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Considerations in Individualized End of Life Planning

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I. Patient Autonomy and the Right to Self-Determination in Medical and End-of-Life Decision Making. A competent individual's right to refuse life-sustaining medical treatment is generally acknowledged and accepted, as is an individual's ability to exercise this right through advance written directives, or through a surrogate decision maker. Self-determination and the right to autonomy in healthcare and end-of-life decision-making is now a cornerstone of medical care, bioethics and jurisprudence.

II. Planning for Future Incapacity: Health Care Durable Power-of-Attorney and Advance Health Care Directives. Validly executed written advance health care directives provide advance consent and enforceable instructions to one's medical and care providers regarding the provision or withholding of specified medical and personal care. One's Health Care Agent appointed under a Health Care Durable Power of Attorney has a legal and fiduciary duty to make decisions in accordance with one's known preferences and written advance directive(s).

A. Health Care Durable Power of Attorney ["HCDPOA"]. Your HCDPOA gives your designated Agent (and alternate Agents, in succession) the legal authority to make medical and health care decisions for you if you are unable to do so for yourself. Your Health Care Agent should be someone with whom you have discussed your values and preferences, who is able to carry out your preferences and instructions (even if different from their own), and who will be a strong advocate for your rights and directives.

B. End-of-Life Health Care Directive. The Washington Natural Death Act, Ch. 70.122 RCW, enacted in 1979 and amended in 1992, authorizes individuals to create written instructions regarding the withholding or withdrawal of life-sustaining treatment in the event of future incapacity and if suffering from a terminal condition or in a permanent unconscious condition.

Standard health care directive forms which follow the rudimentary template provided in the statute may not address individualized goals and circumstances. Standard health care directives apply in only two conditions – a terminal condition or a permanent vegetative condition – and include instructions about a narrow subset of health care interventions – typically, only artificially provided nutrition and hydration. For persons with a specific life-limiting condition or disease or whose personal and/or medical history has resulted in more informed preferences, an individualized health care directive should be considered.

In addition, an emerging form of End-of-Life Health Care Directive addresses the cessation of *oral* nutrition and hydration at the end of life. Advance directives regarding stopping eating and drinking set forth instructions that in the event of future incapacity and when one is suffering from an incurable and debilitating physical and/or cognitive condition, at a defined point all oral nutrition and hydration shall be withheld.

C. Mental Health Advance Directive. Washington's Mental Health Advance Directive Act (the "MHAD Act"), Ch. 71.32 RCW was enacted in 2003. The Washington MHAD Act codifies the right of a person to create a binding advance directive specifying how they would like their mental health treatment and personal affairs handled in the event of future incapacity due to a mental health crisis or period of decompensation.

D. Dementia Advance Directive. Alzheimer's disease or dementia advance directives pertain to the unique disease trajectory, capacity issues, and care and treatment for persons with dementia. A dementia advance directive may address certain decisions often faced by persons with dementia along the disease trajectory, including out-of-home care placement, dealing with aggressive

behavior, voluntary pre-consent to hospitalization (geriatric psychiatry and/or dementia care), future intimate relationships (self and/or spouse), and participation in experimental trials.

III. Washington's Death with Dignity Act.

A. In 2008, Washington voters approved Initiative Measure No. 1000, the Washington Death with Dignity Act, enacted as Chapter 70.245 RCW. The law permits qualifying patients to request a physician's order for a lethal dose of medication with the intent to self-administer the medication and cause one's death.

B. In order to be a qualifying patient under the Act, one must be (qualifications listed in part):

1. Under the care of at least two physicians willing to provide the services required in accordance with the Act.
2. Terminally ill (incurable, irreversible disease that will cause death in less than 6 months).
3. Mentally competent.
4. Physically capable of self-administering and ingesting the lethal medication.

C. In addition, a number of specific procedural requirements regarding the timing and sequence of a patient's oral and written requests for the lethal medication must be met, which result in a period of at least 17 days between the first request and the issuance of the prescription.

D. The rights afforded under the Act are not exercisable by a Health Care Agent or through an advance written directive.

IV. Voluntary Stopping of Eating and Drinking to Hasten Death ("VSED").

A. Voluntarily stopping eating and drinking ("VSED") refers to the willful and voluntary decision of a person with decision-making capacity and who suffers from a chronic, incurable, and debilitating medical condition to cease the intake of oral nutrition and hydration to hasten the individual's death. If one does not qualify for utilization of Death with Dignity, VSED may be the only option to hasten death if suffering from an incurable and intractable illness or condition that is nonetheless not terminal, or not yet terminal. An individual with a progressive neurological disease, such as dementia, may choose VSED preemptively, before their cognitive ability to exert such decision-making is lost, in order to avoid prolonged suffering from advanced dementia.

B. Choosing to die by voluntarily stopping eating and drinking requires tremendous determination and self-discipline, as well as the support and commitment of care providers. Physician involvement is highly advantageous, as medical oversight and management of symptoms (palliative care) as they progress, and a physician's order for hospice services if not already in hospice care, necessitate clinician involvement. Once the individual electing VSED has stopped all intake of food and fluids, death typically comes within 15 days.

C. In advance of preparations to utilize VSED, one should meet with your elder law attorney to update their Health Care Durable Power of Attorney to include specific VSED provisions, execute an advance directive regarding stopping eating and drinking, and consider a Release and Assumption of Risk regarding the participation of loved ones, medical and care providers.

V. Health Care Provider Rights and Patient Rights. Federal and state laws afford substantial authority for the exercise and protection of conscientious objection by health care providers with regard to end-of-life decisions pursued by patients in their care. To increase the likelihood that your rights will be protected and enforced and that your advance directives will be followed, distribute and discuss your Health Care Directive with your designated Health Care Agents, medical providers, and care providers. In addition, you should investigate and determine the policies and practices of current and potential health care providers, insurers and facilities which would either promote or impair your preferences and directives.

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