

CHAPTER 2-A

**LAWYERS, DOCTORS, AND TERMINATION OF LIFE SUPPORT: INTEGRATING
LIVING WILL AND POLSTS (PHYSICIAN ORDERED LIFE-SUSTAINING
TREATMENTS)**

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ON-LINE RESOURCES

www.wsma.org (Washington State Medical Association)

www.nationalhospicefoundation.org

www.ntlc.org ("will to live" project - to "protect person from pressure from health care providers")

www.lawhelp.org (Columbia Legal Services)

www.agingwithdignity.org (5 wishes)

www.doh.gov (Department of Health)

I. Introduction¹

The Natural Death Act, RCW 70.122 *et. seq.*, establishes a statutory form called a Health Care Directive (HCD). Practitioners can safely assure their clients that a statutory HCD is valid and that a statutory HCD will likely result in refusal or withdrawal of life-sustaining treatment under the conditions stated in the directive.

The Washington State Medical Association, Washington State Department of Health and others have also developed a form - called a POLST - which is a physician's order specifying circumstances under which refusal of a patient's life-sustaining treatment is authorized. A POLST is signed by the patient² and the doctor.

The Natural Death Act allows a person to "add to or delete from or otherwise change the wording" of a directive, so long as any changes are consistent with "Washington state law or federal constitutional law." RCW 70.122.030.

What language can be added to a statutory HCD without rendering the HCD invalid? What kind of language added to a statutory HCD would turn that form into an instrument "authorizing" euthanasia, physician-assisted suicide, or homicide? What is a POLST, and is it a legally valid instrument? When a person signs a POLST, should that document simply be considered a non-statutory HCD? If a client executes a statutory HCD and later executes a POLST with inconsistent terms, which document prevails? What are a person's true wishes concerning withdrawal of life-sustaining treatment when the person signs a POLST in the doctor's office, only to later execute an inconsistent HCD in the attorney's office?

This chapter attempts to answer some of these questions.³ Also, attached is a statutory HCD, some non-statutory HCDs, a failed legislative proposal to expand the Natural Death Act, a POLST document, POLST background materials, and other resources.

¹Sharmon Figenshaw has authored Sections VI. B. through F., and VII. B. Neil R. Sarles has authored the balance of this Chapter with assistance from Sharmon Figenshaw.

² Although a surrogate is allowed to sign for the patient.

³Please note that this chapter primarily addresses concerns relating to how far a person's right to refuse life-sustaining treatment extends. It does not address the question of under what circumstances ("substituted judgment" v. "best interests"; "clear and convincing" v. "preponderance") a fiduciary is entitled to make a decision on behalf of a principal. Also, this chapter does not review the question of a minor's "right to die" as exercised by a parent or guardian.

II. The Natural Death Act

The Natural Death Act (NDA), RCW 70.122 *et. seq.*, sets forth a statutory form for withdrawal of life-sustaining treatment. If the form is followed, the legislature has declared that the refusal or withdrawal of treatment shall not constitute a homicide or a suicide, nor shall implementation of such a directive affect a life insurance policy on a person's life. RCW 70.122.070. Any health care professional involved in refusing or withdrawing treatment in good faith "in accordance with the requirements" of the Natural Death Act shall be immune from civil or criminal liability, and shall not be subject to professional conduct sanctions. RCW 70.122.051. However, RCW 70.122.100 makes it clear that the legislative creation of a statutory HCD should not be construed as condoning mercy-killing or physician-assisted suicide.⁴

III. The Common Law and Constitutional Right to Withdraw Life Sustaining Treatment

Again, the statute⁵ says that the statutory HCD can be changed, but how far beyond the statutory HCD can a person go in directing his or her own demise? Answering that question in Washington State requires an examination of the cases which establish, in the absence of any written directive, the outer limits of a person's constitutional and common law right-to-refuse life-sustaining treatment.

As stated by Justice Rehnquist in his majority opinion in the case of *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 270, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990), ". . . medical technology [is] capable of sustaining life well past the point where natural forces would have brought certain death in earlier times . . .". It is with this societal dilemma in mind that the Washington cases addressing withdrawal of life support are reviewed.

In the case of *In Re Colyer*, 99 Wn.2d 114, 660 P.2d 738 (1983), Ms. Colyer, age 69, sustained a cardiopulmonary arrest: i.e., her heart stopped beating. Her body was without oxygen for about ten minutes, resulting in massive brain damage. She fell into a comatose state, was unresponsive to pain or verbal stimuli, and required a respirator to breathe. The court characterized her condition as a persistent vegetative state. Her prognosis for any sort of meaningful existence was considered zero.

⁴ Physician-assisted suicide is a crime (RCW 9A.36.060). See *Washington v. Glucksberg*, 521 U.S. 702, 117 S.Ct. 2258, 138 L.Ed.2d 772 (1997), which upheld the validity of RCW 9A.36.060 against a substantive due process challenge. The court distinguished *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 270, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990), and drew a line between a person's right to refuse unwanted life-sustaining treatment and a person's desire to initiate treatment that causes death.

⁵ RCW 70.122.030.

Ms. Colyer's husband was appointed as her guardian, and he petitioned for the removal of his wife's life support systems.

The court found that Ms. Colyer was not legally dead under the Uniform Determination of Death Act, which requires cessation of all circulatory, respiratory and brain functions. (See *In Re Bowman*, 94 Wn.2d 407, 617 P.2d 731 (1980)). The court also determined that Ms. Colyer's situation was not covered by the Natural Death Act, RCW 70.122 et seq., since she had not executed a directive under that act.

Citing legislative intent, the Washington State Constitution (Art. 1, Sec. 7), and a right of privacy rooted in the U.S. Constitution and made applicable to the states through the Fourteenth Amendment, the *Colyer* court held that:

" . . . an adult who is incurably and terminally ill has a constitutional right of privacy that encompasses the right to refuse treatment that serves only to prolong the dying process, given the absence of countervailing state interests." 99 Wn.2d at pg. 120.

The court also held that a person has a common law right to be free from "non-consensual invasions of one's bodily integrity." 99 Wn.2d at pg. 121.⁶

The *Colyer* court balanced the right to refuse life-sustaining treatment against the following potential countervailing state interests:

1. Preservation of life,
2. Protecting the interests of innocent third parties,
3. Preventing suicide, and
4. Maintaining the ethical integrity of the medical profession.

The court found that the state's interest in preserving life was weakened when treatment would serve only to prolong a "life inflicted with an incurable condition." 99 Wn.2d at pg. 122. The court also said that the state's interest in preserving life must be balanced against the degree of bodily invasion, and in Ms. Colyer's case, the court found the degree of bodily invasion to be great.

⁶ See, also, *Strickland v. Deaconess Hospt.* 47 Wa. App. 262, 735 P.2d 74 (1987) (A doctor ordered "no code" allegedly without the patient's permission, resulting in the patient being taken off a respirator. After objection by the family, the patient was placed back on the respirator and eventually recovered. The patient then sued the hospital, but died before trial. The court, citing *Schuoler*, *infra*, and *Colyer*, *supra*, decided that decedent had a right to determine what shall be done to his own body, but that that was a personal right that did not survive to the personal representative.

The court also said that prevention of suicide was not an issue, because a death occurring after removal of life support was from "natural causes." In Ms. Colyer's case, there were no children or other innocent third parties. Also, the court did not view withdrawal of life support under these circumstances as inconsistent with the ethical integrity of the medical profession.

Therefore, the *Colyer* court found no compelling state interest sufficient to override Ms. Colyer's constitutional and common law right to refuse life-sustaining treatment.

