

STORAGE NAME: h2131.jud

DATE: April 15, 1999

**HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
JUDICIARY
ANALYSIS**

BILL #: HB 2131 (formerly PCB LT 99-02c)

RELATING TO: End-of-Life Care

SPONSOR(S): Committee on Elder Affairs & Long Term Care, Rep. Argenziano & others

COMPANION BILL(S): CS/SB 2228

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

- (1) ELDER AFFAIRS & LONG TERM CARE YEAS 9 NAYS 0
 - (2) JUDICIARY
 - (3)
 - (4)
 - (5)
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I. SUMMARY:

HB 2131 removes the statutory requirement that persons who have made an advance directive or designated a health care surrogate be terminally ill before life-prolonging procedures can be discontinued and brings the statute into congruence with Florida case law. Civil liability protection is expanded to include hospital emergency personnel, nursing home staff, assisted living facility staff, home health agency personnel, hospice care teams, and adult family care home providers who honor Do-Not-Resuscitate Orders (DNRO).

The bill provides that for decedents who completed an organ donation card or otherwise expressed, in writing, their decision to make an anatomical gift, the surrogate, if one was designated and is reasonably available, may consent to the gift. If the decedent did not leave written evidence of intent to make an anatomical gift or if no surrogate was designated, or if the surrogate is not reasonably available, the law remains as it is now with the list of decision makers specified in ch. 732. It provides that an advance directive may include an anatomical gift.

HB 2131 expands provisions relating to transfer of a patient in instances of ethical conflict to apply to all treatment decisions, not just decisions to forego life-prolonging procedures. It adds a new provision to create a procedure for discontinuing life-prolonging procedures for persons in a persistent vegetative state who have no advance directive and no person to act as proxy.

It allows medical and health care professionals to substitute a class in end-of-life care for either the required class in domestic violence or HIV, if they completed both classes in the previous re-licensure or re-certification cycle.

The bill provides for the continuation until January 31, 2000 of the Panel to Study End-of-Life Care and appropriates \$100,000.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

From the founding of the nation through the second decade of this century, most Americans died before age fifty, at home, as a result of pneumonia, influenza, childbirth, childhood diseases or accidents.

In the waning years of the twentieth century, however, most Americans, and Floridians, die in an institution subject to interventions that may not improve the quality of their life and that do not heal, but serve only to defer death.

End-of-life care has emerged as a significant item on the national health care agenda. The 1997 Legislature in 98-327, L.O.F., established the "Panel for the Study of End-of-Life Care" and specified a diverse membership. The Panel was directed to consider three major areas and submit an interim report in January of 1999. The Panel studied:

- pain management
- advance directives
- fiscal and regulatory barriers to good end-of-life care

HB 2131 by the Committee on Elder Affairs & Long Term Care is the result of the panel's work and the committee's interim study. The Panel studied the following areas and traveled the state accepting public testimony to prepare its report.

Patient Autonomy, Self-Determination & Advance Planning

Federal and state law, interpreted and supported by Court cases, provides that each legally competent adult person has the right to make decisions about the amount, duration, and type of medical treatment they wish to receive. This includes the right to refuse or to discontinue medical treatment.

Right to Refuse Treatment

In a series of cases, the Court established:

- the right of a competent but terminally ill person to refuse medical treatment (Satz v. Perlmutter, 379 So.2d 359 (Fla. 1980));
- the right of an incapacitated ("incompetent") terminally ill person to refuse medical treatment (John F. Kennedy Memorial Hospital, Inc. v. Blutworth, 452 So.2d 921 (Fla. 1984));
- the right of a competent but not terminally ill person to refuse medical treatment Wons v. Public Health Trust of Dade County (541 So.2d 96 (Fla. 1989)); and,
- the right of an incapacitated but not terminally ill person to refuse medical treatment (In re Guardianship of Browning, 568 So.2d 4 (Fla. 1990).

The Court recognized four state interests which might, on a case-by-case basis, override this constitutional right with respect to health care decisions which would result in the person's death: preservation of life, the protection of innocent third parties, the prevention of suicide, and maintenance of the ethical integrity of the medical profession (Browning at 14).

Refusing Treatment: Do-Not-Resuscitate Orders & Cardiopulmonary Resuscitation

CPR was developed in the 1960s to treat witnessed cardiac arrest in patients suffering from accidents or acute coronary events. It does not include the Heimlich maneuver or other emergency procedures applied to a person who is still breathing and has a heartbeat.

