for terminal patients living in severe pain who request it" (Gallup Poll Social Series, as cited in Yi 2024). Gallup's data accredits the increase in euthanasia support over assisted suicide to religious attendance, "Sixty-seven percent of those who seldom or never attend religious services say doctor-assisted suicide is morally acceptable, compared with 29% of those who attend services weekly"(Gallup Poll Social Series, as cited in Yi 2024).

A study done in 2020 by Mangino et al examined public attitudes towards what they call "Advance Request Euthanasia/or Assisted Suicide (AR-EAS)" in dementia patients. They surveyed 1,711 adults in the United States about their opinions on AR-EAS before and after they presented them with information about the law and what they deem as its ethical implications. The data showed that 54.4% initially agreed when asked if they supported the law, but that number dropped to a range they reported as 36.5% to 49.3% when they presented the scenarios to them. This study is relevant to mine because I'm focusing on whether the more educated, or in my case medical professionals, feel differently about

MAID than the general public. If after the test group approval was lowered after reading scenarios that could happen with assisted suicide, you can say their score lowered after they received more education on the scenario. This might reflect in my data that the more educated medical population won't be as satisfied with the Washington State Medical Aid in Dying law.

A study done by Abernathy and Covich in 2020 examined if it is more efficient to try and pass a lot of MAID-related bills at once, or if it is better to separate the bills between multiple legislative periods. This study will be relevant to my data because if I do decide to recommend an expansion on the bill, the goal of the recommendation would be a successful new law. The data, though, does not show that more bills change the effectiveness of the passing rate. They credit successful bills more likely to the factors of "previous state victories and shifts in public opinion"(Abernathy and Covich, 2020). With the previous victories we've had in Washington State Death with Dignity laws, now might be the time to pass a bill if medical professionals believe something is missing.

MAID has a history of being supported more by one group of people in the United States- white women. Canetto's 2019 study determines this to be true. She says that "A mix of privilege and disadvantage, combined with dominant physician assisted-suicide rhetoric and dominant-femininity ideals, likely contribute to White women's strong participation in physician-assisted suicide" (Canetto 2019). This current study, however, does not focus on race, but rather, on physician proximity to the patient. Another study by Poma et al determined that people with a history of suicidal behavior tend to be more open to allowing MAID laws. While Canetto's study was conducted by examining public trends, Poma et al's was conducted through an in-person survey. I believe the survey strategy to be more conducive to this type of research.

According to an annual report put out by the Washington State Department of Health regarding MAID usage in 2022, 207 different physicians prescribed life-ending medication to patients who qualified. Therefore, this study focuses on professionals who provide Medical Aid in Dying support/prescriptions as well, so I will partner with End of Life Washington to distribute my survey to their providers.

In a study done by Rosenburg et al, 1488 members of the American Geriatric Society were surveyed to get their opinion on MAID. The conclusion was that there was no consensus among medical providers, but there were trends that would signal if a person was more likely to support it or not. Being informed on the topic and having it be legal in your state were two key aspects to determine your stance. This aligns with previous research done on the topic by Gallup and Mangino.

Chapter 3

Methodology

My study consists of Washington State medical professionals across various medical credentialing. Each group of medical professionals will self-identify which group they are a part of by answering the identifier questions at the beginning of the survey, more specifically questions 1 through 4. A group called End-of-Life Washington helped distribute my survey to their providers, as well as snowball sampling from non-medical aid in-dying providers. This resulted in a total of n=33 respondents. Only medical professionals within Washington State were included in this study. I provided a link to the Washington State law itself and a summary of the procedures of the law to ensure participants had an understanding of the MAID laws. I referenced the official Washington State Department of Health for the law itself, and provided a document summarizing it written by End-Of-Life Washington. The document outlines to potential patients how they can use the law.

The survey instrument was distributed through “Google Surveys” via email. The survey was a cross-sectional quantitative study that collected data in July 2024. I chose a survey as my method for collecting data to reach a wider audience with my data collection. My analysis compares the type of medical professional they identify as, if they provide medical aid in dying services, and how closely they associate themselves with the end-of-life process. These data points should allow me to determine if doctors who are closer to the process feel the medical aid-in-dying process is adequate for patients desiring to utilize this option. Each of my survey questions seeks to gauge the respondents’ feelings on a certain keyword being associated with medical-aid-in-dying. For example, question 5 asks about the effectiveness of the law on a scale from 1 to 5.

