SENATE BILL REPORT

SHB 1481

AS REPORTED BY COMMITTEE ON HEALTH & LONG-TERM CARE, FEBRUARY 27, 1992

Brief Description: Amending the natural death act.

SPONSORS: House Committee on Health Care (originally sponsored by Representatives May, Hine, Ballard, R. Johnson, Betrozoff, Spanel, Broback, Rasmussen, Wood, Brumsickle, Neher, Leonard, Ferguson, Day, Lisk, Cooper, Brough, Prentice, Forner, Basich, Paris, Holland, G. Fisher, Horn, Sprenkle, Dellwo, Moyer, Grant, Braddock, Bowman, Heavey, Kremen, Cantwell, Winsley, Zellinsky, Silver, Franklin, Pruitt, Inslee, Edmondson, Sheldon, McLean, Riley, Wynne, Rayburn, Wilson and Orr)

HOUSE COMMITTEE ON HEALTH CARE

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended.
Signed by Senators West, Chairman; M. Kreidler, Niemi, and Wojahn.

Staff: Martin Lovinger (786-7443)

Hearing Dates: February 25, 1992; February 27, 1992

BACKGROUND:

The Natural Death Act establishes a legal process for evidencing a patient's decision to die naturally. It authorizes adult persons to sign written directives ordering their physicians to withhold or withdraw life-sustaining procedures in situations where the attending physician determines that the patient has a terminal condition and death is imminent. An additional physician must certify that the patient is terminally ill.

Recent state and federal Supreme Court decisions declared that persons have a constitutional right to authorize the withholding or withdrawal of life-sustaining procedures when they have a terminal condition, and that the courts are not normally the proper forums to be making these decisions.

Life-sustaining procedures can be withheld or withdrawn in accordance with a written directive where they would serve only to artificially prolong the moment of death. Life-sustaining procedures include any medical or surgical procedures which utilize mechanical or other artificial means to sustain a vital function, but artificially provided nutrition and hydration are not specifically referenced. Medical intervention cannot be withdrawn if deemed necessary to alleviate pain.

Before treatment can be withdrawn, death must be imminent. The current law does not cover patients in irreversible coma or persistent vegetative states.

The directive must essentially be in the form provided in the statute but may include other specific directions.

There is no reference to the validity of directives written in other jurisdictions.

There is no right granted a patient choosing to die at home to be immediately discharged by a hospital.

Nonlicensed health personnel are not accorded immunity from liability for honoring a patient's directive.

A physician refusing to effectuate the directive must make a good faith effort to transfer the patient to a complying physician, but other persons or health facilities are not so obligated. There is no protection from legal liability for those persons and facilities choosing not to comply with patient directives. Nor is there a duty to inform the patient of any policy that would preclude the honoring of patient directives.

Complying with a patient's directive does not constitute suicide, but there is no reference to homicide. The law does not condone or authorize mercy killing, but physician-assisted suicide is not referenced.

The directive is conclusively presumed to be the patient's directions.

There is no reference regarding the provision of futile treatment.

SUMMARY:

There are legislative declarations that pain medication to increase comfort for terminal patients should not be withheld; that the right to control health care decisions may also be exercised through a durable power of attorney or through an authorized health care decision-maker; and that the court is normally not the proper forum for making decisions regarding life-sustaining treatment.

Life-sustaining procedures are referenced as treatment that can be withheld or withdrawn according to a patient's written directive (also known as a "living will"), where the treatment would serve only to prolong the process of dying. Life-sustaining treatment is clarified to include artificially provided nutrition and hydration. However, surgical, as well as medical intervention, cannot be withdrawn if it is deemed necessary solely to alleviate pain.

The death need not be imminent. The directive authorizes the withholding or withdrawing of life-sustaining treatment where it would serve only to prolong the process of dying of a

patient diagnosed by the attending physician to have a terminal condition which would cause death within a reasonable period of time in accordance with accepted medical standards; or where the patient is diagnosed by two physicians as having no reasonable probability of recovery from an irreversible and incurable comatose or persistent vegetative state.

The model written directive addresses the issue of artificially provided nutrition and hydration. The declarant must specifically indicate his or her choice in the directive.

A directive executed in another political jurisdiction is valid to the extent allowable by Washington and federal law.

A patient who wishes to die with dignity at home must be discharged as soon as reasonably possible.