The low survival rates for some groups of frail people, the poor prognosis following resuscitation including the possibility of severe mental impairment, as well as the intensive and invasive nature of the procedure, has led to a nationwide movement to establish patient-initiated do-not-resuscitate (DNR or DNRO) orders.

In 1992, the Legislature amended s. 401.45, F.S., to permit Emergency Medical Technicians (EMTs) and paramedics to honor a DNR order written by the patient's physician and not provide CPR. The statute also provides liability protection to personnel which act on the basis of such orders. Without the statute and the DNR order, emergency personnel are considered to be under a duty to administer CPR.

The Department of Health (DOH), which is responsible for regulation and procedures relating to emergency services, has developed a yellow-colored form, "*Prehospital Do Not Resuscitate Order Form, DH 1896*," which must be properly completed and presented to emergency personnel. The form must include the signature of the person's attending physician who attests that another physician has been consulted and that the person has a terminal condition, as well as the witnessed signature of the patient or the patient's surrogate, proxy, or guardian.

Emergency Medical Services only considers the form valid on yellow paper. Citizens gave testimony to the Panel about their or friends' anger and confusion because a photocopy of the form on white paper, though appropriately signed, was not honored by EMTs.

Because the statute only applies to and provides liability protection to EMTs and paramedics, the form has no *portability* across health care settings. It is generally not honored in any other setting or by any other type of medical personnel.

Hospitals, nursing homes, and hospices instead rely on the traditional physician issued do-not-resuscitate treatment order. However, these too are setting-specific and must often be re-issued each time a patient moves from a hospital to a nursing home to the hospital again.

Public testimony established that this policy of requiring site-specific documents is very frustrating. Repeatedly, people expressed passionate concern about what seemed to them to be a trivial and bureaucratic burden. They did not understand why their living will which specified that they do not want to be resuscitated does not govern in all of these situations. Further compounding the problem is the plight of people who live in non-medical settings such as assisted living facilities (ALFs) and adult family care homes (AFCHs). Not considered medical facilities, but responsible for the health and safety of residents, staff in these residences are obligated to administer CPR and call 911 despite the presence of the resident's "yellow form" which is presented to emergency personnel upon arrival.

PANEL'S RECOMMENDATION:

Portability of a Do-Not-Resuscitate Order became the second major issue the Panel recommended be addressed in the bill. The Panel recommended that one Do-Not-Resuscitate Order be honored in whatever health-related setting a person finds themselves.

Decisions Making

<p>Person has capacity</p>	<p>Person has capacity</p>	<p>Person never had capacity</p>
<p>Person may or may not have appointed a health care surrogate or made a living will.</p>	<p>Made a living will and/or designated a health care surrogate and/or made an advance directive to retain control over health care decisions, if incapacitated.</p>	<p>Cannot make a living will; cannot make advance directive; cannot appoint a health care surrogate. Only competent adults can execute an advance directive or choose a health care surrogate.</p>
<p><u>HEALTH PROBLEMS</u> </p>	<p><u>HEALTH PROBLEMS</u> </p>	<p><u>HEALTH PROBLEMS</u> </p>
<p>HAS CAPACITY</p>	<p>BECOMES INCAPACITATED</p>	<p>IS INCAPACITATED</p>
<p>Person makes all decisions for himself or herself. Can accept or refuse any treatment or service.</p>	<p>Health care surrogate can make all health care decisions for the person including the decision to discontinue life-prolonging procedures based on "substituted judgement". Living will/advance directives are carried out. If the person had not designated a health care surrogate, a proxy may be appointed. The proxy must make all decisions based on "substituted judgement" except for a decision to discontinue life-prolonging procedures. A decision to discontinue life-prolonging procedures must be based on "clear and convincing evidence" i.e., a living will.</p>	<p>Neither a surrogate or a proxy may make a decision to discontinue life-prolonging procedures. The incapacitated person never designated anyone to make decisions nor left an indication of their wishes. Consequently, all medical treatment is provided. Chapter 765, F.S., does not apply to these persons.</p>

Health Care Surrogates & Proxies

In 1990, the Legislature established a procedure for designating a health care surrogate (Ch. 90-232, L.O.F.) to make all health care decisions for that person upon the individual's incapacity without having to embark upon the complex and expensive procedure of having a guardian judicially appointed.

