The California End of Life Option Act (Patient's Request for a Drug for the Purpose of Ending Life)

ADOPTION DATE:
APPROVED BY:
LAST DATE REVISED:
LAST DATE REVIEWED:

Text Key:
Blue: Optional Language
Black: Statutory Language

Office of Origin: Ethics Committee

I. PURPOSE

A. The California End of Life Option Act allows an adult patient with capacity, who has been diagnosed with a terminal disease with a life expectancy of six months or less, and who meets other requirements, to request a prescription for a drug for the purpose of ending his or her life (aid-in-dying drug) through self-administration of the drug.

B. The purpose of this policy is to describe the requirements and procedures for compliance with The California End of Life Option Act and to provide guidelines for responding to patient requests for information about aid-in-dying drugs in accordance with federal and state laws and regulations and The Joint Commission accreditation standards.

C. The requirements outlined in this policy do not preclude or replace other existing policies, including but not limited to Withdrawing or Foregoing Life Sustaining Treatment, Pain Management, Advance Directives /POLST, Resuscitation Status (DNR) or End-of-Life Care, referenced herein.

II. REFERENCES

A. California Health and Safety Code section 443 et seq. (End of Life Option Act)

B. California Probate Code section 4609

C. BH Administrative Policies:

1. Advance Health Care Directives/POLST
2. Patient Rights and Responsibilities
3. Ethics Consultation
4. Withdrawing or Foregoing of Life Sustaining Treatment
5. End-of-Life Care
6. Resuscitation Status (DNR)
7. Pain Management
8. Interpreting and Translation Services
9. Employee Requests to be Excluded from Patient Care _____

III. DEFINITIONS (for purposes of this policy)

A. **Surrogate:** A surrogate decision maker can be an agent appointed in an advance health care directive or a durable power of attorney for health care, or a court appointed conservator of the person. When patients without such an agent or conservator lose capacity to make health care decisions, a family member, domestic partner or persons with whom the patient is closely associated may be considered to act as surrogates for health care decisions.

B. **Capacity to Make Health Care Decisions:** A patient who, in the opinion of the patient's attending physician, consulting physician or psychiatrist, pursuant to Probate Code section 4609, has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives and the ability to make and communicate an "informed decision" (defined herein) to health care providers.

C. **Aid-in-dying Drug:** a drug determined and prescribed by a physician for a qualified patient, which the qualified patient may choose to self-administer to bring about his or her death due to a terminal disease.

D. **Terminal Disease:** an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

E. **Attending Physician:** the physician who has primary responsibility for the health care of the patient and treatment of the patient's terminal disease. An attending physician does not include a resident, fellow, physician assistant or nurse practitioner. The attending physician may not be related to the patient by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the patient's estate upon death. The attending physician may not serve as a witness to the patient's written request for aid-in-dying drug (see Appendix A).

F. **Consulting Physician:** A physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis regarding a patient's terminal illness. The consulting physician may not be related to the patient by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the patient's estate upon death. A consulting physician does not include a resident, fellow, physician assistant or nurse practitioner.

G. **Mental Health Specialist:** Only a licensed psychiatrist or licensed psychologist may act as a mental health specialist. The mental health specialist may not be related to the patient by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the patient's estate upon death. It does not include a resident, fellow, physician assistant or nurse practitioner.

H. **Informed decision:** A decision by a patient with a terminal disease to request and obtain a prescription for a drug that the patient may self-administer to end the patient's life, that is based on an understanding and acknowledgement of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

1. The patient's medical diagnosis and prognosis;
2. The potential risks associated with taking the drug to be prescribed;
3. The probably result of taking the drug to be prescribed;
4. The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it; and
5. The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

I. **Self-Administer:** a qualified patient's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her death in the method prescribed by the physician.

IV. POLICY

A. The End of Life Option Act (herein after the "Act") allows adult (18 years or older) terminally ill patients, with capacity to make health care decisions, seeking to end their life, to request lethal doses of drugs from an attending physician. These terminally ill patients must be California residents (as defined herein) who will, within reasonable medical judgment, die within 6 months. Patients requesting lethal doses of a drug must satisfy all requirements of the Act in order to obtain the prescription for that drug. Such a request must be initiated by the patient and cannot be made through utilization of an Advance Health Care Directive, POLST or other document. It cannot be requested by the patient's surrogate.