Analysis was conducted using SPSS software program version 24. I will use each identifying variable and correlate them with their responses to the scale-based answering system. I will run Spearman correlations for my question where I ask them to rate their involvement in the end-of-life process due to the fact this question is a scale like my dependent variables. I will know if they are correlated or not with my Spearman's correlation by ranking the strength of the association using the criteria found in Table 1.

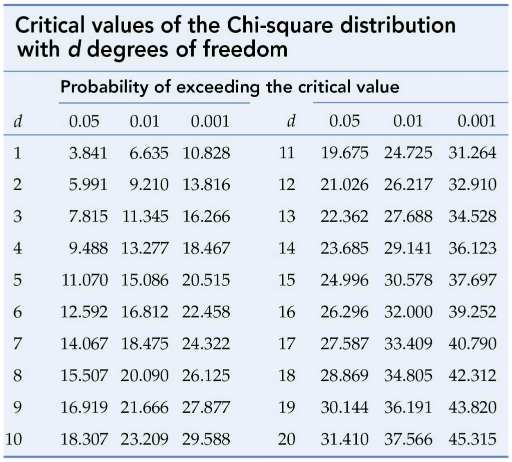
Table 1: Correlation Coefficient Strength Ranking

	Coefficient, *r*	
Strength of Association	Positive	Negative
Small	.1 to .3	-0.1 to -0.3
Medium	.3 to .5	-0.3 to -0.5
Large	.5 to 1.0	-0.5 to -1.0

How to Run Spearman's Correlation test in SPSS (2022)

For my other independent variables, I will run a Chi-Square analysis. I will know if the results are significant by referring to Table 2. SPSS will also flag significance below each chi-square test table.

Table 2: Chi-Square Critical Values



Critical values of the Chi-square distribution with *d* degrees of freedom

	Probability of exceeding the critical value						
d	0.05	0.01	0.001	*d*	0.05	0.01	0.001
1	3.841	6.635	10.828	11	19.675	24.725	31.264
2	5.991	9.210	13.816	12	21.026	26.217	32.910
3	7.815	11.345	16.266	13	22.362	27.688	34.528
4	9.488	13.277	18.467	14	23.685	29.141	36.123
5	11.070	15.086	20.515	15	24.996	30.578	37.697
6	12.592	16.812	22.458	16	26.296	32.000	39.252
7	14.067	18.475	24.322	17	27.587	33.409	40.790
8	15.507	20.090	26.125	18	28.869	34.805	42.312
9	16.919	21.666	27.877	19	30.144	36.191	43.820
10	18.307	23.209	29.588	20	31.410	37.566	45.315

Carr, S. M. (2013)

This study was submitted to the University of Washington IRB and received an exception due to low or minimal risk. However, possible ethical issues of my study were addressed by obtaining consent from each participant via a question on my survey they had to answer before they could take the survey. This question informed them of the possible benefits, who will have access to their data, and what will happen to the data once the study has concluded. While there are no immediate benefits to the participants, the study offers them a chance to participate in data collection that could be used for policy recommendations and to inform future research.

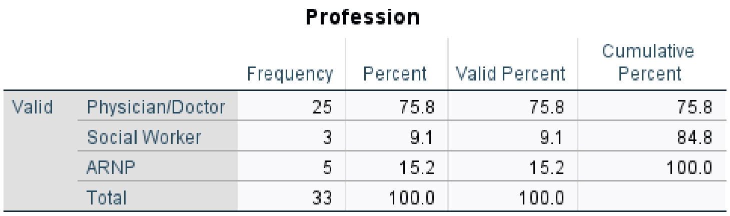
Chapter 4

Results and Discussion:

Independent Variable Frequencies:

Physicians/doctors, social workers, and ARNPs were the three professions who responded to the invitation to complete the survey. When filling out my survey, respondents self-identified their profession by typing in a text box. I recoded the answers to fit into the three categories of professions. The variable was named [PROFESSION].

