Status **Active** PolicyStat ID **11299043**

Implementation	03/2022
Last Reviewed	03/2022
Effective	03/2022
Last Revised	03/2022
Next Review	02/2027

Owner	Ira Byock: SVP Founder IHC
Policy Area	Clinical
Applicability	Providence Systemwide

PSJH-CLIN-1207 Policy on Care Through The End of Life: Responding to Requests for Provider-Hastened Death

Executive Sponsor:	Amy Compton Phillips, MD, EVP, Chief Clinical Officer
Policy Owner:	Ira Byock, MD, CMO Institute for Human Caring
Contact Person:	Ira Byock, MD, CMO Institute for Human Caring

Scope:

This policy applies to all Providers and Caregivers, as defined in the Definitions below, of Providence St. Joseph Health and its Affiliates[i] (collectively known as "PSJH" or "PSJH Affiliates").

This is a management level policy reviewed and recommended by the Policy Advisory Committee for approval by senior leadership which includes vetting by Executive Council with final approval by the President, Chief Executive Officer or appropriate delegate.

Values Context:

Providence St. Joseph Health (PSJH) holds the well-being of every patient as a whole person at the center of its Mission and Values. We strive to accompany patients and families in a welcoming and compassionate manner. PSJH provides care through the end of life grounded in the values of respecting the sacredness of life, providing compassionate care to incurably ill and vulnerable persons, and respecting the integrity of health-care providers.

PSJH is committed to providing the best care possible through the end of life to every person we serve. We honor each individual's inherent dignity and worth. We strive to preserve each patient's opportunity to live as fully and well as possible in the context of their family and community.

It is our privilege to care for and support people who are seriously ill and facing death with respect and love. The values set forth in the *Ethical and Religious Directives for Catholic Health Care Services* ("ERDs")

help guide the PSJH approach to care.

Purpose:

This policy applies the Mission and Values of PSJH and the ERDs to the care for people with serious medical conditions that threaten life or are expected to result in death. The policy expresses our commitment to provide patients with the highest quality care and support for patients and their loved ones through the end of life and into bereavement. This policy affirms PSJH's stance of providing appropriate care while allowing patients to die naturally of underlying conditions. The policy also affirms that PSJH and its Providers and Caregivers will not participate in Provider-Hastened Death as defined below.

This policy will guide a competent, compassionate, and communicative approach to the care of patients who inquire about Provider-Hastened Death and delineates the specific actions that are proscribed by PSJH as falling outside the bounds of legitimate clinical care.

Definitions:

Provider

Provider is defined to include any physician, physician assistant or nurse practitioner who:

(A) (1) is an employee of a PSJH Affiliate; and/or (2) provides services to a PSJH Affiliate pursuant to a contract with any PSJH Affiliate, and/or (3) is a member of the medical and/or allied health staff of any PSJH Affiliate; and

(B) while acting within the scope of employment, contract, and/or medical or allied health staff membership for any PSJH Affiliate; and

(C) whether (1) at a PSJH Affiliate site, or (2) at any other location where a PSJH Affiliate provides care or services to patients.

Caregiver

Caregiver is defined to include any non-Provider who:

(A) (1) is an employee of a PSJH Affiliate; and/or (2) provides services to a PSJH Affiliate pursuant to a contract with any PSJH Affiliate; and/or (3) is a volunteer of any PSJH Affiliate; and

(B) while acting within the scope of employment, contract, and/or volunteer duties for any PSJH Affiliate; and

(C) whether (1) at a PSJH Affiliate site, or (2) at any other location where a PSJH Affiliate provides care or services to patients.

Provider-Hastened Death

For the purposes of this policy, Provider-Hastened Death refers to actions by a physician, physician assistant, nurse practitioner or any person that are intended to cause the death of a patient as a means to end suffering. These actions include, but are not limited to, prescribing a lethal dose of a

drug in which the lethal agent is self-administered for the specific purpose of enabling a patient to end their life. States which have enacted laws or otherwise legalized such actions under specified procedures for people with life-limiting conditions use terms such as Death with Dignity, Medical Aid-in-Dying and End-of-Life Options. Provider-Hastened Death is morally distinct from the withholding and withdrawing of life-support that may result in the foreseen but unintended death of the patient. The term Provider-Hastened Death also encompasses Euthanasia.