B. Blank Hospital ("BH") allows its physicians and other health care providers who qualify under the Act to participate in activities authorized by the End of Life Option Act, if they so choose. BH physicians and other health care providers may, as applicable and as defined in the Act and herein:

1. Perform the duties of an attending physician.
2. Perform the duties of a consulting physician.
3. Perform the duties of a mental health specialist.
4. Prescribe drugs under this Act.
5. Fill a prescription under this Act.
6. Be present when the qualified patient self-administers the aid-in-dying drug provided that the physician does not participate or assist the patient in self-administering the life-ending drugs.
7. Assist in patient or provider support related to the Act.

C. BH neither encourages nor discourages participation in the Act; participation is entirely voluntary. Only those providers who are willing and desire to participate should do so. Those persons who do choose to participate are reminded that the overall goal is to support the patient's end-of-life wishes, and that participation may not necessarily result in aid-in-dying drugs being prescribed if the patient's needs can be met in other ways (e.g. pain management, hospice or palliative care).

D. Participation in activities authorized under the Act is completely voluntary. A BH physician, staff or employee that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized by the Act is not required to take any action in support of a patient's request for a prescription for an aid-in-dying drug, including but not limited to, referral to another provider who participates in such activities. BH physicians or employees who experience moral or spiritual distress related to patient requests to access the Act may utilize supportive services such as _____.

E. BH does not permit the ingestion or self-administration of an aid-in-dying drug in its hospitals, clinics or elsewhere on its premises. However, inquiry and discussion of such a request is permitted during a patient's hospitalization. An attending physician may prescribe the aid-in-dying drug after discharge so long as all the requirements of the Act are fulfilled (see section V for requirements).

F. BH does not accept new patients solely for the purposes of accessing the Act. Eligible individuals must be current BH patients receiving care for a terminal disease.

G. When a patient makes an inquiry about or requests access to activities under the Act, the patient will initially be referred to BH Social Services Department. Social workers who are well versed in the requirements of the Act will assist patient understanding of the Act, inform them about the process and provide educational material related to the patient's end of life options. This activity will augment, but not substitute for, the obligations of the attending and consulting physicians' roles described herein. If the patient's BH physician chooses not to participate in the Act, which is his or her right under the law, a social worker will assist in the identification of a BH physician who does participate.

H. The Act requires the involvement of two physicians; an attending physician and a Consulting physician as defined in the Act and herein in section V. BH requires that at least one of these physicians be privileged pursuant to criteria set forth by the BH Medical Staff for participation in the Act.

I. In consideration of the vulnerabilities of particular patient populations, including but not limited to patients who lack social support or patients with disabilities, BH requires a thorough assessment for consent and capacity determination beyond what is required by the Act. All patients who request an aid-in-dying drug will receive a mental health evaluation. These safeguards will serve the objective of protecting individuals who might seek aid-in-dying drugs but are not capable of making an autonomous and informed choice. [Note: A mental health assessment is required by law only if the attending or consulting physician determines that the patient has indications of a mental disorder. However, a hospital may, if it so chooses, adopt a requirement that attending physicians obtain a mental health assessment prior to prescribing an aid-in-dying drug.]

J. BH may provide oversight and may review records to the extent necessary to ensure all the safeguards of the law have been followed and the correct documentation completed and submitted to the California Department of Public Health. BH will also review all cases of use of the Act for quality improvement purposes. Attending physicians are required to report all patient requests for aid-in-dying drugs to BH Risk Management.

