

Washington's Death With Dignity Act: Impacts On Integrated Health Care Delivery Systems

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Note: The opinions expressed herein are solely those of the author, and are not intended to reflect the policies or viewpoints of the author's employer or any other health care entity in Washington State.

I. Integrated Delivery Models

The concept of an “integrated health care delivery system” is relatively new. Most members of the public tend to think of “hospitals as hospitals” and “doctors as doctors” and probably do not realize the level of integration and systemization that has taken place over the past two decades.

In Washington State, many health care organizations designate themselves as integrated delivery systems, integrated delivery networks, or the like. The most well recognized such system is undoubtedly Group Health Cooperative, which has provided an integrated delivery methodology for much longer than any other organization in the state.

Within an integrated delivery model, one can expect to find what amounts to “birth to death” treatment options, representing the complete range of health care services and support one might need throughout an entire lifetime. For instance, among the departments or internal operating units within an integrated delivery system, you might find:

- Obstetrics & Gynecology Services
- Maternal – Fetal Care (Labor & Delivery)
- Neonatal Intensive Care
- Pediatric Intensive Care
- Pediatric Outpatient Care
- Pediatric Acute Care (Hospitalization)
- Adolescent Medicine
- Adult Outpatient Medicine
- Adult Acute Care (Hospitalization)
- Ancillary Services
 - Pharmacy Services
 - Laboratory Services

- Imaging Services
- Interventional Programs
 - Interventional Radiology
 - Nuclear Medicine
- Palliative Care
- Hospice & Home Health Care
- Specialists & Sub-Specialists, such as
 - Adolescent medicine specialist
 - Allergist (immunologist)
 - Anesthesiologist
 - Cardiac electrophysiologist
 - Cardiologist
 - Cardiovascular surgeon
 - Colon and rectal surgeon
 - Critical care medicine specialist
 - Dermatologist
 - Developmental pediatrician
 - Diagnostic radiologist
 - Emergency medicine specialist
 - Endocrinologist
 - Family medicine physician
 - Forensic pathologist
 - Gastroenterologist
 - Geriatric medicine specialist
 - Gynecologist
 - Gynecologic oncologist
 - Hand surgeon
 - Hematologist
 - Hepatologist
 - Hospitalist
 - Hyperbaric physician
 - Infectious disease specialist
 - Internist
 - Interventional cardiologist
 - Medical ethicist
 - Medical geneticist
 - Medical oncologist
 - Neonatologist
 - Nephrologist
 - Neurological surgeon
 - Neurologist
 - Nuclear medicine specialist
 - Obstetrician
 - Occupational medicine specialist
 - Oncologist
 - Ophthalmologist
 - Oral surgeon (maxillofacial surgeon)
 - Orthopedic surgeon
 - Osteopath
 - Otolaryngologist (ear, nose, and throat specialist)
 - Pain management specialist
 - Palliative Care specialist
 - Pathologist
 - Pediatrician
 - Perinatologist
 - Physiatrist
 - Plastic surgeon
 - Preventive medicine specialist
 - Psychiatrist
 - Pulmonologist
 - Radiation oncologist
 - Radiologist
 - Reproductive endocrinologist
 - Rheumatologist
 - Sleep disorders specialist
 - Spinal cord injury specialist
 - Sports medicine specialist
 - Surgeon
 - Surgical Hospitalist
 - Thoracic surgeon
 - Urologist
 - Vascular surgeon

II. Death With Dignity & Health Care Facilities

Washington's Death With Dignity Act, ("Initiative 1000", "I-1000" or the "Act"), recognizes the distinction between health care providers such as physicians, and hospitals or other health care settings such as long term care facilities (skilled nursing facilities, intermediate care units, etc.). And, in doing so, recognizes that some health care facilities may elect not to allow physicians to support patient's activities undertaken pursuant to I-1000 within their facilities.

A. Facilities "Opting In"

For hospitals and/or integrated delivery systems that are open to allowing I-1000 activities within their facilities, no substantive action is required, although hospitals will need to amend or modify their policies and procedures to accommodate I-1000, at least to some degree. I-1000 becomes effective on March 4, 2009.

By way of example, I-1000 defines health care provider in Section 1 as:

(6) "**Health care provider**" means a person licensed, certified, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession, and *includes a health care facility*.

Separate from "Health Care Provider", the Act defines

(2) "**Attending physician**" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

and

(4) "**Consulting physician**" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

Within the context of any patient's terminal disease, a patient could be primarily attended to by any of the several different "ologists" described above, each of whom could potentially become the primary physician attending to a patient's Terminal Disease processes, which are defined as:

(13) "**Terminal disease**" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

As with any other circumstance in which multiple parties are involved, one can well imagine circumstances where reasonable minds might differ as to who constitutes the "Attending Physician" as well as whether or not the patient's disease status has risen to the level meeting the definition of a "Terminal Disease" process.

Likewise, there will be circumstances where a determination as to whether an individual constitutes a “Qualified Patient” may present challenges to a health care facility. By way of example, if a “Patient” (“a person who is under the care of a physician”) elects to terminate his or her primary healthcare provider, and has not identified a new provider, such a person arguably does not constitute a “Qualified Patient” even if such person might have been qualified at an earlier time in their disease cycle.

Consequently, even for health care facilities who determine that they will allow patients to exercise their statutory rights under the Act within the confines of their facilities, such organizations will need to become familiar with the nuances of I-1000 and make sure that they have adequate processes in place to capture all of the requisite documentation needed to demonstrate compliance with the Act at all points in which a Qualified Patient is enabled to undertake actions within the scope of the Act while within such organization’s facilities, or there would be the potential that the statutory immunities granted under Section 19 of the Act would not be applicable.

Section 18 of the Act makes it clear that:

(2) Nothing contained in this chapter shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist or psychologist, or other health care provider participating under this chapter.

Unless policies and procedures within healthcare facilities are brought into alignment with the provisions of I-1000, there remains the potential that a facility, attempting to support I-1000 patient rights and activities, could inadvertently fail to abide by its own conflicting policies and procedures, leading to a claim of neglect by a patient’s estate or statutory survivors.

Section 9 of the Act mandates that a patient make *both* an **oral request** and a **written request**. Does this imply that patients who are unable to speak, but who are otherwise cognizant, are precluded under the Act?

Section 9 of the Act mandates a fifteen (15) day waiting period between the patient’s initial request in writing and orally, and a second encounter in which the patient must orally reiterate the request. Assuming a patient may be discharged from hospital care during this interval, does a hospital-based physician such as a hospitalist or oncologist continue to qualify as the primary treating provider, if the patient’s care has been handed off to other post-discharge providers? And if not, must the “new” providers force the patient to go through a second 15-day waiting period?

Section 12 of the Act mandates specific clinical record documentation, which will require hospitals “opting in” to ensure that each of the data elements required by Section 12 and other parts of the Act are set forth in the facility’s medical record.

Section 23 of the Act mandates certain data collection and reporting for providers participating under the Act.

Documentation requirements under the Act include many specified details which should be available within the patient's chart or medical record, including:

1. Documentation Related to the Patient's Request:

Document through the statutory form set forth in Section 22 of the Act, that the Patient is requesting medications under the Act.

2. Documentation Related to the Attending Physician:

Document fulfillment of the duties of the Attending Physician who shall:

- a. Make the initial determination of whether a patient:
 - i. Has a terminal disease?
 - ii. Is competent?
 - iii. Has made a request voluntarily?
- b. Has confirmed the patient's residency under the Act.
- c. Inform the patient, for informed consent purposes, of:
 - i. The patient's medical diagnosis
 - ii. The patient's prognosis
 - iii. The potential risks associated with taking the prescribed medication(s) under the Act
 - iv. The probable result of taking the prescribed medication; and
 - v. The feasible alternatives, including but not limited to:
 1. Comfort care
 2. Hospice care
 3. Pain control
- d. Refer the patient to a consulting physician for:
 - i. Medical confirmation of the diagnosis
 - ii. A determination that the patient is competent and
 - iii. Determination that the patient is acting voluntarily
- e. Refer the patient for counseling if appropriate under Section 6 of the Act
- f. Recommend that the patient notify next of kin
- g. Counsel the patient about the importance of:
 - i. Having another person present when taking the medication; and
 - ii. Not taking the medication in a public place
- h. Inform the patient
 - i. of his or her opportunity to rescind the request at any time and in any manner; and
 - ii. Offer the patient an opportunity to rescind at the end of the fifteen-day waiting period under Section 9 of the Act
- i. Verify, immediately before writing the prescription for medication under the Act, that the patient is making an informed decision
- j. Fulfill the medical record documentation requirements of Section 12 of the Act
- k. Ensure that all appropriate steps are carried out in accordance with the Act before writing a prescription for medication intended to enable the patient to end his or her life in a humane and dignified manner

1. Dispense the medications:
 - i. Directly, if authorized under statute and rule to dispense and holding DEA certificate; or
 - ii. With patient's permission:
 1. Contact pharmacist and inform of prescription
 2. Deliver written prescription to dispensing pharmacist and make arrangements for the pharmacist to dispense directly to the patient or patient's agent, or to the Attending Physician
 - m. Document (by the Attending Physician) that all requirements under the Act have been met and specify the steps taken to carry out the request including a notation of the medication(s) prescribed.
 - n. Sign the death certificate which shall list the underlying terminal disease as the cause of death (unless another physician has signed the death certificate.)
 - o. Note: If the Attending Physician elects to attend to the patient at the time the prescribed medications are ingested, the Attending Physician would be prudent to document:
 - i. The fact of the Physician's presence during the patient's ingestion of prescribed medications;
 - ii. The identity of others present;
 - iii. The fact that the Physician did not assist the patient in taking the prescribed medications;
 - iv. The acts or statements of the patient, as observed by the Attending Physician, at the time of ingestion, and the patient's noted reaction to the medications subsequent to ingestion; and
 - v. Any acts of the Attending Physician after death of the patient undertaken at the scene of the patient's death.
3. **Documentation Related to the Consulting Physician:**

Document fulfillment of duties of the Consulting Physician, who shall:

 - a. Examine the patient;
 - b. Examine the patient's relevant medical records;
 - c. Confirm, in writing, the Attending Physician's diagnosis that the patient is suffering from a terminal disease; and
 - d. Verify that the patient is competent, acting voluntarily, and has made an informed decision.
4. **Depression or Psychiatric / Psychological Disorder:**

Document the presence or absence of psychiatric or psychological disorders, or depression causing impaired judgment. If either the Attending Physician or the Consulting Physician determines that the patient is suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either of them shall refer the patient for counseling. Medication shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. (A report of the outcome and

determinations made during counseling should be documented in the patient's medical record.)