Euthanasia

Euthanasia is a form of Provider-Hastened Death in which a physician, physician assistant, nurse practitioner or any person physically administers a lethal drug to another person, usually by injection. Euthanasia is legal for specified conditions and circumstances in Canada and several European countries, but is not currently legal in any U.S. jurisdiction.

Palliative Care

Specialized medical care focused on providing relief from the symptoms, pain, and stress of a serious illness. The goal is to improve quality of life for both the patient and the family. Preferably, palliative care is provided by an interdisciplinary team of physicians, nurses, chaplains, and other specialists who work together with a patient's care team to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Withholding and/or Withdrawal of Life Sustaining Treatment

This is the process of not beginning or of discontinuing ongoing life-sustaining medical treatments with the purpose of forgoing excessively burdensome or insufficiently beneficial treatment. Under appropriate circumstances, withholding or withdrawal of life-sustaining treatment is a part of a plan of care that focuses on care that is proportionate to the condition of the patient and allows death to occur naturally due to an underlying pathology.

Policy:

1. Essential components of care for people with life-limiting medical conditions and those facing the end of life include clear communication with the individual and (as appropriate) the individual's loved ones, which includes discussion of expected physical and functional outcomes and which allows for shared decision-making to articulate an individual's personal values, preferences, and priorities within an advance care planning document.
2. PSJH respects the right of each individual or, at times of incapacity, their health care agent, legal representative, or surrogate decision maker, to make choices without undue influence, including the weighing of benefits and burdens of any treatment, not to begin or to discontinue life-sustaining treatments if the patient/proxy determines that there is no reasonable hope for sufficient benefit or there is excessive burden to themselves or their family or community (cf. ERD 57; Patient Self-Determination Act).
3. PSJH strives to treat each individual's pain and other distressing symptoms effectively in a manner consistent with the standard of care with the goal of achieving comfort and enhancing a person's quality of life. Treatment plans will often require multiple modalities, including

medications and physical treatments.

4. In light of the wholeness of the human person, a person's suffering often entails elements of one's psychosocial, spiritual, and personal world. As such, comprehensive and compassionate care for seriously ill and dying people deserves access to skillful psychosocial therapies and spiritual support for the person who is ill and their family.
5. Palliative Care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment. Specialty palliative care is an important means of providing excellent symptom management, skillful communication to enable shared decision-making and psychosocial counseling and spiritual support. However, these services should be available to patients in need regardless of enrollment in actual palliative care programs.
6. PSJH also supports timely referral to hospice as an indispensable service in assuring comprehensive and coordinated interdisciplinary support to patients and families in the final months, weeks, and days of life, through the dying process, and for family grief support.
7. Whatever the source of suffering, PSJH seeks to preserve consciousness and responsiveness unless the alleviation of suffering requires treatments that are sedating. When suffering persists at an intolerable level despite all reasonable treatments, consideration of palliative sedation as a reasonable option may be offered even if such therapy may indirectly or unintentionally shorten a person's life. Any party directly involved in the care of a patient may request an ethics consultation if there are moral questions about the appropriateness of this plan of care.
8. In several states within our contemporary practice environments, people with limited life-expectancy have legal avenues for intentionally hastening their deaths (terms include Medical Aid-in-Dying, Death with Dignity, End-of-Life Options). PSJH considers intentionally hastening death to fall outside the scope of legitimate medical practice. This determination derives from the PSJH Mission and Values and from the Catholic moral tradition. This stance is consistent with leading medical associations, such as the American Medical Association, the American College of Physicians, and the National Hospice and Palliative Care Organization.
9. PSJH prohibits Providers and Caregivers from encouraging or facilitating Provider-Hastened Death of PSJH patients. The specific limits about which Providers and Caregivers must be aware and clearly communicate to their patients are that they are not permitted to: a) complete legally-mandated forms attesting to eligibility for aid in dying, b) prescribe or administer substances intended to hasten a patient's death, c) prescribe or administer medications for the specific purpose of easing the anticipated effects of such lethal substances (e.g., providing a prophylactic anti-emetic to be used as an adjunct with the lethal agent), and/or d) be present when a patient is in the process of being given or actively taking substances intended to cause death. However, Providers and Caregivers must not actively obstruct eligible patients from discussing, exploring, or pursuing legal avenues to hastening death. Within the context of a therapeutic relationship, Providers and Caregivers should discuss with the patient why they may be inquiring about hastened death and what unmet needs there may be. Although Providers and Caregivers are prohibited from participating in Provider-Hastened Death, this restriction must not inadvertently diminish attention to patient's concerns or needs, or result in real or perceived patient abandonment. Instead, in patients' most vulnerable times, Providers and Caregivers should seek to strengthen therapeutic relationships with patients and, better understand the concerns that led to the inquiry.[ii]
10. This policy does not replace local or regional policies of PSJH Affiliates on the same subject