Table 3: Profession Frequencies

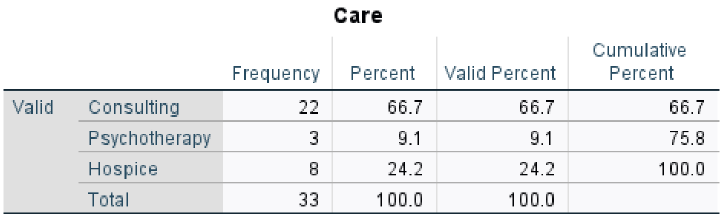


Profession

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Physician/Doctor	25	75.8	75.8	75.8
	Social Worker	3	9.1	9.1	84.8
	ARNP	5	15.2	15.2	100.0
	Total	33	100.0	100.0	

A majority, (75.8%), of the respondents to my survey were doctors as shown in Table 3. I had each profession identify what type of care they provided in a text box as well, which I recoded down to consulting, psychotherapy, or hospice care.

Table 4: Care Frequencies

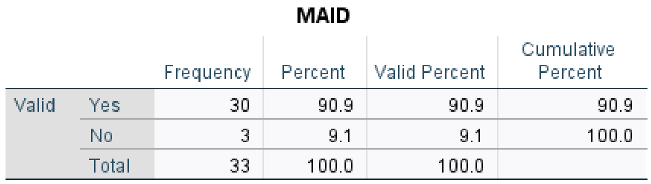


Care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consulting	22	66.7	66.7	66.7
	Psychotherapy	3	9.1	9.1	75.8
	Hospice	8	24.2	24.2	100.0
	Total	33	100.0	100.0	

In Table 4, most of the respondents identified themselves as consulting doctors (66.7%). Respondents answered if they are able to provide Medical Aid in Dying assistance (MAID) to patients by typing either yes or no. The MAID variable was only used as a selection variable due to the fact that there was such a low percentage that identified themselves as not providing Medical Aid in Dying care. The data was compiled into Table 5.

Table 5: MAID Frequencies



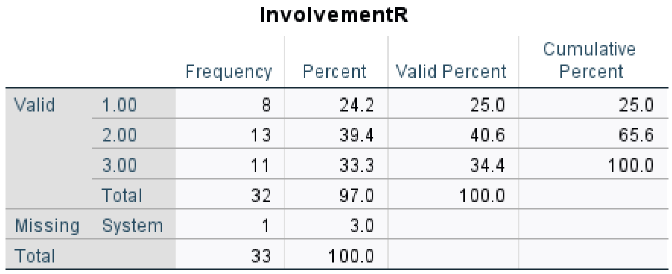
MAID

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	30	90.9	90.9	90.9
	No	3	9.1	9.1	100.0
	Total	33	100.0	100.0	

A large majority of respondents, (90.9%), said they would/had provided MAID care.

The last independent variable was Involvement. This variable, unlike my other independent variables, was ordinal. I had each person rank their involvement with a patient's end-of-life process. I used this variable to run Spearman correlations with my data. I recoded the variable because no one answered 1 on the scale that they were not involved in the end-of-life process and I wanted each possible answer represented in the data. 1-3 was recoded to 1, 4 to 2, and 5 to 3. Recoding the variables allows for proper representation of the data due to the fact that for most of the variables, not every answer was chosen, so the degrees of freedom wouldn't be properly represented. The frequency table is represented by Table 6.

Table 6: InvolvementR Frequencies



InvolvementR

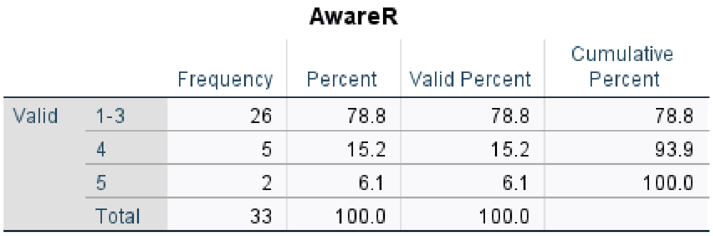
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	8	24.2	25.0	25.0
	2.00	13	39.4	40.6	65.6
	3.00	11	33.3	34.4	100.0
	Total	32	97.0	100.0	
Missing	System	1	3.0		
Total		33	100.0		

Dependent Variable Frequencies:

Due to the nature of me asking my participants to rate their responses on a scale of 1 to 5, not every answer was selected. To properly represent that each number was a possible answer, chosen or not, I recoded the variables similarly to how I recoded the independent variable Involvement. 1-3 was recoded to 1, 4 to 2, and 5 to 3. By grouping the survey responses to this question I was able to adjust for response categories with 0 participants.

