SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/SB 2228

SPONSOR: Judiciary Committee and Senator Klein

SUBJECT: End-of-Life Care

DATE: April 15, 1999 REVISED: 04/19/99

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Carter	Wilson	HC	Favorable/CS
2.	Matthews	Johnson	JU	Favorable/CS
3.	Peters	Hadi	FP	Fav/1 amendment
4.				
5.				

I. Summary:

Committee Substitute for Committee Substitute for Senate Bill 2228 revises a number of statutory provisions relating to end-of-life care to more closely reflect Florida case law as follows:

- Provides legislative findings related to end-of-life care;
- Authorizes the Secretary of the Department of Health to develop and implement up to two demonstration projects to evaluate strategies recommended by the Panel for the Study of End-of-Life Care (Panel), to report annually to the Legislature on project results, and to apply for grants and accept donations;
- Requests the chancellor of the State University System to address educational requirements for health care professionals in the medical, social work, and allied health discipline's schools;
- Provides liability protection from do-not-resuscitate orders for nursing homes, assisted living facilities, home health agencies, and adult family-care home providers;
- Authorizes health care providers, for licensure or certification renewal, to substitute the continuing education course on AIDS/HIV (if this course has been taken in a previous licensure cycle) with the course on end-of-life care under certain circumstances;
- Revises provisions relating to the authorization of anatomical gifts;
- Creates definitions for “persistent vegetative state” and “end-stage condition,” and revises the definition for “terminal condition” for purposes of providing three different conditions in which a person may direct the provision, withholding or the withdrawal of life-prolonging procedures in a living will or through a health-care surrogate in the event the person becomes mentally and physically incapacitated;
- Reduces the requirement from two physicians to one for determining terminal condition, end-stage condition or persistent vegetative state in an advance directive or surrogate scenario;
- Creates a procedure for discontinuing life-prolonging procedures for persons in a persistent vegetative state who have no advance directive or no one to act as a health care proxy;
- Clarifies the inapplicability of advance directives for certain persons; and

- Extends the term of the Panel for the Study of End-of-Life Care until January 31, 2000, provides a General Revenue appropriation of $100,000 to the Pepper Institute on Aging and Public Policy at Florida State University, and requires a final legislative report.

This bill amends the following sections of the Florida Statutes: 400.142, 400.4255, 400.487, 400.6095, 401.45, 732.917, 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, and 765.401, ss. 395.1041, 400.621, 455.604, 458.319, 459.008, 732.912, and 732.914, F.S., 1998 Supplement. This bill also creates. 765.404, F.S., and three yet undesignated sections of law.

II. Present Situation:

Federal and state statutory and case laws provide 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, including the right to refuse or to discontinue medical treatment.[1] The State Supreme Court has 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).

Advance Directives and Health Care Surrogates

Florida law specifically authorizes mentally capacitated individuals to plan and make health care arrangements for when they become incapacitated. Certain legal documents, known as advance directives, are required to implement such plans or arrangements. The person executing or creating the directive is referred to as the *principal*. Directives must be witnessed. They may be written instruments or oral expressions regarding any aspect of the principal's health care to include designating a health care surrogate, serving as a living will, serving as a do-not-resuscitate order (DNRO), containing a power of attorney, or serving as some other lawfully executed instrument or expressions as authorized under another state's law.

In 1992, the Legislature substantially revised and updated chapter 765, F.S., relating to advance directives, and other related chapters. *See* ch 92-199, L.O.F. The 1992 revisions addressed many of the issues relating to living wills and the discontinuation of life-prolonging procedures, in the Florida Supreme Court case, *In re Guardianship of Browning*, 568 So.2d 4 (Fla. 1990). Some of the major changes included:

- subjecting a person with a durable power of attorney under s. 709.08, F.S., for medical care to the provisions of chapter 765, F.S.;

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

- creating health care "proxies," to allow someone to make health care decisions in the absence of a surrogate and without seeking court intervention;
- incorporating the federal "Patient Self-determination Act" which requires medical facilities to inform patients about the individual's rights with respect to advance directives and the facility's policies with regard to those rights;
- providing for the recognition of do-not-resuscitate orders by paramedics and emergency medical technicians (EMTs); and
- amending chapter 744, F.S., relating to guardianship, to accommodate the designation of a health care surrogate.