that might include more specific direction for Providers and Caregivers based on the legislation in their respective states. All Providers and Caregivers are expected to be familiar with and comply with any relevant policies regarding Provider-Hastened Death within or applicable to the PSJH Affiliate(s) in which they serve. Any such policies should be consistent with this policy. If significant discrepancies exist, a review by the regional ethicist should be initiated. PSJH shall provider Providers and Caregivers a copy of the applicable policy.

11. PSJH recognizes an important distinction between administration of medications intended to cause death and the Withholding and/or Withdrawing of Life-Sustaining Treatments (e.g. mechanical ventilation, ECMO, intravenous vasopressors, renal dialysis, etc.). Whenever in the patient's (or the surrogate decision maker's) judgment the potential benefit of a treatment is outweighed by the perceived burden, such choices will typically be honored in accordance with applicable PSJH and regional policies and the patient's advance directive (if available).
12. Providers and Caregivers are provided with the document, "Responding to Questions about Provider-Hastened Death: A Toolkit." (Link) This Toolkit contains important information about engaging in conversations with patients and residents who inquire about Provider-Hastened Death. Managers and Directors are also encouraged to make use of the document, "Provider-Hastened Death: Operational Guidelines for Caregivers." (Link) The Operational Guidelines provide practical guidance to front-line caregivers who encounter questions about Provider Hastened Death from patients or loved ones.

References:

[1] United States Conference of Catholic Bishops (2018). "Ethical and Religious Directives for Catholic Health Care Services." *6TH ed. Washington, D.C.: USCCB*. [Link]

[2] Callahan D. (1996). The Goals of Medicine: Setting New Priorities. Hastings Center Report; 26(6): S1-S27. [Link]

[3] Providence Institute for Human Caring (2021). "Responding to Questions about Provider-Hastened Death: A Toolkit." *Providence*. [Link]

[4]Providence Institute for Human Caring (2021). "Provider Hastened Death: Operational Guidelines for Caregivers." Providence. [Link]

[5] Berlinger N, Jennings B, Wolf SM. (2013) "The Hastings Center Guidelines for Decisions on Life-sustaining Treatment Near the End of Life: Revised and Expanded 2ND ed. Oxford:" *Oxford University Press*. [Link]

[6] American Medical Association (2018). "*Physician-Assisted Suicide, Code of Medical Ethics Opinion 5.7 and 1.1.7.*" [Link]

[7] American College of Physicians (2017). *"American College of Physicians Reaffirms Opposition to Legalization of Physician-Assisted Suicide*." [Link]

[8] National Hospice and Palliative Care Organization (2021). "*Statement on Legally Accelerated Death.*" [Link]

[9] Providence Mission Statement. [Link]

[10] Providence FY 20 Annual Report to Our Communities; Community Health Needs Assessments and Improvement Plans. [Link]

[11] Byock, I. (2017). "We Must Earn Confidence in End-of-Life Comfort Care." *Health Progress*. 2017; November-December: 19-25. [Link]

[12] American Academy of Hospice and Palliative Medicine. "*Advisory Brief: Guidance on Responding to Requests for Physician-Assisted Dying.*" [Link]

State by State Laws for Providence Ministries:

California (2016): AB-15 End of Life Law:[Link]

New Mexico (2021): End of Life Options Act: [Link]

Oregon (1997): Oregon's Death with Dignity Act: [Link]

Washington (2009): The Washing Death with Dignity Act: [Link]

Montana (2009): SB-202 [Link]

Applicability:

