HB

197

22-LS0712\C
Bannister
4/23/01

CS FOR HOUSE BILL NO. 197( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES HUDSON, Kerttula

A BILL

FOR AN ACT ENTITLED

"An Act allowing the use of certain directives relating to the health care and death of a person."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 18.12.100 is amended to read:

Sec. 18.12.100. Definitions. In AS 18.12.010 - 18.12.100 [THIS CHAPTER],

(1) "anatomical gift" means an anatomical gift under AS 13.50;

(2) "attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient;

(3) "cardiopulmonary resuscitation" means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation;

(4) "declaration" means a document executed in accordance with the requirements of AS 18.12.010;

(5) "DNR identification" means identification substantially similar to that approved under AS 18.12.037;

(6) "do not resuscitate order" means a directive from a licensed physician that emergency cardiopulmonary resuscitation should not be administered to a particular person;

(7) "do not resuscitate protocol" means the protocol developed under AS 18.12.035(b);

(8) "health care provider" means a person who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession;

(9) "life-sustaining procedure" means a medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process;

(10) "physician" means a person licensed to practice medicine in this state or an officer in the regular medical service of the armed services of the United States or the United States Public Health Service while in the discharge of their official duties, or while volunteering services without pay or other remuneration to a hospital, clinic, medical office, or other medical facility in the state;

(11) "qualified patient" means a patient who has executed a declaration in accordance with **AS 18.12.010 - 18.12.100** [THIS CHAPTER] and who has been determined by the attending physician to be in a terminal condition;

(12) "terminal condition" means a progressive incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of two physicians, when available, who have personally examined the patient, one of whom must be the attending physician, result in death within a relatively short time.

*** Sec. 2.** AS 18.12 is amended by adding new sections to read:

Article 2. Health Care and Related Directives.

Sec. 18.12.110. Health care and related directives. Notwithstanding any other provision of law and in addition to any other method allowed by law for giving directives for a person's health care, death, and related issues, a person may use a form that is substantially similar to the Five Wishes form for making directives related to the person's health care and death, including designating another person to act as an

attorney-in-fact or other agent for the person when making health care decisions, directing what kind of health treatment the person desires, establishing funeral wishes, and expressing the person's wishes regarding donation of the person's body, or body parts. In this section, "Five Wishes form" means the document entitled "Five Wishes," copyrighted by Aging with Dignity, November 2000.

Sec. 18.12.120 Euthanasia not authorized. The form that is authorized by AS 18.12.110 may not be used to authorize or approve euthanasia or mercy killing.

*** Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REVISOR'S INSTRUCTIONS. The revisor of statutes shall substitute "AS 18.12.010 - 18.12.100" for "this chapter" in

(1) AS 18.12.010(d);

(2) AS 18.12.035(d);

(3) AS 18.12.037;

(4) AS 18.12.040(b);

(5) AS 18.12.050(b);

(6) AS 18.12.060;

(7) AS 18.12.080(a), (d), (e), and (f); and

(8) AS 18.12.090.

REPRESENTATIVE BILL HUDSON Alaska State Legislature

Room 502 • State Capitol, Juneau, Alaska 99801 (907)465-3744 Fax: 465-2273

Sponsor Statement
HB 197

Relating to directives for personal health care services and for medical treatment

House Bill 197 offers a "comprehensive simplified" alternative to the power of attorney enacted in Alaska in 1996 relating to health care services and directives for the terminally ill patient. That was not an oxymoron. The legislation is comprehensive because it speaks to the details and instructions that patients put in place regarding their care should they become incapacitated. It is simple in that the directives speak simply to the patient's wishes (the legislation is known nationally as the Five-Wishes) as follows:

My Wish for:

1. The person I want to make care decisions for me when I can't
2. The kind of medical treatment I want or don't want
3. How comfortable I want to be
4. How I want other people to treat me
5. What I want my loved ones to know

The Five Wishes contained in this bill, will produce a document that helps you express how you want to be treated if you are seriously ill and unable to speak for yourself. It is unique among all other living will and health agent forms because it looks to all of a person's needs: medical, personal, emotional and spiritual. Five Wishes also encourages discussing your wishes with your family and physician.

