# Increasing Access to End-of-Life and Ending-Life Care

## Hospital Compliance with Washington's Updated *Death With Dignity Act* – SB 5179


***Prepared by***
***Gianna R. Strand***
***Karin Sobeck***
***The Completed Life Initiative***

# TABLE OF CONTENTS

# ABOUT MEDICAL AID-IN-DYING

Medical Aid-in-Dying ("MAiD") is medical assistance provided to a terminally ill patient who has decisional capacity enabling them to self-administer prescribed medications, following an explicit written request in order to end their life in a manner that is *safe, certain, and painless*.

In 2008, Washington became the second state to legalize MAiD through their *Death with Dignity Act ("DWDA") Initiative 1000, Chapter 70.245 RCW* which took effect in 2009. Eligible patients must make two oral and one written request using a statutory form, signed by two witnesses, to potentially be eligible for aid-in-dying medications. A second consulting provider must agree to the requests. A patient can withdraw their request for MAiD at any time, and can simply decide not to ingest the prescribed medication.

## Where in the U.S. is Medical Aid-in-Dying Legal in 2023?

- California
- Colorado
- Hawai'i
- Maine
- Montana
- New Jersey
- New Mexico
- Oregon
- Vermont
- Washington
- Washington, DC

## Washington's *Death with Dignity Act* Eligibility Criteria

- ✓ An adult 18 years of age or older
- ✓ A Washington resident
- ✓ Acting voluntarily
- ✓ Terminally ill, with a prognosis of six months or less to live
- ✓ Mentally capable of making healthcare decisions
- ✓ Capable of self-administering the prescription

# WASHINGTON SENATE BILL NO. 5179

As required by the State of Washington Administrative Code ("WAC"), hospitals must post to their organization website a copy of the specific policies describing the types of services that are available at their institutions. These policies must be posted to a hospital's website in a location that is readily accessible to the public without a required login or other barriers. The state requires this "to improve patient care and outcomes by respecting every patient and maintaining ethical relationships with the public."[1] Respect for persons, as outlined in the Belmont Report, requires individuals to be treated as autonomous agents.[2] Autonomy is respected by ensuring that decisionally capacitated individuals are provided with the resources and support necessary to advance their self-interest and well-being when making important healthcare decisions.

In 2023, Washington amended their administrative code via Senate Bill 5179 ("SB 5179")[3] to "increase[e] access to the provisions of the *Washington Death with Dignity Act*". The amendment was adopted on March 24, 2023 and signed by the governor shortly thereafter. It took effect on July 23, 2023.

Section 18 amends existing law to establish that every hospital must both submit and publicly post their policies relating to end-of-life care ("EOL") and the *DWDA*.

Image 1: Example of a hospital web page policy section

## How Does SB 5179 Increase Access to MAiD?

✓ Shortens the waiting period from first oral request to when a prescription may be written from 15 days to 7 days

✓ Allows physician assistants and advanced registered nurse practitioners to serve as a primary or consulting medical provider, in addition to physicians

✓ Allows independent clinical social workers, advanced social workers, mental health counselors, and psychiatric advanced registered nurse practitioners to provide counseling, in addition to psychiatrists and psychologists

✓ Clarifies that a transfer of care or medical records does not restart the waiting period

✓ Requires every hospital to post its policies related to access to care regarding: (a) Admission; (b) Nondiscrimination; (c) End of life care and the death with dignity act, chapter 70.245 RCW; and (d) Reproductive health care