My first dependent variable was Awareness, a variable that asks participants how aware they believe their patients are of the end-of-life process Washington State provides.

Table 7: AwareR Frequencies



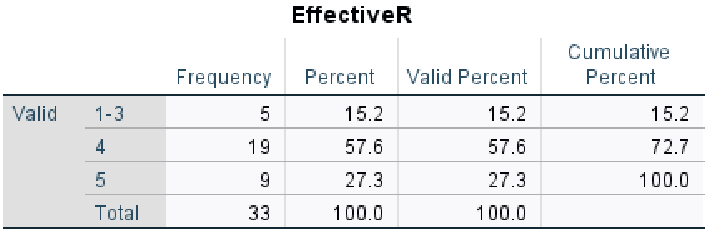
AwareR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-3	26	78.8	78.8	78.8
	4	5	15.2	15.2	93.9
	5	2	6.1	6.1	100.0
	Total	33	100.0	100.0	

Only a small portion of the participants (6.1%) believe that their patients are the most aware of the Medical Aid in Dying laws that Washington State provides, as seen in Table 7.

The second dependent variable was Effectiveness, this question asked the participants to rank how effective they feel Washington State's end-of-life process is.

Table 8: EffectiveR Frequencies



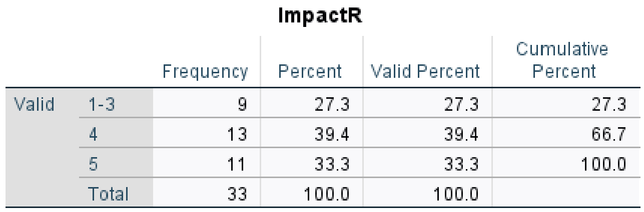
EffectiveR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-3	5	15.2	15.2	15.2
	4	19	57.6	57.6	72.7
	5	9	27.3	27.3	100.0
	Total	33	100.0	100.0	

A little over ¼ of the respondents (27.3%) said they believe Washington State’s Medical Aid in Dying Laws are Most Effective (Table 8).

The third dependent variable was impactful, which was shortened to Impact. I had them rate how impactful they feel the Medical Aid in Dying Laws are in Washington State.

Table 9: ImpactR Frequencies



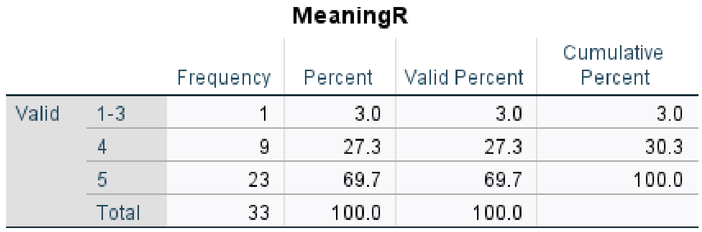
ImpactR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-3	9	27.3	27.3	27.3
	4	13	39.4	39.4	66.7
	5	11	33.3	33.3	100.0
	Total	33	100.0	100.0	

One-third of participants (33.3%) thought that Washington State Medical Aid in Dying Laws are “Most Impactful” (Table 9).

Meaningful, shortened to Meaning, asked participants how meaningful they felt Washington State’s Medical Aid in Dying laws are.

Table 10: MeaningR Frequencies



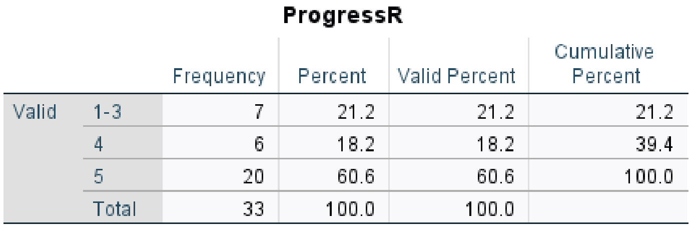
MeaningR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-3	1	3.0	3.0	3.0
	4	9	27.3	27.3	30.3
	5	23	69.7	69.7	100.0
	Total	33	100.0	100.0	

Over two-thirds (69.7%), believe Washington State has the “Most Meaningful” medical aid in dying laws (Table 10).