In the absence of a countervailing and compelling state interest, a cautious reading of *Colyer* would seem to approve as consistent with constitutional and common law limits a non-statutory HCD or POLST which authorizes refusal or termination of life-sustaining treatment for a comatose person under conditions where the person is:

1. "Incurably and terminally ill," and
2. Where life-sustaining treatment only served to "prolong the dying process."

In the case of *In Re Hamlin*, 102 Wn.2d 810, 689 P.2d 1372 (1984), the trial court was confronted with a petition to terminate life support for an individual who was blind and retarded from birth. In addition, Mr. Hamlin experienced a cardiorespiratory arrest which left him with only brain stem functions, such as those related to breathing, heart rate and other automatic functions. The court characterized his condition as a persistent vegetative state. Mr. Hamlin's condition was considered permanent, and if life support were to be withdrawn, the evidence showed that he would die naturally. Also, Mr. Hamlin had no family or friends. A trial court ordered the withdrawal of life support over the objections of a court-appointed guardian and guardian ad litem. The Supreme Court upheld the trial court.

The Supreme Court said, citing *Colyer*, that the Natural Death Act was not the exclusive means to authorize withdrawal of life support, and that under the above factual circumstances, a guardian had the authority to withdraw life-sustaining treatment. The medical circumstances in *Hamlin* were similar to the medical circumstances in *Colyer* because both Colyer and Hamlin were in a persistent vegetative state.

In the case of *In Re Ingram*, 102 Wn.2d 827, 689 P.2d 1363 (1984), the ward had malignant cancer of the larynx. Ms. Ingram could speak fluently, and was goal directed, but, according to the testimony, she suffered from moderately severe dementia, accompanied by delusions. She also had some short-term memory loss, making it difficult for her to retain information relevant to her medical condition. A throat specialist testified that the proactive treatment choices were between radiation treatment, which would give Ms. Ingram a 40 percent chance of survival, or surgery, which was 70 to 80 percent effective in curing the cancer. Without any treatment, Ms. Ingram would die within six to 18 months. No matter what course of treatment or refusal of treatment was chosen, she would likely die within five years as a result of lung disease. A second doctor testified that the only viable option was surgery, and that radiation treatment would fail because the tumor was too large. Ms. Ingram did not object to the radiation

treatment, but objected to the surgery because it was likely that surgery would result in the loss of her ability to speak. The trial court authorized the surgery over Ms. Ingram's objection, and the Supreme Court reversed.

Ms. Ingram was arguably not in a terminal condition, she did not suffer from an incurable coma, and the treatment was not simply to artificially prolong the moment of her death. Rather, treatment would have given her a chance at curing the cancer. Nonetheless, the court engaged in the same analysis as in *Colyer* and *Hamlin*, and gave Ms. Ingram a right to refuse the surgery. On the basis of Ms. Ingram's federal constitutional right to privacy, and her common law right to be free from bodily invasion, the *Ingram* court determined that Ms. Ingram had ". . . a right to chose one medical treatment over another, or even refuse medical treatment altogether." 102 Wn.2d at pg. 836. The court said that:

"A person's right of self determination includes the right to choose between alternative treatments as well as the right to refuse life sustaining treatment . . . ".
102 Wn.2d at pg. 839.

The State's potential interests in this matter included the interest in the preservation of life, but the court said that:

"If the decision maker were to determine, however, that Ingram would chose radiation (despite the curative potential of surgery), then the state's interest in preserving life would not outweigh that choice . . . [Ingram's case presented] a choice between two treatments, one carrying a greater curative potential, but the other offering less severe side effects. A person's right of self-determination includes the power to choose between these two treatments." 102 Wn.2d at pg. 843.

Ingram seems to have expanded a person's ability to refuse life-sustaining treatment. *Colyer* required the person's condition to be "incurable" and "terminal." Life support was permitted to be withdrawn under *Colyer* only when it served to "prolong the dying process." This was clearly not the case with Ms. Ingram. Ms. Ingram only suffered from moderate dementia, paranoia, and short-term memory loss. Her cancer was potentially curable - not terminal. Nonetheless, she was allowed to select a cancer treatment which had only a 40 percent chance of survival, over a treatment that had a 70 to 80 percent chance of survival. Therefore, under *Ingram*, if a person suffers from a very serious illness - even though such person is not in a terminal condition - then that person should be able to validly execute a non-statutory HCD or POLST that permits a choice between treatments - even if the chosen treatment entails a significantly greater risk of death. The *Ingram* court viewed the matter as a choice between two potentially curative procedures, one of which was less effective and would likely result in more certain death, but which would preserve Ms. Ingram's ability to speak.

In the case of *In Re Grant*, 109 Wn.2d 545, 747 P.2d 445 (1987), the Supreme Court was confronted with the situation of Barbara Grant, an individual suffering from an incurable and

terminal neurological disorder known as Batten's Disease. Barbara's mother, the legal guardian, sought a court order that would authorize the *future* withholding of mechanical or artificial life-sustaining procedures from Barbara. The trial court denied the request and the Supreme Court reversed.

Barbara Grant's mental age was estimated at about 2 months; however, she could still feel sensation and could respond to touch. Also, she had not yet lapsed into an irreversible comatose or vegetative state. The court in *Grant*, in a five to four decision, clarified the holding in *Colyer* to allow termination of life support for a terminally ill but non-comatose person. The court held that, absent countervailing state interests, a person has the right to have life-sustaining treatment withheld where he or she:

"(1) is in an advanced stage of a terminal and incurable illness, and (2) is suffering severe and permanent mental and physical deterioration." 109 Wn.2d at pg. 556.

The court added that the right applies even if the person is not experiencing pain.

The court made a distinction between curative treatment, and treatment which merely postpones death. If treatment is curative, then the state's interest in preserving life is increased, but if treatment only serves to prolong death, then the state's interest is diminished. Also, the court said that the state's interest in preserving life is diminished when the treatment is particularly intrusive.

A non-statutory HCD or POLST should be valid under *Grant* if the document allows refusal or withdrawal of life-sustaining treatment when:

1. The condition is terminal and incurable, and
2. The person is severely deteriorated, and
3. The treatment only postpones death, and
4. The treatment is particularly intrusive.

The court in *Grant* determined that the right to withdraw life-sustaining treatment was based upon both a federal and an *independent state right* to privacy, and the common law right to be free from bodily invasion. Further, the *Grant* court explicitly extended the right to terminate treatment to include the right to withhold artificial means of nutrition and hydration.⁷

If potentially curative treatment choices are available, then *Ingram* may be the best authority for choosing a treatment which may be more humane but also more likely to result in

⁷ After the decision, one Justice realigned her vote, thereby clouding the authority to withdraw food and water. The importance of this realignment, however, was diminished by the subsequent enactment of the NDA, which specifically includes a provision for withdrawal of food and water.

death. If death is certain to follow a particular treatment choice, then the test in *Grant* may be more applicable in setting forth the constitutional parameters of the right to withdraw life-sustaining treatment.^{8 9}

In the case of *Cruzan v Director, Missouri Department of Health*, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990), the U.S. Supreme Court was faced with the personal tragedy of Nancy Cruzan. Ms. Cruzan was in an automobile accident, and was deprived of oxygen from 12 to 14 minutes. Ms. Cruzan was initially in a coma, but then progressed to an unconscious state in which she was able to orally ingest some nutrition. In order to ease feeding and further the recovery, doctors implanted a feeding and hydration tube in her. She had motor reflexes, but no cognitive functioning. Hospital employees refused, without court approval, to honor the request of Cruzan's parents to terminate her artificial nutrition and hydration, since that would have resulted in her death. The trial court authorized termination of life support, but the Missouri Supreme Court reversed. At the time of the Supreme Court decision, she resided in a Missouri State hospital in what was referred to as a persistent vegetative state.