Subsequently amended and incorporated into chapter 765, **the surrogate is required to make the decision the surrogate believes the principal would have made under the circumstances**, if the principal were capable of making such decision. (See § 765.205(1)(b), F.S. This standard is otherwise known as 'substituted judgement').

In the absence of a designated surrogate, the statute provides for the appointment of a proxy (§ 765.401, F.S.). The proxy is selected from the following list which is in rank order: a guardian authorized to consent to medical treatment; the patient's spouse; an adult child of the patient, or a majority of adult children; a parent of the patient; an adult sibling or a majority of adult siblings; an adult relative; a close friend of the patient.

Since the establishment of Florida's Health Care Surrogate Act, the concept has gradually become incorporated into other parts of Florida law. The health care surrogate is rapidly becoming a welcome and lawfully recognized spokesperson for incapacitated persons in health care settings. For example, in 1996, Florida's Baker Act was amended to clarify that in selecting a patient advocate for a person judicially determined to be incompetent to consent to mental health treatment, the court shall give preference to a health care surrogate (see § 394.4598, F.S.).

Where a patient has previously expressed his or her wishes with respect to medical treatment, the Court requires that the surrogate or the proxy must:

1. determine that the patient executed any document knowingly, willingly, and without undue influence, and that the evidence of the patient's oral declaration is reliable;
2. be assured that the patient does not have a reasonable probability of recovering competency so that the right can be exercised directly by the patient; and,
3. take care to assure that any limitations expressed either orally or in the written declaration have been carefully considered and satisfied. (Browning at 15).

Currently, the Florida statute governing living wills includes a threshold requirement that life-prolonging procedures may only be withheld or withdrawn from such a patient if the patient has a "terminal" condition [ss. 765.304(2)(b) and 765.305(2)(b), as well as 765.102(3), 765.302(1), 765.306, F.S.].

This requirement for a determination that the person's condition is "terminal" is complicated in clinical practice by the fact that health care providers frequently use a narrow clinical definition of 'terminal illness' instead of the definition in statute which is somewhat broader [sec. 765.101(15), F.S.].

This requirement that a person be diagnosed as "terminal", however, is contrary to the Court's finding in the Browning case. The Court did not find a requirement that the patient be terminally ill before her living will or advance directives took priority. The fact that Estelle Browning's living will expressed that treatment was to be discontinued when she had a "terminal condition" was treated by the court as a specific condition of her will (see 3 above) which must be considered. As stated by the court:

In this instance, Mrs. Browning's wishes were conditional. She indicated that her decision to refuse treatment was limited to a time when she had a 'terminal condition' from which her attending physician determined that there could be 'no recovery' and that 'death (was) imminent' (Browning at 17).

As a result many families and medical professionals who communicated with the Panel expressed frustration with their inability to discontinue life-prolonging procedures and carry out the **expressed** wishes of incapacitated persons.

On this point, in the case of Estelle Browning, the state Supreme Court stated:

Our cases have recognized no basis for drawing a constitutional line between the protections afforded to competent persons and incompetent persons. Indeed, the right of privacy would be an empty right were it not to extend to competent and incompetent persons alike. (Browning at 12)

Panel's Recommendation

Assuring that persons' wishes for their own end-of-life care are honored. To accomplish this, **the Panel recommended that the word "terminal" be deleted from the relevant provisions. Also, the Panel recommended that "life-prolonging procedure" be amended to include "artificially provided sustenance and hydration."**

Anatomical Gifts

In 1974 in an effort to promote organ and tissue donation, the Legislature passed the Florida Uniform Anatomical Gift Act. The Act establishes the process in which individuals or their families may donate organs and tissue. Section 732.912, F.S., provides that any person who can make a will may donate all or part of his/her body for the purposes of transplantation, therapy, medical research, or education.

Alternately, any member of specified classes of relatives and other persons may make a gift of part of or all of a decedent's body, in the following order of priority: the spouse of the decedent; an adult son or daughter of the decedent; either parent of the decedent; a guardian of the person at the time of death; or a representative ad litem appointed by a court of competent jurisdiction upon petition heard ex parte filed by any person. Interestingly, despite the requirement to select the member of the specified class in a certain order of priority, persons of higher priority (who have apparently declined to step forward and assume responsibility for making the gift of the decedent's body) may nevertheless object to and prevent the donation made by a person in a lower level of priority. In addition, a donation by a spouse (who is at the top of the list), may be halted by a son or daughter (second in order of priority) who objects to the donation. Caveats are also provided which would prevent the donation upon a showing that it would be against the decedents religion or evidence that a decedent would not have wanted his/her body to be donated.