Of the participants, a large portion of them (60.6%) strongly agree that Washington State’s Medical Aid in Dying laws should be more progressive. This variable was shortened to Progress (Table 11).

Table 11: ProgressR Frequencies

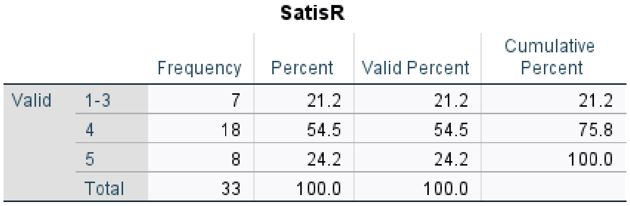


ProgressR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-3	7	21.2	21.2	21.2
	4	6	18.2	18.2	39.4
	5	20	60.6	60.6	100.0
	Total	33	100.0	100.0	

Almost one-fourth of participants (24.2%) are “Most Satisfied” with Washington State’s MAID laws. This variable was shortened to Satis (Table 12).

Table 12: SatisR Frequencies

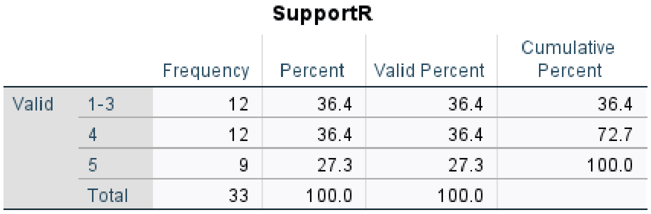


SatisR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-3	7	21.2	21.2	21.2
	4	18	54.5	54.5	75.8
	5	8	24.2	24.2	100.0
	Total	33	100.0	100.0	

Over one-fourth of participants (27.3%) believe that Washington’s MAID laws are the “Most Supportive” of patients. This variable was shortened to Support (Table 13).

Table 13: SupportR Frequencies



SupportR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-3	12	36.4	36.4	36.4
	4	12	36.4	36.4	72.7
	5	9	27.3	27.3	100.0
	Total	33	100.0	100.0	

Significant Results:

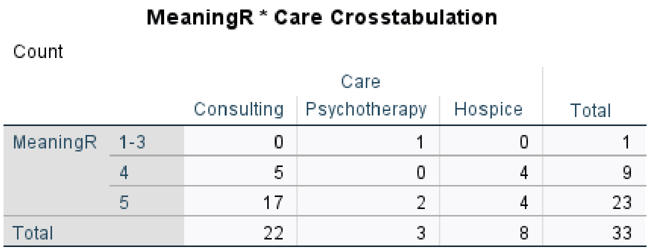
When running the Chi-Square test between the independent variable Care and each dependent variable, two of the tests came out significant: MeaningR (X^2= 13.13; df=4; p=.011)and SatisR (X2=13.17; df=4; p=.01). MeaningR and SatisR both have the R in the variable name to represent that it has been recoded. Table 14 represents the significance of each of the dependent variables when a chi-square test was run between them and the independent variable.

Table 14: Care Chi-Square Test Significance

Dependent	Significance
AwareR	0.349
EffectiveR	0.419
ImpactR	0.691
MeaningR	0.011
ProgressR	0.082
SatisR	0.01
SupportR	0.072

When running the cross-tabulation between MeaningR and Care so we can interpret what the significance means, it produced Table 15.

Table 15: MeaningR and Care Cross Tabulation



MeaningR * Care Crosstabulation

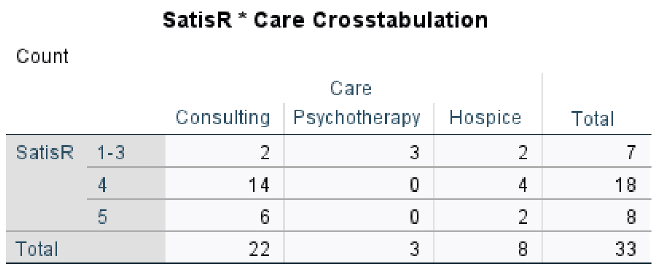
Count

		Care			
		Consulting	Psychotherapy	Hospice	Total
MeaningR	1-3	0	1	0	1
	4	5	0	4	9
	5	17	2	4	23
Total		22	3	8	33

Consulting were more likely to pick 5s as their answer, while the other two types of care were more spread out.

