

Washington Health Law Manual —Third Edition
Washington State Society of Healthcare Attorneys (WSSHA)

Chapter 6:

End of Life

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Volume 1: Patient Care Information, Treatment and Rights

6.1 Chapter Summary

Among the rapidly evolving areas of health law today are the legal, medical, and ethical issues relating to death and dying. This chapter summarizes the health law issues raised by these events. The following areas will be covered: medical behavior that results in death, including withholding or withdrawing life-sustaining treatment and aid in dying; determination and recording of death; investigation of deaths; anatomical gifts; and disposition of human remains.¹

6.2 Medical Decision-Making that Results in Death

6.2.1 Withholding or Withdrawing Life-Sustaining Treatment

Every day many medical decisions are made in Washington regarding whether to withhold or withdraw treatment and allow a patient to die. The decision whether to provide or forgo life-sustaining treatment has typically been made in the context of the patient-family-physician relationship in which law has found little need to meddle. To the extent "bad" decisions are made, redress may be found in criminal and tort law.

The Washington Supreme Court has addressed this subject directly on three occasions.² Also pertinent are Washington's Natural Death Act (the NDA),³ and laws governing informed consent and surrogate decision-making.

This section summarizes: (1) factors that influence the decision to provide or forgo life-sustaining treatment; (2) a competent person's right to forgo life-sustaining treatment; (3) an incompetent person's right to have treatment withheld or withdrawn; (4) standards for decision-making; and (5) the state's countervailing interests.

6.2.1.1 Factors Affecting Life-Sustaining Treatment Decisions

6.2.1.1.1 Condition of the Patient

The condition of the patient is one important factor to be considered. The reported Washington cases allowing a surrogate to direct the withholding or withdrawing of life support involve patients who were permanently unconscious (*Colyer, Hamlin*) or terminally ill (*Grant*). Washington's Natural Death Act provides that the patient must be "terminal" or "permanently unconscious" before life-sustaining treatment can be withdrawn.⁴

The Washington Supreme Court has recognized an emergency circumstances exception to the requirement of informed consent in the case of resuscitating a premature infant in opposition to the parents' wishes, but the holding of this case should not be interpreted to limit surrogate decision-making at the end of life under non-emergency circumstances.⁵

¹ An excellent reference in this field is Alan Meisel & Kathy Cerminara, *The Right to Die, The Law of End of Life Decisionmaking* (Wolters Kluwer), updated annually.

² *In re Welfare of Colyer*, 99 Wn.2d 114, 660 P.2d 738 (1983) ("*Colyer*"); *In re Guardianship of Hamlin*, 102 Wn.2d 810, 689 P.2d 1372 (1984) ("*Hamlin*"); *In re Guardianship of Grant*, 109 Wn.2d 545, 747 P.2d 445 (1987), amended by 757 P.2d 534 (1988) ("*Grant*").

³ Chapter 70.122 RCW.

⁴ *Id.*

⁵ In *Stewart-Graves v. Vaughn*, 162 Wash. 2d 115, 132-33, 170 P.3d 1151 (2007), the Court considered whether parents could maintain a cause of action against a physician who performed CPR for 24 minutes on a premature baby born without a heartbeat, without consent for such treatment. The infant survived but with severe and permanent disabilities. The parents brought suit, alleging that they had the right to decide whether their baby receive CPR beyond 10 minutes. The Court noted that "[the child] was neither terminally ill nor in a persistent vegetative state" *Id* at pp.132-33, and declined to extend the classes of

6.2.1.1.2 Patient's Competency and Intent

Courts regard as legally significant whether the patient (1) is currently competent,⁶ (2) has previously been competent,⁷ or (3) never was competent.⁸ If the patient is competent to make decisions regarding life-sustaining treatment, the law of informed consent controls. If the patient is not capable of making his or her treatment wishes known, a surrogate may make treatment decisions on the patient's behalf.⁹

6.2.1.2 Treatment Decisions by Competent Patients

Although there is no Washington law on the issue, it is generally well settled that a competent person can legally refuse life-sustaining treatment, including artificially administered nutrition and hydration. Courts have grounded this right in constitutional rights to privacy and liberty and common law rights to self-determination and informed consent.¹⁰

6.2.1.2.1 Constitutional Rights

- U.S. Constitution: In *Cruzan v. Director, Missouri Department of Health*,¹¹ the U.S. Supreme Court stated, “The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions” under the Fourteenth Amendment.¹² Prior to *Cruzan*, many courts based the right to refuse life-sustaining treatment on the constitutional right to privacy. The Court rejected, however, the trend of these courts to ground this right under a “generalized constitutional right of privacy.”¹³
- State Constitutions: Courts in many states, including Washington, have found constitutional privacy rights as to life-sustaining treatment decisions under their respective state

persons for whom surrogates could direct that life-sustaining treatment be withheld or withdrawn to babies born without heartbeats, although noting: “We need not decide, here, whether a parent may decide to refuse life-saving treatment on behalf of a child and, if so, under what circumstances” because the court found that informed consent to refuse treatment could not have reasonably been given in the circumstances: “we need only recognize that such a decision cannot be truly “informed” in the context of neonatal resuscitation when the circumstances permit no more than a hasty explanation of probable outcomes by a physician whose attention must primarily focus on life-saving efforts.”