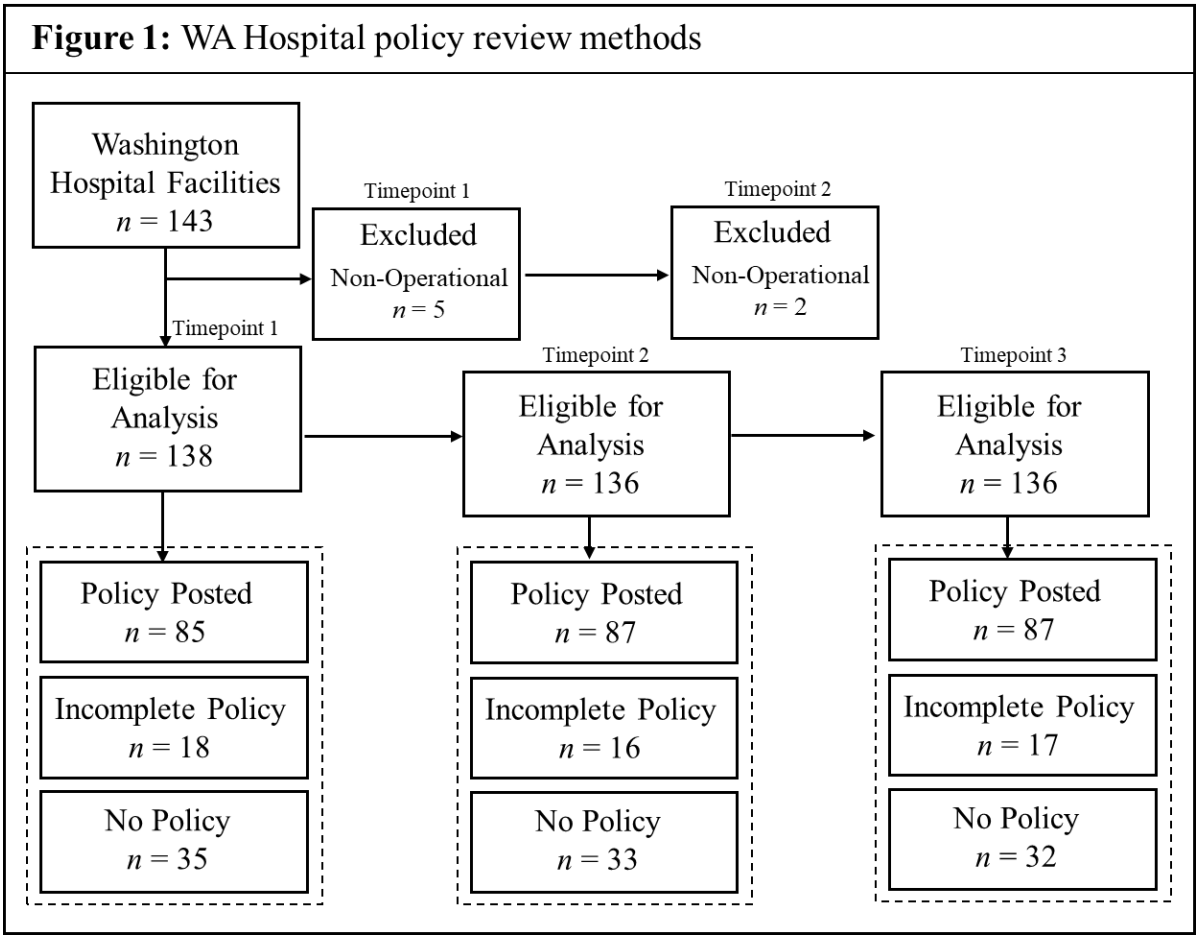
# STUDY

**Objective:** To measure the public availability of end-of-life and *DWDA* policies at hospitals in Washington before and after SB 5179 took effect, in order to assess the impact this legal mandate had on policy availability and health information transparency.

**Methods:** To ensure a thorough evaluation of diverse hospital facilities, a list of hospitals was generated from three public hospital directories: (1) membership in the Washington State Hospital Association; (2) the Washington State Department of Health 'Directory of Washington Hospitals'; and (3) the online State Guides 'Washington Hospitals Directory'. Hospital addresses were cross-referenced to avoid duplication.

Hospitals were eligible for review if they: (1) were open and operational and (2) had an English language public web page that was (3) accessible via internet search engine without a log in, as required by WAC. The policy page for each hospital website was searched for EOL and *DWDA* policies at three timepoints. Timepoint 1 (May) was two months before SB 5179 took effect. Timepoint 2 (July 31st) was one week after SB 5179 took effect. Timepoint 3 (August 31st) was five weeks after SB 5179 took effect. Policies were considered incomplete if the link on the hospital webpage was non-functioning ($n = 1$); the policy statement was unclear ($n = 1$); or if the policy only covered EOL care but did not also cover *DWDA* care as required by SB 5179 ($n = 16$).