When running the crosstabs between SatisR and Care, Table 16 was produced.

Table 16: SatisR and Care Crosstabulation



SatisR * Care Crosstabulation

Count

		Care			
		Consulting	Psychotherapy	Hospice	Total
SatisR	1-3	2	3	2	7
	4	14	0	4	18
	5	6	0	2	8
Total		22	3	8	33

This table shows that consulting and hospice were more likely to pick 4 as their answer, while psychotherapy didn't pick any higher numbers.

When running cross tabulations between the independent variable Profession and each dependent variable, no results were statistically significant as shown in Table 17.

Table 17: Profession Chi-Square Test Significance

Dependent	Significance
AwareR	0.584
EffectiveR	0.722
ImpactR	0.3
MeaningR	0.212
ProgressR	0.372
SatisR	0.154
SupportR	0.996

The Spearman correlations between InvolvementR and each dependent variable produced two statistically significant results: AwareR (R_s([30])= [.357], p= .045) and MeaningR (R_s([30]=[-.464], p=.007). This is shown in Table 18.

Table 18: InvolvementR and Dependent Variable's Coefficient and Significance

Dependent	Coefficient	Significance
AwareR	0.357	0.045
EffectiveR	-0.204	0.262
ImpactR	-0.041	0.822
MeaningR	-0.464	0.007
ProgressR	0.319	0.075
SatisR	-0.198	0.276
SupportR	-0.188	0.303

The positive correlation between InvolvementR and AwareR is one of medium strength due to the fact the correlation coefficient lies in the range of 0.3-0.5. It is significant at the p=.05 level. InvolvementR and MeaningR are negatively correlated at a significance level of p= .01. The strength of the relationship is medium as well.

When MAID was used as a selector variable, meaning that only cases where people answered yes (1) or no (2) were selected, slight changes in the data can be observed. There were 30 respondents when MAID=1. Care produced no statistically significant results when the selector variable of MAID was set to 1, removing three data points from the set.

Table 19: Care Chi-Square Significance when MAID=1

Dependent	Significance
AwareR	0.418
EffectiveR	0.525
ImpactR	0.394
MeaningR	0.311
ProgressR	0.173
SatisR	0.186
SupportR	0.359

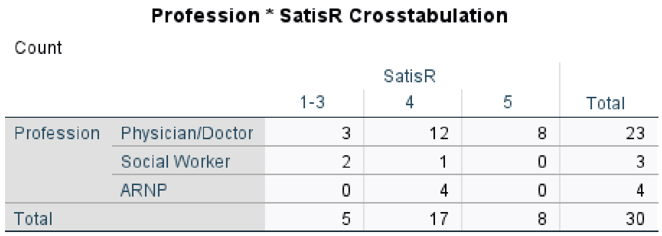
Without the selector variable, SatisR and MeaningR produced significant results. With MAID as the selector, SatisR changes from a p=0.01 (df=4) to a p=0.186 (df=4). MeaningR changes from a p=.011(df=2) to p=.311 (df=2).

With Profession previously before the selector variable, no variables were significant. With MAID=1, SatisR becomes significant at exactly p=.05 as opposed to the original value of p=0.154. When running the crosstabulation, it shows that only people who identified as physicians/doctors said they were the most satisfied with the law.

Table 20: Profession Chi-Square Significance when MAID=1

Dependent	Significance
AwareR	0.595
EffectiveR	0.572
ImpactR	0.351
MeaningR	0.968
ProgressR	0.3
SatisR	0.05
SupportR	0.99

Table 21: SatisR and Profession Crosstabulation when MAID=1



Profession * SatisR Crosstabulation

Count

		SatisR			
		1-3	4	5	Total
Profession	Physician/Doctor	3	12	8	23
	Social Worker	2	1	0	3
	ARNP	0	4	0	4
Total		5	17	8	30

With the Spearman Correlations with Involvement, originally without the selector variable, both AwareR (R_s([30])= [.357], p= .045) and MeaningR (R_s([30]=[-.464], p=.007) were significant. With the selector variable, this stays the same. The significance for

AwareR changes from p=.045 to p=.042 and MeaningR from p=.007 to p= .027. Notably, the significance level changes for MeaningR from p=.001 to p=.05.