While Florida's Surrogacy Act is presently limited to health care decisions for an incapacitated, non-deceased person, many states have integrated these provisions, expanding the duties of a surrogate and/or incorporating the opportunity to make an organ donation into an written advance directive (see e.g., Alaska, Arizona, California, Delaware, Maine, Maryland, Minnesota, Oklahoma, Tennessee, Vermont).

Continuing Education for Health-related Professionals

Current law provides that:

(1) The appropriate board shall require each person licensed or certified under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry, dental hygiene, and dental laboratories); part II, part III, or part V of chapter 468 (speech-language pathology and audiology); or chapter 486 (physical therapy) to complete a continuing educational course, approved by the board, on human immunodeficiency virus and acquired immune deficiency syndrome as part of biennial re-licensure or recertification.

B. EFFECT OF PROPOSED CHANGES:

Removes the statutory requirement that a person who has executed an advance directive or appointed a health care surrogate be terminally ill before life-prolonging procedures can be discontinued and brings the statute into congruence with Florida case law. The bill provides that such persons must be both mentally and physically incapacitated and have "no reasonable medical probability" of recovery. The bill states that the provisions of chapter 765, F.S., related to advance directives, and withholding or withdrawing life-prolonging procedures **do not apply** to a person who never had capacity to execute an advance directive or designate a health care surrogate. The bill revises the example of a living will provided in chapter 765 to provide a sentence which would allow

a person to specify that his or her living will's direction concerning life-prolonging treatment is to be "triggered" by the mental and physical incapacity, a finding of no reasonable medical probability of recovery **AND** a diagnosis of a "terminal" condition.

Civil liability protection is expanded to include hospital emergency personnel, nursing home staff, assisted living facility staff, home health agency personnel, hospice care teams, and adult family care home providers who honor DNR orders.

Making an anatomical gift under part X of chapter 732, F.S., is included as an advance directive, and procedures for making anatomical gifts in the absence of an express donation are conformed to the surrogate provisions in chapter 765, F.S.

Expands provisions relating to transfer of a patient in instances of ethical conflict to apply to all treatment decisions not just decisions to forego life-prolonging procedures.

Allows specified licensed or certified health professionals to take a class in end-of-life care as a required continuing education class.

Adds a new provision to create a procedure for discontinuing life-prolonging procedures for persons in a persistent vegetative state who have no advance directive and no person to act as proxy.

Makes it easier to honor a person's medical treatment decisions when that person becomes incapacitated and is not able to personally direct his or her own care. This bill should also help health care and residential facilities to honor residents' wishes not to be subjected to CPR. This bill should streamline procedures relating to anatomical gifts and give more opportunities for persons to consider this alternative. Finally, this bill may provide a mechanism for dealing with the difficult situation of hopeless patients, in a persistent vegetative state, who have left no instructions with respect to the administration or withdrawal of life-prolonging procedures.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes. The DOH is directed to promulgate a rule related to do-not-resuscitate orders (DNROs).

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes. The DOH is to prepare a rule and prepare forms and other devices to allow people to represent their DNRO choice.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

A new fee is authorized. The DOH is authorized to charge a fee to cover the cost of duplicating the Do Not Resuscitate Order (DNRO) forms and other identifying devices that the department is authorized to develop and distribute. Requesting one of the forms or devices, however, is voluntary.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Individuals who request a copy of materials from the DOH will pay the cost associated with production and mailing.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/ associations to conduct their own affairs?

Yes. The bill clarifies the procedures involved in persons expressing their wishes for end-of-life care. The bill assures that a person's wishes are more likely to be honored across health care settings by making the DNR orders valid in and out of the hospital. The bill brings the statutes into congruence with rulings from the State Supreme Court.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Amends sections 395.1055; 395.1041; 400.142; 400.4255; 400.487; 400.621; 401.245; 401.45; 455.604; 458.319; 732.922; 765.101; 765.102; 765.103; 765.104; 765.107; 765.110; 765.204; 765.205; 765.301; 765.302; 765.303; 765.304; 765.305; 765.306; 765.308; 765.310; 765.401. Creates 765.404.