Do-Not-Resuscitate Orders

The 1992 revisions to the law also provided for the recognition of Do-Not-Resuscitate Orders (DNROs) by emergency medical services personnel to honor the wishes of those who wanted to die at home without being subjected to extraordinary resuscitation measures in the event of an emergency call. The Legislature also addressed the sunset review of Part III of chapter 401, F.S., relating to medical transportation services. *See* chapter 92-78, L.O.F. It provided that an emergency medical technician (EMT) and a paramedic was immune from liability if he or she withheld resuscitation or life-prolonging treatment from a patient if there was evidence of a physician's order not to resuscitate. *See* s. 401.45(3), F.S. In the absence thereof, the emergency personnel is under a duty to administer cardiopulmonary resuscitation (CPR).

The Department of Health is responsible for the establishment of rules relating to the circumstances and procedures for honoring DNROs. *See* s. 401.35(4), F.S. Under department rules, DNROs must be on a written yellow-colored form entitled,*"Prehospital Do Not Resuscitate Order Form, DH 1896."* DNROs 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 signature of the patient or the patient's surrogate, proxy, or guardian as properly witnessed.

The Panel for the Study of End-of-Life Care has identified the yellow form restriction as problematic in cases in which the emergency medical services personnel and paramedics did not honor a DNRO form that had been appropriately signed but had been photocopied onto white paper. Additionally, the DNRO form is not honored in other health care settings because the liability protection afforded in chapter 401, F.S., does not transfer to other medical personnel in hospitals, nursing homes, and hospices who, instead, rely on the traditional physician issued do-not-resuscitate treatment order, or those personnel in assisted living facilities and adult family-care homes. The DNROs are also site-specific and often must be reissued each time a patient is transferred.

Guardians & Surrogates

The court-appointment of guardians has long been the traditional arrangement for providing decision-making authority for a person who has become incapacitated. However, the process is oftentimes cumbersome, time-consuming, and expensive. Consequently, the concept of a health care surrogate emerged.

Health care surrogacy permits a person, prior to incapacity, to designate someone to make health care decisions on his or her behalf after he or she becomes incapacitated. A health care surrogate, however, is limited to making only medical treatment decisions and to making decisions based on what he or she has been instructed to do or believes the principal would have done (substituted judgment). In contrast, a guardian may be authorized to make all decisions for a ward, including health care decisions, and may do so on the basis of the *ward's best interest*. However, a surrogate takes priority over a later appointed guardian. *See* s. 765.205, F.S. Nonetheless, in a guardianship proceeding, it appears that a court has authority to revoke a surrogacy. *See* s. 744.3115, F.S.

There is a conflict between provisions in chapter 744 and chapter 765, relating to consent to the termination of life-support. A limited guardian may not consent without first seeking court approval. *See* s. 744.3215, F.S. The court must be persuaded by clear and convincing evidence that such a decision is in the best interest of the incapacitated person. In contrast, a guardian under s. 765.401, F.S., may consent to medical treatment or decision in the same manner as a surrogate, except that he or she must have clear and convincing evidence that this is the decision that the patient would have wanted. A surrogate under chapter 765, F.S., does not have to seek court approval which is consistent with the ruling in *Browning, supra*.

Surrogate as Decision-Maker and the Living Will

The issue of withholding life-prolonging procedures from an incompetent person and the doctrine of "substituted judgment" was addressed in *John F. Kennedy Hosp. v. Bludworth*, 452 So.2d 921 (Fla. 1984). "Substituted judgment" means that an authorized person may exercise the patient's right to refuse extraordinary life-sustaining measures by substituting his or her judgment for what he or she believes the terminally ill incompetent person, if competent, would have done under the circumstances.