V. PROCEDURES

A. Requirements of the California End of Live Option Act

1. Patients qualified to request aid-in-dying drugs: Existing BH adult patients who have capacity to make health care decisions and who have a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are met:

    a. The patient's attending physician has diagnosed the patient with a terminal disease;

b. The patient has voluntarily requested an aid-in-dying drug on three separate occasions as described herein;

c. The patient has the physical and mental capacity to self-administer the aid-in-dying drugs;

d. The patient is a California resident and is able to establish residency through at least one of the following:

   i. Possession of a California Driver license or ID card issued by the State of California

   ii. Registration to vote in California

   iii. Evidence that the patient owns, rents or leases property in California

   iv. The filing of a California tax return for the most recent tax year

e. Notwithstanding fulfillment of the above requirements, eligible individuals must be current BH patients receiving care for a terminal disease. Individuals who present to BH for the sole purpose of requesting an aid-in-dying drug are not eligible to request aid-in-dying drugs from BH physicians, staff or employees.

f. A patient must not be considered a "qualified individual" under the Act solely because of age or disability. If there is concern regarding the voluntariness of the patient's request by any member of the health care team, or if there is disagreement between health care team members regarding whether the patient's needs can be met in ways other than by a prescription for an aid-in-dying drug, these concerns must be shared with the Ethics Committee which will pursue the concerns with the utmost seriousness to avoid inappropriate utilization or application of the Act. Aid-in-dying drugs will not be prescribed at any time in the presence of concerns on the part of BH regarding the voluntary nature of the request.

2. Method of request for aid-in-dying drug and documentation requirements: Requests for aid-in-dying drugs must come directly and solely from the patient who will self-administer the drugs. Such requests cannot not be made by a patient's surrogate or by the patient's health care provider.

   To make a request for a prescription for an aid-in-dying drug, the patient must directly submit to his or her attending physician:

   a. Two oral requests (made in person) that are made a minimum of 15 days apart. Patients who are unable to speak because of their medical condition shall communicate their request in a manner consistent with their inability to speak, such as through sign language. The attending physician must document these requests in the medical record (the Act does not specify any particular language); AND

b. One written request using the form required by the State of California "Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner" (CHA Form 5-5). This form must be placed in the patient's medical record. Form 5-5 sets forth the following conditions:

   i. The written request form (Form 5-5) must be signed and dated, in the presence of two witnesses, by the patient seeking the aid-in-dying drug.

   ii. The witnesses must also sign the form and by so doing attest that to the best of their knowledge and belief the patient is all of the following:

      (a) An individual who is personally known to them or has provided proof of identity.

      (b) An individual who voluntarily signed the request in their presence.

      (c) An individual whom they believe to be of sound mind and not under duress, fraud or undue influence.

c. The patient's attending physician, consulting physician and mental health specialist cannot serve as witnesses. Additionally, only one witness may be related to the requesting patient by blood, marriage, registered domestic partnership or adoption or be entitled to a portion of the requesting patient's estate upon death or own, operate or be employed by a health care facility where the patient is receiving medical care or resides.

d. The request may not be made through a nurse practitioner, physician assistant, resident or fellow. Nurse practitioners, physician assistants, residents and fellows must notify their attending physician about any patient request for aid-in-dying medication. They are not authorized under BH policy to participate as statutory providers under the Act.

e. Within 48 hours prior to self-administration of the aid-in-dying drug, the patient must complete the State of California issued form "Final Attestation for an Aid-in-Dying Drug to End my Life in a Humane and Dignified Manner" (CHA Form 5-6). If the attending physician receives this document, he or she is required to put it in the patient's medical record.

3. Responsibility of the attending physician: The responsibilities of an attending physician are non-delegable. Before prescribing the aid-in-dying drug, the attending physician must do all of the following:

   a. Make the initial determination about whether the patient is qualified under the Act as described in section A 1 above, including determination that:

      i. The patient has capacity to make health care decisions

ii. The patient has a terminal disease, medically confirmed by a consulting physician

iii. The patient has made a voluntary request for an aid-in-dying drug, including completion of witness attestations that the patient is of sound mind and not under fraud, duress or undue influence

iv. The patient has met the residency requirements of the Act

b. Confirm that the patient is making an informed decision as defined herein.

c. Refer the patient to a consulting physician. (NOTE: BH requires that at least one of the involved physicians be privileged to participate in the Act through the BH Medical Staff.)

d. If the attending or consulting physician determines that the patient has indications of a mental disorder, the patient must be referred for a mental health assessment. This assessment must be documented in the patient's medical record.

e. Confirm that the patient's request does not arise from coercion or undue influence. The physician must do this by discussing with the patient, outside the presence of any other person (except for a BH-provided interpreter as described in Section 7 below) whether or not the patient is feeling coerced or unduly influenced by another person. Family members or friends of the patient cannot act as interpreters.