⁶ See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (1986).

⁷ See *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261 (1990).

⁸ See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977); *Grant*, 109 Wn.2d 545, 747 P.2d 445 (1987), amended by 757 P.2d 534 (1988).

⁹ See materials at Chapter 2C: *Consent to Healthcare (Decision-Making for Incompetent Patients)*, Washington Health Law Manual, Third Edition.

¹⁰ *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (1986). Twenty-eight-year-old Elizabeth Bouvia, an intelligent and mentally competent individual with severe cerebral palsy, sought to have her nasogastric feeding tube removed by the hospital where she was resident. She was not terminally ill or in danger of imminent death. HELD: a competent patient has the right to control her own body. This includes the right to refuse any medical treatment, even life-sustaining treatment. This right is included under the right to privacy protected by both state constitutions and the U.S. Constitution. Bouvia, without means to go to a private hospital and incapable of caring for herself, was allowed to stay in the public hospital and have the tube removed. See also, *In re Jobes*, 529 A.2d 434 (N.J. 1987); *In re Milton*, 505 N.E.2d 255 (Ohio 1987); *In re Guardianship of Ingram*, 102 Wn.2d 827, 840, 689 P.2d 1363, 1370 (1984) (“*Ingram*”) (patient’s expressed wishes must be given substantial weight even if expressed while patient incompetent).

¹¹ 497 U.S. 261 (1990).

¹² *Id.* at 278.

¹³ *Id.* at 279 n.7.

constitutions. Thus courts in Washington, California, and Florida, among others, have found that state constitutional privacy rights include rights to forgo life-sustaining treatment.¹⁴

6.2.1.2.2 Common Law Right to Self-Determination

Authority for making treatment decisions is often predicated on the common law right to self-determination. The right is a right to be left alone, to act autonomously, to have no state interference with one's legitimate private life, and to refuse to have operations performed. Courts have applied this right of self-determination or personal autonomy in the context of life-sustaining treatment decisions.¹⁵

6.2.1.2.3 Doctrine of Informed Consent

Once a common law right or a constitutional right is found to encompass life-sustaining treatment decisions, some courts next consider whether the competent patient has knowingly consented to the withholding or withdrawing of life-sustaining treatment. The right to refuse or withdraw consent may be viewed as a corollary of the common law right of self-determination regarding medical treatment decisions. According to this view, if one must give informed consent to receive medical treatment, then one must give informed consent to forgo medical treatment.¹⁶ The doctrine of informed consent would appear to be inapplicable to patients for whom no consent could ever be possible: minors and certain mentally handicapped or incapacitated individuals. The doctrine may, however, be applicable to those mentally handicapped or incapacitated individuals who are otherwise capable of making informed health care decisions, or who were competent prior to becoming handicapped or incapacitated.¹⁷

6.2.1.3 Treatment Decisions for Incompetent Patient

6.2.1.3.1 Overview

Frequently, patients are incompetent at the time a decision regarding life-sustaining treatment must be made. When the patient is not capable of expressing his or her wishes, a surrogate will make decisions for the patient. Courts have articulated different standards for these surrogate decisions.

The landmark case of *In re Quinlan*¹⁸ held that an irreversibly unconscious young woman had a constitutional right to be disconnected from a respirator, at the request of her surrogates, in this case her parents. Subsequently, a number of courts have embraced this analysis and determined that the constitutional right of privacy extends to decisions to forgo life-sustaining treatment in a variety of circumstances.¹⁹

¹⁴ See *Colyer*, 99 Wn.2d 114, 660 P.2d 738 (1983); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (1986); *Corbett v. D'Alessandro*, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986).

¹⁵ See *In re Westchester County Med. Ctr.*, 531 N.E.2d 607 (N.Y. 1988); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 633 (Mass. 1986); *In re Gardner*, 534 A.2d 947 (Me. 1987).

¹⁶ See Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 New Eng. J. Med. 955, 957 (1984).

¹⁷ See, e.g., *Ingram*, 102 Wn.2d 827, 689 P.2d 1363 (1984).