Chief Justice Rehnquist authored the high court's majority opinion. He recognized the common law right to reject unwanted invasions of bodily integrity, and recognized the right of informed consent for medical treatment. The court said that the logical corollary of informed consent is a right not to consent, or to refuse treatment. Justice Rehnquist then stated the constitutional right as follows:

"The Fourteenth Amendment provides that no State shall 'deprive any person of life, liberty, or property, without due process of law.' The principle that a competent person has a constitutionally protected liberty interest in refusing

⁸ *Colyer, Hamlin, Ingram* and *Grant* were all decided before the 1992 amendments to the Natural Death Act. The 1992 amendments provide explicit authority to withdraw life-sustaining treatment for persons who are not terminal but are in a coma. Also, explicit authority is granted for withdrawal of food and water.

⁹ The courts in *Colyer, Hamlin* and *Grant* also established a procedure for exercise of the right to withdraw life-sustaining treatment in the absence of written directives: unanimous consent of family, treating physician, and a prognosis committee. In 1987 the legislature established a prioritized list of persons who have authority to consent to treatment (and, presumably, refusal of treatment (RCW 7.70.050(3)(d)) on behalf of an incompetent patient. RCW 7.70.065. An AIF is listed as an authorized person. However, it is not clear that, in the absence of a court order or written directive signed by the principal, an AIF has a legal right to (1) direct a doctor to withdraw life-sustaining treatment, or (2) execute a HCD on behalf of another. Compare the last sentence of RCW 70.122.010 with the last sentence of RCW 70.122.030(b).

unwanted medical treatment may be inferred from our prior decisions." *Cruzan*, supra, 497 U.S. 261, 278, 110 S.Ct. 2841, 2851.¹⁰

Also, the Supreme Court assumed that the U.S. Constitution granted a competent person the right to refuse nutrition and hydration.¹¹

IV. *The Right To Refuse Treatment for Persons Civilly Committed or in Jail or Prison*

In the case of clients who are institutionalized under the Involuntary Treatment Act, RCW 71.05 et seq., or who reside in prison or jail following conviction of a crime, the right to refuse treatment may be balanced against the state's interests in a manner which is more favorable to the state's interests and less favorable to the individual. For example, in the case of *In Re Schuoler*, 106 Wn.2d 500, 723 P.2d 1103 (1986), the issue was whether or not an individual committed under the Involuntary Treatment Act (RCW 71.05 et. seq.) could be given electroconvulsive treatment (ECT) against the patient's will. The *Schuoler* court recognized a common law and constitutional right of a competent adult to determine what should be done to his or her own body. The Court found that a mental patient's right of privacy includes privacy of the mind and freedom from unwanted ECT. But the court said it would permit ECT under circumstances where the state showed a compelling state interest and that ECT "is both necessary and effective . . .". See also, *Harper vs. State*, 110 Wn.2d 873, 759 P.2d 358 (1988), *rev'd*, 494 U.S. 210, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990) (establishing a limited right to refuse psychiatric medications).

The most recent Washington case analyzing a person's right to withhold life-sustaining treatment is *McNabb v. Dept. Of Corrections*, 127 Wash. App. 854, 112 P.3d 592 (2005). Mr. McNabb, a prisoner, was declining food, so he sued to prevent the state from force-feeding him. The court recognized that a right to refuse life-sustaining treatment, including a right to refuse force-feeding, stems from an independent right under the Washington Constitution, Article 1,

¹⁰ The court cited *In Re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied *sub nom. Garger v. New Jersey*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976) as an example of the many state cases establishing a federal constitutional right to refuse treatment. Also, Justice Rehnquist cited with approval the decision in *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990), which found that the forcible injection of psychiatric medication into a non-consenting person's body represents a substantial interference with that person's liberty.

¹¹The U.S. Supreme Court, after establishing the right to refuse life-sustaining treatment as emanating from a Fourteenth Amendment liberty interest, went on to find that the State of Missouri had a compelling interest in safeguarding the process, and could legitimately require proof of the patient's wishes by clear and convincing evidence. Since the trial court did not find clear and convincing evidence, the Missouri Supreme Court decision was upheld. Also, the majority was explicit in ruling that the right to refuse emanated from the due process clause, and not from any right of privacy.

Section 7. However, the court cited the state interest in preserving life as overriding McNabb's right to refuse. The court emphasized that (1) Mr. McNabb was not suffering from a terminal and incurable illness, and (2) McNabb's privacy expectations had been reduced by his incarceration.

The legal test is somewhat different and the interests of the state seem to loom larger in the context of a committed person's right to refuse psychiatric treatment, or a prisoner's right to refuse food and water, so it is not known whether the court, when the time comes, will allow a committed patient or inmate the same right to refuse other life-sustaining treatment as is allowed to a non-committed person.

V. *Non-Statutory Health Care Directives*

Possible modifications to a statutory HCD are divided into two categories: changes (V. A.-K. below) that do not likely implicate the state's potential interests (preservation of life, prevention of suicide, protection of innocent third parties, and protection of the ethical integrity of the medical profession), and changes (V. L.-N. below) that may implicate those state interests.

A. *Adding a Requirement of Additional Doctors*

Practitioners sometimes include a requirement that two physicians certify the terminal condition. The NDA only requires the certification of a terminal condition by one physician. Attorney John J. Sullivan, from Seattle, includes an optional provision for certification by three doctors.

B. *Adding a Requirement of Consent of the Attorney-in-Fact*

One practitioner often includes a clause in a HCD requiring consent of the AIF under the client's Health Care Power of Attorney. This effectively creates a three person committee (the AIF to provide the "go ahead," and two doctors to certify the condition and its incurability) before life support can be withdrawn. The clients that have requested this type of change have done so because they want a trusted family member to be a check and balance against the discretion given to the medical profession under the HCD. On the other hand, including a provision requiring consent of a family member AIF may result in insertion into the decisional process a family member who is not willing to follow the person's directions as set forth in the directive, thereby undermining the usefulness of the directive.

A HCD could also provide for discussion with and/or approval from "family members" before implementation of the HCD. Again, the benefit of a wider discussion might undermine the usefulness of the directive.

C. *Waiting Periods to Allow Time for Last Respects*

Some practitioners insert time requirements into the HCD, as some clients want a clause requiring an additional short waiting period - after the certifications - before withdrawal of life support. This allows time for close family who live in other states to pay their last respects.

One attorney includes a clause that requires the person to be returned to the city of that person's residence (if diagnosed as terminal while in a foreign country), before implementation of the directive.

D. *Waiting Periods After Coma is Certified*

Clients sometimes ask for a clause that sets a minimum period of time after certification of an incurable coma, but before withdrawal of life support can occur. For example, a modification might read that life support can be withdrawn no sooner than 30 days after the required certifications of an incurable comatose state.

E. *Allowing Fluids Needed to Administer Pain Medicine*

Some clients who are concerned about relief from pain may want clarification that a direction to withdraw water not be interpreted to exclude fluids necessary to administer pain medicine, and optional language along the following lines is included: "By this directive I do not mean to preclude the use of pain medication or other treatment to make me comfortable or alleviate pain."

