Characteristics	2017 (N=143)	1998–2016 (N=1,132)	Total (N=1,275)
DWDA process			
Referred for psychiatric evaluation (%)	5 (3.5)	57 (5.1)	62 (4.9)
Patient informed family of decision (%)[3]	139 (97.9)	982 (93.1)	1,121 (93.7)
Patient died at			
Home (patient, family or friend) (%)	129 (90.2)	1,052 (93.4)	1,181 (93.1)
Long term care, assisted living or foster care facility (%)	13 (9.1)	55 (4.9)	68 (5.4)
Hospital (%)	0 (0.0)	4 (0.4)	4 (0.3)
Other (%)	1 (0.7)	15 (1.3)	16 (1.3)
Unknown	*0*	*6*	*6*
Lethal medication			
Secobarbital (%)	71 (49.7)	676 (59.7)	747 (58.6)
Pentobarbital (%)	0 (0.0)	386 (34.1)	386 (30.3)
Phenobarbital (%)	6 (4.2)	57 (5.0)	63 (4.9)
Morphine sulfate (%)	66 (46.2)	6 (0.5)	72 (5.6)
Other (%)	0 (0.0)	7 (0.6)	7 (0.5)
End of life concerns[4]	**(N=143)**	**(N=1,132)**	**(N=1,275)**
Losing autonomy (%)	125 (87.4)	1,029 (91.4)	1,154 (90.9)
Less able to engage in activities making life enjoyable (%)	126 (88.1)	1,011 (89.7)	1,137 (89.5)
Loss of dignity (%)[5]	96 (67.1)	769 (76.9)	865 (75.7)
Losing control of bodily functions (%)	53 (37.1)	526 (46.8)	579 (45.7)
Burden on family, friends/caregivers (%)	79 (55.2)	475 (42.2)	554 (43.7)
Inadequate pain control or concern about it (%)	30 (21.0)	297 (26.4)	327 (25.8)
Financial implications of treatment (%)	8 (5.6)	39 (3.5)	47 (3.7)
Health-care provider present (collected since 2001)	**(N=143)**	**(N=1,062)**	**(N=1,205)**
When medication was ingested[6]			
Prescribing physician	24	163	187
Other provider, prescribing physician not present	24	270	294
No provider	6	91	97
Unknown	*89*	*538*	*627*
At time of death			
Prescribing physician (%)	23 (16.1)	149 (14.3)	172 (14.6)
Other provider, prescribing physician not present (%)	19 (13.3)	295 (28.4)	314 (26.6)
No provider (%)	101 (70.6)	595 (57.3)	696 (58.9)
Unknown	*0*	*23*	*23*
Complications[6]	**(N=143)**	**(N=1,121)**	**(N=1,264)**
Difficulty ingesting/regurgitated	1	24	25
Seizures	2	0	2
Other	1	6	7
None	38	554	592
Unknown	*101*	*537*	*638*

Table 3. Death with Dignity Act process for the participants who have died

	2017		2016		2015[1]	
	Number	%	Number	%	Number	%
Family and Psychiatric/Psychological involvement						
Referred for psychiatric/psychological evaluation[2]	4	2	11	5	8	4
Patient informed family of decision[3]	174	94	224	95	174	93
Medication[4]						
Secobarbital	66	34	77	32	109	51
Pentobarbital	0	0	2	1	4	2
Secobarbital/Pentobarbital Combination	0	0	0	0	0	0
Phenobarbital	0	0	2	<1	10	5
Phenobarbital/Chloral Hydrate Combination	0	0	106	44	88	41
Chloral Hydrate	0	0	1	<1		
Morphine sulfate	130	66	53	22	4	2
Other	0	0	1	<1	0	0
Timing						
Duration of patient-physician relationship[5]						
<25 weeks	94	51	125	52	99	49
25 weeks – 51 weeks	21	11	25	10	18	9
1 year or more	71	38	88	37	81	40
Unknown	0	0	2	1	4	2
Range (min – max)	<1 wk – 38 yrs		<1 wk – 31 yrs		<1 wk – 2 yrs	
Duration between first oral request and death[6]						
<25 weeks	167	90	209	88	164	81
25 weeks or more	18	10	28	12	33	16
Unknown	0	0	0	0	5	2
Range (min – max)	2 wks – 81 wks		2 wks – 112 wks		0 wks – 95 wks	

Notes:

1. Data published in 2016 report: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.
2. Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
3. Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.
4. Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 196 participants in 2017 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.
5. Data are collected from the After Death Reporting form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
6. Data are collected from the After Death Reporting form and Attending physician Compliance Form. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.

Washington State

Speak to a Morphine Intake Coordination Specialist now.

(tel:352-771-2700)

+ What to expect when I call?

Morphine Sulfate

As mentioned above, morphine is found in or is the precursor of many other medicines. It also has many variants of its own. One such variety is known as morphine sulfate. What exactly constitutes the difference between conventional morphine and morphine sulfate? Not much at all, as it turns out. Morphine sulfate, as the name implies, is manufactured with an additional sulfate component within its chemical makeup — sulfates are more commonly referred to as salts. Morphine is not easily soluble in water in its base form. Sulfates, on the other hand, are highly water-soluble. When both are put together, morphine is more readily absorbed at the source of pain. Essentially, morphine sulfate allows the body to use morphine more efficiently.

Morphine Sulfate Side Effects

All prescription medications come with potential side effects, and morphine sulfate is no different. However, because morphine is an opioid, special care must be given in the use of such compounds. This is mainly due to the increased likelihood of patients developing unintended tolerances to the drug. Once a tolerance is built up, more of the medicine must be used to achieve the desired effect. The more that morphine is used, the more unpredictable the reactions and greater the concerns become. Though not technically a side effect in the traditional sense, an individual may end up with a dangerous substance use disorder after extended morphine sulfate usage. The rate of which an adverse side effect may emerge is