Five Wishes is changing the way America talks about and plans for care at the end of life. Nearly one million copies of the document are circulating throughout the nation, and more than 1,400 organizations are distributing this revolutionary document, including churches, synagogues, hospices, hospitals, doctor and law offices, and social service agencies. Many employers are providing the document to their employees, to help them plan for themselves as well as have those delicate discussions with their aging parents.

Five Wishes speaks to people in their own language, helping families talk with their physician about a subject that is often avoided as being too hard to face.

The 15 states that Five Wishes is not legally valid in, either require a specific state form or that the person completing an advance directive be read a mandatory notice or "warning." Residents of these states can still use Five Wishes to put their wishes in writing and communicate their wishes with their family and physician. Most health care professionals understand they have a duty to listen to the wishes of their patients no matter how they are expressed.

Subject: [Fwd: Five Wishes]
Date: Mon, 12 Mar 2001 15:50:11 -0900
From: Representative Bill Hudson <Representative_Bill_Hudson@legis.state.ak.us>
Organization: Alaska State Legislature
To: Melanie Lesh <Melanie_Lesh@legis.state.ak.us>

Subject: Five Wishes
Date: Mon, 12 Mar 2001 12:54:05 -0900
From: "Samet, Sue" <SSamet@provak.org>
To: "'Rep. Bill Hudson'" <Representative_Bill_Hudson@legis.state.ak.us>

Hello. I am the head of a year old organization called the Senior Advocacy Coalition. We have about twenty-five people statewide who are active in this new coalition with our numbers growing. Sioux Plummer was on line last Friday for our March meeting. She stated that you were going to be putting forth a bill so that the Five Wishes could be implemented in our state.

This is excellent news. We want you to know that we support this fine effort and that if we can be of any assistance in making this a reality, please do not hesitate to call on us. I have had to make several presentations in the last month regarding what/who the SAC is. I always have Five Wishes information with me when I do these presentations. People are most receptive and interested in the Five Wishes and hopeful our state might too become a "Five Wishes state". With your bill, this can happen.

Again, please call on us if we can help advance the need for this bill. Thank you for the hard work you are doing.

Sue H. Samet,MSW
Director Providence Horizon House and Convenor of Senior Advocacy Coalition

WL ——→ Bill Folder

FEB 27 2001

Subject: follow-up regarding Five Wishes legislation
Date: Mon, 26 Feb 2001 18:14:14 -0900
From: Jane Demmert <jane_demmert@admin.state.ak.us>
Organization: Executive Director, Alaska Commission on Aging, Department of Administration
To: "Hudson, William" <Representative_Bill_Hudson@legis.state.ak.us>, Melanie_Lesh@legis.state.ak.us
CC: "plummer, sioux" <twoplums@alaska.net>

Hello.

A short follow-up to share with you as I go through my notes from our Commission's briefing on *Aging in Alaska* made to the House HESS Committee February 13. In the briefing I noted that the Commission supports Alaska's adoption of the Five Wishes format for advance directives. Rep. Dyson requested that as its available, he would like to see the draft legislation.
Thanks for your interest in helping make the framework for defining our wishes at the end of our lives less forbidding and more accessible. That in itself is a big step forward.

Greetings!

Jane

Jane Demmert <jane_demmert@admin.state.ak.us>
Executive Director
Alaska Commission on Aging
Department of Administration

THE
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Initiatives

Issue 9, January 2001

Focus: Policy Leaders and End-of-Life Care—Part I

There is no doubt that America is getting older. Currently, the American elderly population stands at 34.5 million—up more than 10 percent in the past decade. In some states—such as Florida, the state with the largest per-capita population of seniors—the elderly population is increasing at nearly twice the rate of the general population. Longer life expectancies, even for those with life-limiting illnesses, are one result of advances in medical technology. "We are getting to a point at which medical science can keep us alive in terrible shape," says U.S. Rep. Nancy Johnson (R-Conn.), just one of many legislators working to remove legal barriers to good pain management (see p. 6).

David Eulitt

A dying woman at home, cuddling her grandson. Leading policy makers are helping a greater number of Americans fulfill their wishes to die at home among family, with their pain and other symptoms managed.