F. *Withholding Life Saving Treatment During Surgery*

It is often the case that medicine, fluids and other immediate life-sustaining treatments are required to keep a patient alive during surgery. One could reasonably assume that if surgery is authorized by the patient, then the means necessary to keep the patient alive during surgery are also authorized. A HCD could include a statement that "If I authorize a surgical procedure, then I also authorize my health care professionals to make all efforts to keep me alive and provide life-sustaining treatment during the surgery."

G. *Organ Donation; Autopsy*

Some practitioners include a provision in their HCDs that allow a person to designate donation of organs to a living person or charity. Also, a provision concerning autopsy could be included in a HCD.

H. *Withdrawal of Food and Water as Separate Options*

Many practitioners use separate lines so that a person can chose to have food but not water, or visa versa.

Attorney Margaret K. Dore has an option that reads as follows:

It is difficult for me to know the future and/or whether continuing to provide hydration and nutrition, or not providing it, would be appropriate. I want to be as comfortable as possible. I do not want my quality of life artificially prolonged only to prolong the process of dying.

I. *Listing Treatments That Can be Withdrawn*

Food and water are treated separately in the statutory HCD form, but some practitioners also specifically list other treatments that can be withdrawn.

The Columbia Legal Services form specifically lists "cardiopulmonary resuscitation" and "assisted ventilation" as treatments that can be refused or withdrawn.

Swedish Hospital, in Seattle, has a HCD form which provides for refusal or withdrawal of treatment, including refusal of CPR, but only under circumstances where a terminal condition or coma is certified.

Attorney Larry Weiser, from Spokane, specifically lists assisted ventilation, nutrition, hydration and organ donation.

Some attorneys give clients the option to specify which treatments can be withdrawn, as follows:

- cardiopulmonary resuscitation
- defibrillator
- artificial respirator
- intubation
- nasogastric tube
- intravenous feeding
- kidney dialysis

Attorney Roger S. Kohn, from Seattle, provides detailed options for withdrawal of treatment in the case of kidney failure. Mr. Kohn also has detailed provisions regarding organ donation.

J. *Sample Form for Jehovah's Witnesses*

Attorney John J. Sullivan has an optional provision for Jehovah's Witnesses. A person's religious beliefs are usually factored into the balancing process between that person's right to refuse life-sustaining treatment and the state's interest in preserving life.

K. *Excluding Coma From Conditions Triggering Withdrawal of Life Support*

Some attorneys, using "right to life" principles, have created forms which are specifically designed for persons wishing to direct end of life decisions consistent with the "Catholic faith as taught by Magisterium of the Catholic Church." A coma is not included as a condition which warrants withdrawal of life support. Also, one form allows withdrawal of certain kinds of life support when death is "imminent," defined as death coming within one week or less, and withdrawal of other kinds of life support when the person is "terminally ill," defined as death coming within seven weeks or less.

L. *Extending Time for Terminal Condition Beyond Accepted Standards*

If a client asks that life support be withdrawn under circumstances where the client's condition is incurable and - within five years - terminal, is that kind of provision in a HCD permissible? The longer the period of time,¹² the more aggressive the HCD becomes, likely invoking the state's interest in preserving life.

The statutory form does not say precisely how close death must be before a person is considered terminal. The statutory form defines a terminal condition as an incurable condition that:

" . . . would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards . . . ".

Hospice care can be initiated when a doctor predicts that life will end within six months, but does that mean that a person whose life will likely end within seven months should not be considered "terminal?" In a sense, every person's condition is both terminal and incurable - it is just a question of time. Ms. Ingram's doctors said that without any throat cancer treatment, she would survive the throat cancer no more than six to 18 months. The throat cancer was potentially curable. Her doctors also said that in any event she would die from lung disease within five years. Is a patient, like Ms. Ingram, whose underlying disease will end life in no more than five years, considered terminal under "accepted medical standards?" If a directive were drafted so as to only

¹² The shorter the period of time, the more cautious the HCD becomes. Designating a short period of time probably does not implicate any state interest.

require certification by a doctor that the condition be considered terminal within five years, would such a directive run afoul of the state interest in protecting the integrity of the medical profession, or the state interest in preventing suicide? Are "accepted medical standards" uniform throughout the state? Is there any disagreement within the medical profession as to what is a "reasonable period of time in accordance with accepted medical standards?"

It seems that *Ingram* may have left open the door to an expansion of the time frame within which a person retains a constitutional right to refuse life-sustaining treatment, and that time frame may extend beyond a "reasonable period of time" in accordance with "accepted medical standards" under the NDA. As long as a non-statutory HCD or POLST provides some treatment choices, a "terminal condition" could be defined in the document as a condition which would likely result in death in 18 months or sooner (*Ingram*'s throat cancer), or maybe even five years or sooner (her lung disease).

M. *Withdrawal of Life-Sustaining Treatment Upon Certification of a Severely Deteriorated Condition*

The NDA, passed in 1979, initially allowed for withdrawal of life support only in the case of a terminal condition. Withdrawal of life support for a non-terminal person in a coma was not allowed. In *Colyer* and *Hamlin*, a right to withdraw treatment for a terminal patient was established, but the people in those cases were also in a comatose state. In *In Re Grant*, a 1987 case, the court allowed withdrawal of life support for a person who was terminal *and* in a severely deteriorated condition. A comatose state was not required. But it was not until the 1992 amendments to the NDA that life support could be withdrawn if either a terminal condition *or* a coma was present. Therefore, although the NDA allows changes consistent with state law and federal constitutional law, the 1992 amendments to the NDA probably go further than most of Washington's existing constitutional cases in allowing withdrawal of life support.

On the other hand, there is language in *Ingram*, and also in *Grant*, that likely expands the legal right to withdraw life support beyond what is approved under the NDA. *Ingram*, as discussed above, has expanded our conception of what constitutes a "terminal" condition. And *Grant* probably paves the way for a court to allow withdrawal of life support for a person who is in a severely deteriorated condition, but not terminal or in a coma. *Grant* may have also opened the door for a non-statutory HCD or POLST to authorize refusal or withdrawal of life support for persons who are in a severely deteriorated condition - but who are neither comatose nor terminal. Many "frail elderly" fall into this category. For example, there are many elderly, in nursing homes, who are suffering from advanced Alzheimer's disease, who no longer recognize their family, who are wheelchair bound, who are in constant pain, and who by any measure have very little to live for. Nonetheless, a person suffering from these maladies may not be terminal or in a coma. What if such a person contracts curable pneumonia and needs medicine to survive? What if tube feeding on a temporary basis is required? If a person does not have an underlying terminal condition, and is not in a coma, then their situation is not covered under the statutory form. In these cases, as a result of *Grant*, a HCD or POLST that allows refusal or withdrawal of life-

sustaining treatment for a frail elderly person in a severely deteriorated condition might withstand scrutiny.

In the case of *Matter of Kathleen Farrell*, 212 N.J. Super 294, 514 A.2d 1342 (1986), the court was confronted with Ms. Farrell's medical condition of amyotrophic lateral sclerosis (ALS). Ms. Farrell was on a respirator, but she was not otherwise terminal nor was she in a coma. She could only move her eyes and mouth. The court weighed her rights against the interests of the state and concluded that a competent adult's right to refuse life-sustaining treatment overrides a state's interest in preserving life when ". . . the quality of the life in question is so poor, so minimal and wracked with pain, that it would be unfair and unjust to force its continuance against the person's wish. Mrs. Farrell's mind, soul and spirit are really imprisoned in a dead body, and to force her to continue to live in this fashion would constitute cruel and unreasonable punishment." 212 N.J. Super 294, at pgs. 303 and 304. There is no Washington case which directly addresses the issue of termination of life support for a person who is neither terminal nor in a coma.