**Figure 1:** WA Hospital policy review methods



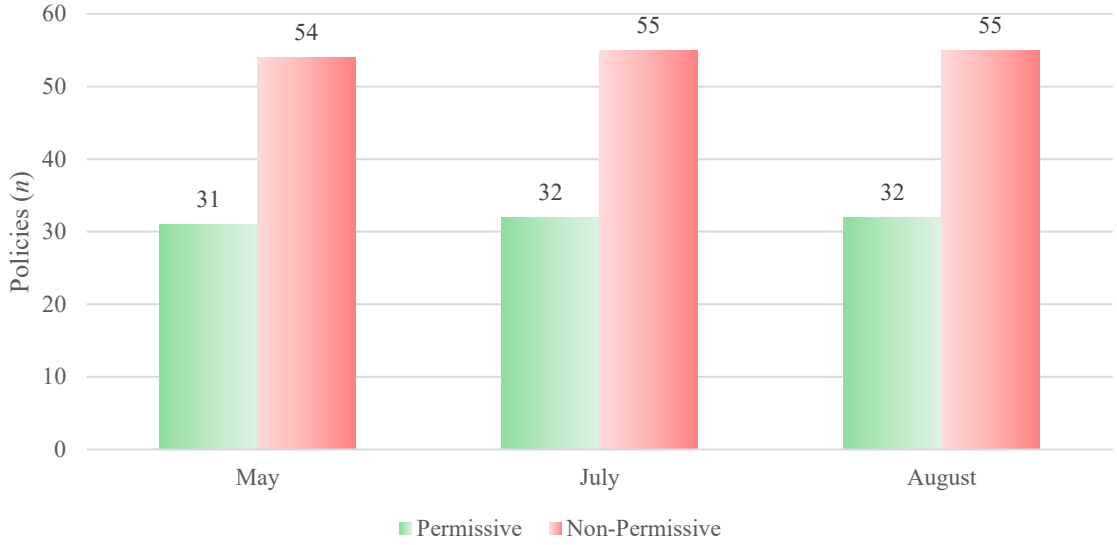
# RESULTS

A total of 143 unique hospital facilities were identified.

### Key Takeaways

- 5 facilities (3.49%) were closed or non-operational. Two additional facilities closed mid-study
- The number of hospitals with (62-64%) or without (23-25%) a policy posted remained mostly unchanged [Figure 1]
- 17 hospitals (12.5%) posted a policy that contained information on some types of EOL care, but not MAiD or the *DWDA*
- 1.75x as many hospitals **do not** support[ɬ] MAiD compared to those who do [Figure 2]
- Among hospitals that do not support MAiD care:
  - 21 hospitals (38.89%) require the transfer of patients who wish to access MAiD
  - 9 hospitals (16.36%) affirmatively provide referrals for patients seeking MAiD
  - 1 hospital (1.82%) prohibits providers from making referrals to MAiD providers
  - 19 hospitals (34.55%) took no clear position, instead stating "the provider may choose to provide the patient with a referral, or may instruct the patient that he or she must find a participating provider on his or her own."[4]
- 7 policies covering 33 separate care facilities (31.7%) used value-laden terminology such as "suicide" or "euthanasia"
  - 4 of these 7 policies were from religious hospitals while 3 were from secular hospitals

Figure 2: Washington Hospital Policies and DWDA / MAiD Permissibility




ɬ Examples of a supportive policy include permitting staff to serve as attending or consulting providers, allowing pharmacists to fill and dispense medications, allowing staff to be present during ingestion, and providing referrals for other needs and services. Examples of a non-supportive policy include prohibiting staff from serving as attending or consulting, prohibiting pharmacists from filling and dispensing medications, not allowing staff presence during ingestion, forcibly discharging patients, requiring patients to transfer care elsewhere, and refusing to provide referrals for other needs and services.