[i] For purposes of this policy*, "Affiliates" is defined as any not-for-profit or non-profit entity that is wholly owned or controlled by Providence St. Joseph Health (PSJH), Providence Health & Services, St. Joseph Health System, Western HealthConnect, Kadlec, Covenant Health Network, Grace Health System, NorCal HealthConnect, or is a not-for-profit or non-profit entity majority owned or controlled by PSJH or its Affiliates and bears the Providence, Swedish Health Services, St. Joseph Health, Covenant Health, Grace Health System, Kadlec, or Pacific Medical Centers names (includes Medical Groups, Home and Community Care, etc.). *Policies and/or procedures may vary for secular Affiliates. Further, where an organization is not wholly owned or majority owned, exceptions may apply.

[ii] When there is a question regarding the provision of information on Provider-Hastened Death or about providing a specific referral, an ethics consultation with a PSJH ethicist is encouraged.

Approval Signatures

Step Description	Approver	Date
PSJH President/CEO	Cynthia Johnston: Sr Compliance Spec PSJH	3/1/2022
PSJH Executive Council	Cynthia Johnston: Sr Compliance Spec PSJH	3/1/2022
PSJH Policy Advisory Committee	Cynthia Johnston: Sr Compliance Spec PSJH	3/1/2022

Status **Active** PolicyStat ID **13554192**

Implementation	5/5/2023
Last Reviewed	5/5/2023
Effective	5/5/2023
Last Revised	5/5/2023
Next Review	5/4/2026

Owner	Andrea Chatburn: Senior Director Ethics
Policy Area	Ethics
Applicability	WA - EWA/MT Region

Advance Directives

ADMINISTRATIVE POLICY

PURPOSE:

To describe how the hospitals, clinics, and staff at both comply with their legal ethical obligations regarding Advance Directives. The purpose of assisting in completing Advance Directives or getting already completed Advance Directives into patient's Electronic Health Record (EHR) is to increase adherence to the patient's preferences and values, doing so is in keeping with our promise to "Know Me, Care for Me, Ease My Way" and represents a good faith effort to practice in a manner consistent with highest clinical and ethical standards, while acknowledging the realities of clinical practice.

DEFINITIONS:

The following are key terms to be aware of when reading and implementing this policy:

- **Advance Directive:** A written document(s) created by a person who exhibits decision-making capacity to inform health care teams about their wishes for specific medical treatment and/or to designate a Durable Power of Attorney for Health Care to be used if the individual becomes unable to make decisions for themselves. Typically, an Advance Directive must either be witnessed or notarized to be legally valid, although requirements vary by state. **When an Advance Directive is executed appropriately, it is effective until or unless a new Advance Directive has been completed. At that time, the most recent document is to be honored.**
- **Decision Making Capacity:** The ability to understand and appreciate the nature and consequences of a decision and the ability to reach and communicate an informed decision. Durable Power of Attorney for Health Care: An individual named in an Advance Directive or other legal form who is legally authorized to make decisions for a patient who lacks decision-making capacity. Also called Health Care Power of Attorney, Health Care Agent, or Health Care Proxy.

- **Provider:** A physician, nurse practitioner or a physician assistant.
- **Surrogate Decision Maker:** If there is no Health Care Agent, most states provide for default Surrogate Decision Makers in their State laws. State laws must be followed to determine the Surrogate Decision Makers:
    - State of Montana, per MCA 50-9-106
    - Washington State, per RCW 7.70.065
- **Trusted Decision Maker (TDM):** Documentation within the ERH, this is a Providence-approved procedure for detailing a patient's verbally expressed choice of surrogate decision-maker. The TDM note documents the conversation with a provider (physician, NP, or PA) who also attests that the patient has decision-making capacity at the time of the conversation. When a provider completes a TDM form in EPIC, the system generates a preliminary AD: DPOAH, which needs to be signed by a patient and statutory hierarchy, therefore the individual chosen by the patient (as recorded in their TDM document) can advise the family, surrogate decision-maker and/or provider of the person's verbally expressed choices. The TDM is evidence of a person's expressed wishes and can be considered by the surrogate decision-maker. Learn more here.

POLICY:

Providence Eastern Washington/Montana ministries encourage patient self-determination and will facilitate patients' active participation in shared decision-making concerning their care. Advance Directives will be honored by health care providers and caregivers of these facilities within the limits of applicable law, regulation, and the hospital's capability. An Advance Directive helps guide patient care decisions if the patient is unable to communicate and or make decisions. Providence does not discriminate against patients based on whether or not they have an Advance Directive.