¹⁸ 355 A.2d 647 (N.J. 1976). The New Jersey Supreme Court grounded this right in the penumbral right to privacy and the Fourteenth Amendment. As the court reasoned, if one has a constitutional right to receive certain kinds of medical treatment (such as abortion), then one has a constitutional right to refrain from receiving certain kinds of medical treatment (such as life-sustaining procedures).

¹⁹ See e.g., *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 633 (Mass. 1986).

In *Cruzan v. Director, Missouri Department of Health*,²⁰ Nancy Cruzan became permanently unconscious following an auto accident and was maintained by a gastrostomy feeding tube. She did not have an advance directive. Her parents asked the hospital to terminate the tube feeding. The hospital requested a court order authorizing it to terminate artificial feeding. Thereafter, Ms. Cruzan's parents, as her co-guardians, filed for a declaratory judgment. The trial court approved the request, maintaining that Ms. Cruzan had a constitutional right to liberty and equal protection of the law to have the request honored. Both the state and her guardian *ad litem* appealed the decision and won at the state appeals and supreme court levels.²¹ Ms. Cruzan's parents appealed to the United States Supreme Court, which affirmed. The Court held that a state may, pursuant to its interest in preserving life, require clear and convincing evidence that an incompetent person would refuse artificially administered nutrition and hydration. This is necessary to ensure that the patient's wishes are respected and not usurped. Subsequently, Nancy's parents brought forward additional evidence of her wishes, sufficient to meet the clear and convincing standard, and the life-sustaining treatment was removed.

Barbara Grant was a Washington citizen, suffering from a degenerative, incurable condition of the nervous system known as Batten's disease. She had been in an institution since the age of 14, and was at the end stage of terminal illness. Her mother, as her guardian, requested that the institution not provide life-sustaining treatment. The Washington Supreme Court held that an individual suffering from an incurable terminal illness has the right, rooted in common law and state and federal constitutional rights to privacy, to forgo life-sustaining treatment, and that this right could be exercised by a surrogate if the patient lacked decision-making capacity. There is no distinction between the withdrawing and the withholding of life-sustaining treatment.²²

6.2.1.4 Standards for Surrogate Decision-Making in Washington

If a patient is competent, they have authority to accept or decline treatment as they wish. If a patient is unable to make medical decisions on their own behalf, Washington statute and case law require a surrogate to make medical decisions on behalf of the patient.

6.2.1.4.1 Statutory context for surrogate decision-making

Washington has a statute governing surrogate decision-making on behalf of incapacitated patients. RCW 7.70.065 establishes a hierarchy of surrogate decision-makers, beginning with a court-appointed guardian and proceeding to a person appointed by a durable power of attorney, spouse, adult children, parents or adult siblings of the patient. If any surrogate decision-maker is unavailable, the next category of decision-maker is authorized to act. If the statute indicates a class of decision-makers, all members of that class must agree in making a health care decision (which can pose challenges for a health care team seeking clarity).

RCW 7.70.065 defines the standard for surrogate decision-making as first, the decision the patient would have made, if competent (ie: substituted judgment). If the patient's wishes cannot be determined, the statute directs the decision be made in the best interest of the patient. The statute does not limit the types of health care decisions a surrogate may make.

²⁰ 497 U.S. 261 (1990).

²¹ *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988).

²² *In Re Grant*, 109 Wn.2d 545, 747 P.2d 445 (1987), amended by 757 P.2d 534 (1988).

6.2.1.4.2 When a patient has an advance directive

Washington adopted the Natural Death Act (NDA), RCW 70.122, more than forty years ago. The statute provides a sample form for competent patients to use in creating an advance directive. When completed and witnessed in accordance with the NDA, “The directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining treatment.”²³ A surrogate is obligated to implement a valid directive.

Clinicians may face challenges if instructions in an advance directive conflict with the patient’s best interest. For example, a patient completing a directive in middle age may indicate they want life-sustaining treatment, but that directive no longer reflects their wishes at age 80. In many cases the directive does not actually become legally binding because the medical context does not exactly match the statutory requirements.

The NDA suggests that a surrogate decision-maker may be allowed to consider other communications indicating a patient’s end of life wishes: “If another person is appointed to make these decisions for me . . . I request that the person be guided by this directive and any other clear expressions of my desires.”²⁴ If this language is in a directive, a surrogate may have greater discretion to rely on more current expressions of a patient’s wishes.

However, this text is not mandated in statute. If this language is not included in a particular advance directive, it is not clear what discretion a surrogate may have to make decisions in the patient’s best interest in case of an outdated or otherwise inappropriate advance directive.