# SUBGROUP RESULTS

**Key Takeaway:**

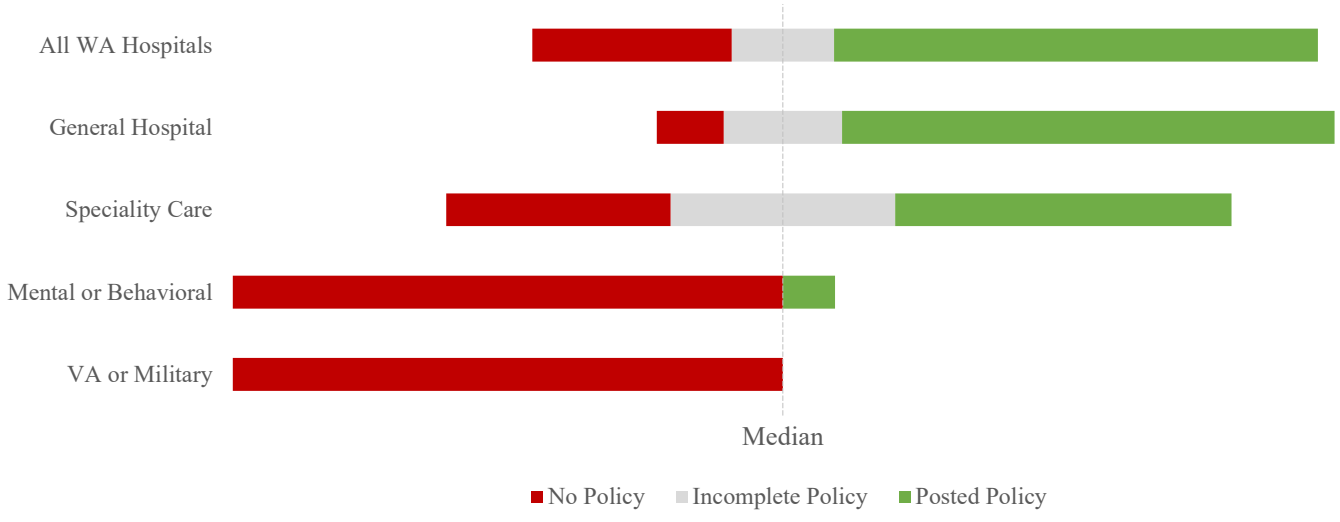
Compliance with the posting requirements of SB 5179 varied significantly by facility type.

Washington's administrative code applies to *every* hospital facility, regardless of specialty or affiliation. A diverse group of hospitals was included in this study including:

- □ public non-profit hospitals
- □ for-profit hospitals
- □ a cancer center
- □ critical access hospitals
- □ an Air Force hospital
- □ Naval hospitals
- □ an Army medical center
- □ behavioral health hospitals
- □ a Coast Guard medical clinic
- □ Veterans Affairs medical centers
- □ residential and long-term addiction treatment hospitals
- □ rehabilitation hospitals for stroke, brain, spinal cord, and other neurological injuries

Although 80.19% of general hospitals had a complete policy posted, compliance dropped to 50.0% for specialty care hospitals (such as cancer centers and burn centers), and only 6.67% for mental, behavioral, or counseling centers. No VA or military medical center posted a policy. One-third of specialty care hospitals posted an incomplete policy referencing some EOL care policies but no information about *DWDA*.

Figure 3: Washington Hospital Policy Availability by Subgroup



# THE IMPORTANCE OF UPDATING POLICIES

The WAC, and its amendment via SB 5179, do not compel hospitals to provide specific medical services. Rather, WAC requires hospitals to clearly communicate to patients what types of care and procedures are, **or are not**, available. Having a clear, comprehensive hospital policy reduces practice variation. This allows for practice standardization across multiple facilities within a single hospital system, and provides a valuable resource for patients and staff.

Over 20% of hospital policies reviewed in this study were outdated (≥ 5 years since last review) or expired. This leaves patients and providers without guidance on whether such policies are still applicable or enforceable.

As clinical practices evolve, so too must the policies that govern provision of care. Emerging standards of care, changes in clinical practices, and the availability of novel interventions are among the many reasons why clinical policies and guidelines require review and, if necessary, updates.[5] Failure to review or update policies could indicate that a hospital is offering services inconsistent with clinical practice standards. This prejudices both providers and patients.[6]

> All policies and procedures should be reviewed at least annually, revised as necessary, and clearly marked to indicate when revisions have occurred.
>
> Source: Joint Commission on Accreditation of Healthcare Organizations[7]

The enactment of SB 5179 could have been a catalyst from an evaluation, quality review, and process improvement standpoint. Only 7 of 87 hospitals updated or reviewed their policies in response to SB 5179. Six of these hospital policies had been updated or reviewed within the last 5 years. These hospitals were already complying with the best practice standards. SB 5179 provided insufficient motivation to produce widespread review by hospitals statewide to ensure that policies were reflective of best practices and in compliance with the updated posting requirements.