5. **Informed Decision:** Document that the patient is making an informed decision.
6. **Family Notification:** Document that the Attending Physician recommended that the patient notify his or her family, and if family is not informed, document that the Patient declined or was unable to notify family.
7. **Written & Oral Requests:** Document:
 - a. That the patient initially made both written and oral requests for medications under the Act;
 - b. That fifteen (15) days have passed;
 - c. That the patient has reiterated the request at least orally 15 or more days after the original request; and
 - d. That at the time of the patient's second oral request, the patient was given the opportunity to rescind the request.
 - e. That at least 48 hours have elapsed between the date that the patient signed the written request and the writing of a prescription under the Act. [Author's note: This seems to be a drafting error, as 15 days must pass between the first oral request and the second oral request, so it would seem that few physicians would write the prescription sooner than expiration of the second oral request. Presumptively it was intended to allow a short waiting period after the second oral request prior to dispensing pharmaceuticals?]
8. **Disposal of Unused Medications.** Document that any medications dispensed under the Act that are not self-administered are disposed by lawful means.
9. **Filing of Dispensing Record.** Document that:
 - a. A copy of the dispensing record and other administratively required documentation specified by the Department of Health is mailed to DOH within 30 days of the prescription; and
 - b. Within 30 days after the death of the patient, submit any reports required by DOH.
10. **DOH Record-Keeping.** Document collection and/or transmission of all data required by DOH under the Act.

B. Facilities "Opting Out"

Hospitals and health systems that choose not to allow I-1000 activities within their facilities must prepare in different ways from those who "opt in."

To begin with, each hospital in Washington is defined, within I-1000, as a healthcare provider. See Section 1, Subpart 6, of the Act.

Section 19 of the Act authorizes a health care facility such as a hospital or skilled nursing facility to disallow I-1000 practices within such provider's facilities:

(2)(a) A health care provider may prohibit another health care provider from participating under this act on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under this act. This subsection does not prevent a health care provider from providing health care services to a patient that do not constitute participation under this act.

The Act further allows a health care facility to sanction any health care provider with privileges to practice at such facility, should they engage in actions under the Act while within the facility. Sanctions can include limitations, restrictions or potentially loss of practice privileges at such facility, and could potentially spill over to a lease termination or loss of access to clinical sites associated with such facility. See Section 19.

However, there are strong public policy statements contained within Section 19 that imply that "even if" an individual is employed by a prohibiting health care facility, public policy mandates that if such employee is "willing" to support activities under the Act, the employer cannot prohibit or restrict such employee from engaging in I-1000 activities outside of the course and scope of such employee's regular employment, at sites other than the prohibiting facility. This is a very rare and interesting intrusion upon the employer-employee relationship and would, by implication, raise some interesting questions for both the employer and employee. For example,

- Would employer-provided errors and omissions coverage, applicable to the employee's routine duties, cover actions undertaken outside of such individual's ordinary course of employment? It would seem unlikely that such coverage would extend to a provider's moonlighting activities, especially where such provider is clearly advised by his or her employer that such activities are not authorized within the scope of employment.
- Could the employer deny bonuses or benefits to those employees opting to engage in I-1000 activities outside of the ordinary course of employment? Are I-1000 activities specially protected, as against other social activities of employees undertaken outside of the work environment?
- Could the employer elect not to renew contracts of employment for those who routinely engage in I-1000 activities? It would seem not, if those activities were the sole or substantial reason for non-renewal?

Health care facilities intending to "opt out" of allowing I-1000 activities within their facilities must take special care to review all policies and procedures that relate to the patient's rights under I-1000. These include:

- Making sure that the patient's relevant medical records are transferred, along with the patient, to any downstream facility willing to facilitate the patient's request for I-1000 options. (Section 19 (1) (c))
- Notifying all health care providers with privileges at the facility of the provider's policy regarding participation under the Act. This will likely entail specific notices to each existing member of a hospital's medical staff, together with formal amendment or modification of existing Medical Staff Bylaws and Rules, reflecting the hospital's prohibition of I-1000 activities within the facility.
- Notifying the general public of the provider's policy regarding participation under the Act. This would likely require public notices, together with amendments to the hospital's Patient Rights Handbooks and potentially its Consent for Treatment Forms, in order to be able to document that each patient is reasonably informed of the hospital's policies related to the Act.
- Amending any leases or contracts pertaining to health care providers who are precluded from engaging in I-1000 activities at a hospital facility, if the hospital desires to impose sanctions in the form of contract termination or lease termination as a result of breach of the hospital's policies related to I-1000.
- Certain activities associated with informing patient's of their statutory rights under I-1000 are defined to "not constitute" activities under the Act. See Section 2 (d) (iii). Hospitals must ensure that those activities are not inadvertently included in definitions of prohibited acts associated with I-1000.
- Health care facilities gathering information pertaining to a patient's advance directives should clarify for any patient who has indicated a desire to access rights under I-1000, that such facility does not support I-1000 activities on its premises, and should offer to make arrangements to transfer the patient to an I-1000 compatible facility, when feasible to do so, if the patient reasonably anticipates accessing his or her rights under I-1000 during such hospitalization.

III. Related Statutes

There are a number of related Washington laws that touch upon issues surrounding patient care in end-of-life circumstances. Representative examples of existing statutory provisions that will of necessity touch upon I-1000 activities are included in Appendix B below.

IV. Case Law & Other Initiatives

Many health care related litigation proceedings are initiated by persons desiring to undertake treatment efforts on behalf of a patient. The most controversial of these cases tend to be those where there is a strong difference of opinion as to the patient's perceived wishes and desires as they relate to life-sustaining treatment.

There are innumerable sources of material on the *ethics* of withholding or withdrawing life support available to health care providers.

In the United States, the withholding and withdrawal of life support is legally justified primarily by the principles of informed consent and informed refusal, both of which have strong roots in the common law. The principles hold that treatment may not be initiated without the approval of patients or their surrogates excepting in emergency situations, and that patients or surrogates may refuse any or all therapies. The application of these principles to the care of the critically ill began in the *Quinlan* case . . .

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The *Quinlan* decision aptly summarized the issues facing the treating providers:

[W]e herewith declare the following affirmative relief on behalf of the plaintiff. ***Upon the concurrence*** of the guardian and family of Karen, ***should the responsible attending physicians conclude*** (emphasis added) that there is no reasonable possibility of Karen's ever emerging from her ***present comatose condition*** to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, ***they shall consult with the hospital "Ethics Committee" or like body of the institution*** in which Karen is then hospitalized. ***If that consultative body agrees*** that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others. We herewith specifically so hold.²

In essence, the *Quinlan* court left the decision to the patient's family and her treating physicians to resolve. This, at least in part, in deference to the ethical codes under which physicians practice the art of medicine:

The physician must be able to tell the antecedents, know the present, and foretell the future - must mediate these things, and have two special objects in view with regard to disease, namely, **to do good or at least to do no harm**. The art consists in three things - the **disease**, the **patient**, and the **physician**. Hippocrates, *Epidemics*

- ◆ The Disease
- ◆ The Patient
- ◆ The Physician

In response to the *Quinlan* case, and seemingly in response to every subsequent high-profile death and dying case that hits the media, state legislatures have enacted (and amended) *Death With Dignity* laws in an attempt to address the potential legal concerns

¹ Luce, John M. and Ann Alpers, Legal Aspects of Withholding and Withdrawing Life Support from Critically Ill Patients in the United States and Providing Palliative Care to Them, Am. J. Respir. Crit. Care Med., Volume 162, Number 6, December 2000, 2029-2032

² *In re the Matter of Quinlan*, 70 N.J. 10 (1976) reported at http://www.csulb.edu/~jvancamp/452_r6.html

raised in any environment where less-than-everything-possible in the way of medical care or treatment is to be provided.

Physicians were (and to this day, remain) understandably concerned about the prospects of facing the loss of their licenses, or even criminal charges, for the wrongful death of a patient, should they participate, even under the direction of a family, in withdrawing life support. Such fears are exacerbated in the context of undertaking affirmative life-ending activities such as those authorized by I-1000.

This dialogue, reported in a 1982 article in *The New York Times*, is indicative of the times:

Hospitals in New York City have asked state health officials to adopt regulations for withholding emergency life-saving procedures from terminally ill hospital patients who suffer cardiac or respiratory failure.

In a letter to Dr. David Axelrod, the State Commissioner of Health, the president of the Greater New York Hospital Association, Dr. S. David Pomrinse, said, "It would be a genuine and long-lasting contribution to everyone if you would initiate a regulatory approach to 'do not resuscitate' orders."

But Dr. Axelrod, who received the letter yesterday, said through a spokesman that he would not recommend or adopt any regulations "pending further study" of the highly sensitive issue. The spokesman, Peter Slocum, said Dr. Axelrod had no further comment.

The hospitals contend that without the protection of state regulations, many of them feel obliged to apply emergency life-saving procedures to dying patients who suffer cardiac or respiratory arrest - even if it violates the right of such patients to "die with dignity" - because of the fear of malpractice suits or criminal charges if the hospitals do not.

Subsequently, much has been written on these topics. In an effort to educate physicians on these issues and provide patients and families with appropriate choices in end-of-life decision-making, the American Medical Association developed a curriculum on this topic under the title "Education for Physicians on End-of-life Care (EPEC) which is described below:

Withholding or withdrawing life-sustaining therapies is ethical and medically appropriate in some circumstances. This article summarizes the American Medical Association's Education for Physicians on End-of-life Care (EPEC) curriculum module on withholding or withdrawing therapy. Before reviewing specific treatment preferences, it is useful to ask patients about their understanding of the illness and to discuss their values and general goals of care. Family physicians should feel free to provide specific advice to patients and families struggling with these decisions. Patients with decision-making capacity can opt to forego any medical

intervention, including artificial nutrition/hydration and cardiopulmonary resuscitation.³

Again, we see references within EPEC to:

- ◆ The Disease
- ◆ The Patient
- ◆ The Physician

Recently, we saw these same issues erupt in the media with the Terry Schiavo case. Despite the national attention this case derived, attempts at Congressional intervention and the efforts of the Governor of the State of Florida to prosecute, criminally, those he deemed responsible for the untoward death of Ms. Schiavo, we found the courts focusing upon:

- ◆ The Disease
- ◆ The Patient
- ◆ The Physician

And most recently, a transplant surgeon has been charged with a felony as a result of commencing an organ transplant process at a time when the local prosecutor apparently believed that the patient remained viable. The following excerpts illustrate the need to consider appointment of a formal guardian even where statutory decision-makers appear to have agreed to a plan of care:

San Luis Obispo County prosecutors charged a transplant surgeon with prescribing excessive drugs to a comatose, disabled patient to hasten his death and harvest his organs for transplantation.

He was taken in a coma to a medical center 150 miles northwest of Los Angeles, in 2006 after suffering respiratory and cardiac arrest. Although the patient was found to have irreversible brain damage and was kept on a respirator, he was not considered brain dead because he still had limited brain function.