6.2.1.4.3 Constitutional and common law protections also apply

Grant states that a guardian of an incapacitated individual may consent to any necessary medical treatment for the ward. As stated previously, consent includes the right to refuse treatment. Prior court approval to withdraw treatment is not required if the patient is either terminal or permanently unconscious and the diagnosis is made by the attending physician(s) and confirmed by two other disinterested physicians.²⁵ The disinterested physicians are referred to as a “prognosis committee.”²⁶

PRACTICE TIP

It should be noted that the Washington Supreme Court has indicated that refusal of life-sustaining treatment at the direction of a surrogate may be effected in two specific situations: permanent unconsciousness (*Colyer; Hamlin*) and terminal condition (*Grant*). It is not clear that in a condition other than these, surrogate authority to direct the withholding of life support would be upheld.²⁷ Similarly, the Supreme Court’s articulation of other procedural protections (i.e., the need for confirmation of condition) defines a “safe harbor.” If these procedures are followed, exposure to malpractice or other claims is minimized. The common law procedures articulated in *Colyer, Hamlin*, and *Grant* differ from those defined legislatively in the NDA. For example, the NDA requires that a patient’s terminal or permanent unconscious condition be confirmed by one disinterested physician, rather than a minimum of

²³ RCW 70.122.060(3).

²⁴ RCW 70.122.030(b) (text of sample directive provided in statute, emphasis added).

²⁵ *Grant; Colyer; Hamlin*.

²⁶ The Washington State Supreme Court took pains to articulate why it opted to require a prognosis, as opposed to an ethics committee. *Colyer*, 99 Wn.2d at 135 n.8, 660 P.2d at 750.

²⁷ Other states have considered whether to extend the power of a surrogate to direct the withdrawal of treatment from a patient who was neither permanently unconscious nor terminally ill, and have declined to do so. See e.g., *Conservatorship of Wendland*, 26 Cal. 4th 519 (2001) (patient was in “minimally conscious state”).

two. The provisions of the NDA apply only where there is an advance directive and are not to be transposed to the surrogate decision-making context.²⁸ Health care institutions and physicians who choose to employ procedures less protective of patients than those articulated by the Washington Supreme Court may risk disciplinary and/or malpractice exposure, unless and until the Court alters those procedures in a subsequent decision or legislation specifically changes the applicable procedures.²⁹

6.2.1.4.4 Problems in effective surrogate decision-making

Some patients' rights advocates question the policy of giving family members surrogate decision-making authority on behalf of incapacitated or disabled patients. It can be very challenging for family members to grasp the obligations of substituted judgment and to appreciate the realities of patient preferences that differ from their own. Furthermore, family members may devalue a patient's stated wishes. For example, a study of non-therapeutic experimentation on incompetent nursing home residents found that 31 percent of relatives, who believed that a patient would have refused to participate in experimentation, nevertheless consented on his or her behalf.³⁰ In the context of decision-making on behalf of a disabled patient, family members may not fully appreciate the value of sustaining life despite the presence of disability: "Many a person has imagined that death would be preferable to a certain illness, deformity, or disability, only to find an unsuspected capacity to deal with the handicap when it eventuates."³¹

Health care treatment teams, especially in hospitals or other settings familiar with the decision-making needs of incapacitated patients, have developed skills to educate surrogate decision-makers about their obligations under the law. Some will stage a family meeting with an empty chair or other mechanism for evoking the presence and values of the incapacitated patient. However if a provider suspects a treatment decision does not appropriately reflect the patient's wishes or best interest, they should consider requesting a consultation from the hospital ethics committee or guidance from in-house counsel.

6.2.1.4.5 Physician Orders on Life Sustaining Treatment: Effectuating health decisions here and now

Washington State established its program for Physician Orders on Life Sustaining Treatment (POLST) more than fourteen years ago. POLST is used statewide to translate patient wishes into standardized medical orders that can be followed in real time. It is intended to guide immediate treatment decisions for patients with serious illness and frailty.

Because an advance directive is not a medical order, a directive alone cannot protect a patient against unwanted resuscitation in case of cardiac arrest. POLST has become the standard Washington State non-hospital medical order. The Department of Health has directed emergency medical services providers across the state to honor valid POLST orders, which decline CPR or other emergency medical treatments.

²⁸ *Grant*, 109 Wn.2d at 553, 747 P.2d at 449 (recognizing that the NDA is "inapplicable" where no advance directive).

²⁹ See Kathryn L. Tucker, *Surrogate End of Life Decision-making: The Importance of Providing Procedural Due Process, A Case Review*, 72 Wash. L. Rev. 859 (1997).

³⁰ J.W. Warren et al., *Informed Consent by Proxy*, 315 New Eng. J. Med. 1124, 1125 (1986).