Attorney John J. Sullivan includes a clause that allows withdrawal of life support for a person who suffers from "irreversible physical brain damage or deterioration to the extent that I cannot interact with those around me."

Attorney Janet L. Smith, from Seattle, enumerates several different conditions - and then gives the option to withdraw treatment for each separate condition. Her conditions include:

- (1) terminal condition (defined as death within six months),
- (2) irreversible coma,
- (3) severe brain damage,
- (4) unacceptable quality of life as evidenced by
 - (a) use of a ventilator,
 - (b) inability to move without assistance (MS or ALS),
 - (c) tube feeding,
 - (d) constant pain,
 - (e) constant discomfort, or
 - (f) financial hardship.

The Washington State Medical Association has a sample HCD form which allows withdrawal of life support under circumstances where the person is terminal, in a coma, or in a "permanent unconscious condition." The WSMA form is attached.

Neil R. Sarles has attached his form, containing some but not all of the above options and modifications.

N. *Pregnancy and the State's Interest in Protecting Third Parties*

The approved form provides that it is inapplicable if the person is pregnant. Is that part of the legislation valid?¹³ Is the state's interest in protection of innocent third parties implicated by removal of that clause from a HCD? The POLST form makes no mention of pregnancy. If a young woman is terminally ill with cancer, and is pregnant, can she validly sign a POLST form, and if she does, what are the consequences for her doctor who also signs the form?

VI. *The POLST Form*

A. *A POLST is a Physician's Order. Its Primary Purpose is to Prevent Unwanted Medical Intervention, Including Unwanted Hospitalization*

When death approaches, patients and families experience an inordinate amount of stress, fear and confusion. It is often difficult at this time for patients to make end-of-life treatment choices. As a result, health care professionals began to encourage patients to execute "advance directives," such as the HCD. This enabled end-of-life choices to be specified in writing, and *in advance*. As it turns out, many health care professionals now believe that the initial promise of advance health care directives has not been met.

HCDs are viewed by some health care professionals as difficult to implement because they require last minute certification by doctors, and in an emergency, that takes time. A HCD often sits in the lawyer's office, doing little for the patient in a crisis. HCDs are hard to understand for health care professionals, and front line emergency care-givers are often confused about what to do with "legal documents."

The WSMA web site covering the HCD states, in part, as follows:

"Will advance directives be recognized in emergencies? No. During most emergencies, there is not enough time"

In her client transmittal letters, attorney Mary C. Wolney, from Seattle, bluntly states that:

". . . your Health Care Directive is a directive rather than an order. It may not necessarily be followed by any emergency health care provider, while a POLST will be."

Also, HCDs signed in a lawyer's office are often "out of date" with respect to the person's/patient's wishes. Those wishes may change from month to month, or even hour to hour, depending upon the circumstances. A client recently diagnosed with incurable cancer, or who has

¹³ In *DiNino v. State*, 102 Wn.2d 327, 684 P.2d 1297 (1984), a challenge to the pregnancy provisions in the NDA was dismissed because of lack of standing.

had a stroke, may quickly change his or her views on end-of-life decision-making, and may want his or her revised views to supersede the HCD executed in the comfort of the attorney's office many years before.

Finally, even when a patient has a HCD, a physician's order is still required to implement that directive. A HCD is not a "self executing" instrument. Rather, the directions in the HCD must be translated into specific physicians orders by a physician. During this critical period, when end-of-life decisions have to be made, someone - usually the doctor - needs to find the HCD, read it, interpret it, talk to the patient and/or family to see if there have been any changes in the directions in the directive, and then write a physician's order implementing the patient's choices.

As a result of these limitations on the usefulness of the HCD, health care professions have come up with a new form - a form being promoted nation-wide - called the POLST.¹⁴

A POLST is a physician's order. Its primary purpose is to prevent unwanted medical intervention, including unwanted hospitalization. The intent of the POLST form is to address the refusal of treatment rather than the withdrawal of treatment that has already commenced. A POLST specifies the precise degree of medical intervention in light of a person's current medical condition.

A POLST is a physician's order, *made in advance*. A POLST is an order to emergency medical personnel and others who regularly follow doctors' orders.¹⁵ It is intended to direct the degree of medical intervention¹⁶ for a patient who is not yet in the "medical system," avoiding in many cases unwanted medical intervention, including unwanted hospitalization. The goal is for a doctor to execute a POLST *prior to* the critical decision-making period. Instead of waiting until the last moment to retrieve a HCD, interpret it, determine any changes, and then write an

¹⁴ DNR designations ("EMS NO CPR" forms) were precursors to the POLST. A DNR designation is a very simple "advance physician's order." The author has found no reported case upholding a DNR designation under circumstances less "severe" than a terminal condition or a coma. See, *Propriety of, and Liability Related to, Issuance or Enforcement of Do No Resuscitate (DNR) Orders*, 46 A.L.R. 5th 793.

¹⁵ Although it is not stated on the face of the POLST, the POLST form is apparently not designed for use in hospital settings. A POLST signed by the patient and family doctor has no force in the hospital, especially if the family doctor lacks hospital privileges. Except in the emergency room, an outside doctor's order does not bind the hospital physician. After a patient is transferred to a treatment ward, the attending physician will talk with the family, review any existing HCD, and issue new physician's orders appropriate to the situation.

¹⁶ Absent a contrary order from a doctor, an emergency response worker is required to provide full treatment.

appropriate order, the doctor theoretically works with the patient ahead of time, so that doctor and patient can discuss and arrive at treatment choices for end-of-life decision-making. The POLST is signed by both the doctor and the patient.¹⁷

The POLST is essentially an "advance physician's order," which is also executed and approved by the patient. It is a physician's order, but also acts as a patient's expression of his or her right to refuse life-sustaining treatment. These dual goals of the POLST make it a difficult document to legally characterize.

Insofar as a POLST attempts to act as a patient's advance expression of his or her right to refuse or withdraw life-sustaining treatment, it necessarily covers much of the same ground as a HCD. The WSMA web site covering the POLST states, in part, that:

"The form accomplishes two major purposes:

- It is portable from one care setting to another.
- It *translates wishes of an individual* into actual physical orders."
(emphasis added)

The same website also states that:

"While Advance Directives are often very helpful in determining end-of-life decisions, they are not required or necessary for having a POLST form."

A POLST form is a flexible and portable document, which is recognized by front line health care workers as a doctor's order. POLST forms, bright green in color, are being widely promoted within the medical community. Legal practitioners are well advised to familiarize themselves with the POLST, and to recognize both the POLST's strengths and its weaknesses.

B. *Introduction to Current/Advancing Medical Practice: Patient-centered Care and Decision-making* (Sharmon Figenshaw)

1. A trend in medicine to tailor the plan of care to a patient's values and life goals.
2. Dr. Stuart Farber at the University of Washington teaches this approach as Basic End of Life Care. Other approaches are being pursued in medical schools including the patient story approach used at OHSU, NY and others.

¹⁷ However, the POLST does allow for a nurse practitioner, physician's assistant, or other primary care provider to sign for a doctor. It also allows an attorney-in-fact to sign for the principal.

3. In the case of terminal illnesses, the patient determines what they consider to be a life worth living.

This humanistic approach has shown up most strikingly in the field of palliative medicine where the focus is largely on helping patients decide how far to go/when to stop a curative treatment-focused plan of care.