The day before he died, his family gave approval for a surgical team to recover his organs for donation, though the procedure never occurred because the patient did not die within 30 minutes of being removed from life support. He died the next day.⁴

³ ABSTRACT: Ackermann, Richard J., M.D., Withholding and Withdrawing Life-Sustaining Treatment, *Am Fam Physician* 2000;62:1555-60,1562,1564 <http://www.aafp.org/afp/20001001/1555.html> See also: Education for Physicians on End-of-life Care (EPEC) curriculum, a program of the Institute for Ethics at the American Medical Association. © EPEC Project, The Robert Wood Johnson Foundation, 1999

⁴ CBS News, February 28, 2008, as posted at: <http://www.cbsnews.com/stories/2008/02/28/earlyshow/main3886268.shtml?source=RSSattr=U.S.3886268> See also: <http://www.patriciaebauer.com/2008/11/05/doctor-faces-trial/>

Trial in the above matter is currently pending in San Luis Obispo, CA, with an estimated duration of three months. (Roughly November 2008 through January 2009.)

V. Natural Death Act & POLST

Like most progressive-thinking states, in the aftermath of the Quinlan case Washington enacted its Natural Death Act, RCW 70.122. Excerpts from the Natural Death Act are included in Appendix A below, including the stated intent of the Act:

[I]n the interest of protecting individual autonomy, . . . prolongation of the process of dying for persons with a terminal condition or permanent unconscious condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient. The legislature further believes that physicians and nurses should not withhold or unreasonably diminish pain medication for patients in a terminal condition where the primary intent of providing such medication is to alleviate pain and maintain or increase the patient's comfort.

From this Act springs the ability of a patient to provide written direction to his or her physician(s), directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition – the so-called “Living Will.”⁵

Because of numerous instances where First Responders (the Emergency Medical Services community) were placed in the awkward position of providing “Full Code – Full Court Press” care in emergency circumstances, only to learn afterward that neither the patient nor the family wanted heroic measures to be performed, in light of the patient’s known disease process, the concept of a state-wide, easily recognized form, signed by a physician, authorizing the EMS team to step back from the patient prior to initiating a full code came about.

This evolved into the Physician’s Orders for Life Sustaining Treatment (POLST) forms, which are authorized by RCW 43.70.480.⁶ POLST forms are designed for use in conjunction with the EMS community, and were not, despite widespread confusion on this point, originally intended to replace the patient’s separate Directive to Physicians.

What POLST does accomplish, that can be quite different from a Directive to Physicians, is a completion of the tie between the patient’s wishes and the physician’s orders, in the context of the patient’s disease process. Once again, we see a reaffirmation and reemergence of focus on:

- ◆ The Disease
- ◆ The Patient
- ◆ The Physician

⁵ RCW 70.122.030. See Appendix A

⁶ See Appendix A and <http://www.doh.wa.gov/hsqa/emstrauma/resuscitation.htm>

A relatively recent refinement in these processes comes through RCW 70.122.130, which became effective June 7, 2006. This bill established a registry for patients to post their Advance Directives and Mental Health Advance Directives online, enabling any health care provider to directly access the patient's Advance Directives in furtherance of the plan of care sought by the patient in the context of his or her disease process, allowing all parties to focus on the needs of:

- ◆ The Disease
- ◆ The Patient
- ◆ The Physician

VI. Palliative Care

Palliative Care has undergone enormous change over the past several years. It has been defined as:

The total care of patients who are not responsive to curative treatment. Patients may be treated at home, in the hospital, or in an inpatient hospice care facility. The goal of palliative care is to achieve the highest quality of life possible.⁷

- Palliative care aims to relieve suffering and improve quality of life for patients with advanced illness and their families.
- Palliative care is provided by an interdisciplinary team and offered in conjunction with all other appropriate forms of medical treatment.
- Palliative care programs structure a variety of hospital resources to effectively deliver the highest quality of care to patients with advanced illness.
- The resources and team include: medical and nursing specialists, social workers, clergy, and others.
- Vigorous pain and symptom control is integrated into all stages of treatment.
- The palliative care approach decreases length of hospital and ICU stays and eases patient transitions between care settings. This results in increased patient and family satisfaction and compliance with hospital care quality standards.
- Successful palliative care programs have used an array of delivery systems from consultative services to inpatient units.⁸

⁷ http://www.stoppain.org/palliative_care/ See also: http://en.wikipedia.org/wiki/Palliative_care

⁸ Center to Advance Palliative Care, <http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc>

The End of Life / Palliative Education Resource Center (EPEC) at the Medical College of Wisconsin provides numerous resources on Palliative Care Medicine and developing theories and methodologies for dealing with end-of-life issues with patients who are no longer responding to curative treatment. Among those materials is an excellent article, *Evaluating Requests for Hastened Death*, by Tim Quill, MD and Robert Arnold, MD. With the permission of the authors, this article is reproduced in full in Appendix B.⁹

Palliative care focuses on:

- ◆ The Disease
- ◆ The Patient
- ◆ The Physician

VII. The Oregon Experience: Death With Dignity

Oregon Health Sciences University, in cooperation with numerous health care and health law professionals, has published an excellent on-line resource for professionals entitled *The Oregon Death With Dignity Act: A Guidebook for Healthcare Professionals*¹⁰ which contains a complete history of the Act, the ensuing litigation and appeals and the state of the Act in Oregon at this time.

Additional information is also available through Compassion and Choices in Dying. See www.candcofwa.org which is part of a larger coalition of Compassion & Choices organizations with offices in most states. The Oregon offices provide detailed information regarding access to medications under the Oregon Act.

VIII. Physician Organizations' Views

For an excellent discussion of end-of-life issues faced by health care providers every day, see World Medical Association, Medical Ethics Manual, Chapter Two¹¹:

END-OF-LIFE ISSUES

End-of-life issues range from attempts to prolong the lives of dying patients through highly experimental technologies, such as the implantation of animal organs, to efforts to terminate life prematurely through euthanasia and medically assisted suicide. In between these extremes lie numerous issues regarding the initiation or withdrawing of

⁹ Quill, Tom and Robert Arnold., Fast Facts and Concepts #156 Evaluating requests for hastened death. May 2006. End-of-Life Physician Education Resource Center www.eperc.mcw.edu

¹⁰ <http://www.ohsu.edu/ethics/guidebook.pdf> Developed by The Taskforce To Improve the Care of Terminally Ill Oregonians.

¹¹ Excerpts from World Medical Association, Medical Ethics Manual, Chapter Two, Pages 12-14. The complete WMA Medical Ethics Manual is available for download at: <http://www.wma.net/e/ethicsunit/resources.htm>

potentially life-extending treatments, the care of terminally ill patients and the advisability and use of advance directives.

Two issues deserve particular attention: euthanasia and assistance in suicide.

- **EUTHANASIA** means knowingly and intentionally performing an act that is clearly intended to end another person's life and that includes the following elements: the subject is a competent, informed person with an incurable illness who has voluntarily asked for his or her life to be ended; the agent knows about the person's condition and desire to die, and commits the act with the primary intention of ending the life of that person; and the act is undertaken with compassion and without personal gain. Id.
- **ASSISTANCE IN SUICIDE** means knowingly and intentionally providing a person with the knowledge or means or both required to commit suicide, including counseling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs. Id.

Euthanasia and assisted suicide, according to these definitions, are to be distinguished from the withholding or withdrawal of inappropriate, futile or unwanted medical treatment or the provision of compassionate palliative care, even when these practices shorten life. Id.

This article goes on to recite the World Medical Association's Declaration on Euthanasia:

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness. Id.¹²

The American Medical Association's approach to euthanasia is in line with the WMA declaration:

. . . [P]ermitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. . . .¹³

¹² <http://www.euthanasia.com/belgium.html> World Medical Association Declaration on Euthanasia

¹³ <http://www.ama-assn.org/ama/pub/category/8458.html> E-2.21 Euthanasia. AMA Code of Medical Ethics.

Likewise, the AMA pronouncement on physician-assisted suicide is fundamentally in line with its position on euthanasia, recommending instead that physicians adhere to an approach toward end-of-life issues that is much more in line with the palliative medicine concepts set forth above:

. . . [A]llowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. . . .¹⁴

The WMA materials cited above note that:

. . . Individuals differ greatly with regard to their attitude towards dying; some will do anything to prolong their lives, no matter how much pain and suffering it involves, while others so look forward to dying that they refuse even simple measures that are likely to keep them alive, such as antibiotics for bacterial pneumonia. Once physicians have made every effort to provide patients with information about the available treatments and their likelihood of success, they must respect the patients' decisions.

- ◆ The Disease
- ◆ The Patient
- ◆ The Physician

During the I-1000 debates leading to passage of the Act, the Washington State Medical Association announced its formal opposition to the Act, citing numerous references, such as those above, to the effect that any form of physician-assisted suicide was contrary to the fundamental tenets of the practice of medicine (“first, do no harm.”)

Polls of physicians indicated that physicians in Washington were actually split nearly evenly as a whole (52%-48% against) and within some subgroups of physicians, were slightly more in favor as against passage of the Act. See, for example: <http://www.ama-assn.org/amednews/2008/10/27/prsb1027.htm>

¹⁴ http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-2.211.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-1.02.HTM&nxt_pol=policyfiles/HnE/E-2.01.HTM&E-2.211 Physician-Assisted Suicide AMA Code of Medical Ethics

As can be seen from the foregoing, passage of I-1000 will not automatically open the door to the availability of such a process for all patients. Many physicians will predictably refuse to engage in such activities, even when legalized. And many health care facilities, including hospitals and skilled nursing facilities, are likely to “opt out” of allowing I-1000 activities within their facilities.

Having the *option* of timing one’s death may have more palliative effects on patients than would actually be realized through utilization of the option. There are numerous reports on the utilization of rates of patient-driven physician-assisted suicide in countries such as the Netherlands that imply that while many patients prefer to have the option available; few actually trigger the process prior to becoming debilitated to the point of having no end-of-life control over the disease process leading to their death.

For example, in the Netherlands, after legalization of physician-assisted suicide, studies indicate that roughly 0.2% of patient deaths involved physician-assisted suicide, while roughly 18% to 20% of patient deaths involved the withdrawal of life-sustaining treatment, allowing nature to take its course much in the same way that patients in Washington are allowed to die under existing law.¹⁵

The Oregon experience provides substantial data regarding effective utilization rates among qualified patients opting to seek access to life-ending medications under the Oregon statute. One would anticipate Washington’s experience will be numerically similar in terms of utilization.

IX. Plan of Care: Sample Hospital Policies

Patients admitted to hospitals are provided a number of statutory and regulatory protections through licensing activities at the state level, along with various conditions of participation that apply to hospitals enrolled in federal health care programs such as Medicare and Medicaid. Separately, private health care insurers may impose limitations or restrictions on the management of their members admitted to hospitals, through contractual remedies. And most hospitals participate voluntarily in credentialing programs such as those offered by the Joint Commission.

This milieu of regulatory, contractual and voluntary program development and oversight results in policies and procedures designed to ensure that patients’ rights are protected and providers are held to consistent standards of care for all patients admitted to health care facilities.