³¹ Walter M. Weber, *Substituted Judgment Doctrine: A Critical Analysis*, 1 Issues in L. & Med. 131, 146-47 (1985).

The Washington POLST form is vivid green, and follows a specific format established by the Washington State POLST Task Force, with the cooperation of the Department of Health and the Washington State Medical Association.³²

A POLST must be signed by a health care provider (physician or physicians' assistant, or advance registered nurse practitioner) and also signed by the patient or surrogate decision-maker. It allows the patient to specify whether or not they want medical interventions such as CPR, and whether their treatment should be focused on comfort measures, limited interventions, or full treatment. The POLST should be updated to reflect changes in a patient's preferences or medical condition.

As of 2014, Washington did not provide statutory immunity for providers or others honoring a POLST order. There have been no lawsuits related to POLST in Washington State. If a POLST reflects decisions made by a patient in an advance directive, the immunity protections established in RCW 70.122.051 should apply. Furthermore, the process of creating a POLST, involving extensive discussions with patient family, and the highly visible form itself should reduce the potential liability exposure for providers honoring a POLST.³³

6.2.2 Aid in Dying

Some terminally ill patients find themselves trapped in an unbearable dying process and desire to achieve a peaceful death, avoiding continued suffering and loss of dignity. Such patients may request a prescription for medication that, if ingested, will precipitate a peaceful death. This practice is known as aid in dying.³⁴ It is an option favored by a majority of Americans.³⁵ The growing support for the option of aid in dying may be a natural response to the reality articulated by a leading medical commentator: "For all but our most recent history, dying was typically a brief process These days, swift catastrophic illness is the exception; for most people, death comes only after long medical struggle with an incurable condition"³⁶

³² The 2014 POLST form is available online:

http://www.wsma.org/doc_library/ForPatients/EndOfLifeResources/POLST/POLST_Master_final_2014.pdf.

³³ There are many excellent resources for more information about POLST, including:

- <http://www.wsma.org/polst#download>
- <http://www.wsha.org/EOL-POLST.cfm>
- www.polst.org.

³⁴ Terminology pertaining to this practice has evolved over time. Referring to this practice as 'assisted suicide' is inaccurate and pejorative, and this term has been rejected, except by opponents. The American Public Health Association, for example, in its policy supportive of aid in dying recognizes "the importance of using accurate language to describe care options." APHA notes that the Oregon Department of Human Services, which reports on Oregon's aid in dying practice, rejects using the term "assisted suicide" or "physician assisted suicide." Accordingly, APHA "Rejects the use of inaccurate terms such as "suicide" and "assisted suicide" to refer to the choice of a mentally competent terminally ill patient to seek medications to bring about a peaceful and dignified death." APHA Policy Statement, *Patients' Rights to Self-Determination at the End of Life*. Policy Number: 20086 (2008). See generally, Kathryn L. Tucker, *At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical and Health Policy Associations*, *Harvard Health Policy Review*, vol. 10, no. 1, pp 45-47 (2009). Washington law prohibits referring to aid in dying pursuant to the Washington Death with Dignity Act as "assisted suicide". RCW See RCW 70.245.180 ("Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, . . . under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide.").

³⁵ See e.g., Gallup Poll 2014, <http://www.gallup.com/poll/171704/seven-americans-back-euthanasia.aspx>.

³⁶ Atul Gawande, *Letting Go: What Should Medicine Do When It Can't Save Your Life?*, *NEW YORKER*, August 2, 2010, http://www.newyorker.com/reporting/2010/08/02/100802fa_%20fact_gawande.

Washington permits aid in dying under the Washington Death with Dignity Act, enacted by initiative in 2008.³⁷ Washington is among a growing number of states to have an open practice of aid in dying, along with Oregon³⁸, Montana³⁹, Hawaii⁴⁰, Vermont⁴¹ and in at least part of New Mexico.⁴²

A majority of states, including Washington,⁴³ have statutes that prohibit aiding suicide. These statutes have been assumed to prohibit physicians from providing aid in dying. Washington's assisted suicide statute was upheld by the U.S. Supreme Court following a challenge in federal court under the Fourteenth Amendment to the United States Constitution.⁴⁴ The Supreme Court held that there is no "general" right to physician assistance in dying.⁴⁵ However, five of the Justices, in concurring opinions, left open the question of whether such a right would be recognized in a future case.⁴⁶ The entire Supreme Court recognized that the matter could be redressed legislatively and, indeed, invited legislative resolution.⁴⁷

³⁷ WASH. REV. CODE ANN. §70.245 et seq. (West, Westlaw through 2013 Sess.). Former Washington Governor Booth Gardner, when himself confronting terminal illness, led the successful initiative effort, ably assisted by a coalition created by Compassion & Choices of Washington. Washington voters had considered a similar measure in 1991, which was defeated. See generally, Kathryn L. Tucker, *When Dying Takes Too Long: Activism for Social Change to Protect and Expand Choice at the End of Life*, 33 *Whittier Law Review* pp 109-160 (2011).