f. Counsel the patient about the importance of:

i. Having another person present when he or she ingests the aid-in-dying drug.

ii. Not ingesting the aid-in-dying drug in a public place. "Public place" means any street, alley, park, public building, or any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.

iii. Notifying the next of kin of his or her request for an aid-in-dying drug. A patient who declines or is unable to notify next of kin must not have his or her request denied for that reason.

iv. Participating in a hospice program.

v. Maintaining the aid-in-dying drug in a safe and secure location until the patient takes it.

g. Inform the patient that he or she may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner. The patient has the right to change his or her mind without regard to his or her mental state. Therefore, if a patient makes a request for an aid-in-dying drug while

having capacity to make health care decisions, then loses his or her capacity, the patient can still decide not to take the aid-in-dying drug.

h. Offer the patient an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the drug.

i. Verify, for a second time, immediately before writing the prescription for an aid-in-dying drug, that the patient is making an informed decision.

j. Confirm that all requirements are met and all appropriate steps are carried out in accordance with the law (as outlined in this policy) before writing a prescription for an aid-in-dying drug.

k. Fulfill all the documentation requirements (see Section 6 below).

l. Inform BH Risk Management that such a request has been made.

m. Complete the Attending Physician Checklist & Compliance form (CHA Form 5-7) and place it as well as the completed Consulting Physician Compliance form (CHA Form 5-8) in the patient's medical record. Arrange for the forms submittal to CDPH by the _____ Office.

n. Give the requesting patient the Final Attestation form (CHA Form 5-6) to the patient and instruct the patient about completing it.

o. Complete the Attending Physician Follow-up form (CHA Form 5-9) and submit it to CDPH through the _____ Office.

4. Responsibility of consulting physician: A physician who chooses to act as a consulting physician must not be involved in the patient's health care and must do all the following:

   a. Examine the patient and his or her relevant medical records.

   b. Confirm in writing the attending physician's diagnosis and prognosis.

   c. Determine that the individual has the capacity to make medical decisions, is acting voluntarily and has made an informed decision.

   d. If the attending or consulting physician determines that the patient has indications of a mental disorder, the patient must be referred for a mental health assessment. This assessment must be documented in the patient's medical record.

   e. Fulfill the documentation requirements (see section 6 below).

   f. Complete the State of California form "End of Life Option Act Consulting Physician Compliance form (CHA Form 5-8).

5. Responsibility of mental health specialist: In the interest of protecting mentally ill patients, or patients lacking capacity, from receiving prescriptions for aid-in-dying drugs and to ensure a vigilant and systematic examination for depression or other mental health conditions that could be interfering with informed decision

making, all patients who request an aid-in-dying drug shall be screened through a mental health assessment.

A psychiatrist or psychologist who chooses to act as a mental health specialist must conduct one or more consultations with the patient and do all of the following:

a. Examine the qualified patient and his or her relevant medical records.

b. Determine that the patient has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.

c. Determine that the patient is not suffering from impaired judgment due to a mental disorder. Patients with depression are not automatically excluded and it must be determined that a mental illness is interfering with decision making capacity.

d. Document in the patient's medical record a report of the outcome and determinations made during the mental health specialist's assessment.

e. Fulfill the documentation requirements (see Section 6 below).

6. Documentation requirements: All of the following must be documented in the patient's medical record:

a. All oral requests for aid-in-dying drugs.

b. All written requests for aid-in-dying drugs.

c. The attending physician's diagnosis and prognosis, and the determination that the qualified patient has the capacity to make healthcare decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified patient.

d. The consulting physician's diagnosis and prognosis and verification that the qualified patient has the capacity to make health care decisions, is acting voluntarily and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified patient.

e. A report of the outcome and determination made during a mental health specialist's assessment.

f. The attending physician's offer to the qualified patient to withdraw or rescind his or her request at the time of second oral request.

g. A note by the attending physician indicating that all requirements of the Act have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

h. Death Certificate: The Act does not provide direction as to what cause of death should be referenced on the patient's death certificate. The Act provides that actions taken under the Act shall not, for any purpose,

constitute suicide, assisted suicide, homicide or elder abuse. It is BH policy that the physician reference the California End of Life Option Act as the manner of death and the patient's underlying medical condition that qualified the patient for the aid-in-dying drug should be reported as the underlying cause of death. The ingestion of the aid-in-dying drug should be recorded as an antecedent cause.