Persons and health facilities participating in good faith with a patient's directive are immune from legal liability. Persons or health facilities choosing not to comply with the directive must immediately take reasonable steps to transfer the patient to another physician or health facility, and are unconditionally protected from legal liability unless otherwise negligent. A physician or health facility must inform the patient of any policy precluding the honoring of a patient's directive.

The withholding or withdrawal of life-support treatment does not constitute a suicide or homicide, but the law is not to be construed to condone or authorize physician-assisted suicide. Nor is it to be construed to require futile treatment, nor to be the exclusive means by which individuals may decide to withhold or withdraw life-support treatment.

A person or health facility may assume that a patient's directive complies with this law, and directives executed prior to these amendments are valid.

The Department of Health is directed to adopt guidelines for emergency medical personnel for persons evidencing a desire not to receive futile treatment.

Appropriation: none

Revenue: none

Fiscal Note: requested February 20, 1992

SUMMARY OF PROPOSED SENATE AMENDMENT:

Language has been added to the intent section that clarifies that this bill deals with people who had the capacity to make health care decisions when they made those decisions.

Language is deleted from the intent section that this bill covers authorized health care decision makers other than those granted the durable power of attorney by the patient. Also deleted are declarations that courts are not the proper forum

regarding these decisions and that avoiding treatment that is not desired by a terminally ill patient is in the interest of public health and welfare.

The definition of qualified patient is changed to specify that the person must be an adult. Also a qualified person can only be diagnosed to be in a permanent unconscious condition "in accordance with accepted medical standards."

If a patient requests a discharge from a health facility, the health care provider must inform the patient of the medical risks of immediate discharge. If the provider complies with that requirement there is no liability that will result from the discharge. Also the words "by words or actions" and "in dignity" have been deleted.

The clause, "or in accordance with appropriate direction from a lawfully authorized decision maker" has been deleted.

Health care providers must inform patients of any policy that would preclude honoring directives and if the patient still wishes to be admitted or remain at the facility, then the provider and patient or patient's representative must work out a written plan that will be used should the circumstances arise when the directive would become operative. If the provider complies with either the directive or the written plan under this section then no liability attaches to the provider.

The provision that the Natural Death Act shall not be construed to require futile treatment is deleted.

TESTIMONY FOR:

Persons should have the right to control the decisions regarding their own health care when they become terminal by executing "living wills." The 1979 Natural Death Act limits this right in several regards. First, the act is unclear with regard to the ability to authorize the withholding or withdrawal of artificially provided nutrition and hydration. People should have an opportunity to evidence a choice in the document. Second, death must be "imminent" in order to have life-support procedures withheld or withdrawn, which leaves uncovered the majority of situations involving persons who may be in incurable and irreversible unconscious conditions.

TESTIMONY AGAINST:

Artificial nutrition and hydration should never be withdrawn as it is tantamount to life itself, one of the mainstays of comfort care, and is on a higher plane than other medical procedures that are curative. To permit such a thing is a version of euthanasia as equally unethical as "physician assisted aid-in-dying" in Initiative 119, rejected by the voters in November 1991. Further, there are occasions when persons in comatose or persistent vegetative states actually recover. Some 58 percent regain consciousness within three years. Physicians and health care facilities objecting to

carrying out "living wills" for ethical reasons should not be obliged to refer the patient to other health providers who will honor such directives because it is equally unethical.

The language is this bill is too broad. It could lead to quality of life decisions in which society decides that disabled and fragile people should not be kept alive because the quality of their lives does not justify the expense.

TESTIFIED: PRO: Representative Fred May, prime sponsor; Dr. Jim Kilduff, President, Washington State Medical Association; Dr. Maureen Callaghan, Washington State Medical Association; Esther Stohl, Senior Citizens Lobby; Sister Sharon Park, Washington Catholic Conference; Catherine Allen, Nurse; Karen C. Tynes, Washington Association of Homes for the Aging; Jan Williams, Nurse, Hospice of Seattle; Johnny Cox, PhD, Staff Ethicist, Sacred Heart Hospital, Spokane; CON: Thomas J. Marzen, National Legal Center for the Medically Dependent; Diane Coleman, Tennessee Human Rights Commission; Dr. Leslie Newton, Seattle physician; Eileen Brown, Hospice nurse, Chair, 119 Vote No; Melyn Brock, Cottesmore Nursing Home; Mary Jo Kahler, Human Life of Washington; Kenneth Van Der Hoef, Seattle attorney