Table 22: InvolvementR Spearman's Coefficients and Significance when MAID=1

Dependent	Coefficient	Significance
AwareR	0.38	0.042
EffectiveR	-0.166	0.389
ImpactR	-0.122	0.564
MeaningR	-0.409	0.027
ProgressR	0.362	0.053
SatisR	-0.239	0.211
SupportR	-0.194	0.312

There were only three respondents who answered MAID=2, or no, to the MAID question on the survey. No statistical analysis was substantial or conclusive with only three data points.

Discussion:

Before the selector variable of whether a participant provides Medical Aid in Dying Care (called MAID), the specific profession a participant possessed had no influence on their choices. This means that there is no difference between Physicians/Doctors, Social Workers, and ARNPS in the data. When you select only those in the profession that have/are able to provide MAID care, however, it shows a trend in the table that physicians/doctors are more likely to be the most satisfied with Medical Aid in Dying laws compared with the other professions. This implies that physicians/doctors who provide MAID care are more satisfied with the laws than the other professions who also provide MAID care.

With the Care variable, and without the selector, two results were significant. MeaningR and SatisR both showed significance at the p=.05 level. This means that the type of care the respondent provides correlates with how meaningful they believe the law is and how satisfied they are with the law. With the selector variable, however, those two variables are not significant. The selector variable essentially takes out the three cases of people not providing MAID care in the data set. This can be interpreted as those who are more directly involved in providing MAID care having more varied views than those who do not provide MAID care.

For the Involvement independent variable, two results were significant with and without the selector variable. AwareR and MeaningR both showed medium correlation strength in both cases. AwareR has a positive correlation without the selector variable, this implies that the more involved a respondent is in the end-of-life process, the more likely they are to believe their patients are aware of the Medical Aid in Dying laws. MeaningR has a negative correlation without the selector variable, this shows that the more involved they believe they are, the less likely they are to believe the Medical Aid in Dying laws are meaningful.

Chapter 5

Conclusion:

The purpose of my study was to determine if there was variance between the types of medical professionals in Washington State and their opinions on Medical Aid in Dying (MAID) laws. I separated this into different professions (physician/doctor, social worker, ARNP), different care types (consulting, psychotherapy, and hospice), and if they provided MAID care (yes or no).

I hypothesized that the more involved a physician was in the end-of-life process, the more skeptical they would be about the law. This was shown to be true by InvolvementR having a negative correlation coefficient with the MeaningR variable. The specific implications of it being meaning that showed a correlation instead of ImpactR of EffectiveR though is interesting. This shows that there is no strong correlation between if a medical professional finds the laws effective or impactful, but there is evidence to show that they are less likely to find the law meaningful. Meaningful can be defined as "having a serious, important, or useful quality or purpose" (Oxford Languages). By saying you don't find something meaningful, specifically not finding a law meaningful, you can infer from the dictionary definition that they believe the law doesn't have good quality or purpose.

The data does show that those who are physicians/doctors and provide MAID care are more likely to pick 4's on a scale of 1 to 5 and are the only profession to choose 5s at all on the level of satisfaction question. You can conclude from this that MAID-providing physicians/doctors are satisfied with the law.

The type of care provided only produced significant results without the selector variable. For the variable MeaningR, providers that identified as providing consulting care were more likely to answer that they find the Medical Aid in Dying laws more meaningful compared to the other two types of care. For SatisR, psychotherapy didn't answer anything above a 3, while hospice and consulting had a preference for 4s. When selecting only cases of those who provide MAID, these trends disappear. Notably, only one person in the psychotherapy care type identified themselves as providing MAID care.

It is difficult to compare my findings to those I discuss in my literature review. While their studies were interesting to frame my data with, none of the responses can be directly compared to mine. My data supports that MAID-providing physicians are, to at least some extent, satisfied with the law. Physicians in general, though, are not. This can be compared to Mangino's study where they show that more education on the subject leads to lower approval. Theirs, though, was surveying the general American population, mine is just medical professionals. Also, the lack of correlation found between profession, care, and involvement with how progressive they believe the law should be shows that there is no conclusive evidence according to my data to show that the law becoming more progressive is a worry in Washington State.