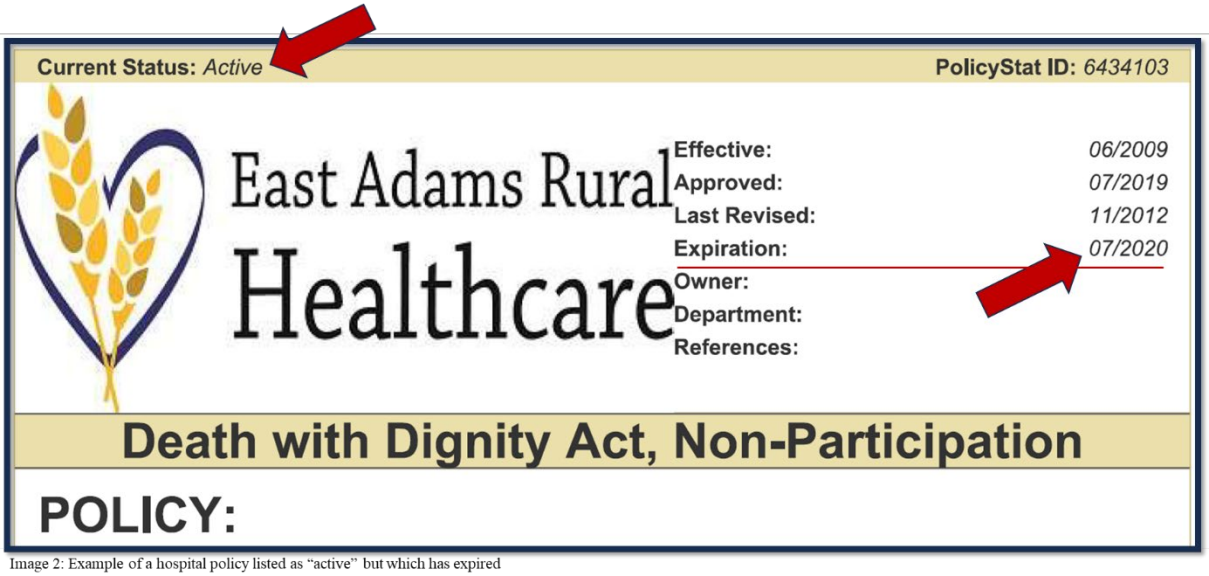
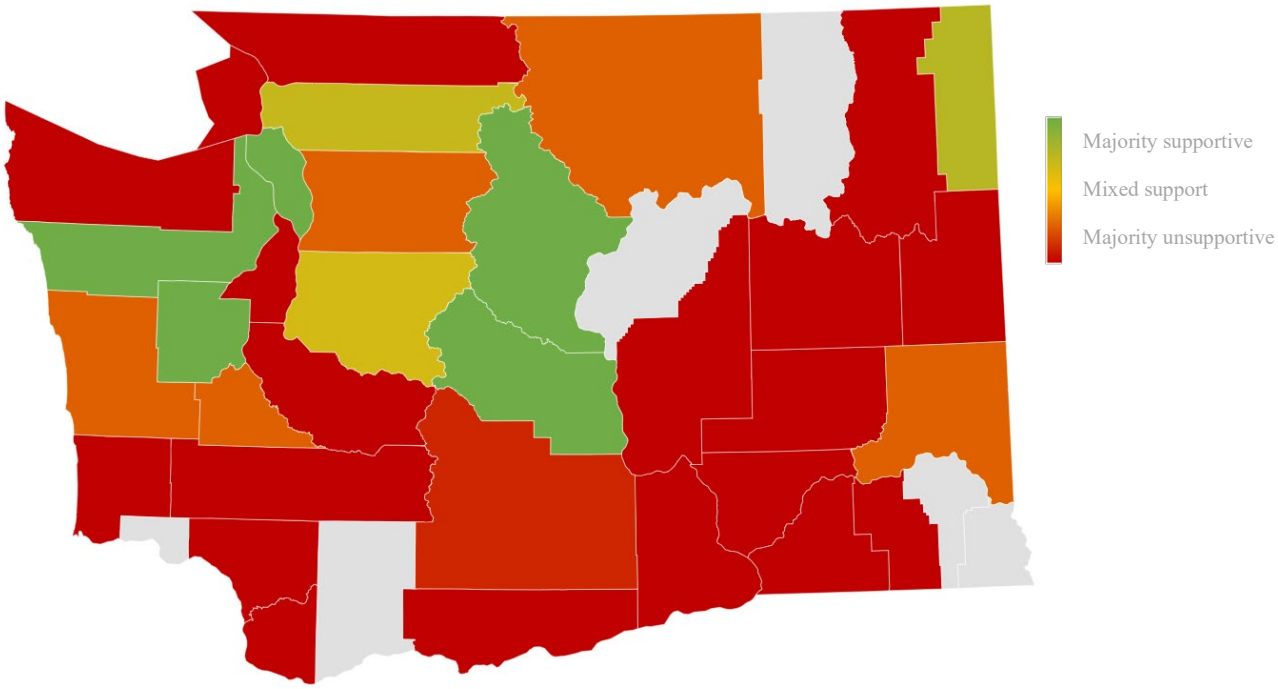