INSIDE

Political Leaders Rethink End-of-Life Policy

A recent Gallup Poll showed 90 percent of Americans wish to die at home, but the reality is that only 10 to 15 percent will die there, with the rest spending their final days among strangers in a hospital or nursing home. Dying people feel such loss of control keenly; fear of pain and loss of control over one's last days contribute to depression and anxiety as death approaches. State policy makers working to improve care near the end of life believe that addressing these problems and establishing a supportive climate for palliative care would help insulate their states against efforts to secure a right to assisted suicide. "People have to feel confident that the health care system will take good care of them when they are dying," says Assemblywoman Helen Thomson (D-Calif.—see p. 4). "Lack of faith in that system is what moves people to demand desperate measures."

More and more policy makers are dedicating their own time and visibility and the resources of their offices to creating new policy, revising existing policy, and interpreting laws and regulations for physicians and families, who often feel unsure of how their states govern their choices and actions. This issue is the first in a mini-series that will profile leaders with impressive track records in end-of-life care policy. This issue features three leaders, with briefer profiles on several others whose work bears watching. Clearly a political leadership exists that has found end-of-life care a positive issue with virtually no political downside, because every single constituent in these leaders' districts benefits from good end-of-life-care policy.

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MEMORANDUM December 14, 2000

SUBJECT: Five Wishes draft legislation (Work Order No. 1LS-0623\A of the 21st Legislature) -- sectional analysis

TO: Representative Bill Hudson

FROM: Jack Chenoweth
Assistant Revisor of Statutes

This sectional analysis addresses draft work order 1LS-0623A of the 21st Legislature, prepared for you in March, 1999. You have a copy of the draft and a clean copy of the text of the "Aging With Dignity -- Five Wishes" document that was the starting point for the drafting effort.

Bill section 1: Some years ago, the legislature enacted, as part of AS 13.26, the Statutory Form Power of Attorney legislation, a checklist approach for preparing a comprehensive power of attorney. One element that could be covered by the Statutory Form Power of Attorney was "health care services". The "Aging With Dignity -- Five Wishes" document was offered as a comprehensive simplified alternative to the Statutory Form Power of Attorney that focused on health care services. So, in drafting the "Five Wishes" document into bill form, bill section 1 eliminates "health care services" from the comprehensive coverage that may be addressed as an element of a power of attorney. The operative deletion is on page 2, line 26. Corresponding text in the Statutory Form Power of Attorney that substantively addresses "health care services" is repealed in AS 13.26.335(l) and 13.26.344(l), the repeals appearing in **bill section** 4.

Bill section 2: AS 18.12 (Chapter 12 of Title 18) sets out material relating to "living wills" and "do not resuscitate orders," two areas dealing with health care directives. The "Five Wishes" approach relates to that general topic. We proposed to add the "Five Wishes" material as new sections (actually, a new article) within AS 18.12. Consequently, so that the "Five Wishes" material may stand on its own unencumbered by unrelated definitions, bill section 2 serves to limit the scope of the definitions that tie to "living wills" and "do not resuscitate orders" to the material already set out in AS 18.12.010 - 18.12.100. To keep a 16 page draft from becoming still longer, **bill section 5** tells the revisor of statutes to make similar changes in the existing sections that are there listed in paragraphs (1) - (8).

Bill section 3: The "Five Wishes" material is here set out as a statutory form power of attorney for health care services. The power of attorney is basically the model that begins on page 6, at line 3, and ends at page 16, line 12.

We prepared this language by simply working through the "Aging With Dignity -- Five Wishes" document. You should be able to lay the document and the bill down side by side and follow the course of the drafting. To the extent I was able, I captured the text of the "Five Wishes" document and simply assigned a section or subsection number. As set out --

AS 18.12.200 provides a general power of attorney for another to serve as the person's general "health care agent," enumerating alternative powers granted to that agent, giving the person the opportunity to delete provisions that should not be exercised by the agent on the person's behalf, and allowing the person making the "Five Wishes" power of attorney to add or modify any of the powers. To give effect to the document, the person may execute the power of attorney before a notary public or before witnesses.

AS 18.12.210 provides a general power of attorney that is specific to the provision of medical treatment, covering "general instructions," "life-support treatment," and alternatives in the event the person faces imminent death. Again, the person may execute this power of attorney before a notary public or before witnesses. Subsections (b) and (c) of AS 18.12.210 provide supplemental instructions as to the person's comfort, treatment, relationship to family and friends, funeral and memorial services, and expression of an expectation of death with dignity.