Discharge planning is one such area, which is regulated and both state and federal levels and is overseen through compliance guidance provided by credentialing organizations. Each patient is entitled to a discharge plan intended to maximize the patient’s chances for the best recovery available to them, under the circumstances. When dealing with patients with terminal illnesses, discharge planning, of necessity, includes planning for end-of-life issues such as pain management, medication management, nutrition, and so on. Often,

¹⁵ <http://www.euthanasia.cc/dutch.html> See also: <http://content.nejm.org/cgi/content/abstract/335/22/1699>

home health and/or hospice programs supplement care for the patient after formal discharge from a hospital.

Appendix C contains provisions from a number of representative hospital policies related to informed consent and management of patients in dire circumstances. These are included merely to assist the reader in capturing the complexity of existing processes surrounding the patient who is in extremis, and who may be incapable of directing his or her own care decisions.

Among the sample policies attached are:

- Informed Consent and Patient Competency
- Patient Rights and Responsibilities
- Advance Directives: Living Will and Mental Health
- Do Not Resuscitate (“DNR”) Orders
- Dying Patient, Care Of
- Withholding/Withdrawing Life Support

As you scan these materials, consider how you would address each of the following factors when responding to an inquiry as to what would be in a patient’s best interests:

- ◆ Disease: How is the patient’s underlying disease process factored into the administration of the policy and plan of care?
- ◆ Patient: How are the patient’s rights and interests factored into the administration of the policy and plan of care?
- ◆ Physician: How are the needs of treating physicians factored into the administration of the policy and plan of care?

X. Medical Staff Issues

Whether “opting in” or “opting out”, health care facilities with credentialed medical staffs should revisit their Medical Staff Bylaws and Rules, to make sure that they are consistent with the decision of the organization to allow, or disallow, I-1000 activities within such facilities.

In any circumstance where a facility’s Medical Staff Bylaws preclude I-1000 activities within the facility, special communications with all members of the Medical Staff will be required in order to impose any sanctions as a result of a Medical Staff Member engaging in I-1000 activities within a facility, and ultimately each facility should adopt Medical Staff Rules and Bylaws which are consistent with each facility’s elections under I-1000.

Of particular importance, it should be noted that participation in I-1000 activities is statutorily protected lawful activity and is particularly identified as “not constituting unprofessional conduct.” Consequently, even if sanctions are undertaken against a member of the Medical Staff, no reports are likely required, or even authorized, under DOH rules

As to reports required by the National Practitioner Data Bank, there remains an open question as to any need to report sanctions based upon the engagement of a provider in I-1000 activities within a healthcare facility (although it would seem under NPDB rules that if any suspension of privileges arising under I-1000 activities exceeds 30 days in duration, a report may be triggered under the NPDB rules.) This seeming disconnect between a facility's election not to participate in I-1000 actions, and a Medical Staff member's subsequent violation of the facility's Medical Staff Rules or Bylaws, creates an interesting dilemma for counsel engaged in enforcing and/or defending Medical Staff Rules and Bylaws.

See Section 19, Subpart 2, of the Act.

XI. Conclusion

Washington's Death With Dignity Act presents new options and opportunities for health care providers to assist patients with end-of-life care management. For organizations that provide an integrated health care delivery methodology, the Act presents interesting challenges, particularly where an organization may choose to elect not to allow I-1000 activities within its facilities.

Whenever a patient has been diagnosed as having a terminal illness, with a prognosis of less than six months to live, that patient will face many choices and opportunities associated with the management of his or her end-stage plan of care. I-1000 now allows one additional option, an option not available in most states.

Members of the care team often will include hospice or home health nurses; palliative care practitioners; pain management specialists; and a cadre of specialists and sub-specialists providing elements of care.

Treating providers, nursing staff, social workers and care planning personnel will be involved in assisting the patient in understanding all available options and locating facilities where the patient can best be managed, taking into account:

- ◆ The Disease
- ◆ The Patient
- ◆ The Physician

In circumstances where options for the patient are limited as a result of an organization's decision to "opt out" of allowing I-1000 activities within its facilities, the care team will be challenged to assist the patient who desires I-1000 options to find a facility and care team that will support the patient's desires as they related to taking life-ending medications as authorized under I-1000.

Organizations that allow I-1000 activities within their facilities will face similar challenges in managing against the decisions of members of the care team (physicians, nurses, etc.) to individually "opt out" of any support of I-1000 activities at such facilities.

If the experience under I-1000 in Washington mirrors that of Oregon, the Act will likely become part and parcel of the environment of care within a few short years.

Cautionary Note: Many of the statutes excerpted here will be amended by the Code Reviser's Office to fully incorporate the terms of I-1000. Do not rely upon these statutory provisions in the form below:

70.122.020

Definitions. [Pre-Initiative 1000]

Unless the context clearly requires otherwise, the definitions contained in this section shall apply throughout this chapter.

(1) "Adult person" means a person who has attained the age of majority as defined in RCW 26.28.010 and 26.28.015, and who has the capacity to make health care decisions.

(2) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(3) "Directive" means a written document voluntarily executed by the declarer generally consistent with the guidelines of RCW [70.122.030](#).

(4) "Health facility" means a hospital as defined in *RCW 70.41.020(2) or a nursing home as defined in RCW 18.51.010, a home health agency or hospice agency as defined in RCW 70.126.010, or a boarding home as defined in RCW 18.20.020.

(5) "Life-sustaining treatment" means any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which, when applied to a qualified patient, would serve only to prolong the process of dying. "Life-sustaining treatment" shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.

(6) "Permanent unconscious condition" means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(7) "Physician" means a person licensed under chapters 18.71 or 18.57 RCW.

(8) "Qualified patient" means an adult person who is a patient diagnosed in writing to have a terminal condition by the patient's attending physician, who has personally examined the patient, or a patient who is diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient.

(9) "Terminal condition" means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

[1992 c 98 § 2; 1979 c 112 § 3.]

Notes:

***Reviser's note:** RCW 70.41.020 was amended by 2002 c 116 § 2, changing subsection (2) to subsection (4).

RCW 70.02.130

Consent by others — Health care representatives.

(1) A person authorized to consent to health care for another may exercise the rights of that person under this chapter to the extent necessary to effectuate the terms or purposes of the grant of authority. If the patient is a minor and is authorized to consent to health care without parental consent under federal and state law, only the minor may exercise the rights of a patient under this chapter as to information pertaining to health care to which the minor lawfully consented. In cases where parental consent is required, a health care provider may rely, without incurring any civil or criminal liability for such reliance, on the representation of a parent that he or she is authorized to consent to health care for the minor patient regardless of whether:

(a) The parents are married, unmarried, or separated at the time of the representation;

(b) The consenting parent is, or is not, a custodial parent of the minor;

(c) The giving of consent by a parent is, or is not, full performance of any agreement between the parents, or of any order or decree in any action entered pursuant to chapter [26.09](#) RCW.

(2) A person authorized to act for a patient shall act in good faith to represent the best interests of the patient.

[1991 c 335 § 601.]

RCW 7.70.065

Informed consent — Persons authorized to provide for patients who are not competent — Priority.

(1) Informed consent for health care for a patient who is not competent, as defined in RCW 11.88.010(1)(e), to consent may be obtained from a person authorized to consent on behalf of such patient.

(a) Persons authorized to provide informed consent to health care on behalf of a patient who is not competent to consent, based upon a reason other than incapacity as defined in RCW 11.88.010(1)(d), shall be a member of one of the following classes of persons in the following order of priority:

(i) The appointed guardian of the patient, if any;

(ii) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;

(iii) The patient's spouse or state registered domestic partner;

(iv) Children of the patient who are at least eighteen years of age;

(v) Parents of the patient; and

(vi) Adult brothers and sisters of the patient.

(b) If the health care provider seeking informed consent for proposed health care of the patient who is not competent to consent under RCW 11.88.010(1)(e), other than a person determined to be incapacitated because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care:

(i) If a person of higher priority under this section has refused to give such authorization; or

(ii) If there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.

(c) Before any person authorized to provide informed consent on behalf of a patient not competent to consent under RCW 11.88.010(1)(e), other than a person determined to be incapacitated because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, exercises that authority, the person must first determine in good faith that that patient, if competent, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

(2) Informed consent for health care, including mental health care, for a patient who is not competent, as defined in RCW 11.88.010(1)(e), because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, may be obtained from a person authorized to consent on behalf of such a patient.

(a) Persons authorized to provide informed consent to health care, including mental health care, on behalf of a patient who is incapacitated, as defined in RCW 11.88.010(1)(e), because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, shall be a member of one of the following classes of persons in the following order of priority:

(i) The appointed guardian, or legal custodian authorized pursuant to Title 26 RCW, of the minor patient, if any;

(ii) A person authorized by the court to consent to medical care for a child in out-of-home placement pursuant to chapter 13.32A or 13.34 RCW, if any;

(iii) Parents of the minor patient;

(iv) The individual, if any, to whom the minor's parent has given a signed authorization to make health care decisions for the minor patient; and

(v) A competent adult representing himself or herself to be a relative responsible for the health care of such minor patient or a competent adult who has signed and dated a declaration under penalty of perjury pursuant to RCW 9A.72.085 stating that the adult person is a relative responsible for the health care of the minor patient. Such declaration shall be effective for up to six months from the date of the declaration.

(b) A health care provider may, but is not required to, rely on the representations or declaration of a person claiming to be a relative responsible for the care of the minor patient, under (a)(v) of this subsection, if the health care provider does not have actual notice of the falsity of any of the statements made by the person claiming to be a relative responsible for the health care of the minor patient.

(c) A health care facility or a health care provider may, in its discretion, require documentation of a person's claimed status as being a relative responsible for the health care of the minor patient. However, there is no obligation to require such documentation.

(d) The health care provider or health care facility where services are rendered shall be immune from suit in any action, civil or criminal, or from professional or other disciplinary action when such reliance is based on a declaration signed under penalty of perjury pursuant to RCW 9A.72.085 stating that the adult person is a relative responsible for the health care of the minor patient under (a)(v) of this subsection.

(3) For the purposes of this section, "health care," "health care provider," and "health care facility" shall be defined as established in RCW 70.02.010.

[2007 c 156 § 11; 2006 c 93 § 1; 2005 c 440 § 2; 2003 c 283 § 29; 1987 c 162 § 1.]

RCW 70.122.010**Natural Death Act: Legislative findings.**

The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own health care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition.

The legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The legislature further finds that, in the interest of protecting individual autonomy, such prolongation of the process of dying for persons with a terminal condition or permanent unconscious condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient. The legislature further believes that physicians and nurses should not withhold or unreasonably diminish pain medication for patients in a terminal condition where the primary intent of providing such medication is to alleviate pain and maintain or increase the patient's comfort.

The legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining treatment where the patient having the capacity to make health care decisions has voluntarily evidenced a desire that such treatment be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition. The legislature also recognizes that a person's right to control his or her health care may be exercised by an authorized representative who validly holds the person's durable power of attorney for health care.

[1992 c 98 § 1; 1979 c 112 § 2.]