From the data, it shows that people who provide psychotherapy are less likely to be satisfied with the Medical Aid in Dying process. I would suggest further research into why this is the case specifically. I propose a study in which a survey is conducted with psychotherapy care providers and get their opinions on the law and how they are represented in the law's process. I would hypothesize that they feel left out of the whole process due to the lack of specific language including them. Those who identified as being more involved in the end-of-life process consistently showed, with or without the selector variable, that they are dissatisfied with the law. A study would need to be conducted to pinpoint the exact reason.

The limitations of my experiment lie mainly with the language I chose to use with my survey. I asked for opinions using keywords such as meaningful and impactful, but I failed to provide a definition of these words. With so much data relying on these words, I would question the internal validity. When writing the questions, I assumed there was a universally understood definition of these words, but after receiving some feedback, I found that many respondents found the word choice vague and confusing. If I were to redo the survey, I would use more concise language and/or provide dictionary definitions of keywords.

I received a total of n=33 responses. While this was a pilot study, a larger sample size is needed for more generalizable results. Data analysis for my MAID variable in particular suffered due to the lack of responses on certain items and as a result I had to recode some variables due to the fact not every answer on the scale was chosen. Some questions had two missing number answers from its data set.

My findings have external validity because there is application in the real world for my data. Showing that there is dissatisfaction with the Medical Aid in Dying process among those who believe they are very involved with it is vital in pushing for further change in the law. Also, showing that different professions and care types have a difference in views can highlight the weaknesses in the law. From my data, you can assume people within psychotherapy care have different views than a consulting physician/doctor. With further research into why, this could lead to genuine policy change.

Overall, my research acts as a starting point when it comes to analyzing how medical professionals feel about Medical Aid in Dying laws in Washington State. With the new changes in the laws, there is some uncertainty on if we should further rework it. I believe my data shows further work is required on the law, more research needs to be done to conclude what exactly that change needs to be though. My data by itself points in a direction, it’s up to further research to determine how medical professionals believe it should be changed.

Appendices

Survey:

This research is a part of my final project for my Master's in Policy Studies program. I am reaching out for this survey as a way of collecting data for my project. You are being asked to fill out the survey due to your contact as a medical professional in the field that helps people participate in Medical Aid in Dying in Washington State. The purpose of this form is to give you the information you will need to help you decide whether to be in the study or not. If you have any questions about the study, its purpose, the possible risks and benefits, your rights as a responder, and anything else about the research or this form that is not clear, please feel free to ask. While there are no immediate benefits to you, the findings from this study will serve as valuable data to the University and as a basis for possible policy implementation to appropriate organizations, bodies, or policy professionals. There are no plans to provide results to participants. Only the researcher listed on this form will have access to the data you provide. All data will remain confidential and will not be provided to any individuals or organizations until deleted after the study is concluded. This survey will take 5-10 minutes. If you have questions or would like a copy of the consent form, please email Mkh2002@uw.edu.

I agree to allow the University of Washington researcher to collect my responses and identifiers for research about Medical Aid in Dying in Washington State. *

Identifier Questions:

1. What is your Profession? (Nurse, Doctor, etc.)
2. What kind of care do you provide your patients with? (Hospice, Prescribing Doctor, etc.)

3. Do you provide Medical Aid in Dying Assistance?
4. On a scale of 1 to 5, how would you rate your overall involvement in a patient's end-of-life process?

Opinion Section:

Link to the Law:

https://doh.wa.gov/data-and-statistical-reports/health-statistics/death-dignity-act

Link to a Summary:

https://endoflifewa.org/wp-content/uploads/2023/07/WA.DWDA_.An_.Overview.for_.Patients.and_.Families-07-26-2023.pdf

5. On a scale of 1 to 5, how would you rate the overall effectiveness of Washington State's Medical Aid in Dying laws?
6. On a scale of 1 to 5, how would you rate your overall satisfaction with the Medical Aid in Dying law in Washington State as written?
7. On a scale of 1 to 5, how would you rate the overall meaningfulness of Washington State's Medical Aid in Dying laws and practices?
8. On a scale of 1 to 5, how would you rate your patient's awareness of Medical Aid in Dying laws in Washington State?
9. On a scale of 1 to 5, how much support do you think Washington State's Medical Aid in Dying laws give to patients?
10. On a scale of 1 to 5, how would you rate the overall impactfulness of Washington State's Medical Aid in Dying laws?

11. On a scale of 1 to 5, rate how much you agree or disagree with the following statement: Washington State should make Medical Aid in Dying laws more progressive

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