The most compelling conversation in medicine of late is the move toward a plan of care and goals that are completely based on and consistent with the patient's own stated goals. If the patient is unable to state these goals, discussion of the patient's condition is commenced with the patient's surrogate (by family or appointment, either the AIF or a court-appointed guardian).

The first and main objective is to determine what the patient would want. Often times, patients have a skewed image of what is possible through the application of medical treatment. The health care professional's job is to first understand the patient's values and goals, and then to offer medical options that help the patient meet those values and goals. For instance, if the patient talks about meaning in their life coming from spending time in their garden or with grandchildren, then any offer of treatment should include a thorough discussion of how the patient's ability to do these things would be affected. For another example, if a patient with a lung cancer has a prognosis of a survival rate of two to five years without treatment, but if the only treatment is chemotherapy that has a less than 10 percent chance of cure with perhaps a 50 percent chance of prolonging life for six to 12 months, with side effects from the treatment that would render the patient significantly ill during a portion of that time, then the patient must be given the information that would allow for the patient to weigh refusal of the treatment in terms of loss of quality of life against the value of the added life.

The relationship of curative, palliative and end of life care will be shown by chart.

C. *Why the POLST Form was Developed* (Sharmon Figenshaw)

The movement in Washington (and perhaps in Oregon) was instigated because of DSHS regulations that dictate aggressive care for patients, even those who may have an advance directive made prior to any incompetence delineating non-aggressive care.

The situation was resulting in many trips to the hospital for pneumonia and antibiotics, even ICU care, for people who had earlier in life were clear about their quality of life decisions.

This was part of meeting the DSHS requirement in nursing homes that patients be given full access to medical care. Even if incompetent, patients must be asked about their wishes for medical intervention and CPR on admit and at regular (yearly) intervals. Even if they have a prior HCD which was done while competent, they may not be able to fully and meaningfully repeat the desire to have medical treatment withheld (and many a confused DAT patient will say yes to CPR and other treatments offered because they now say yes to everything, or because they

now lack the insight to comprehend the consequences). While it seems to undermine the notion of truly informed consent, these regulations were irrefutable.

The other compelling reason for developing a tool that allows people to ensure that they do not receive care that they do not want, including the initiation of care in a hospital setting, is the statistics that show to what little degree HCDs are both completed and honored. One arm of the support study, run by Teno, et. al, looked at the degree to which HCDs were completed and patient preferences discussed with their doctors. Though 83 percent of elderly patients surveyed voiced a desire to have a discussion with their doctor regarding their preferences for end-of-life care, only 11 percent had done so, citing the reason for not discussing it was mostly due to the physician not initiating the conversation. The same study also showed that even when HCDs were completed with legal counsel, less than 25 percent of the time were these brought to the attention of the physician caring for the patient (Teno, Licks, et. al., 1997).

In another study, physicians were polled. While 86 percent of the physicians thought that a HCD should be discussed with patients (these numbers increased to 95 and 96 percent for patients with serious and chronic illnesses), the study found that less than 20 percent of these physicians had *ever* discussed HCDs with ten or more patients (Hughes & Singer, 1992).

While these figures may seem old now, they offer perspective on the huge increase in interest regarding technologies that allow preferences to be honored. Oregon began its work on the first POLST form in 1992 and a subsequent study showed that the rate of preferences being honored when the POLST form was used for nursing home patients went from 30 percent (prior to the POLST being available) to 100 percent (in residents who had a POLST form five years after it had been used in the state) (Tolle, Tilden, 1998). In a retrospective study done in Oregon interviewing 475 families after death in a 14 month period in 1996-7, it was found that two-thirds of the patients had documentation of their preferences for life-sustaining care (either a POLST or HCD); this is the highest rate of completion ever reported by a state. It may seem that as we turn our attention toward finding better ways to honor people's wishes, people gain confidence that it is worth their effort to complete the documentation.

D. *Who Should Fill out a POLST* (Sharmon Figenshaw)

1. A POLST is intended for use only for patients who have a life-limiting disease and who, in examination of their goals, want to limit the amount of aggressive care they receive.
2. The physician's determination of terminal illness is partially dependent on the patient's own definition of a life worth living. In general, a patient and care provider should be having the conversation about their decisions and fill out a POLST when the provider "wouldn't be surprised" if the patient were to die.

3. The POLST should always be the end result of a frank conversation between a patient and a provider where frank and honest information about the nature of the patient's illness is discussed in the context of the patient's values and life goals.

Regarding time frame: How can any consideration of time frame of terminal illness leave out the patient's own reaction and perception of their life? The wording of the NDA, "reasonable time, accepted medical standards" seems to avoid specificity with regard to time and also the expectation of accuracy in prognosticating time until death.

Recently, the framing of the question of prognostication was recently adopted, as developed by a team to help doctors make referrals to a palliative care services. This is helping physicians identify the time period in which a person might be likely to die from their disease, allowing families time to prepare, and allowing certification for services such as hospice. Trandum and Patteson revised the standard question of time from, "How long does this person have to live?" but rather "Would you be surprised if the patient were to die from their illness within XX time?" (Greene, 2000).

- E. *Detailed Examination of the POLST Form by Section* (Sharmon Figenshaw)
- F. *The Nationwide POLST Paradigm* (Sharmon Figenshaw)

The POLST is being promoted nationally. A support team is available to help states develop similar programs. Contact numbers for this team can be reached at the website: www.ohsu.edu/ethics.polst (look under nationwide POLST paradigm for a list of states with their contacts).

As history of the POLST Paradigm Development, as explained from the website, is: States and communities have developed programs similar to Oregon's POLST program, and some of them may have a different name. The term "POLST Paradigm" is used to describe these programs.

The POLST Paradigm was developed over a four-year period by a multidisciplinary task force of the Center for Ethics in Health Care at Oregon Health & Science University, with representatives from numerous health care professionals, governmental, and institutional organizations.

At a 1991 statewide meeting of Oregon ethics committees, concern was voiced about the problem of respecting DNR orders when patients were transferred from nursing home to hospital. In response to this need, the multi-disciplinary task force was convened to address the problem of preventing unwanted transfer and intensive medical interventions to those patients who did not want such interventions. Although less common, the document also can ensure intensive interventions are provided for those patients with such preferences.

In July 1996, the Oregon Board of Medical Examiners redefined the Scope of Practice for EMTs, first responders, and their supervising physicians. EMTs/first responders are now directed to respect patient wishes for life-sustaining treatment and to comply with life-sustaining treatment orders executed by a physician, such as those recorded on the POLST document (OAR 847-35-0030 [7]).

Over 1,000,000 Oregon POLST forms have been distributed to date and continue to be targeted for use for patients who have a higher potential need of life-sustaining treatment decisions.

The National POLST Paradigm Initiative: Several other states are developing POLST Paradigm programs similar to Oregon's. Format and implementation may need to be modified to meet the legal and regulatory requirements of each state.

G. *Problems With the POLST*

1. A POLST Lacks the Necessary Formality to be Considered a Health Care Directive

A deed not executed with the required statutory formalities is just a piece of paper. A variety of governmental interests are served by that rule. The NDA allows for changes to the statutory HCD form, but do those changes include an absence of formality in execution? RCW 70.122.030 contemplates that the "words" of a HCD might be changed. I have referred to that kind of document as a non-statutory HCD. But there is no indication in the statute that the formalities of execution can be dispensed with altogether.

This is not to say that a person's rights are lost by lack of formal execution: the cases show that the common law and constitution give a person a right to refuse treatment even without any writing. But without the necessary formalities in a writing, a person's right to withdraw life-sustaining treatment is probably not covered under the NDA.