E. SECTION-BY-SECTION ANALYSIS:

Section 1 provides Legislative findings related to demographic characteristics of the state; the recommendations of the Panel for the Study of End-of-Life Care; that all persons should have access to effective pain management and palliative care; that a person's experience of death, dying and preferences about end-of-life care are rooted in ethnic cultural values and beliefs; that health care workers must be trained to work within cultural parameters; that measurement of pain as a "fifth vital sign" would aid health care providers in more aggressively assessing and managing pain; that health care providers should feel safe from blame or discipline in using adequate medication to effectively

manage pain; that the State Supreme Court has declared, on the Constitutional right to privacy, that competent adults can express their wishes to receive, refuse, withhold, or withdraw any medical treatment and that the right continues even when a person becomes incapacitated.

The Chancellor of the State University System is requested to convene a working group to review available curricula for end-of-life care and make recommendations through the respective boards for content and materials to be included in the curriculum of each medical, social work, and allied health discipline's school.

The Secretary of the DOH is authorized to develop and implement up to two demonstration projects to evaluate strategies recommended by the Panel. The department is authorized to apply for grants and accept donations. The Secretary will report the results of the demonstration projects to the Legislature no later than January 30 of each year.

Section 2. Amends s. 395.1041, F.S., relating to hospital emergency services, to permit emergency personnel to withhold or withdraw CPR pursuant to a do-not-resuscitate order (DNRO) issued under chapter 401, F.S. Provides liability protection to personnel and to the facility when acting pursuant to such orders.

Section 3. Amends s. 400.142, F.S., relating to nursing homes, to permit nursing home staff to withhold or withdraw CPR pursuant to a do-not-resuscitate order issued under chapter 401, F.S. Provides liability protection if acting pursuant to such orders.

Section 4. Amends s. 400.4255, F.S., relating to assisted living facilities, to permit ALF staff to withhold or withdraw CPR pursuant to a do-not-resuscitate order issued under chapter 401, F.S. Provides liability protection if acting pursuant to such orders.

Section 5. Amends s. 400.487, F.S., relating to home health agencies, to permit home health agency personnel to withhold or withdraw CPR pursuant to a do-not-resuscitate order issued under chapter 401, F.S. Provides liability protection if acting pursuant to such orders.

Section 6. Amends s. 400.6095, F.S., relating to hospice care, to permit members of the hospice care team to withhold or withdraw CPR pursuant to a do-not-resuscitate order issued under chapter 401, F.S. Provides liability protection if acting pursuant to such orders.

Section 7. Amends s. 400.621, F.S., relating to adult family care homes, to permit the AFCH provider to withhold or withdraw CPR pursuant to a do-not-resuscitate order issued under chapter 401, F.S. Provides liability protection if acting pursuant to such orders.

Section 8. Amends s. 401.45, F.S., relating to civil liability, to:

1. Permit EMTs and paramedics to withhold or withdraw CPR upon presentation of a DNRO;
2. Provide liability protection for acting upon such orders;
3. Direct the DOH, in consultation with the Department of Elder Affairs (DOEA), and the Agency for Health Care Administration (AHCA), to develop standardized DNRO devices, and to permit the DOH to charge a fee to cover the cost of producing and distributing such devices.

The DOH is directed to develop and enforce rules to implement this section.

Section 9. Amends s. 455.604, F.S., to allow licensed health care professionals to substitute a continuing education course on end-of-life care for either of the currently required courses after they have taken the domestic violence and the HIV course in the previous licensure cycle.

Current law provides that:

(1) The appropriate board shall require each person licensed or certified under chapter 457 (*acupuncture*); chapter 458 (*medical practice*); chapter 459 (*osteopathic medicine*); chapter 460 (*chiropractic medicine*); chapter 461 (*podiatric medicine*); chapter 463 (*optometry*); chapter 464 (*nursing*); chapter 465 (*pharmacy*); chapter 466 (dentistry, dental hygiene, and dental laboratories); part II, part III, or part V of chapter 468 (*speech-language pathology and audiology*); or chapter 486 (*physical therapy*) to complete a continuing educational course, approved by the board, on human

immunodeficiency virus and acquired immune deficiency syndrome as part of biennial relicensure or recertification.

Section 10. Amends s. 458.319, F.S. Specifies that physicians may substitute a course in end-of-life care for either the required domestic violence or HIV training, if they have satisfied the requirement for those courses in the previous relicensure or recertification cycle.

Section 11. Amends section 459.008, F.S., to specify that osteopathic physicians may substitute a course in end-of-life care for either the required domestic violence or HIV training, if they have satisfied the requirement for those courses in the previous relicensure or recertification cycle.