It is an "open" question as to whether health care providers who fail to carry out some part of what the person expresses may be charged in a civil action. The "Five Wishes" document suggests that they may not, for the concluding part of the AS 18.12.210(c) declares that the person "[does] not expect [the] wishes in this section to place *new or added legal duties* on my doctors or other health care providers." Remember that the document is intended to express the person's "wishes" for his or her treatment in health care institutions and with health care providers, not to add another level of later argument or debate before the courts.

*

In the second paragraph of the December 13 memo is a reference to "the issues of euthanasia." I'm not sure what the reference is intended to cover. Under current law (AS 13.26.344(l)(2)), a statutory power of attorney covering health care elements affirmatively withholds from the attorney any decision to terminate life-sustaining procedures unless, under AS 13.26.344(l)(3), the person has executed a living will declaration under existing AS 18.12. But those provisions are repealed by this draft and would no longer operate under a "Five Wishes" power of attorney. Moreover, AS 18.12.080(f) expressly declares its disapproval of the use of the living will declaration in conjunction with euthanasia or mercy killing.

If you are asking that this draft be expanded to incorporate a statement that in essence says that the use of a "Five Wishes" power of attorney may not be used to justify or endorse euthanasia, that could be done. I'd probably simply add language that is based on existing AS 18.12.080(f). If, by reference to "the issues of euthanasia" you have something else in mind, you'll need to let me know.

JBC:lmb
00-123.lmb

UNIFORM HEALTH-CARE DECISIONS ACT

PREFATORY NOTE

Since the Supreme Court's decision in *Cruzan v. Commissioner, Missouri Department of Health*, 497 U.S. 261 (1990), significant change has occurred in state legislation on health-care decision making. Every state now has legislation authorizing the use of some sort of advance health-care directive. All but a few states authorize what is typically known as a living will. Nearly all states have statutes authorizing the use of powers of attorney for health care. In addition, a majority of states have statutes allowing family members, and in some cases close friends, to make health-care decisions for adult individuals who lack capacity.

This state legislation, however, has developed in fits and starts, resulting in an often fragmented, incomplete, and sometimes inconsistent set of rules. Statutes enacted within a state often conflict and conflicts between statutes of different states are common. In an increasingly mobile society where an advance health-care directive given in one state must frequently be implemented in another, there is a need for greater uniformity.

The Health-Care Decisions Act was drafted with this confused situation in mind. The Act is built around the following concepts. *First*, the Act acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances, including the right to decline health care or to direct that health care be discontinued, even if death ensues. An individual's instructions may extend to any and all health-care decisions that might arise and, unless limited by the principal, an agent has authority to make all health-care decisions which the individual could have made. The Act recognizes and validates an individual's authority to define the scope of an instruction or agency as broadly or as narrowly as the individual chooses.

Second, the Act is comprehensive and will enable an enacting jurisdiction to replace its existing legislation on the subject with a single statute. The Act authorizes health-care decisions to be made by an agent who is designated to decide when an individual cannot or does not wish to; by a designated surrogate, family member, or close friend when an individual is unable to act and no guardian or agent has been appointed or is reasonably available; or by a court having jurisdiction as decision maker of last resort.

Third, the Act is designed to simplify and facilitate the making of advance health-care directives. An instruction may be either written or oral. A power of attorney for health care, while it must be in writing, need not be witnessed or

acknowledged. In addition, an optional form for the making of a directive is provided.

Fourth, the Act seeks to ensure to the extent possible that decisions about an individual's health care will be governed by the individual's own desires concerning the issues to be resolved. The Act requires an agent or surrogate authorized to make health-care decisions for an individual to make those decisions in accordance with the instructions and other wishes of the individual to the extent known. Otherwise, the agent or surrogate must make those decisions in accordance with the best interest of the individual but in light of the individual's personal values known to the agent or surrogate. Furthermore, the Act requires a guardian to comply with a ward's previously given instructions and prohibits a guardian from revoking the ward's advance health-care directive without express court approval. .

Fifth, the Act addresses compliance by health-care providers and institutions. A health-care provider or institution must comply with an instruction of the patient and with a reasonable interpretation of that instruction or other health-care decision made by a person then authorized to make health-care decisions for the patient. The obligation to comply is not absolute, however. A health-care provider or institution may decline to honor an instruction or decision for reasons of conscience or if the instruction or decision requires the provision of medically ineffective care or care contrary to applicable health-care standards.

