



August 5, 2013

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Via email to: fslcon@doh.wa.gov

Re: CON hearing to protect patient access

Dear Ms. Sigman,

Thank you for the opportunity to comment. Compassion & Choices of Washington helped sponsor and now acts as "steward" to Washington's Death with Dignity law (DWDA).

This law was passed through Initiative 1000 in 2008, which won the approval of 59% of Washington voters. We appreciate the Department's work in creating regulations to implement the law and in collecting data for annual reports, which show 121 people used the law to obtain medication in 2012. We have no doubt that thousands of patients and family members discussed the law and posed questions to their caregivers about the law and what relief it might provide to them in their dying process.

In the four years of experience with this law in Washington, Compassion & Choices of Washington has found that patients face significant barriers in obtaining information to make informed decisions about the end of life. Many health care providers are refusing to answer patient questions about the law and whether they could count on their caregivers' support in using the law. Some entities have corporate or system policies which prohibit caregivers from providing accurate information, as well as policies prohibiting referrals for information or assistance in obtaining medications under the law.

While virtually all hospitals in Washington have "opted out of participating" in the Death with Dignity law, such simple "opt out" policies do not change patient access significantly. This is because few if any patients wish to die in a hospital—those who use the DWDA typically return home to die in a familiar and comfortable setting. For example, Multicare Health Systems has adopted a policy prohibiting patients from ingesting life-ending medications in their acute care facilities. However, the Multicare policy also allows physicians to freely discuss the DWDA with patients and to prescribe as they choose in their individual office settings.

<http://www.multicare.org/tacomageneral/news/article/multicare-announces-position-on-i-1000>.

The restrictions some religiously-affiliated hospitals have placed on participation go far beyond "opting out" under the definitions of the DWDA. Many prohibit candid conversations by

caregivers, physicians, social workers and others, even when patients press them for information. When a hospital with restrictive policies merges with another, the restrictions typically apply to candid communications wherever they might occur, in the acute care or primary care settings.

As a hypothetical example, if Providence were to acquire a hospital from Multicare, the CON statement might state that Death with Dignity would remain prohibited in the facility—suggesting no change in the patient experience related to the change in ownership. However, if the hypothetical hospital were acquired by Providence, existing Providence policies would likely restrict not only the use of DWDA medications on the premises, but would also restrict the communications of staff: “Providence Mount Carmel Hospital will not participate in any aspect of physician-assisted suicide, including, but not limited to, the provision of information intended to promote physician-assisted suicide.” <http://washington.providence.org/hospitals/st-josephs-hospital/patients-and-visitors/information-for-patients/patient-rights/> (emphasis added).

Health care consolidation is extending restrictive policies far beyond hospitals into hospital-owned physician groups, including primary care clinics. Most patients assume their doctors give them full and accurate answers to their questions—but more and more providers are finding themselves subject to restrictions as a condition of employment, or hospital privileges, or even as a condition of their office lease.

We have obtained a copy of a restrictive office lease that requires the provider to agree “that the Tenant shall not utilize the premises for the performance of any of the following services, procedures or activities: abortion, euthanasia, physician assisted suicide, and research involving the use of embryonic stem cells from the destruction of human embryos or the tissue of aborted fetuses.”

When provider "gag" policies prevent caregivers from giving patients information, we believe patients are getting inadequate care and their caregivers may be risking unprofessional conduct in withholding information. We would welcome further analysis to determine whether a provider obeying a restrictive policy would be engaging in unprofessional conduct by depriving patients about their lawful options, or whether withholding this information would violate the requirement of informed consent.

Regardless of their personal commitment to patients, providers are cowed into compliance. We hear from providers in Whatcom county that they are not allowed to answer patient requests for information about aid in dying—they asked us not to identify them by name or profession or work location because they fear they would be terminated from their jobs for communicating with Compassion & Choices of Washington—even though they are not violating their employer’s policies prohibiting discussion or referral for more information. We used to have five cooperating physicians in the Vancouver area of Southwest Washington—in the wake of the merger between South West Washington Medical Center and PeaceHealth in 2011, our number of cooperating providers has shrunk to one.

Sometimes provider communications are impaired in the wake of mergers in which Compassion & Choices of Washington was assured no change of policy would take place. For example, when Swedish merged with Providence, Swedish corporate leaders assured us their policy to permit free communications about aid in dying would not change. In fact the old policy is still posted on the Swedish website. But Compassion & Choices of Washington hears regularly of patients who asked Swedish providers for information and are told “we’re not allowed to talk about that anymore.”

None of these mergers underwent review by the Department of Health, because they were structured to create a new corporate parent entities or “affiliation” agreements, rather than a sale, purchase or lease which would have triggered CON review. We appreciate the DOH's consideration of how to assure effective oversight of the hospital consolidations underway in Washington State, to consider how the policies of merging entities might impact patient access to services such as candid information about aid in dying.

Specifically, we believe the Department of Health would be well served to obtain and evaluate the following in considering whether a proposed merger would continue to serve the public interest:

- Expand the Department’s jurisdiction to capture all relevant transactions, making it more difficult for deal counsel to structure the agreements to evade review.
- Identify whether corporate policies will restrict the scope of services offered following the transaction in ways unrelated to the hospital’s certification or level of care, regardless of whether affected services were provided in the past.
- Identify if corporate policies would alter information available to patients in giving informed consent for treatment decisions.
- Identify all the subsidiary entities and practice settings in which restrictive policies would apply, including health-system owned hospice and primary care practices.
- Make formal findings in the award of a Certificate of Need of the parties’ representations related to patient access to services and information.
- Establish a process for post-merger audits of affected facilities or health systems to detect if the post-merger entities are not implementing policies as promised, or if subsequent non-disclosed restrictions are implemented.
- Empower the Department to issue meaningful sanctions if post-merger audits detect misrepresentations were made in the CON application and patient access has been impaired.

Patients who cannot get information and support sometimes resort to more desperate solutions. This year a terminally ill Compassion & Choices of Washington client in a rural part of the state where Providence owned the nearest hospital was frustrated in his attempts to find a cooperating physician. He obtained a handgun and shot himself in the head.

I am afraid his case could be a window into the future if patient access continues to be restricted in the wake of mergers with health systems which restrict patient information and services.

Thank you for the opportunity to comment.

Very truly yours,

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