RCW 70.122.030**Directive to withhold or withdraw life-sustaining treatment.**

(1) Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition. The directive shall be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the declarer upon declarer's decease under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon declarer's decease at the time of the execution of the directive. The directive, or a copy thereof, shall be made part of the patient's medical records retained by the attending physician, a copy of which shall be forwarded by the custodian of the records to the health facility when the withholding or withdrawal of life-support treatment is contemplated. The directive may be in the following form, but in addition may include other specific directions:

Health Care Directive

Directive made this day of (month, year).

I, having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

I DO want to have artificially provided nutrition and hydration.

I DO NOT want to have artificially provided nutrition and hydration.

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(e) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(g) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

Signed

City, County, and State of Residence

The declarer has been personally known to me and I believe him or her to be capable of making health care decisions.

Witness

Witness

(2) Prior to withholding or withdrawing life-sustaining treatment, the diagnosis of a terminal condition by the attending physician or the diagnosis of a permanent unconscious state by two physicians shall be entered in writing and made a permanent part of the patient's medical records.

(3) A directive executed in another political jurisdiction is valid to the extent permitted by Washington state law and federal constitutional law.

[1992 c 98 § 3; 1979 c 112 § 4.]

RCW 70.122.040

Revocation of directive.

*** CHANGE IN 2006 *** (SEE [2342-S2.SL](#)) ***

(1) A directive may be revoked at any time by the declarer, without regard to declarer's mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in declarer's presence and by declarer's direction.

(b) By a written revocation of the declarer expressing declarer's intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time and date when said physician received notification of the written revocation.

(c) By a verbal expression by the declarer of declarer's intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when said physician received notification of the revocation.

(2) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual or constructive knowledge of the revocation.

(3) If the declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarer's condition renders declarer able to communicate with the attending physician.

[1979 c 112 § 5.]

70.122.080

Effects of carrying out directive on cause of death.

The act of withholding or withdrawing life-sustaining treatment, when done pursuant to a directive described in RCW [70.122.030](#) and which results in the death of the declarer, shall not be construed to be an intervening force or to affect the chain of proximate cause between the conduct of anyone that placed the declarer in a terminal condition or a permanent unconscious condition and the death of the declarer.

[1992 c 98 § 8; 1979 c 112 § 10.]

70.122.110

Discharge so that patient may die at home.

If a qualified patient capable of making health care decisions indicates that he or she wishes to die at home, the patient shall be discharged as soon as reasonably possible. The health care provider or facility has an obligation to explain the medical risks of an immediate discharge to the qualified patient. If the provider or facility complies with the obligation to explain the medical risks of an immediate discharge to a qualified patient, there shall be no civil or criminal liability for claims arising from such discharge.

[1992 c 98 § 4.]

RCW 43.70.480

Emergency medical personnel — Futile treatment and natural death directives — Guidelines.

The department of health shall adopt guidelines and protocols for how emergency medical personnel shall respond when summoned to the site of an injury or illness for the treatment of a person who has signed a written directive or durable power of attorney requesting that he or she not receive futile emergency medical treatment.

The guidelines shall include development of a simple form that shall be used statewide.

[2000 c 70 § 1; 1992 c 98 § 14.]

RCW 70.122.130

Health care declarations registry — Rules — Report.

(1) The department of health shall establish and maintain a statewide health care declarations registry containing the health care declarations identified in subsection (2) of this section as submitted by residents of Washington. The department shall digitally reproduce and store health care declarations in the registry. The department may establish standards for individuals to submit digitally reproduced health care declarations directly to the registry, but is not required to review the health care declarations that it receives to ensure they comply with the particular statutory requirements applicable to the document. The department may contract with an organization that meets the standards identified in this section.

(2)(a) An individual may submit any of the following health care declarations to the department of health to be digitally reproduced and stored in the registry:

- (i) A directive, as defined by this chapter;
- (ii) A durable power of attorney for health care, as authorized in chapter [11.94](#) RCW;
- (iii) A mental health advance directive, as defined by chapter [71.32](#) RCW; or
- (iv) A form adopted pursuant to the department of health's authority in RCW [43.70.480](#).

(b) Failure to submit a health care declaration to the department of health does not affect the validity of the declaration.

(c) Failure to notify the department of health of a valid revocation of a health care declaration does not affect the validity of the revocation.

(d) The entry of a health care directive in the registry under this section does not:

- (i) Affect the validity of the document;
- (ii) Take the place of any requirements in law necessary to make the submitted document legal; or
- (iii) Create a presumption regarding the validity of the document.

(3) The department of health shall prescribe a procedure for an individual to revoke a health care declaration contained in the registry.

(4) The registry must:

- (a) Be maintained in a secure database that is accessible through a web site maintained by the department of health;
- (b) Send annual electronic messages to individuals that have submitted health care declarations to request that they review the registry materials to ensure that it is current;
- (c) Provide individuals who have submitted one or more health care declarations with access to their documents and the ability to revoke their documents at all times; and
- (d) Provide the personal representatives of individuals who have submitted one or more health care declarations to the registry, attending physicians, advanced registered nurse practitioners, health care providers licensed by a disciplining authority identified in RCW [18.130.040](#) who is acting under the direction of a physician or an advanced registered nurse practitioner, and health care facilities, as defined in this chapter or in chapter [71.32](#) RCW, access to the registry at all times.
- (5) In designing the registry and web site, the department of health shall ensure compliance with state and federal requirements related to patient confidentiality.
- (6) The department shall provide information to health care providers and health care facilities on the registry web site regarding the different federal and Washington state requirements to ascertain and document whether a patient has an advance directive.
- (7) The department of health may accept donations, grants, gifts, or other forms of voluntary contributions to support activities related to the creation and maintenance of the health care declarations registry and statewide public education campaigns related to the existence of the registry. All funds received shall be transferred to the health care declarations registry account, created in RCW [70.122.140](#).
- (8) The department of health may adopt rules as necessary to implement chapter 108, Laws of 2006.
- (9) By December 1, 2008, the department shall report to the house and senate committees on health care the following information:
- (a) Number of participants in the registry;
- (b) Number of health care declarations submitted by type of declaration as defined in this section;
- (c) Number of health care declarations revoked and the method of revocation;
- (d) Number of providers and facilities, by type, that have been provided access to the registry;
- (e) Actual costs of operation of the registry;
- (f) Donations received by the department for deposit into the health care declarations registry account, created in RCW [70.122.140](#) by type of donor.



FAST FACT AND CONCEPT #156: Evaluating Requests for Hastened Death

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A patient's request to a health care professional to help hasten death is not uncommon. The motivation for this request is usually a combination of relentless physical symptoms, progressive debility, in combination with a loss of sense of self, loss of control, fear of the future, and fear of being a burden on others. Some physicians are frightened by these requests, feeling that they are being asked to cross unacceptable professional boundaries. Others may be tempted to quickly accede, imagining that they would want the same thing in the patient's shoes. But requests for a hastened death may provide an entree into a patient's experience of suffering, and may lead to opportunities for more effective treatment if fully evaluated. In general, the clinician should carefully clarify, explore, evaluate, intensify treatment, and support the patient to ensure a full understanding of the request and to ensure that all alternatives have been considered before responding. This Fast Fact provides guidance on how to evaluate and initially respond to a patient who raises the topic of a hastened death. A subsequent Fast Fact will explore how to respond when the request for a hastened death persists after a full evaluation and search for alternatives.

1. **Clarify** which question is being asked before responding. Is the patient simply having thoughts about ending his life (very common), or is he exploring the possibility of a hastened death in the future if his condition deteriorates, or is he exploring your willingness to assist right now. (1;2)
2. **Support** the patient, and reinforce your commitment to trying to find a mutually acceptable solution for the patient's problem and to continue to work through the process. This does not mean violating fundamental values, but it does mean searching in earnest with the patient and family to find a way to approach the dilemma. (3) Attend to your own support by discussing the patient with trusted colleagues and/or with your multidisciplinary team.
3. **Evaluate** the patient's decision-making capacity. Is he seeing his medical condition clearly? Is the request proportionate to the level of unrelieved suffering? Are there dominating aspects of anhedonia, worthlessness and guilt, or is the capacity for pleasure and joy preserved in some small ways? Is this request consistent with the patient's past values? Get help from an experienced psychiatrist or psychologist if you are unsure. (4)
4. **Explore** the many potential dimensions that may contribute to the patient's "unbearable" suffering to be sure you (and the patient) fully understand its underlying cause(s). Sometimes it may be an unrelenting physical symptom, other times feelings of depression, or a family or spiritual crisis, or perhaps a combination of many factors. (1;2)
5. **Respond** to the associated emotions, which may be strong and conflicted. Try to empathically imagine what the patient is going through and asking for. Distinguish your own feelings and reactions from those of the patient.
6. **Intensify treatment** of any potentially reversible elements of the patient's suffering. Depending on the patient's circumstances, offer to increase treatment of pain or other physical symptoms, consider biological or interpersonal treatment of depression; see if an

- appropriate and acceptable spiritual counselor is available. Be creative and brainstorm potential solutions with your multidisciplinary team. (1;2)
7. **Respond** directly to the request for hastened death only after this multidimensional evaluation has been completed. If the patient has full decision-making capacity and all alternative approaches to the patient's unbearable suffering have been fully considered, then re-explore exactly what is being requested, and look for mutually acceptable ways to potentially respond. (5) Note that many patients may be looking for the potential of an escape they will never use, but a smaller number will be looking for a way to hasten death in the present.

References

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Purpose: Self-Study Guide, Teaching

Audience(s)

Training: Fellows, 3rd/4th Year Medical Students, PGY1 (Interns), PGY2-6, Physicians in Practice

Specialty: Anesthesiology, Emergency Medicine, Family Medicine, General Internal Medicine, Geriatrics, Hematology/Oncology, Neurology, OB/GYN, Ophthalmology, Pulmonary/Critical Care, Pediatrics, Psychiatry, Surgery

Non-Physician: Nurses

ACGME Competencies: Interpersonal and Professional Communication Skills

Policy & Procedure

Informed Consent and Patient Competency

1. Purpose: To establish guidelines so that patients receive sufficient information to reach an informed decision in deciding between proposed medical treatment and any alternative methods of treatment.

2. Policy:

a. The informed consent process includes a clear explanation of any proposed treatment or procedure. Documentation of the process includes use of the MultiCare standardized consent form, for invasive treatment or procedures as set forth below, which will be placed in the medical record.

b. Obtaining a patient's informed consent involves discussion of anticipated benefits, and serious possible risks and complications of the proposed treatment, and any alternative forms of treatment including nontreatment. The identity of the individual performing the procedure or treatment and his/her assistants should also be included in the discussion.

c. The name of the individual who provides information as well as the individual who will perform the procedure/treatment and his/her assistants should be documented (may be in the progress note).

d. Informed consent will be obtained and documented for any invasive procedure or treatment, and for non-invasive treatments for which a recognized serious possible risk or complication exists, including but not limited to chemotherapy medication, thrombolytic agents for stroke, sedation and anesthetic agents, the use of patient own compound sterile products and/or infusion devices, except as set forth in 6.n.

e. In Washington, signature by the patient or person legally responsible for the patient on the consent form acknowledging disclosure of risks, benefits and alternatives is considered prima facie evidence of informed consent. It is strongly suggested that the practitioner include documentation of the informed consent discussion in the pre-procedure history and physical or progress note.

f. Informed consent for any experimental procedure under the jurisdiction of any Investigational Review Board (IRB) shall be in accordance with the forms and procedures specified and approved by the IRB.