Sixth, the Act provides a procedure for the resolution of disputes. While the Act is in general to be effectuated without litigation, situations will arise where resort to the courts may be necessary. For that reason, the Act authorizes the court to enjoin or direct a health-care decision or order other equitable relief and specifies who is entitled to bring a petition.

The Health-Care Decisions Act supersedes the Commissioners' Model Health-Care Consent Act (1982), the Uniform Rights of the Terminally Ill Act (1985), and the Uniform Rights of the Terminally Ill Act (1989). A state enacting the Health-Care Decisions Act which has one of these other acts in force should repeal it upon enactment.

UNIFORM HEALTH-CARE DECISIONS ACT AND STATE VARIATIONS

A. Key Elements Of The Uniform Health-Care Decisions Act (UHCDA)

Adopted by the National Conference of Commissioners on Uniform State Laws, August 1993. A more detailed analysis of the Act may be found in an article: Charles P. Sabatino, "The New Uniform Health-Care Decisions Act: Paving a Health Care Decisions Superhighway?" 53 *Maryland Law Review* 101 (1994).

1. The Act is comprehensive and address topics now usually dealt with by separate statute. Act is designed to replace existing living will, power of attorney for health care, and family health-care consent statutes, topics now dealt with separately in most states.

2. The Act does not address decision making for unemancipated minors. The considerations involved in decision making for unemancipated minors differ sufficiently form those for adults and emancipated minors to justify treatment in separate legislation.

3. The Act does not attempt to legislate restrictions on the withholding or withdrawal of life-sustaining treatment. Although case law imposes limitations on the withholding or withdrawal of life-sustaining treatment attempts by the states to convert these limitations into statutory language have met with little success. The Act does not attempt to duplicate this failure.

4. The Act contains a comprehensive provision on the authority of family and close friends. The Act addresses the authority of the family and, in the absence of available family, permits health-care decisions to be made by a close friend. The authority of the family or close friend is activated if no guardian or agent has been appointed or if an appointed agent or guardian is unavailable. A priority list of relatives is established, and a health-care provider may request an affidavit substantiating the claimed relationship. Provision is made for the disqualification of family or close friends. Under the Act, a family member or close friend with authority to make health-care decisions us referred to as a "surrogate."

5. The Act extends to <u>all</u> health-care decisions. Unlike most living will statutes, the Act permits an individual to give instructions as to any health-care decision and not just decisions relating to withholding or withdrawal of life-support. Also, in the absence of an express limitation, an agent or surrogate has authority to make all health-care decisions. The Act clarifies that this authority extends to several areas not clearly covered by many state statutes, including life-sustaining treatment, artificial nutrition and hydration, and cardiopulmonary resuscitation.

6. The Act permits immediately effective powers. The Act authorizes a principal to make the authority of the agent effective upon some event other than loss of capacity, including immediately upon execution. However, in the absence of an express provision, the authority of the agent commences only upon a determination of incapacity.

7. The Act contains one combined form. The Act contains one combined form instead of separate living will and power of attorney for health care forms. The form also provides for organ and tissue donation and the designation of a primary physician. Use of the form is entirely optional.

8. The Act minimizes execution requirements. The optional statutory form contains space for the signature of two witnesses, but a failure to witness does not invalidate the document. A signature alone is sufficient. Formalities for a nonstatutory form are kept to a minimum. A power of attorney for health care must be signed but need not be witnessed or acknowledged. An instruction regarding health care may be either oral or written.

9. The Act binds agents and surrogates to a standard of care. Agents and surrogate are required to follow the patient's expressed wishes, if known, and must otherwise act in the patient's best interest, following consideration of the patient's personal values.

10. The Act addresses the role of guardians. The Act requires a guardian to comply with the ward's instructions regarding health care and prohibits a guardian from amending or revoking the ward's instructions or power of attorney for health care except by express order of court. Absent a court order to the contrary, a health-care decision of an agent takes precedence over that of a guardian.

11. The Act disqualifies certain health-care providers from acting as agent or surrogate. Unless related to the principal, an owner, operator or employee of a residential health-care facility at which the principal is receiving care is disqualified from acting as agent or surrogate.