A POLST, for example, which lacks the formality of having disinterested witnesses, probably does not fall within the NDA, and is not a HCD. In fact, the NDA prohibits a person's doctor from being a witness, and a POLST is actually signed by the person's doctor. Since a POLST is probably not a HCD, a doctor's actions in withdrawal of life-sustaining treatment are probably not covered by the immunity from liability section of the NDA.

2. A POLST's Validity as a Directive of the Person's Wishes on Withdrawal of Life Support

Insofar as a POLST acts solely as a physician's order, it does not need to fall within the NDA to be valid, nor does it need to be considered a HCD. The validity of a POLST independently rests on a different set of rules - those rules which govern a physician's order.¹⁸

But insofar as a POLST also attempts to act as a patient's advance expression of his or her right to refuse or withdraw life-sustaining treatment, the question arises as to whether a POLST is a valid and enforceable directive of the person's wishes concerning life-sustaining treatment.

In the opinion of one of the authors, since a POLST form acts as an expression of a person's right to refuse life-sustaining treatment,¹⁹ there is no reason why a POLST should not be subject to the same substantive restrictions on refusal or withdrawal of life support that apply to a statutory or non-statutory HCD. If a patient can't direct the refusal or withdrawal, the doctor should not be able to order the refusal or withdrawal. It could be argued that, in some respects, a POLST form is simply an expanded "do not resuscitate" designation, and a DNR designation has support in the WACs. However, just because a DNR designation may be based on executive authority, or even legislative authority, that does not necessarily insulate the DNR designation from substantive constitutional limits placed upon an individual's right to select treatment which would result in death.

This view, however, runs directly contrary to common practice and understanding in the health care community. There seems to be a very wide "disconnect" between legal authority and health care practice in this area.

Health care professionals essentially view the patient's choice as being controlling. Common experience tells us that we can go to our doctor and freely select among various treatment options.²⁰ This right to consent to or decline medical treatment is legally rooted in the

¹⁸ Of course, the authority of a doctor to issue an order is derivative; that is, it rests upon the informed consent of the patient. See Footnote No. 6.

¹⁹The POLST is not intended to cover the withdrawal of treatment, but on its face, the POLST is not limited to the refusal or withholding of treatment.

²⁰ However, we can't ask our doctor to do something unethical, such as asking our doctor to amputate our limb when amputation is not necessary. And in some cases our doctor can refuse our choice based on so-called "medical futility." This is where the doctor is not obliged to perform a procedure because it would be pointless. For example, I can't insist that my doctor give me antibiotics to cure a cold.

common law right to be free from bodily invasion, which was the origin of the right to informed consent.²¹

For example, patients who do not suffer from a terminal illness or a coma have, as a matter of choice, frequently directed execution of a "do not resuscitate" order. "Do not resuscitate" designations find specific support in Washington State Department of Health rules concerning medical futility.²² Since the "do not resuscitate" order is legally supported in the Department of Health rules, and since a POLST can be seen as merely an expanded DNR form, there is a reasonable argument that both a DNR and POLST should be perfectly acceptable as directing a patient's choices concerning termination of life-sustaining treatment.

On the other hand, health care professionals seem to agree that DNR and POLST forms should not be prepared for young healthy individuals, and that there are some minimal health care conditions which should exist before such a form is signed. Since there are some minimal health care conditions needed before a doctor should issue a DNR or POLST, the question becomes why those minimal health care conditions are not clearly stated in the forms. This is especially true of the POLST form, which is not only a doctor's order, but a detailed statement by the patient concerning refusal of treatment choices likely to result in death.

The structure of the HCD is such that a person states that if "X" condition exists, then "Y" treatment can be withheld or withdrawn. The patient and the doctor called upon to interpret the patient's wishes both know the medical conditions that are preconditions to withdrawal of life-support, because those medical conditions are stated in the instrument.

²¹ The right to informed consent as a basis to allow a person's refusal of treatment has been developed in this state under the case law; however, RCW 7.70.050(3)(d), which addresses conditions precedent to suit against health care professionals for malpractice, provides oblique statutory approval of "no treatment" as a treatment choice within the doctrine of informed consent. Also, regulations governing nursing home procedures clearly provide nursing home patients with a right to informed consent and a general right to refuse treatment. WAC 388-97-090(4)(b); WAC 388-97-07005(3)(b). However, no regulation specifically establishes a right to refuse life-sustaining treatment.

²² RCW 43.70.480 gives the Health Department authority to adopt rules 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 "directive or durable power of attorney requesting that he or she not receive futile emergency medical treatment." The POLST form is a product of those rules.

Although the POLST form has the advantage of being both an advance patient's statement and an advance doctor's order, except for section A of the POLST, there are no minimal medical conditions required for refusal of life saving treatment. Absent some minimal medical conditions clearly stated on the face of Sections B-D of the POLST form, a reasonable question is raised as to whether a patient's signature and "consent" on a POLST form can be considered "informed."

Also, do the patient and doctor have unfettered discretion to order refusal of treatment when the result is the death of the patient? At least in the view of one of the authors, when our treatment choices involve a result likely to produce death, we need to look further than the common law right to choose one's own treatment. The *Colyer* line of cases, and *Cruzan*, clearly restrict or limit our right to refuse treatment when the result would be death. Just because everyone is doing it does not make it legal, and just because a Department of Health rule allows a DNR designation or POLST does not mean that a court would decline to balance the interests of the individual against the interests of the state, and limit the lawful use of such forms to circumstances outlined in *Cruzan* or the *Colyer* line of cases.

With the above considerations in mind, there are two specific aspects of the POLST form that stand out as being particularly troubling.

On its face, Sections B-D of the POLST form do not require that the patient be in a terminal condition, in a coma, or even sick. Neither does the POLST form limit itself to situations of medical "futility." The POLST does describe various treatments that can be refused, but there is little to inform the reader as to the medical conditions under which the treatments can be refused. There is nothing in the form itself that limits a perfectly healthy person from simply directing a doctor to withhold antibiotics, nutrition and other care subsequent to a car accident which may have rendered a person temporarily disabled. Even though a POLST is supposed to be used by health care professionals only in situations where a person is dying or is very elderly and frail, the document itself does not state these limitations.

Also, the person's signature is not required before a doctor signs a POLST. It is sufficient for family members, or an AIF, to provide information to the doctor, which could result in a doctor signing a POLST. And, it is not always required that a doctor sign a POLST; a nurse practitioner or other primary care provider can also do so. So, potentially, withdrawal of life support can be ordered by a nurse practitioner or other primary care provider on the approval of the person's AIF under circumstances where an AIF may or may not have the legal authority to give approval for withdrawal of life support.²³ This raises concerns as to whether or not the

²³ It is not clear that an AIF can ever acquire authority to authorize withdrawal of life-sustaining treatment, at least without a court order or HCD signed by the principal. Compare the

person has given his or her informed consent to the POLST. Also, the NDA, recognizing a potential for "foul play," prohibits persons who would directly benefit from the death of the principal from witnessing the HCD. The POLST, on the other hand, can be authorized by a fiduciary or family member with a beneficial interest in the principal's estate.

On its face, therefore, a POLST, despite the fact that a POLST finds support in Department of Health rules, does not appear to meet either the common law or constitutional threshold for approval of refusal or withdrawal of treatment that would result in death. And since it is not also a HCD, a physician that implements a POLST does not have immunity from liability under the NDA.

However, assuming that the actual implementation of refusal of treatment under a POLST is limited to cases where the individual's medical condition comes within the common law and constitutional framework, and the person or an AIF with actual authority signs the document, there is no reason why a POLST cannot be effective as a directive of the person's wishes.