Image 2: Example of a hospital policy listed as "active" but which has expired

# ADDITIONAL DISCUSSION: CARE DESERTS

Availability of MAiD care is dependent on geographic location. Washington hospitals with policies that are supportive of MAiD, and allow their providers and pharmacies to provide ending life care, were predominantly in the North and South Puget Sound regions. Patients in other parts of the state, particularly in the Columbia Basin and Rocky Mountain areas, experience care deserts. A medical care desert is defined as a region where a population has inadequate access to healthcare.[8] This may be the result of rural geography, but care deserts also occur when patients cannot access desired or necessary care due to socio-cultural barriers involving cost, language, religion, or cultural norms. West of the Cascade Range, a patient might need to drive 200 miles to seek ending life care at one of two hospitals in Pend Orielle and Whitman County whose policies are supportive of MAiD and *DWDA* care.

Figure 4: Heat Map of Washington Counties by Policy Supportiveness




Accessing EOL care can also be difficult because half of hospital beds statewide are in facilities that are bound by religious directives. In Cowlitz, San Juan, Stevens, and Whatcom County, 100% of beds are operated by religiously affiliated organizations.[9,10] Catholic health care providers frequently limit access to end-of-life and reproductive health care services.[11,12] Washington's conscience clause (RCW 48.43.065) permits health care providers and their religiously-affiliated employers to opt out of participating in medical procedures concerning which they have a religious objection, but does not require facilities to provide referrals for care that they are unable or unwilling to provide. Some Washington hospitals have retained secular policies even after incorporation into a larger Catholic/Christian network.

# CONCLUSION

Having consistent access to information about the scope of services a hospital and its clinicians will or will not provide is essential for patients to make informed healthcare decisions. By adding EOL and *DWDA* policies to the list of required information hospitals must post, Washington is affirming that end-of-life and ending-life care are valid and important components of comprehensive patient care. SB 5179 represented an update to existing policy posting requirements rather than a new initiative. Despite this, the requirements imposed by SB 5179 have not produced a noticeable impact on the total number of hospitals that post EOL and *DWDA* policy on their web page, nor effect how hospitals updated or reviewed existing policies. Compliance remained around 60% at all assessment timepoints. General hospitals were more likely than specialty care and behavioral health hospitals to be compliant. No military facilities had a policy posted. It is possible that these results may change if re-assessed at later timepoints. However, given the data from other states with similar policy posting requirements, significant changes should not be expected.[13]

California and New Mexico have similar "MAiD policy" posting requirements, but – like Washington – neither state has mandated review or enforcement mechanisms to ensure compliance and information veracity. Colorado has proposed similar legislation that will require covered healthcare entities to provide a service availability form to the public and require that all forms be updated at least biennially.[14] The requirement to give notice will be enforceable and punishable by a fine of $1,000 for each day that the covered entity is not in compliance. (Of note, Colorado's bill does not explicitly include MAiD as part of its covered EOL services, which it defines as palliative care, hospice care, advance directives, and withdrawal of nutrition.) If enactment occurs, further research is warranted to assess the effectiveness of Colorado's transparency and notice requirements.