Section 12. Amends s. 732.912, F.S., relating to anatomical gifts. It provides that if the decedent had executed an agreement concerning organ and tissue donation or in some other way, in writing, expressed his or her intention or wish to donate that the surrogate may give all or any part of the body. If the decedent did **not** express his wishes about organ and tissue donation and did not designate a surrogate, the law remains unchanged in the list of persons who can give or prevent the giving of an anatomical gift.

Section 13. A cross-reference is corrected.

Section 14. A cross-reference is corrected.

Section 15. Amends s. 732.922, F.S., relating to the duty of hospital administrators, to first seek consent from the health care surrogate for a decedent who had not executed an organ donation decision. If the decedent did not designate a health care surrogate, or the surrogate is not reasonably available, consent for an anatomical gift would be from the list as it is currently in law.

Section 16. Amends s. 765.101, F.S., providing definitions in the chapter on advance directives, to:

1. Amend the definition of "advance directive" to add anatomical gifts, and to delete DNROs;
2. Amend definition of "health care decision" to add making an anatomical gift;
3. Amend definition of "incapacity" or "incompetent" to include a patient who is deceased for the purpose of making an anatomical gift;
4. Amend definition of "informed consent" to provide clarification;
5. Amend definition of "life-prolonging procedure" to specify that it includes artificially provided sustenance and hydration, and to delete reference to "terminal condition";
6. Add a definition for "persistent vegetative state"; and
7. Delete the definition for "terminal condition."

Section 17. Amends s. 765.102, F.S., relating to Legislative intent in the chapter on advance directives, to delete reference to "terminal condition."

Section 18. Amends s. 765.103, F.S., relating to statutory effect of changes on existing advance directives, to clarify that directives made prior to effective date of act are given effect as executed.

Section 19. Amends s. 765.104, F.S., relating to revocation of an advance directive, to extend provisions to amendments as well as revocations.

Section 20. Amends s. 765.107, F.S., relating to statutory construction to include a provision that specifies that **chapter 765, F.S., does not apply to a person who never had capacity to designate a health care surrogate or to execute a living will.**

Section 21. Amends s. 765.110, F.S., relating to duty of health care facilities and providers, to:

1. specifically prohibit a facility from requiring a patient to execute an advance directive, or to use the facility or provider's forms. Also directs that a patient's advance directive be made a part of the patient's medical record; and,
2. update provisions relating to rule authority, and require the DOH, the AHCA, and the Department of Children & Families (DCF), to consult with DOEA, with respect to rule adoption.

Section 22. Amends s. 765.204, F.S., relating to the determination of capacity for the purpose of activating the authority of a health care surrogate. Makes a technical change, but retains the current requirement for two physicians to determine if the principal lacks capacity.

Section 23. Amends s. 765.205, F.S., relating to the responsibility of a surrogate, to clarify that the surrogate may authorize the admission, discharge, or transfer of a principal to any facility or program licensed under chapter 400 (i.e., assisted living facilities, adult family care homes, adult day care centers) as well as health care facilities as defined in chapter 395.

Section 24. Amends s. 765.301, F.S., to make a conforming correction.

Section 25. Amends s. 765.302, F.S., relating to procedure for making a living will, to remove reference to requirement that persons suffer from a "terminal condition".

Section 26. Amends s. 765.303, F.S., relating to the statutory suggested form for a living will. It includes a mechanism for persons to indicate if they wish to condition their living will upon receipt of a diagnosis of "terminal condition". This section also adds a requirement that a second physician confirm that there is no "reasonable" medical probability of recovery.

Section 27. Amends s. 765.304, F.S., relating to execution of a living will, to delete the requirement that person be terminally ill and updates the language "competency" to "capacity".

Section 28. Amends. s. 765.305, F.S., relating to surrogate decision to forego treatment, to delete requirement that a person be terminally ill, and substitutes the word "capacity" for "competency."

Section 29. Amends s. 765.306, F.S., relating to determination of a patient's condition. Provides that the patient's attending or treating physician and at least one other consulting physician examine the patient to determine if the patient has a terminal condition, may recover "mental and physical capacity," or whether a medical condition or limitation expressed in the patient's living will exists.