3. Definitions:

a. Express (Informed) Consent – given by a patient or person with the legal authority to act on a patient's behalf to proposed medical care, with consideration given to:

(1) The nature and character of the proposed treatment and/or procedure to be performed,

(2) The anticipated results of the proposed treatment and/or procedure,

(3) The recognized possible alternative forms of treatment, and

(4) The recognized serious possible risks, complications and anticipated benefits involved in the proposed treatment and possible alternative forms of treatment, including nontreatment.

b. Consent Form – A written document, signed by the patient or other person with legal authority to act on the patient's behalf, documenting the patient's consent to the proposed treatment.

c. Implied Consent - When there is an emergency (i.e., immediate treatment is necessary to preserve life or prevent serious deterioration of a patient's condition) and the patient is unable to make an informed decision and the consent of another person qualified to represent

him/her is not reasonably available, consent to treatment is implied by law. The implied consent in an emergency is to the treatment of the emergency only. The medical record documentation should define the nature of the emergency and specify the threat to life or health. Entries should clearly document any attempts to obtain express consent from any authorized person.

d. Incompetency - Under Washington state law, for the purposes of giving informed consent for health care, incompetent is defined as a person who is under the age of 18 years or who is incompetent by reason of mental illness, developmental disability, senility, habitual drunkenness, excessive use of drugs, or other mental incapacity to manage one's property, or to care for oneself or both (RCW 11.88.010). Exceptions include emancipated minors as set forth in 7.d.(1).

e. Invasive Procedure – A procedure involving puncture or incision of the skin or insertion of an instrument or foreign material into the body including, but not limited to, surgery, bronchoscopy, cardiac catheterization, colonoscopy, renal biopsy, radiation therapy. Examples that do not require completion of the “Special Consent to Medical Treatment, Operation, Post-Operative Care, Medical Treatment, Anesthesia or Other Inpatient/Outpatient Procedures” form include, but are not limited to, venipuncture or simple phlebotomy, peripheral intravenous access, arterial puncture, PAP smears, skin testing, ultrasound procedures, bladder catheterization, naso- or orogastric catheterization, plain film radiography, examination of the nose, mouth, genitalia, rectum or eye, or closure of minor lacerations.

f. Emergency – A life or health threatening condition requiring immediate care wherein the patient is incapable of participating in the consent process and there is not sufficient time to obtain consent from a duly authorized representative or next of kin.

g. Provider of Service – Physician, dentist, podiatrist, etc. who are licensed individual practitioners (LIP) individually privileged by MultiCare (nurses, technicians, etc. are not included in this definition).

ATTACHMENT A DECLARATION OF RELATIVE RESPONSIBLE FOR HEALTH CARE OF MINOR PATIENT

I, _____, declare under penalty of perjury under the laws of the State of Washington that the following is true and correct.

I am over 18 years of age and I am competent to make this declaration. I make this declaration upon personal knowledge.

I am a relative of _____ (minor patient's name), and I am responsible for the health care of such minor patient.

Signature of Relative

Date and place signed

Print Name

Relative's Relationship to Minor Patient

Under state law, this declaration is only effective for six months from the date it is signed.

Policy & Procedure

Subject:

Patient Rights and Responsibilities:

1. Purpose: To define patient rights by law and policy, and define the procedure for providing this information to patients and families with SampleCare.

2. Policy:

a. Patient Rights and Responsibilities posters will be prominently displayed throughout SampleCare Health System in patient care areas.

b. All patients admitted to an acute care facility (in-patient status) will be provided a copy of the Patient Rights and Responsibilities brochure at the time of admission (or as soon as feasible).

c. SampleCare supports the philosophy of patient rights and all staff (employed, volunteer and contracted staff) will support and follow the rights of patients at SampleCare. Observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his/her physician and the organization.

5. Patient Rights:

a. Patients Have the Following Rights by Law:

- (1)** The right to personal privacy.
- (2)** The right to receive care in a safe setting.
- (3)** The right to be informed of their rights and responsibilities, and receive a written copy, in advance of furnishing or discontinuing patient care whenever possible.
- (4)** The right to be free from all forms of abuse or harassment.
- (5)** The right to file a grievance (see back panel of brochure for more information on how to file a grievance) and if filed, the right to a written notice that contains the name of the contact person, steps taken to investigate, results and completion date.
- (6)** The right to participate in the development and implementation of their plan of care.
- (7)** The right to make informed decisions regarding their care, including being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
- (8)** If the patient is an adult, the patient has the right to formulate Advance Directives and to have hospital staff and practitioners who provide care in the hospital comply with these Directives.
- (9)** The right to have a family member or representative of the patient's choice and the patient's physician notified promptly of the patient's admission to the hospital.
- (10)** The right to the confidentiality of the patient's clinical records.
- (11)** The right to access information contained in the patient's clinical records within a reasonable time.
- (12)** The right to be free from restraints and seclusion of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.

b. Additional Patient Rights:

- (1) The right to an interpreter, free of charge.
- (2) The right to a complete explanation of the patient's condition.
- (3) The right to appropriate assessment and management of pain.
- (4) The right to understand all the choices for treatment including alternatives (including no treatment), risks and benefits.
- (5) The right to obtain a second opinion.
- (6) The right to choose whether or not to participate in medical research studies with complete information about the study, written consent to participate if the patient chooses to do so, and no reprisal in the patient's medical care if the patient chooses not to participate.
- (7) The right to know the name and role of each person participating in the patient's care.
- (8) The right to know about the patient's medications, any equipment used and community resources the patient might need.
- (9) The right to pastoral care and other spiritual services.
- (10) The right to have the patient's bill explained.
- (11) The right to obtain copies of the patient's medical records.

Policy & Procedure

Subject:

Advance Directives: Living Will and Mental Health

1. Purpose: To establish the SampleCare Health System (SHS) policy and procedure pertaining to advance directives.

a. Living Will/Advance Directive

(1) To support the federal and state laws that give all patients, 18 years of age or older, the right to execute a Living Will/Advance Directive (AD) specifying how they want decisions to be made about life sustaining treatment if they become gravely ill and are unable to speak for themselves.

(2) This policy also establishes procedures for patient education on AD, obtaining a patient's AD and including the patient's defined wishes into his/her care for adult patients who are admitted as an inpatient to the hospital, or before a patient comes under the care of a SampleCare provider for home health, hospice, or personal care services.

(3) An AD allows patients to participate in their care and express their desires regarding their health care if they become gravely ill and are unable to speak for themselves, and is consistent with SampleCare's support of patients' rights.

b. Mental Health Advance Directive

(1) This policy establishes procedures for including a patient's defined wishes into his/ her mental health care and treatment.

(2) All patients 18 years of age or older have the right to execute a Mental Health Advance Directive (MHAD) specifying how they would like their mental health treatment handled in the event they become mentally incapacitated and are unable to make sound decisions about their mental health care due to mental illness. Mental Health Advance Directives provide a method of giving instructions and preferences for mental health treatment in advance of a period of incapacity, and may authorize someone else to make mental health decisions on behalf of the patient.

Policy & Procedure

Subject:	
Do Not Resuscitate (“DNR”) Orders	

1. Purpose: Cardiopulmonary resuscitation (CPR), a lifesaving emergency treatment, should be initiated when cardiac or pulmonary arrest is recognized. A physician’s order is necessary if CPR is not to be initiated. Do Not Resuscitate (DNR) is an order to withhold resuscitation in the event of a cardiac, pulmonary or cardiopulmonary arrest. Resuscitation includes mechanical ventilation, endotracheal intubation, chest compression, defibrillation and the administration of emergency medications or fluids.

2. Policy: SampleCare Health System supports the patient’s right to make decisions about their care. After discussion with the patient or patient’s legal representative, if the patient wishes a DNR order the physician will write the order, according to this policy.

3. Reference: SHS Policy - Dying Patient, Care of

4. Responsibilities:

a. A DNR order should be considered for a competent patient who has requested DNR status, or if the attending physician otherwise considers a DNR order appropriate.

b. A DNR order shall be considered for incompetent patient only in the following circumstances:

(1) When the patient has a terminal condition. Terminal being defined as incurable condition caused by injury, disease, or illness, which regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures would serve only to postpone the moment of death.

(2) When the patient is in an advanced stage of terminal and incurable illness and is suffering severe and permanent mental and physical deterioration.

(3) When the patient is in a comatose or persistent vegetative state from which there is no reasonable probability of recovery.

c. If the patient is incompetent, the patient’s attending physician and two other physicians qualified to assess the patient’s condition should agree, based on reasonable medical judgment, that the patient meets the above criteria.

d. For a competent patient, the patient’s attending physician must obtain informed consent by advising the patient of the seriousness of the illness and prognosis, discussing the role of CPR, alternatives to CPR, including DNR, and the potential risks and benefits of each option. Valid consent for a DNR order shall be documented in the progress notes. The patient should be informed that he/she might change the resuscitation status at any time.

e. For an incompetent patient, informed consent as described above is obtained through discussion with the legally recognized surrogate (see policy on Consent) and with input from family members, after required consults have been obtained.

Policy & Procedure

Subject:

Care Of Dying Patient

1. Purpose: To establish the SampleCare Health System (SHS) policy and procedure for providing competent, compassionate end-of-life care to the patient and their family.

2. Policy: Patients requiring end-of-life care will be managed per the procedure below.

3. References:

- a. SHS Policy & Procedure: Family Viewing Room, Use of (MMC Campus), Death Post Mortem Care
- b. SHS Policy & Procedure: Patient Comfort Medications: Adult, Acute Care
- c. SHS Policy & Procedure: Pain Management
- d. SHS Policy & Procedure: Family Centered Care and Healing Environment
- e. SHS Policy & Procedure: Organ, Tissue and Eye Donation
- f. SHS Policy & Procedure: Withholding/Withdrawing Life Support

4. Definitions:

a. Family: Refers to those significant others to whom the patient defines as his/her “family”, the persons who play a significant role in the individual’s life. This may include a person not legally related to the individual. This person is often referred to as a health care agent if authorized to make healthcare decisions for an individual should the individual lose decision-making capacity.