12. The Act recognizes a conscience exception. Following the lead of many state statutes, the Act authorizes a health-care provider to decline to comply with a health-care decision or instruction for reason of conscience. However, a provider who refuses to comply is required to assist in the transfer of the patient.

13. The Act recognizes out-of-state advance directives. The Act validates advance health-care directives that comply with the Act, regardless of when or where executed or communicated. Given the Act's absence of execution requirements, all should qualify.

14. The Act contains a provision authorizing judicial relief. The Act authorizes the court to enjoin or order a health-care decision of direct other equitable relief. The Act limits those who may file a petition to individuals with a direct interest in the patient's care.

B. State Variations (in chronological order)

1. NEW MEXICO - 1995 New Mexico Laws Ch. 182 (H.B. 483), enacted April 6, 1995 and effective July 1, 1995, entitled the "Uniform Health-Care Decisions Act," and codified at N. Mex. Stat. Ann. §24-7A-1 to 24-7A-18 (1995).

New Mexico was the first state to adopt the new Uniform Health-Care Decisions Act. The following variations from the Uniform Act are noteworthy:

1. Statutory Form: The Act makes only a few minor changes to the model form. It eliminates the organ donation section of the form.
2. List of Surrogates: The New Mexico act adds a category of surrogates that appears to be modeled on the Arizona advance directive law which includes "domestic partners" as surrogates. New Mexico defines this new surrogate category as...

   "an individual in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other's well-being."

   The New Mexico act also adds "grandparent." The priority list of surrogates thus includes the following:

   (1) Orally designated surrogate
   (2) Spouse
   (3) Long-term spouse-like relationship
   (4) Adult Child
   (5) Parent
   (6) Adult Brother or Sister
   (7) Grandparent
   (8) Close Friend

3. Capacity: New Mexico's act requires that, unless otherwise specified in the patient's advance directive, capacity be determined by two professionals, the primary physician and another "qualified health care professional" (defined as physician, physician assistant, nurse practitioner, nurse, psychologist or social worker). In addition, the New Mexico act permits a patient, at any time, to challenge a determination that the individual lacks capacity.

4. Other changes to the UHCDA include a slightly expanded immunity provision; a notice requirement if a court grants a guardian precedence in making health care decisions over an agent; the recognition of oral instructions for health care only if made directly to the health care provider; and a definition of "medically ineffective" (defined as "treatment that would not offer the patient any significant benefit, as determined by a physician").

2. MAINE - 1995 Laws Ch. 378 (H.P. 182 - L.D. 230), enacted June 30, 1995, and effective October 1, 1995, entitled "Uniform Health-Care Decisions Act," codified at Me. Rev. Stat. Ann. tit. 18-A, §5-801 to §5-817.

Maine is the second state to adopt the Uniform Health-Care Decisions Act, although with a few significant alterations. Like the Uniform Act, the Maine statute is a comprehensive law that provides a multi-purpose advance health care directive covering the appointment of a power of attorney for health care, instructions for health care, and the designation of a primary physician, plus a family consent provision that applies in the absence of an advance directive.

The most significant deviation from the Uniform Act is its treatment of surrogates, i.e., individuals authorized to make health care decisions for an incapacitated patient in the absence of an appointed agent or guardian. The Uniform Act authorizes surrogates to make all health care decisions for an incapacitated patient. The Maine statute limits the authority of surrogates to decisions regarding withholding or withdrawing life-sustaining treatment when the patient is either in a terminal condition or in a persistent vegetative state. The terms "life-sustaining treatment," "persistent vegetative state," and "terminal condition" are defined terms in the Maine statute. The Uniform Act does not define those terms, since they have no operative significance in the Uniform Act.

Under these terms, a surrogate appears to have authority to make only a narrow range of end-of-life decisions. For example, a surrogate would not appear to have authority to make decisions about pain control for a terminal patient, since it is not a life-sustaining treatment. Nor would a surrogate be authorized to make a broad range of treatment, care, and placement decisions that face incapacitated patients who are chronically ill but not terminal.

The list of authorized surrogates is also modified. The Maine statute does not recognize an orally designated surrogate, recognized in Section 5(b) of the Uniform Act. At the same time, Maine adds four more classes to the priority list of surrogates after spouse, adult child, parent, and adult sibling, specifically:

1. adult grandchild
2. adult niece or nephew
3. adult aunt or uncle
4. another adult relative, related by blood or adoption, who is familiar with the patient's personal values.