³⁸ OR. REV. STAT. ANN. §§ 127.800–127.897 (West, Westlaw through 2013 Reg. and Spec. Sess. 2013).

³⁹ *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

⁴⁰ In Hawaii a constellation of statutory enactments creates an environment in which this option can be provided and is practiced subject to professional medical practice standards, without a statute or court decision specifically authorizing the practice. For a full discussion of law and policy pertinent to aid in dying in Hawaii, see Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices*, 8 J. HEALTH & BIOMEDICAL L. 9, 12–20 (2012).

⁴¹ Patient Choice and Control at End of Life Act, 2013 Vt. Acts & Resolves 292, 296 (codified at VT. STAT. ANN. tit.18, ch. 133 (Supp. 2013)). See, Kathryn L. Tucker, *VERMONT'S PATIENT CHOICE AT END OF LIFE ACT: A HISTORIC "NEXT GENERATION" LAW GOVERNING AID IN DYING*, 38 VT L. Rev. 687, 699(2014) (describing the Vermont law as "a new and different approach to aid in dying, demonstrating that the "laboratory of the States" is open and serving its intended function. The PCEOL embraces briefly the tried-and-true approach employed for more than 15 years in Oregon, and then transitions to an approach that essentially leaves the practice to traditional medical practice governance while continuing to provide a clear safe harbor for physicians.").

⁴² A lower court in New Mexico found the conduct of aid in dying to be within the ambit of a statute prohibiting assisted suicide, but went on to hold that the statute violated the state's constitution. *Morris v. Brandenburg*, No. D-202-CV-2012-02909, slip op. at 6, 13–14 (N.M. Dist. Ct. Jan. 13, 2014), available at <https://newmexico.tylerhost.net/ServeDocument.ashx?SID=0730da82-c2ce-4331-9d34-98fe74190124&RID=001664dd-e045-4d6c-b5ce-1294189b0a7a>. ("This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying. If decisions made in the shadow of one's imminent death regarding how they and their loved ones will face that death are not fundamental and at the core of these constitutional guarantees, than what decisions are? . . . The Court therefore declares that the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution.") *Id.* at 12–13. The decision has been appealed.

⁴³ RCW 9A.36.060.

⁴⁴ *Compassion in Dying v. State of Wash.*, 850 F. Supp. 1454 (W.D. Wash. 1994) (summary judgment granted to plaintiffs holding that competent, terminally ill patients have a constitutionally protected right to choose to hasten death with physician assistance), *aff'd*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom. Wash. v. Glucksberg*, 521 U.S. 702 (1997); *cf. Quill v. Koppel*, 870 F. Supp. 78 (S.D.N.Y. 1994) (aid in dying is not constitutionally protected), *rev'd, Vacco v. Quill*, 521 U.S. 793 (1997).

⁴⁵ *Glucksberg*, 521 U.S. at 724.

⁴⁶ See Kathryn L. Tucker, *The Death with Dignity Movement: Protecting Rights and Expanding Options After Glucksberg and Quill*, 82 Minn. L. Rev. 923 (1998).

⁴⁷ "Throughout the nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." *Glucksberg*, 521 U.S. at 735; "The Court should accordingly stay its hand to allow reasonable legislative consideration," and "the legislative process is to be preferred." *Id.* at 788-89 (Souter concurrence). "States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. In such circumstances, 'the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States. . . ." *Id.* at 737 (citation omitted) (O'Connor concurrence).

6.2.2.1 Washington’s Death With Dignity Act

Located at RCW 70.245, Washington’s Death with Dignity Act (DWDA) establishes a specific lawful procedure for patients to obtain life-ending medications. Following the model of the Oregon Death with Dignity Act, which passed in 1994, the Washington DWDA requires a patient to make two oral requests over not less than a period of fifteen days or more, along with a written request on a form specified by the Department of Health, which must be signed by two qualified witnesses. A patient must then wait 48 hours before receiving life-ending medication. Two physicians, a prescribing physician and a consulting physician, must confirm the patient’s terminal diagnosis, intent to hasten death, and capacity to make an informed decision. The law provides for a psychological assessment for any patient whose competence to make medical decisions is in question. Patients must self-administer the medications.