5. Responsibilities:

- a. Licensed Independent Practitioner
 - (1) Provide orders for comfort care
 - (2) Provide DNR order
 - (3) Provide adequate pain and symptom management
 - (4) Provide patient and family psychosocial support
 - (5) Consider obtaining hospice consult
 - (6) Contact LifeCenter Northwest (or assign a member of the healthcare team to call) to determine patient eligibility for organ, tissue and eye donation.
- b. Department Director/Manager/Supervisor
 - (1) Assure the physical environment is pleasing for patients, families, and staff by attending to aesthetics, noise control and by role modeling caring actions – knowing, being with, doing for, enabling and maintaining belief.
 - (2) Assure that support is provided for patient/family and staff, i.e., via arranging for social work consultation, chaplain, critical incident stress debriefing, etc., as necessary.
 - (3) Act as advocate for patient/family/staff.

c. Registered Nurse

(1) Adequately assess, monitor and treat pain and symptoms acting as a patient/family advocate. Decrease patient disturbances, i.e.:

(a) Decrease vital signs to every 24 hours or less.

(b) Do not suction patient, unless it will promote comfort.

(c) Remove oxygen if patient desires.

(d) Remove artificial barriers from between patient and loved ones, i.e., oxygen, tubes, visiting hours.

(2) Assist patient and/or family in discussing issues related to impending death.

(3) Assure that Advance Directive information is current and present on the chart.

(4) Working with the physician, ensure contact with the Organ Procurement Agency to determine eligibility for organ, tissue and/or eye donation

(5) For inpatients, visit patient room frequently to show that you are available to patient and family.

(6) Provide comfort care for family, i.e., fluids and nourishment, sleeping facilities, personal care facilities and supplies.

(7) Allow patient and family complete access to each other.

(8) Encourage family to assist with the comfort care of patient.

(9) Be non-judgmental of all feelings and actions from patient and family.

(10) Provide privacy for patient and family.

(11) Provide appropriate referral to Oncology Counselor/Chaplain/Spiritual Provider for anticipatory grief support.

(12) Discuss obtaining hospice consult with physician.

d. Care Team Member

(1) Be non-judgmental of all feeling and actions from patient and family.

(2) For inpatients, visit patient room frequently to show your support and availability.

(3) Provide privacy for patient and family.

(4) Decrease patient disturbances:

(a) Decrease vital signs or discontinue.

(b) Keep noise level down. Provide appropriate music or videos.

(c) Do not tune television to news channels. Use quiet, soothing stations.

(5) Remove artificial barriers from between patient and family, including those that originate from policy, i.e. visiting hours and number of family at bedside.

(6) Keep patient clean and comfortable, giving particular attention to meticulous oral care.

(7) Provide clean, neat, uncluttered environment with personal pictures, familiar belongings, and favorite bed cover.

e. Oncology Counselor/Social Services/Chaplain/Spiritual Advisor

(1) Provide support as desired for patient/family.

(a) Assess patient/family feeling and concerns regarding death.

- (b) Educate regarding anticipatory death and grief.
 - (c) Educate the importance of self-care for the caregivers.
 - (d) Suggest ways to be helpfully present for dying loved one.
 - (e) Promote open communication.
- (2) Provide spiritual support and counseling.
 - (a) Make appropriate referral if denominational preference.
 - (b) Support the spiritual integrity of patient/family.
 - (c) Process fear, provide space for working with doubt and other difficult emotions.
 - (d) Facilitate and provide appropriate rituals that support patient spirituality.
- (3) Acknowledge patient's contribution to life.
 - (a) Support patient in taking care of business and end of life issues.
- (4) Acknowledge caregiver/family contribution to patient's life.
- (5) Provide alternative therapies as desired, i.e.:
 - (a) Therapeutic touch
 - (b) Relaxation therapy/visualization
 - (c) Aromatherapy
 - (d) Pet Therapy
 - (e) Prayer/rituals of celebration
 - (f) Consider any request from patient and family
- (6) In order to facilitate ongoing bereavement care, consider with physician obtaining a hospice consult.

<h1>Policy & Procedure</h1>		
	Subject:	
	<h2>Withholding/Withdrawing Life Support</h2>	

1. Purpose: To establish the SampleCare Health System (SHS) policy and procedure for withholding/withdrawing life support.

a. In the interest of protecting individual autonomy the legislature finds that the prolongation of the dying process for person with a terminal condition or permanent unconscious condition may cause loss of patient dignity, and unnecessary pain and suffering while providing nothing medically necessary of benefit to the patient.

b. The patient has the fundamental right to control decisions relating to his/her health care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition.

2. Policy:

a. Withholding and withdrawing life support (life-sustaining treatment) are considered to be equal acts. A physician may consider withholding or withdrawing life support from a patient in instances of a terminal condition or permanent unconscious condition.

b. Decisions regarding health care may be exercised by an authorized representative for a patient who validly holds the patient’s power of attorney and is acting in the person’s best interest in the case of an unconscious or minor patient.

c. Discussion of the option to donate organs, tissues or eyes is a separate decision from withdrawal of life support, but must be addressed prior to the withdrawal. Families have a right to the information in making their decision. When the decision of medical futility has been reached, contact should be made with the organ procurement counselor to discuss options with the family concerning donation after cardiac death. See Organ Donation Policy.

d. This policy does not apply to a competent patient more than 23 weeks pregnant, to a patient who is brain dead, or to a patient with an Advanced Directive/Living Will. If the patient is competent refer to the policy: Refusal to Consent to Blood Transfusion or Other Lifesaving Treatment. If the patient is brain dead refer to the policy: Brain Death. If the patient is more than 23 weeks pregnant refer to Risk and Legal (xxx-xxxx) or the Administrator on-call (xxx-xxxx). If the patient has an Advanced Directive/Living Will refer to the policy: Advance Directives (Living Will).

3. Definitions:

a. Life-sustaining treatment: Any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which when applied to a qualified patient, would serve only to prolong the process of dying. “Life-sustaining treatment” shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.

b. Terminal condition: an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

c. Permanent Unconscious Condition: an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state.

d. Persistent Vegetative State: describes the chronic condition that sometimes emerges after severe brain injury and compromises a return of wakefulness accompanied by an apparent lack of cognitive function. An operational definition is that the eyes open spontaneously in response to verbal stimuli. Sleep-wake cycles exist. The patients spontaneously maintain normal levels of blood pressures and respiratory control. They show no discreet localizing motor responses and neither offer comprehensible words or obey any verbal commands. This condition usually follows a 2-4 week sleep-like coma and beings upon return of wakefulness.

e. Examples of, but not inclusive of, patient conditions that would meet this condition include terminal chronic conditions, chronic unconscious states, and acute terminal conditions.

4. Responsibilities:

a. Any physician or health care provider acting under the direction of a physician or health facility and its personnel who participate in good faith in the withholding or withdrawal of life-sustaining treatment from a qualified patient in accordance with the requirements of this policy, shall be immune from legal liability, including civil, criminal, or professional conduct sanctions, unless otherwise negligent.

b. The patient's attending physician together with two other physicians qualified to assess the patient's condition, must determine with reasonable medical judgement that the patient is in an advanced stage of a terminal and incurable illness and is suffering severe and permanent mental and physical deterioration, or the patient is in an irreversible comatose or persistent vegetative state from which there is no reasonable probability of recovery, and further medical intervention is considered futile; i.e. prolonging death rather than prolonging life, before life-sustaining treatment is withheld or withdrawn.

c. Once the attending physician has made the determination that there is no reasonable probability of recovery, contact with the Organ Procurement Agency will be initiated to determine if the patient is a candidate for donation after cardiac death. This determination **must be made prior to withdrawal of life-support**. If the patient is a candidate for organ donation, the Organ Donation Specialist will work with the health care team to discuss options with the family. The physician will direct the communications and timing.

d. The attending physician will meet with the patient's immediate family and/or guardian to fully explain the patient's condition, prognosis, and expected future function. The risks, limits and benefits of the patient's current treatment should be thoroughly discussed. Other health professionals involved with the patient are encouraged to participate in the discussions and should be advised of the meeting.

e. Persons authorized to consent/next-of-kin hierarchy:

- (1)** Legal Guardian
- (2)** Person holding durable power of attorney for health care decisions
- (3)** Spouse
- (4)** Adult Children
- (5)** Parents
- (6)** Siblings

f. Minors over the age of 12, who are conscious and suffering from chronic terminal conditions, should be given the opportunity to actively participate in the discussions and decisions regarding their health care including the withholding/withdrawing life-supportive treatment. The Ethics Committee is available to participate in this discussion at the request of the family or the health care team.

g. Once these matters have been fully discussed and no questions remain, the attending physician should encourage the patient's immediate family and any guardian to consider the facts and discuss the implications.

INITIATIVE MEASURE 1000**The Washington Death with Dignity Act**

Section Outline

Section 1. Definitions

Adult

Attending physician

Competent

Consulting physician

Counseling

Health care provider

Informed decision

Medically confirmed

Patient

Physician

Qualified patient

Self-administer

Terminal disease

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

Section 2. Who may initiate a written request for medication

Section 3. Form of the written request

Safeguards

Section 4. Attending physician responsibilities

Section 5. Consulting physician confirmation

Section 6. Counseling referral

Section 7. Informed decision

Section 8. Family notification

Section 9. Written and oral requests

Section 10. Right to rescind request

Section 11. Waiting periods

Section 12. Medical record documentation requirements

Section 13. Residency requirement

Section 14. Disposal of unused medications

Section 15. Reporting requirements

Section 16. Effect on construction of wills, contracts, and statutes

Section 17. Insurance or annuity policies

Section 18. Construction of Act

Immunities and Liabilities

Section 19. Immunities--basis for prohibiting health care provider from participation--
notification--permissible

sanctions

Section 20. Liabilities

Section 21. Claims by governmental entity for costs incurred

Additional Provisions

Section 22. Form of the request

Section 23. Amendments

Section 24. Amendments
Section 25. Amendments
Section 26. Short title
Section 27. Severability
Section 28. Effective date
Section 29. New chapter in Title 70
Section 30. Captions, part headings, and subpart headings not law
Section 31. Expiration date

Initiative Measure No. 1000

AN ACT Relating to death with dignity; amending RCW 70.122.100; reenacting and amending RCW 42.56.360 and 42.56.360; adding a new chapter to Title 70 RCW; prescribing penalties; providing an effective date; and providing an expiration date.
BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

THE WASHINGTON DEATH WITH DIGNITY ACT

General Provisions

NEW SECTION. **Sec. 1. DEFINITIONS.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

- (1) "Adult" means an individual who is eighteen years of age or older.
- (2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- (3) "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
- (4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- (5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- (6) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.
- (7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
 - (a) His or her medical diagnosis;
 - (b) His or her prognosis;
 - (c) The potential risks associated with taking the medication to be prescribed;
 - (d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.

(8) “Medically confirmed” means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient’s relevant medical records.

(9) “Patient” means a person who is under the care of a physician.

(10) “Physician” means a doctor of medicine or osteopathy licensed to practice medicine in the state of Washington.

(11) “Qualified patient” means a competent adult who is a resident of Washington state and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.

(12) “Self-administer” means a qualified patient’s act of ingesting medication to end his or her life in a humane and dignified manner.

(13) “Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

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

NEW SECTION. Sec. 2. WHO MAY INITIATE A WRITTEN REQUEST FOR MEDICATION. (1) An adult who is competent, is a resident of Washington state, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication that the patient may self-administer to end his or her life in a humane and dignified manner in accordance with this chapter.