Both Maine and the Uniform Act recognize a close friend as surrogate if none of the above are available. Surrogate disqualification criteria in the Maine Act vary somewhat from the Uniform Act [see ¤5-805(i)].

Other differences from the Uniform Act include the requirement that a written advance directive have two witnesses (the Uniform Act requires none). However, there are no witness disqualification criteria in the Maine Act. Maine also imposes some additional limitations on the decisionmaking authority of guardians and recognizes a broader range of persons with standing to seek judicial relief to challenge a health care decision.

3. **DELAWARE** - 1996 Delaware Laws Ch. 392 (S.B. 408), enacted June 26, 1996, and codified at Del. Stat. ti. 16 ¤¤2501 to 2517, repeals most of Delaware=s current living will and health care agent statute and replaces it with a comprehensive advance directive act based loosely on the Uniform Health-Care Decisions Act. Delaware is the third state to adopt some version of the Uniform Act (following New Mexico and Maine). Like the Uniform Act, the new law provides for comprehensive advance directives (which may name an agent, provide instructions of the declarant's choice, make anatomical gifts, and designate a primary physician); includes an optional form; and provides for surrogate decisionmakers in the absence of an advance directive. Also similar to the Uniform Act, the default surrogates include any person who is orally designated as a surrogate, followed by spouse, adult child, parent, adult brother or

sister, and finally (unlike the Uniform Act) adult grandchild. If none of the above are available, the act follows the current statutory trend and Uniform Act in recognizing a close friend as authorized decisionmaker, but then eliminates the significance of this option by restricting it only to such persons appointed as guardian.

Contrary to the Uniform Act, the Delaware act adds several preconditions and limitations common to many living will statutes, including the following requirements:

1. Life-sustaining procedures can be withheld or withdrawn only if the patient is incapacitated and in a "qualifying condition," i.e., in a terminal condition or permanently unconscious;
2. An advance directive must be signed in the presence of two witnesses, neither of whom is related to the declarant, nor entitled to any portion of the declarant's estate, nor a creditor of the estate, nor someone with a financial responsibility for the declarant's care, nor an owner with controlling interest in or an operator or employee of the health care institution providing care;
3. Pregnancy prevents the withholding or withdrawal of life-sustaining procedures if it is probable that the fetus will develop to viability with continued application of life-sustaining procedures;
4. The initiation of emergency treatment is presumed to represent a suspension of an advance directive.
5. The decisionmaking standard to be used by appointed agents and default surrogates is described in greater detail than in the Uniform Act.

4. ALABAMA - 1997 Al. Laws Ch. 187 (H.B. 553), approved April 15, 1997, effective immediately, and codified at Ala. Code §§ 22-8A-2 to -10 (1997), retains the existing Alabama Natural Death Act but makes fundamental changes to reconstruct the act into a comprehensive advance directive law only remotely resembling the Uniform Health-Care Decisions Act ("UHCDA"). The amended act provides for comprehensive advance directives (which can appoint an agent and provide health care instructions); includes a form which must be substantially followed; and provides for surrogate decision makers in the absence of an advanced directive.

Significant differences from the official UHCDA:

1. The declarant's instructions in the advance directive concerning providing, withholding, and withdrawing life-sustaining treatment have no effect regarding the declarant's pregnancy;
2. The designated proxy must signify an acceptance of the responsibility in writing;
3. The advance directive is required to be signed in the presence of two witnesses, neither of whom is related to the declarant, nor entitled to any portion of the declarant's estate, nor someone with financial responsibility for the declarant's care, nor an owner with controlling interest in or an operator or employee of the health care institution providing care;
4. The proxy has precedence over any instructions regarding health care decisions provided in the declarant's living will unless the declarant indicates otherwise;

or in any medical circumstances in which they lack capacity. The Act also provides for default decision-makers, called surrogates, authorized to speak on a person's behalf if there is no designated decision-maker.