All cooperating physicians and any pharmacist dispensing medications are required to file reports with the Washington Department of Health, which issues annual reports documenting utilization of the DWDA and patient demographics. Information submitted in reports to the Department of Health is kept strictly confidential. The DWDA specifies that the underlying illness must be listed as the cause of death on the death certificate. Providers who participate in good faith are provided immunity from civil or criminal liability or professional discipline under the DWDA.⁴⁸

6.2.2.2 Washington Patients’ Experience with the DWDA

In the six years Washington’s DWDA has been in effect, patients have used the law with roughly similar frequency to Oregon’s experience. In 2013, 173 patients obtained medications under the DWDA, and of these, 119 died after ingesting their medication. 26 died without taking the medication, and the rest may still be living or did not get reported in time to be included in the annual report. Of the patients who died, 95% had health insurance, and almost 80% of them had cancer. 97% were white/non-hispanic. The vast majority were enrolled in hospice care and died at home. Demographics of patients using the law have not substantially changed over previous years.

Patients’ major challenges in accessing aid in dying have come from lack of information about the law and lack of willing providers to cooperate in making medications available. One major health system and another large specialty oncology practice in Washington provide support and assistance to patients seeking aid in dying, and several other health systems allow providers to cooperate with patient requests at the provider’s discretion. Compassion & Choices of Washington acts as the “steward” for Washington’s DWDA and provides support and physician referrals to the large majority of patients who choose aid in dying.⁴⁹

Because of the lack of information, willing providers, and the policies of certain providers who discourage the provision of information and referrals, some patients find they cannot complete the consent process and obtain medications while they are still capable of self-administering them. Delaying or denying access to information and services may deprive patients of the option of aid in dying.

6.2.2.3 Provider responses to aid in dying in Washington

The DWDA specifies that “only willing providers” will participate in providing aid in dying. Health providers are allowed to refuse to participate in the DWDA. Participation is defined as performing the

⁴⁸ RCW 70.245.190(1).

⁴⁹ Compassion & Choices of Washington information is available at www.compassionwa.org.

duties of an attending or consulting physician.⁵⁰ Participation does not include making a terminal diagnosis, providing information and referrals related to an aid in dying request, or cooperating with a patient request outside the scope of a provider's relationship with any entity prohibiting participation.⁵¹

The DWDA allows facilities or medical practices to adopt policies prohibiting aid in dying, as long as notice is given to all affected providers and to the general public.⁵² Most of Washington's hospitals have provided public notice declining to allow aid in dying on the premises. However, because the vast majority of patients choose to die at home, this has not significantly impacted patient access to services. Currently few if any other health care providers have complied with the public disclosure requirement for policies prohibiting aid in dying.

The DWDA protects providers who decide to cooperate with patient requests outside the scope of employment by a prohibiting employer. Only a few providers have chosen this route to support patient requests for aid in dying, possibly because off-the-clock medical practice generally is not covered by their employers' malpractice insurance or because standard provider employment or independent contractor agreements assure the employer's right to review moonlighting activities. Providers have also stated they fear for their jobs and medical privileges if they choose to participate off the clock while employed or holding medical staff privileges at health care entities prohibiting participation.

Some hospital and other provider policies go further than prohibiting participation in the DWDA and prohibit providers from sharing information or providing referrals. These prohibitions may violate informed consent requirements and could prove problematic under health professional licensing ethics requirements.

6.3 Determination and Recording of Death

6.3.1 Determination of Death

Washington has not enacted legislation regarding determination of death, nor has it legislatively adopted the Uniform Determination of Death Act. However, the Washington Supreme Court has adopted the Uniform Determination of Death Act.⁵³ That act provides that a person is dead if there is either irreversible cessation of circulatory and respiratory function or irreversible cessation of all functions of the entire brain, including the brain stem. Such determination is to be made in accordance with acceptable medical standards.⁵⁴

6.3.2 Recording of Death

A certificate of death shall be filled out by the funeral director, with cause of death certified by the attending physician.⁵⁵ The certificate must be filed with the local registrar of the district in which the death occurred within three business days after the occurrence is known. If the cause of death is undetermined at that time, the certificate may be completed later, provided that the attending physician, coroner or prosecuting attorney gives written notice regarding the reason for delay to the local registrar.⁵⁶

⁵⁰ RCW 70.245.190(2)(d)(ii).

⁵¹ RCW 70.245.190(2)(d)(2)(A)-(D).

⁵² RCW 70.245.190(2)(b)(1).

⁵³ *In re Welfare of Bowman*, 94 Wn.2d 407, 617 P.2d 731 (1980).

⁵⁴ *Id.* at 421, 617 P.2d at 738.

⁵⁵ RCW 70.58.170.

⁵⁶ RCW 70.58.190.