(2) A person does not qualify under this chapter solely because of age or disability.

NEW SECTION. Sec. 3. FORM OF THE WRITTEN REQUEST. (1) A valid request for medication under this chapter shall be in substantially the form described in section 22 of this act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage, or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient’s attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the department of health by rule.

Safeguards

NEW SECTION. Sec. 4. ATTENDING PHYSICIAN RESPONSIBILITIES. (1) The attending physician shall:

- (a) Make the initial determination of whether a patient has a terminal disease, is competent, and has made the request voluntarily;
 - (b) Request that the patient demonstrate Washington state residency under section 13 of this act;
 - (c) To ensure that the patient is making an informed decision, inform the patient of:
 - (i) His or her medical diagnosis;
 - (ii) His or her prognosis;
 - (iii) The potential risks associated with taking the medication to be prescribed;
 - (iv) The probable result of taking the medication to be prescribed; and
 - (v) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control;
 - (d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily;
 - (e) Refer the patient for counseling if appropriate under section 6 of this act;
 - (f) Recommend that the patient notify next of kin;
 - (g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this chapter and of not taking the medication in a public place;
 - (h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the fifteen-day waiting period under section 9 of this act;
 - (i) Verify, immediately before writing the prescription for medication under this chapter, that the patient is making an informed decision;
 - (j) Fulfill the medical record documentation requirements of section 12 of this act;
 - (k) Ensure that all appropriate steps are carried out in accordance with this chapter before writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and
 - (l)(i) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under statute and rule to dispense and has a current drug enforcement administration certificate; or
 - (ii) With the patient's written consent:
 - (A) Contact a pharmacist and inform the pharmacist of the prescription; and
 - (B) Deliver the written prescription personally, by mail or facsimile to the pharmacist, who will dispense the medications directly to either the patient, the attending physician, or an expressly identified agent of the patient. Medications dispensed pursuant to this subsection shall not be dispensed by mail or other form of courier.
- (2) The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death.

NEW SECTION. Sec. 5. CONSULTING PHYSICIAN CONFIRMATION. Before a patient is qualified under this chapter, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is competent, is acting voluntarily, and has made an informed decision.

NEW SECTION. Sec. 6. COUNSELING REFERRAL. If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. Medication to end a patient's life in a humane and dignified manner shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

NEW SECTION. Sec. 7. INFORMED DECISION. A person shall not receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision. Immediately before writing a prescription for medication under this chapter, the attending physician shall verify that the qualified patient is making an informed decision.

NEW SECTION. Sec. 8. FAMILY NOTIFICATION. The attending physician shall recommend that the patient notify the next of kin of his or her request for medication under this chapter. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

NEW SECTION. Sec. 9. WRITTEN AND ORAL REQUESTS. To receive a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician at least fifteen days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the qualified patient an opportunity to rescind the request.

NEW SECTION. Sec. 10. RIGHT TO RESCIND REQUEST. A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this chapter may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

NEW SECTION. Sec. 11. WAITING PERIODS. (1) At least fifteen days shall elapse between the patient's initial oral request and the writing of a prescription under this chapter.

(2) At least forty-eight hours shall elapse between the date the patient signs the written request and the writing of a prescription under this chapter.

NEW SECTION. Sec. 12. MEDICAL RECORD DOCUMENTATION REQUIREMENTS.

The following shall be documented or filed in the patient's medical record:

- (1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
- (2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
- (3) The attending physician's diagnosis and prognosis, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;
- (4) The consulting physician's diagnosis and prognosis, and verification that the patient is competent, is acting voluntarily, and has made an informed decision;
- (5) A report of the outcome and determinations made during counseling, if performed;
- (6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request under section 9 of this act; and
- (7) A note by the attending physician indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

NEW SECTION. Sec. 13. RESIDENCY REQUIREMENT. Only requests made by Washington state residents under this chapter may be granted. Factors demonstrating Washington state residency include but are not limited to:

- (1) Possession of a Washington state driver's license;
- (2) Registration to vote in Washington state; or
- (3) Evidence that the person owns or leases property in Washington state.

NEW SECTION. Sec. 14. DISPOSAL OF UNUSED MEDICATIONS. Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means.

NEW SECTION. Sec. 15. REPORTING REQUIREMENTS. (1)(a) The department of health shall annually review all records maintained under this chapter.

- (b) The department of health shall require any health care provider upon writing a prescription or dispensing medication under this chapter to file a copy of the dispensing record and such other administratively required documentation with the department. All administratively required documentation shall be mailed or otherwise transmitted as allowed by department of health rule to the department no later than thirty calendar days after the writing of a prescription and dispensing of medication under this chapter, except that all documents required to be filed with the department by the prescribing physician after the death of the patient shall be mailed no later than thirty calendar days after the date of death of the patient. In the event that anyone required under this chapter to report information to the department of health provides an inadequate or incomplete report, the department shall contact the person to request a complete report.
- (2) The department of health shall adopt rules to facilitate the collection of information regarding compliance with this chapter. Except as otherwise required by law, the information collected is not a public record and may not be made available for inspection by the public.

(3) The department of health shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section.

NEW SECTION. Sec. 16. EFFECT ON CONSTRUCTION OF WILLS, CONTRACTS, AND STATUTES. (1)

Any provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, is not valid.

(2) Any obligation owing under any currently existing contract shall not be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner.

NEW SECTION. Sec. 17. INSURANCE OR ANNUITY POLICIES. The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication that the patient may self-administer to end his or her life in a humane and dignified manner. A qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner shall not have an effect upon a life, health, or accident insurance or annuity policy.

NEW SECTION. Sec. 18. CONSTRUCTION OF ACT. (1) Nothing in this chapter authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide." Consistent with sections 1 (7), (11), and (12), 2(1), 4(1)(k), 6, 7, 9, 12 (1) and (2), 16 (1) and (2), 17, 19(1) (a) and (d), and 20(2) of this act, state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication.

(2) Nothing contained in this chapter shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist or psychologist, or other health care provider participating under this chapter.

Immunities and Liabilities

NEW SECTION. Sec. 19. IMMUNITIES -BASIS FOR PROHIBITING HEALTH CARE PROVIDER FROM PARTICIPATION -NOTIFICATION -PERMISSIBLE SANCTIONS.

(1) Except as provided in section 20 of this act and subsection (2) of this section:

(a) A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner;

(b) A professional organization or association, or health care provider, may not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter;

(c) A patient's request for or provision by an attending physician of medication in good faith compliance with this chapter does not constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator; and

(d) Only willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(2)(a) A health care provider may prohibit another health care provider from participating under this act on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under this act. This subsection does not prevent a health care provider from providing health care services to a patient that do not constitute participation under this act.

(b) A health care provider may subject another health care provider to the sanctions stated in this subsection if the sanctioning health care provider has notified the sanctioned provider before participation in this act that it prohibits participation in this act:

(i) Loss of privileges, loss of membership, or other sanctions provided under the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in this act while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(ii) Termination of a lease or other property contract or other nonmonetary remedies provided by a lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in this act while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(iii) Termination of a contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in this act while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subsection (2)(b)(iii) prevents:

(A) A health care provider from participating in this act while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(B) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions under (b) of this subsection shall follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For the purposes of this subsection:

(i) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider before the provider's participation in this act of the

sanctioning health care provider's policy about participation in activities covered by this chapter.

(ii) "Participate in this act" means to perform the duties of an attending physician under section 4 of this act, the consulting physician function under section 5 of this act, or the counseling function under section 6 of this act. "Participate in this act" does not include:

(A) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(B) Providing information about the Washington death with dignity act to a patient upon the request of the patient;

(C) Providing a patient, upon the request of the patient, with a referral to another physician; or

(D) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(3) Suspension or termination of staff membership or privileges under subsection (2) of this section is not reportable under RCW 18.130.070. Action taken under section 3, 4, 5, or 6 of this act may not be the sole basis for a report of unprofessional conduct under RCW 18.130.180.

(4) References to "good faith" in subsection (1)(a), (b), and (c) of this section do not allow a lower standard of care for health care providers in the state of Washington.

NEW SECTION. Sec. 20. LIABILITIES. (1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death is guilty of a class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication to end the patient's life, or to destroy a rescission of a request, is guilty of a class A felony.

(3) This chapter does not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct that is inconsistent with this chapter.

NEW SECTION. Sec. 21. CLAIMS BY GOVERNMENTAL ENTITY FOR COSTS INCURRED. Any governmental entity that incurs costs resulting from a person terminating his or her life under this chapter in a public place has a claim against the estate of the person to recover such costs and reasonable attorneys' fees related to enforcing the claim.

Additional Provisions

NEW SECTION. Sec. 22. FORM OF THE REQUEST. A request for a medication as authorized by this chapter shall be in substantially the following form:

[Statutory Form]

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMAN AND DIGNIFIED MANNER

I, _____ am an adult of sound mind.

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, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and to 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 three 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.

Signed: _____

Dated: _____

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 the above request:

Witness 1

Witness 2

Initials

Initials

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

Printed Name of Witness 1: _____

Signature of Witness 1/Date: _____

Printed Name of Witness 2: _____

Signature of Witness 2/Date: _____

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 an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

Sec. 23. RCW 42.56.360 and 2007 c 261 s 4 and 2007 c 259 s 49 are each reenacted and amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;

(b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, and notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170;

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1); ((and))

(h) Information obtained by the department of health under chapter 70.225 RCW; and

(i) Information collected by the department of health under chapter 70. - RCW (sections 1 through 22, 26 through 28, and 30 of this act) except as provided in section 15 of this act.

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

Sec. 24. RCW 42.56.360 and 2007 c 273 s 25, 2007 c 261 s 4, and 2007 c 259 s 49 are each reenacted and amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;

(b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, and notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170;

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1); ((and))

(h) Information obtained by the department of health under chapter 70.225 RCW; and

(i) Information collected by the department of health under chapter 70. - RCW (sections 1 through 22, 26 through 28, and 30 of this act) except as provided in section 15 of this act.

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

Sec. 25. RCW 70.122.100 and 1992 c 98 s 10 are each amended to read as follows: Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing ((or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying)), lethal injection, or active euthanasia.

NEW SECTION. **Sec. 26.** SHORT TITLE. This act may be known and cited as the Washington death with dignity act.

NEW SECTION. **Sec. 27.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 28.** EFFECTIVE DATE. This act takes effect one hundred twenty days after the election at which it is approved, except for section 24 of this act which takes effect July 1, 2009.

NEW SECTION. **Sec. 29.** Sections 1 through 22, 26 through 28, and 30 of this act constitute a new chapter in Title 70 RCW.

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NEW SECTION. **Sec. 30.** CAPTIONS, PART HEADINGS, AND SUBPART HEADINGS NOT LAW. Captions, part headings, and subpart headings used in this act are not any part of the law.

NEW SECTION. **Sec. 31.** Section 23 of this act expires July 1, 2009.