# PROPOSALS

(1) All Washington hospitals should be compelled to achieve compliance with the state requirements, and to post all required patient care policies to their public web page immediately, by dissemination of the findings of this study
(2) If a hospital does not or cannot provide a specific service, the associated policy should clearly indicate whether a referral will be provided
(3) Other states, territories, and districts with legalized aid-in-dying should be urged to enact similar policy transparency requirements
(4) Jurisdictions should consider an enforcement mechanism to encourage compliance

# REFERENCES


[1] Washington Administrative Code, Title 246, Chapter 246-320, Section 246-320-141. "WAC 246-320-141: Patient rights and organizational ethics." https://app.leg.wa.gov/WAC/default.aspx? cite=246-320-141&pdf=true%20Section%2018(4).

[2] Porter, J.P., Koski, G. "Regulations for the Protection of Humans in Research in the United States: The Common Rule." *The Oxford Textbook of Clinical Research Ethics*, edited by Ezekiel J. Emanuel, et al., Oxford University Press, Incorporated, 2008. ProQuest Ebook Central, pp. 156-167.

[3] Engrossed Substitute Senate Bill 5179. State of Washington, 68th Legislature, 2023 Regular Session. SB 5179 Sec. 18. RCW 70.41.520 and 2019 c 399 s 4. https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Senate%20Passed%20Legislature/5179-S.PL.pdf

[4] Odessa Memorial Hospital. WA State Death with Dignity Act Policy Reviewed/Revised: January 2019. Pg 1-2.

[5] Shekelle P, Eccles MP, Grimshaw JM, Woolf SH. When should clinical guidelines be updated? *BMJ*. 2001;323(7305):155-157. doi:10.1136/bmj.323.7305.155

[6] O'Donnell J, Vogenberg FR. Policies and procedures: enhancing pharmacy practice and limiting risk. *Pharm & Therapeutics.* 2012;37(6): 341-344.

[7] Indian Health Service. Clinic Management "Policies and Procedures." https://www.ihs.gov/doh/clinicmanagement/ohpgdocs/chapter1/html/Policies%20and%20Procedures.html

[8] Brînzac MG, Kuhlmann E, Dussault G, Ungureanu MI, Chereches, RM, Baba CO. Defining medical deserts - an international consensus-building exercise. *Euro J Pub Health*, 2023. doi: 10.1093/eurpub/ckad107

[9] Clarridge, C. How his twin brother's deathbed plea was a call to action for Washington state's insurance commissioner. *The Seattle Times*. Oct 21, 2021. https://www.seattletimes.com/seattlenews/health/how-his-twin-brothers-death-bed-warning-was-a-call-to-action-for-washington-states-insurance-commissioner/

[10] Shapiro, N. Religious health care restrictions prompt call for Washington merger oversight. *The Seattle Times*. Feb 6, 2023. https://www.chronline.com/stories/religious-health-care-restrictions-prompt-call-for-washington-merger-oversight

[11] Ayer, T. Death with Dignity services will be affected by Virginia Mason merger. *Yakima Herald Republic*. Aug 30, 2020. https://www.yakimaherald.com/news/local/death-withdignity-services-will be-affected-by-virginia-mason-merger/article_aa3e2cb2-1ea9-5fae-a3c0a44c3e0494ef.html

[12] Catholic Health Association of the United States. Caring for People at the End of Life. Washington, DC, USA, 1-16.

[13] Strand GR, Sobeck K, Hoffman DN. "A National Survey of Hospice Aid-in-Dying Policy Availability and the Impact of Legal Mandates." *J Hospice Palliat Med Care*. 2023; 5(20): 1-4.

[14] Colorado House Bill 23-1218. Article 58: "Patients' Right to Know Act." https://leg.colorado.gov/sites/default/files/2023a_1218_signed.pdf


THE completed life INITIATIVE