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6.4 Investigation of Deaths

County coroners have jurisdiction of dead bodies where the cause of death occurred under irregular circumstances and may conduct an autopsy, post mortem, or inquest.⁵⁷

6.5 Anatomical Gifts

6.5.1 Scope of Statute

Washington has adopted the Uniform Anatomical Gift Act.⁵⁸ This act governs the manner in which anatomical gifts can be made and received and hospital responsibilities related to such donations.

6.5.2 Authorization to Make Anatomical Gift

6.5.2.1 Self-Donation

Under Washington law, any individual 18 years of age or older and of sound mind may give all or any body part of that individual. The donation is effective upon death.⁵⁹

6.5.2.2 Donation by Others

In many cases, an individual dies without having made prior arrangements for an anatomical gift. The statute recognizes this and provides authority for other interested persons to make an anatomical gift.⁶⁰ It authorizes seven classes of persons who may give all or any part of a decedent's body absent contrary instructions by the decedent. The following seven classes are prioritized and consent must be obtained in order of priority:

1. a guardian of the decedent at the time of the death;
2. an individual with durable power of attorney for health care decisions;
3. the spouse;
4. a son or daughter 18 years of age or older;
5. either parent;
6. a sibling 18 years of age or older; and
7. a grandparent.⁶¹

If an objection arises between class members, an anatomical gift may be made if agreed to by a majority of class members reasonably available.

6.5.3 Hospital Responsibilities Regarding Anatomical Donation

Washington law requires hospitals to have procedures in place for identifying potential anatomical donors.⁶² Inquiry must be made regarding donation. Notice to procurement organizations or donees must be given.⁶³ Hospitals are held to a good-faith standard.⁶⁴ Hospitals must consult with other hospitals in the state as well as

⁵⁷ RCW 68.50.010.

⁵⁸ RCW 68.50.500 *et seq.*

⁵⁹ RCW 68.50.540(1).

⁶⁰ RCW 68.50.550.

⁶¹ RCW 68.50.550(1)(a)-(g).

⁶² RCW 68.50.500, .560.

⁶³ RCW 68.50.500.

⁶⁴ RCW 68.50.510.

procurement organizations and establish agreements or affiliations for coordination of procurement and use of human bodies and parts.⁶⁵

6.5.4 Donees

Donees may be designated or not. If a donee is not designated, or the donee rejects the anatomical gift, any hospital may accept, absent knowledge of the donor's contrary intent.⁶⁶

6.5.5 Manner of Executing and Revoking Anatomical Gift

The statute recognizes two ways a donor may document an anatomical gift.⁶⁷ The first is by way of a document of gift.⁶⁸ The second is by will. The gift is effective upon death without waiting for probate of the will.⁶⁹ If the will is later declared invalid, the gift is still valid.⁷⁰

A donor may revoke or amend the anatomical gift.⁷¹ It may be revoked in writing or orally if made in the presence of two witnesses.⁷² It may also be revoked by any communication made during a terminal illness or injury.⁷³ Revocation of a donation in a will may be made by means of amendment or revocation of a will.⁷⁴

6.5.6 Medical Acceptability

Anatomical donation authorizes medical examination necessary to ensure acceptability.⁷⁵ This may include an examination of the donor's medical records.

6.6 Disposition of Human Beings

6.6.1 Scope of Statute

Codified in Chapter 68.50 RCW are Washington statutes concerning the disposition of human remains.

6.6.2 Right to Control Remains

A person has the right to control the disposition of his or her own body without the consent of another person.⁷⁶ If the decedent has arraigned for an agent to control the remains, (through a signed document, in the presence of a witness) the agent directs disposition.⁷⁷ If no arrangement has been made by the decedent, five classes of persons have the authority to control the disposition. The following five classes are prioritized and consent must be obtained from persons in order of priority:

1. the spouse;
2. children of decedent 18 years of age or older;

⁶⁵ RCW 68.50.600.

⁶⁶ RCW 68.50.570.

⁶⁷ RCW 68.50.540.

⁶⁸ RCW 68.50.540(2).

⁶⁹ RCW 68.50.540(5).

⁷⁰ *Id.*

⁷¹ RCW 68.50.540(6) & (7).

⁷² *Id.*

⁷³ *Id.*

⁷⁴ RCW 68.50.540(7).

⁷⁵ RCW 68.50.620.

⁷⁶ RCW 68.50.160.

⁷⁷ RCW §68.50.160(3)(b).

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3. parents;
4. siblings 18 years of age or older; and
5. a court appointed guardian at the time of death.⁷⁸

6.6.3 Undisposed Remains

If a body is not disposed of as provided above after ninety days, the entity with possession may direct the disposition in accordance with the Rules of the Funeral and Cemetery Board.⁷⁹

⁷⁸ RCW § 68.50.160(3)(c)-(e).

⁷⁹ RCW § 68.50.230.