7. Use of an Interpreter: Requirements:
    a. Option 1: The written request form signed by the patient (CHA Form 5-5) must be written in the same language as any conversations, consultations or interpreted conversations or consultations between a patient and his or her attending or consulting physician.
    b. Option 2: CHA Form 5-5 may be prepared in English even when the conversations or consultations were conducted in a language other than English if the interpreter completes the interpreter attestation on the form.
    c. The interpreter must not be related to the patient by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the patient's estate upon death. The interpreter must meet the standards promulgated by the California Healthcare Interpreting Association or the National Council on Interpreting in Health Care or other standards deemed acceptable by CDPH. BH will also provide its interpreters training from the California Healthcare Foundation. 2011. Web: www.chcf.org/publications/2011/11/interpreting-palliative-care-curriculum or the equivalent. Whenever practicable, BH will provide interpreters who have received this training.
8. Prescribing or delivering the aid-in-dying drug: After the attending physician has fulfilled his or her responsibilities under the Act, the attending physician may deliver the aid-in-dying drug in any of the following ways:
    a. Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the patient's discomfort, if the attending physician meets all of the following criteria:
        i. Is authorized to dispense medicine under California law (the Act does not specify which drugs can be used as an aid-in-dying drug);
        ii. Has a current USDEA certificate; and
        iii. Complies with any applicable administrative rule or regulation.
    b. Aid-in-dying drugs cannot be dispensed by a physician in the inpatient setting.
    c. With the patient's written consent, contacting a pharmacist, informing the pharmacist of the prescription, and delivering the written prescription personally, by mail, or electronically to the pharmacist. It is not

permissible to give the patient a written prescription to take to a pharmacy. The pharmacist may dispense the drug to the patient, the attending physician, or a person expressly designated by the patient. This designation may be delivered to the pharmacist in writing or verbally.

d. Delivery of the dispensed drug to the patient, the attending physician, or a person expressly designated by the patient may be made by personal delivery, or with a signature required on delivery, by UPS, US Postal Service, Federal Express or by messenger service.

e. Physicians should counsel patients that leftover aid-in-dying drugs should be properly disposed by returning to a facility authorized to dispose or as provided by the Board of Pharmacy.

9. CDPH reporting requirements: Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician (through BH's _____ Office) must submit the documents listed below to CDPH either by mail or by fax, (916) 440-5209. If mailed, the completed forms should be sent in envelopes marked "confidential" to:

CDPH Public Health Policy and Research Branch
Attention: End of Life Option Act
MS 5205
P.O. Box 997377
Sacramento, CA 95899-7377

To protect confidentiality, CDPH has not established an email address for forms submission.

a. A copy of the qualifying patient's written request: Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner (CHA Form 5-5);

b. The End of Life Option Act Attending Physician Checklist & Compliance form (CHA Form 5-7);

c. The End of Life Option Act Consulting Physician Compliance form (CHA Form 5-8);

d. Within 30 calendar days following the qualified patient's death from ingesting the aid-in-dying drug, or any other cause, the attending physician (through the _____ Office) must submit to CDPH the End of Life Option Act Attending Physician Follow-Up form (CHA Form 5-9). The Act does not specify the attending physician's obligation in the event the physician does not receive this form.