The Hawaii Act varies from the Uniform Act in the following ways:

1. It includes a detailed definition of "Best Interests" (modeled on the Maryland law);
2. Execution of an advance directive requires two witnesses meeting qualifications, or in the alternative, notarization.
3. The default surrogate decision maker provisions do not follow the Uniform Act's next-of-kin/close friend hierarchy. Instead the provision essentially adopts the Colorado approach, wherein the Act defines "interested persons" and requires the primary physician to locate as many interested persons as practicable, inform them of the patient's lack of decisional capacity, and requiring an effort to reach consensus among the interested persons as to the appointment of a surrogate. If consensus is not reached, then the only option available is a guardianship petition which may be filed by an interested party or health-care provider.
4. The decision-making authority of a surrogate is the same as that of the patient's or a patient's designated agent, except that a surrogate who has not been designated by the patient may make a decision about withholding or withdrawing artificial nutrition and hydration only when the primary physician and a second independent physician certify that the provision or continuation of artificial nutrition and hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future. Additional guidelines for life-support decision-making for such surrogates include prohibitions against withholding or withdrawing treatment based on the patient's preexisting, long-term mental or physical disability, or the patient's economic status, and a requirement that the surrogate attempt to inform the patient, to the extent possible, or the proposed procedure and the fact that someone else is authorized to make a decision regarding the procedure (modeled upon the Maryland advance directive law)
5. The Act requires a new review of the decisional capacity of the patient if any interested person, guardian, or the primary physician believes that the patient has regained capacity.

7. CALIFORNIA -- 1999 Cal. Legis. Serv. Ch. 658 (A.B. 891) (West), called the "Health Care Decisions Law," and signed by the Governor on October 10, 1999, replaces the state's long-standing living will law (the "Natural Death Act") and Durable Power of Attorney for Health Care Act. Effective July 1, 2000, the new law draws heavily upon features of the Uniform Health Care Decisions Act while retaining some features of former law.*

New features generally make the law more flexible and comprehensive. For example, the new law adopts the generic term " advance health care directive" or simply "advance directive" to describe any form of health care instruction or appointment of an agent to make health care decisions. Instructions may be written *or oral*, and mandatory medical prerequisites such as "terminal condition" or "permanent unconscious condition" are eliminated. Appointment of an agent must be written, but the law recognizes the oral designation of a "surrogate" to make health care decisions if the patient personally communicates the designation to a supervising

health care provider. The new law does not adopt the Uniform Act's recognition of next of kin or a close friend acting as default "surrogate" to make health care decisions. The only surrogate California recognizes is an orally-designated one.

In another nod to flexibility, the new law does away with a mandatory "Warning" to persons signing a power of attorney for health care and permits individuals to modify the statutory advance directive model form or use a different form altogether. However, the signing requirements of the old law stay substantially the same – the form must be either witnessed by two persons or notarized. Notarization is the simpler option, since witnesses must meet specific qualifications and sign mandatory witness declarations. As under the old law, if the advance directive is signed by a resident in a nursing home, special witnessing steps must be followed.

The law continues to recognizes a fairly broad scope of agent authority of the old law, including the authority to make after-death decisions regarding autopsy, organ donation, and disposition of remains. The law spells out an optional sphere of decisionmaking that may be unique among the states in that it explicitly permits the individual to grant authority to make decisions relating to his or her "personal care," including "determining where the principal will live, providing meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment." The standard of decision making for anyone making health decisions on behalf of another is derived from the Uniform Act. The decision is to be made in accordance with the principal's individual health care instructions, if any, and other wishes to the extent known by the decisionmaker. Otherwise, the decision shall be made in accordance with the authorized decisionmaker's determination of the principal's best interest. In determining the principal's best interest, the decisionmaker is to consider the principal's personal values to the extent known.

The law includes fairly detailed standards and procedures for judicial review, although it explicitly and clearly provides that advance directives and decisions made by agent's or designated surrogates are effective without judicial approval. Finally, the law retains the state's recognition of requests to forego resuscitative measures according to procedures developed by the state EMS Authority.

Summary prepared by ABA Commission on Legal Problems of the Elderly (with UHCDA summary by Prof. David English)

COMMITTEE:HOUSE HEALTH, EDUCATION & SOCIAL SERVICES	SUBJECT: HB 197-HEALTH CARE SERVICES DIRECTIVES

DATE: April 24, 2001

PLEASE SIGN IN

PLEASE PRINT: NAME & TITLE	ADDRESS (MAILING & ZIP)	PHONE	REPRESENTING (No Acronyms, Please)	DO YOU WANT TO TESTIFY ?
Jerry Bannister	LAA Legal			If needed.