Section 30. Amends s. 765.308, F.S., relating to transfer of a patient to:

1. Renumber section as s. 765.1105, F.S., so that it applies to all treatment decisions, not just decisions to forego life-prolonging procedures;
2. Revises phrase "declaration of patient" to a "patient's advance directive;" and,
3. Provides that a health care provider that is unwilling to carry out the wishes of the patient and adds "or the treatment decision of his or her surrogate" must take certain actions to transfer the patient or provide treatment.

Section 31. Amends s. 765.310, F.S., relating to falsification or destruction of advance directive, to renumber section as s. 765.1115, F.S., so that it applies to all advance directives, not just to living wills.

Section 32. Amends s. 765.401, F.S., relating to the proxies, to require that a proxy's decision to withhold or withdraw life prolonging must either be:

1. supported by written declaration; or,

2. if there is no written declaration, the person must be terminally ill and the proxy's decision must be supported by "clear and convincing evidence" that withholding or withdrawing life prolonging procedures is the decision the person would have made if they were competent.

Section 33. Creates s. 765.404, F.S., relating to persons in a persistent vegetative state, to create a procedure for withdrawing or withholding life-prolonging procedures when the person has no advance directive, left no indication of what they would have wanted, and no person is available to serve as the person's proxy.

Section 34. DOEA is directed to convene a workgroup to develop model advance directive forms. DOEA is permitted to reconvene the group as necessary.

Section 35. Repeals subsection (6) of section 3 of chapter 98-327, L.O.F., related to the Panel for the Study of End-of-Life Care. The Panel is continued until January 31, 2000. The sum of \$100,000 is appropriated to support the work of the Panel.

Section 35. Provides an effective date of October 1, 1999.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:
None are projected.
2. Recurring Effects:
None are projected.
3. Long Run Effects Other Than Normal Growth:
None are projected.
4. Total Revenues and Expenditures:
None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:
No impact is projected.
2. Recurring Effects:
No impact is projected.
3. Long Run Effects Other Than Normal Growth:
No impact is projected.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Persons who choose to request a bracelet, form, or other device to signal their wish to not receive CPR will be charged a fee by the DOH sufficient to offset the costs incurred by the Department.

2. Direct Private Sector Benefits:

The direct economic benefits to the private sector are incalculable.

3. Effects on Competition, Private Enterprise and Employment Markets:

No effect is projected.

D. FISCAL COMMENTS:

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

The mandates provision does not apply.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce revenue raising authority.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

The bill makes no reduction.

V. COMMENTS:

There is a drafting error on page 29, line 23: it should be designated as "Section 36". An amendment should be prepared and offered in the next committee of reference.

Prior to the issuance of the recommendations of the Panel to Study End-of-Life Care, they were thoroughly discussed and debated by the Panel and its advisory group. The Panel endorsed the recommendations which have been incorporated into this bill with only one dissenting vote. The Panel included representation from Hospice, the Pepper Institute on Aging and Public Policy, Florida Nurses Association, Association of Community Hospitals and Health Systems of Florida, Inc., a consumer advocate, a person from Health Quality Assurance in the AHCA, the Board of Medicine, the Board of Osteopathic Medicine, Florida League of Health Systems, Florida Health Care Association, the Florida Bar, Florida Association of Homes for the Aging, the Florida Medical Association, the Commission on Aging with Dignity, the Florida Hospital Association, the Secretary of DOEA, a member of the House of Representatives, and a member of the Senate.

Judiciary Committee staff comments

Section 16 of the bill expands the definition of "life-prolonging procedure" to include artificially provided sustenance and hydration and defines "persistent vegetative state" as a permanent and irreversible condition of unconsciousness. Section 25 expands living wills to be able to direct the withholding or withdrawal of a life-prolonging procedure even if a person does not suffer from a terminal condition, and it expands the conditions under which a living will can be implemented to include a determination by a physician that there is no reasonable medical probability of recovery. Section 33 creates 765.404 on

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“persistent vegetative state” and permits the withholding or withdrawal of life prolonging procedures for persons with no advance directive, no evidence indicating what the person would have wanted, and no family or friends available to serve as proxy for health care decisions under certain conditions. All of these changes are substantial departures from present law and the policy implications warrant careful review..

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

VII. SIGNATURES:

COMMITTEE ON Elder Affairs & Long Term Care:

Prepared by:

Staff Director:

Melanie Meyer

Tom Batchelor, Ph.D.

AS REVISED BY THE COMMITTEE ON JUDICIARY:

Prepared by:

Staff Director:

Jo Ann Levin

Don Rubottom