10. Guidelines for physicians: Attached as Appendix A are "Guidelines for Physicians About the End of Life Option Act."

VI. RESPONSIBILITY

A. Ethics Committee

VII. HISTORY OF POLICY

Reviewed by BH Task Force for Aid-in-Dying Policy

Reviewed by Risk Management and Legal Department

VIII. APPENDIX

A. Guidelines for Physicians

Appendix A: Guidelines for Physicians about the End of Life Option Act

1. Guidelines for a physician responding to a patient's request for an aid-in-dying drug:
    a. The highest quality health care is an outgrowth of a partnership between the patient, the family and the health professional or professional team. Within the context of this continuing relationship, physicians must seek to ascertain the underlying causes of suffering at the end of life, and then aggressively implement measures to correct them. Appropriate education in palliative care and medical management; advanced communication skills to discover the patient's wishes and value choices; connection to services, support and resources; and appropriate sharing of decision making with the patient and the patient's family can go a long way toward alleviating suffering and improving care at the end of life. Physicians should continue to provide assistance in dealing with dying patients' symptoms, needs and fears.
    b. When a patient asks about the End of Life Option Act, the attending physician's initial response should be to explore the meaning behind the question, regardless of his/her personal views or willingness to participate. Loss of control, abandonment, financial hardship, burden to others, and personal or moral beliefs may be areas of concern to many patients.
    c. The attending physician should seek to understand what constitutes unacceptable suffering in the patient's view. Pain, other physical symptoms, psychological distress, and existential crisis are potential causes of suffering.
    d. The attending physician has an obligation to explore treatment for symptoms for which there are treatment options available. This includes hospice, psychological support, and other palliative care.
    e. The physician should recommend that a patient complete an advance directive and POLST.
    f. The attending physician should reflect on his/her own beliefs and motivations and the policies of the health care system, and consider the impact of those motivations on decision making with patients near the end of life.
2. Guidelines for a physician speaking to family members, caregivers or supporters about a patient's request for an aid-in-dying drug:
    a. When a patient has authorized the attending physician to share protected health information with his or her family, caregiver or supporters, the following are suggested as guidelines for participating physicians and other health care professionals work with families:
    b. It is important for health care professionals to recognize the critical role that family and friends play in the life and care of a patient. Families can provide knowledge of a patient's values and personality. Families are profoundly affected by the care of the patient at the end of life.
    c. It is also important to recognize the different responses family members and supporters may have to a patient's request for an aid-in-dying drug under the Act. Some may be supportive, others may become supportive, and still others may be consistently opposed.

d. Physicians who agree to participate in the Act are required to recommend to the patient that the next of kin be notified of the request for a lethal dose of medication. However, a refusal to do so does not in itself make a patient ineligible for the Act. Some patients have difficult relationships or religious or moral differences with family members; their decisions regarding disclosure generally should be respected on the basis of confidentiality. However, there may be circumstances which create concerns regarding an adverse impact on family, and that would indicate the need for further dialogue.

e. Physicians are required to counsel patients about the importance of having another person present when the aid-in-dying drug is taken. However, the Act does not require another person to be present.

f. Patients and family members have a great need for information about the Act and its requirements, what to expect during the ingestion of a lethal dose of medication, and what to expect afterwards. Also, the attending physician should confirm that the members of the health care team are willing to participate. It behooves the attending physician and other appropriate professionals or volunteers to supply the needed information in as much detail as possible, and to plan strategies for care. This planning should include:

   i. The specific requirements and process of the Act, including a timeline.

   ii. Alternatives to the Act, including comfort care, palliative care, hospice care, and pain control.

   iii. Discussion of disclosure to family members; discussion of who will be present at the time the patient takes the lethal dose of medication.

   iv. Suggesting that Advance Directives and Physician Orders for Life-Sustaining Treatment (POLST) are appropriately completed and available where the patient is receiving care.

   v. An idea of what to expect during the ingestion of the aid-in-dying drug, and contingency plans if things do not proceed as expected, especially if the death takes longer than expected. Death may not be immediate and may take hours.

   vi. Discussion of the availability of the attending physician, either in person or by phone, to deal with questions and complications, or for support.

   vii. Information on funeral arrangements, including a plan to have the attending physician notify the hospice and funeral home that the death was expected and that he/she will sign the death certificate.

   viii. Health care professionals should understand the special needs of families involved with the Act for discussion of their experiences and the concern about secrecy. Secrecy may prolong the grieving process.

3. Guidelines for physicians when an aid-in-dying patient presents to the Emergency Department (ED) following ingestion of aid-in-dying drug:

   a. Even with careful planning, it is possible that deaths that take longer than expected might lead to occasional ambulance calls and transport to emergency departments and thus, ED physicians may care for patients who are brought to the ED.

b. EDs should have policies for addressing the care of these patients consistent with following the known wishes of the patient as evidenced by an Advance Directive and POLST.