PROCEDURE / IMPLEMENTATION:

1. Determine if the patient has an Advance Directive (AD) in the EHR
    1. You can find scanned Advance Directive forms in the chart by clicking on the POLST or Code Status field on the patient banner.
2. For patients who don't have an AD in the EHR, Inpatients will be asked as outlined in the AD screen of the EHR.
    1. If the patient has an AD, but it is not in the EHR:
        a. Attempts will be made to enter the AD into the EHR (either by asking family members or
        friends to bring it in or reaching out to other health care entities that may have copies).
        b. If the AD is obtained it should be reviewed with patient for accuracy, and then scanned to
        medical records. The original should be returned to the patient.
        c. If the patient's AD is unable to be obtained, or found to be inaccurate, patient should be given the option to complete a new AD.
    2. If the patient does not have an AD and does not want to complete one:

a. This will be noted in the patients EHR by a frontline caregiver.

3. If the patient does not have an AD and wants to complete one, but wishes to do so at a later time:
    a. Forms and information should be provided to the patient to complete their AD at the time and place of their choosing:
        i. General Guide to Advance Directives, Institute for Human Caring (all states, multiple languages available)
        ii. State of Montana Advance Directive
        iii. Washington State Advance Directive

4. If the patient would like to complete an AD while in the Hospital setting:
    a. Determine patient has decision-making capacity (see Definitions Section. If concerned about capacity, it must be determined by provider).
    b. Once determined patient has capacity, decide what type of AD they would like to complete:
        i. General Guide to Advance Directives, Institute for Human Caring (all states, multiple languages available)
        ii. "EZ Advance Directive DPOAH" – State of Montana
        iii. "EZ Advance Directive DPOAH" – State of Washington
    c. Process for determining which form to use based on the patient situation:
        i. The Providence Institute for Human Caring recommends using the "short" or "EZ" Advance Directive Durable Power of Attorney for Healthcare form during clinic visits, hospital stays, and before surgeries. Longer versions should be reviewed and updated at home, and the patient's own pace (questions that arise from the longer form(s) can be discussed with healthcare providers as needed/scheduled).
        ii. The "EZ" Advance Directive Durable Power of Attorney for Healthcare document can be witnessed by members of the healthcare team because it does not contain a healthcare directive. Rather its purpose is to name someone to speak for you if you can't and to provide them and your healthcare team with guidelines for care you might want.
        iii. Please check the following link for FAQs regarding AD/DPOAH in both Washington and Montana.
    d. Process for completing the form:
        i. Assist patient in completing the form as needed.
        ii. Ensure patient signature is witnessed by two appropriate people or a notary (specific guidance can be found on the individual document).

iii. Scan original to medical records. Give the original and as many copies requested to the patient. Keep one original until the new Advance Directive is verified in the patients EHR

iv. Update patient contacts to reflect Power of Attorney for Healthcare

REFERENCES:

Ethical and Religious Directives for Catholic Health Services (Sixth Edition)

Patient Self-Determination Act of 1990 (H.R. 4449)

Washington State Natural Death Act, RCW 70.122

Montana Rights of the Terminally Ill, MCA 50-9

Providence Trusted Decision-Maker Delegation Policy (PSJH_CLIN-1204, 5/2019)

Approval Signatures

Step Description	Approver	Date
EWA/MT Ethics Council	John Kleiderer: Division Chief Mission Officer - Central	5/5/2023
Policy Owner	Andrea Chatburn: Senior Director Ethics	4/26/2023

Standards

No standards are associated with this document

History

Created by Chatburn, Andrea: Senior Director Ethics on 4/26/2023, 1:47PM EDT

> New EWA/MT Policy, Approved by EWA/MT Ethics Council in November 2022. Updated correct MT links and laws.

Last Reviewed by Chatburn, Andrea: Senior Director Ethics on 4/26/2023, 1:47PM EDT

Last Reviewed by Kleiderer, John: Division Chief Mission Officer - Central on 5/5/2023, 5:24PM EDT

Activated on 5/5/2023, 5:24PM EDT