3. Revocation of a HCD; Revocation of a POLST

Under circumstances where a HCD is signed in an attorney's office, and then a POLST with inconsistent provisions is subsequently signed by the client/patient and the doctor, which document prevails? RCW 70.122.040 (c) allows a person to revoke a HCD by "verbal" statement of revocation to the person's doctor. The verbal revocation must be recorded by the doctor in the patient's medical records. For many reasons, one can imagine that formal revocation of a HCD is not often done prior to signing a POLST.

If the statutory procedure for revocation of a HCD is not followed, and a more "liberally" drafted POLST is subsequently executed, then despite the fact that a HCD and a POLST are different documents, there would be a serious conflict with respect to a person's actual wishes that would be difficult to reconcile. Unless the documents are better coordinated by doctors and lawyers, or unless there is additional legislation, it is likely that sooner or later a claim of negligence will be brought against a doctor who withdraws life support under a POLST despite the existence of a valid unrevoked HCD containing conflicting provisions.

In an effort to reconcile the two documents, I now have some clients execute both a POLST and a HCD in my office. I have the POLST refer to the HCD, thereby tying the two documents together. I ask the client to obtain the doctor's signature on the POLST, and return to

last sentence of RCW 70.122.010 with the last sentence of RCW 70.122.030(b).

me a copy of the fully executed POLST. My legal assistant Susan Williams is also suggesting that we regularly send HCDs to the client's doctors.

Another solution to potential conflicts between the documents would be to specify in the HCD whether it is supplemented or revoked by a subsequently executed POLST, and whether it supplements or revokes a previously executed POLST.

If a POLST is drafted and signed by the patient and doctor, and then the patient subsequently signs a statutory HCD in the lawyer's office, it is not clear whether the POLST would be revoked by the HCD. Is the most recent expression of the person's wishes always the most controlling? Is the most formal expression of a person's wishes always controlling? The revocation procedures for a POLST will be discussed during the seminar presentations.

Insofar as the POLST is primarily a physician's order, there is no way a subsequent but inconsistent HCD could entirely "revoke" a POLST - the most it could do would be to revoke that portion of the POLST that provides the patient's consent. Doctors might consider adding a clause to a POLST concerning previously and subsequently executed HCDs, and whether those HCDs are intended to supplement or revoke the POLST.

H. *ESSB 5401 (1987)*

Non-statutory HCDs, POLST documents, and verbal instructions directing the withdrawal of life-sustaining treatment all fall within a gray area, the boundaries of which are currently established only by state law and federal constitutional law. In 1987, an effort was made in the State Legislature to establish procedures by which a physician may "withdraw or withhold life support treatment when the patient has not executed a written directive." ESSB 5401 (1987) (attached). The proposed legislation allowed withdrawal of life support in the absence of a directive only in the case of a terminal condition. That effort failed, and there is no current pending bill covering the right to withdraw life support under a POLST or in cases where a HCD is not executed.

I. *Possible Solutions to Problems With the POLST* (Sharmon Figenshaw)

The preparation for and process of this presentation, as well as the input received today from this audience, is already informing the POLST task force of the changes that may be needed to bring the POLST form into greater clarity regarding its intent and purpose. We are not hoping to make it a statutory form, but to keep it as a tool for conveyance of medically pertinent information needed to carry out the orders that it indicates. We look forward to an on-going

dialogue with this community and others to help us revise and adapt the form so it may continue to help people avoid the suffering of unwanted medical intervention.

VII. Conclusions

A. (Neil R. Sarles) A HCD that adheres to the statute is valid. Many minor modifications to a statutory HCD are also likely valid, as long as those changes do not go beyond the common law or constitutional limits ((1) terminal condition (even if a terminal condition is one which extends as long as 18 months or possibly five years), (2) coma, (3) possibly a "severely deteriorated condition," and (4) possibly "medical futility"). When a modification presses up against common law and constitutional limits, that modification needs to be analyzed in light of the particular state interests involved.

A POLST is, in part, a physician's order, made in advance. Its primary purpose is to prevent unwanted medical intervention, including unwanted hospitalization. There is a nationwide movement to promote the POLST as a "patient-centered" instrument which focuses on a patient's view of what is a "life worth living." A POLST is not a HCD, and the immunity provisions of the NDA do not apply. A POLST is usually signed by a doctor and a patient. A POLST directs the actions of emergency personnel who are required to provide full treatment in the absence of contrary instructions from a doctor.

A POLST is also, in part, a statement of a person's wishes concerning life-sustaining treatment. In this respect, it covers some of the same ground as a HCD, and its widespread use may largely replace the use of the HCD, especially with respect to the refusal of treatment as opposed to withdrawal of treatment.²⁴ On its face, the POLST does not meet minimal constitutional standards with respect to termination of life support causing death, since the POLST form itself allows for termination of life support for a person who is not otherwise terminal, in a coma, severely deteriorated, or even sick. The POLST form is also not limited to cases of medical futility. Also, the informality of execution may result in misunderstandings which generate claims of violations of a patient's right of informed consent.

²⁴One of the debates between the authors is whether and to what extent POLSTs and Health Care Directives actually overlap. It seems clear that the intent of the POLST is to primarily address concerns where a doctor is not available and where an emergency exists that might result in hospitalization. For example, a POLST can be used in a nursing home setting with a resident who has a heart attack. On the other hand, the POLST form itself is not limited to these situations. A reasonable interpretation from a reading a POLST form is that it applies in emergency and non-emergency situations whether or not a person is in a hospital setting. Also, the HCD covers refusal or withdrawal of treatment. The POLST form on its face appears to cover refusal or withdrawal of treatment, but its intent is to cover only refusal of treatment.

On the other hand, a POLST form has definite benefits in terms of its greater ease of use (as compared to a HCD) in implementing a person's health care choices by front-line health care workers. As long as the POLST form is actually used under circumstances which come within common law and constitutional limits, and it is signed by a competent person or surrogate with actual authority, it is likely a valid and enforceable directive.

There are changes to the statutory HCD that would improve its usefulness to clients. There are also changes to the POLST that would improve the likelihood of a court's enforcement of the POLST as a valid expression of a patient's end-of-life decision-making.

Doctors and lawyers should discuss with their patients and clients whether previously executed HCDs or POLSTs are revoked, and whether subsequently executed documents will automatically revoke the document under consideration. The POLST form is not intended for use by non-health care personnel. Nonetheless, elder law attorneys should consider integrating into their elder law practice, with assistance from the client's doctor, the execution of a POLST along with the execution of a HCD and durable power of attorney for health care decision-making.

B. (Sharmon Figenshaw) My conclusions are humanistic in nature as my work in this field leads me to see our treatment of these very important issues as more human than medical or legal. We watched the medical profession take the very natural process of birth and medicalize it to the detriment of families; we later found that the practices involving separation of mothers from their husbands, and babies from their mothers, were both unnecessary and harmful. Even now, with all of our advances, we have not delivered on the promise of greater health for infants; we continue to rank far below our European neighbors in rates of infant mortality among first world nations. It took 30 years to start to reverse the tide of unnecessary and unwanted medicalization of birth and return some measure of control over the birthing process back to mothers and families, though I think we all can see what the burden of arbitration and liability has done to the field of obstetrics.

I hope that we in medicine and law, can and should be very conscious, as we watch the bulge in the numbers of seniors who will be living and dying in the next generation, of how our practices in both medicine and law are going to impact what is still a very significant and personal human process for each family that is touched by it.