If such person, while competent, had executed a living will, the living will would be persuasive evidence of the subsequently incompetent person's intention and would be given great weight by the person who substitutes their judgment on behalf of the terminally ill incompetent. In *Browning, supra,* the court held that an incompetent person's right to refuse medical treatment may be exercised by close family members, friends, and guardians based on a medical choice that the patient would have made if competent. A living will provides a presumption of clear and convincing evidence of the patient's wishes. Additional conditions that must be met by the surrogate exercising an incompetent person's right to forgo treatment include: (1) a determination that the patient does not have a reasonable probability of recovering competency so that the right can be directly exercised by the patient (person determined to be incompetent); and (2) any limitations or conditions expressed orally or in the living will have been carefully considered and satisfied. This procedure was incorporated into chapter 765, F.S., in 1992.

In 1996, Florida's Baker Act, relating to the voluntary or involuntary temporary commitment of a person for mental health reasons, was amended to give preference to a health care surrogate in selecting a patient advocate for a person judicially determined to be incompetent to consent to mental health treatment. *See* s. 394.4598, F.S.

Some health care providers' view the living will as a self-executing document upon which an attending physician can carry out the patient's instructions without having to consult with the patient's family, guardians, or close friends. In such cases, it places the person acting for the patient in the position of "approving" the instructions of the patient, as expressed in the living will, and avoids the difficulties presented by family members who are often not emotionally able to direct that life-support be discontinued, despite an incompetent patient's clear instructions. However families and others have recourse to an expedited judicial intervening process to "swiftly resolve claims when nonlegal means prove unsuccessful." *See* Fla. Prob. R. 5.900 (1991) On the other hand, if a health care provider does not wish to carry out the treatment decisions of a patient or otherwise comply with the patient's wishes regarding life-prolonging procedures, the patient may be transferred to another health care provider. *See* s. 765.308, F.S.

Anatomical Gifts or Organ Donations

Florida "Uniform Anatomical Gift Act," modeled after the national Uniform Anatomical Gift Act, established the process by which individuals or their families may donate organs and tissues. *See* Chapter 69-88, L.O.F. Organ transplant recipients are selected on the basis of urgency of need and compatibility of body size and blood chemistries, not race, sex, or creed. *See* Part X, chapter 732, F.S. (ss. 732.910-732.922)

Any person can execute a will to donate all or part of his or her body for the purposes of transplantation, therapy, medical research, or education. *See* s. 732.912, F.S. Alternatively, any member of specified classes of relatives and other persons may make a gift of part or all of a decedent's body, in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class. These classes include, in order of priority, the spouse of the decedent, an adult son or daughter of the decedent, either parent of the decedent, an adult brother or sister of the decedent, a grandparent of the decedent, a guardian of the person at the time of his death, or a representative ad litem appointed by a court of competent jurisdiction upon a petition heard ex parte filed by any person.

An anatomical gift may be made by a will or by another document which is signed by the donor in the presence of two witnesses, who must sign the document in his or her presence. *See* s. 732.914, F.S. The gift may or may not specify a donee. In the latter case, a gift may be accepted by the donor's attending physician, provided the physician does not participate in the removal or transplant procedures.

Other features of the current law include a program administered by the Department of Highway Safety and Motor Vehicles (DHSMV) in which driver's license applicants express their consent to be an organ donor by completing a document and having their intent noted on the front of their driver's license. These registration cards are placed in a central registry developed by the Agency for Health Care Administration (AHCA or agency) and DHSMV. *See* s. 732.915, F.S. However, there is currently no mechanism in place to get copies of the donor document to the appropriate hospital in the event a donor dies. No funds have been appropriated for implementing a statewide registry accessible to hospitals via Internet through a securitized process.

Federal law requires an entity to be designated as an organ procurement organization (OPO) prior to certification by the Secretary of the Department of Health and Human Services. The OPO must

follow guidelines established by the national Organ Procurement Transplant Network regarding the priority of recipients who receive organs. The allocation of organs is federally mandated in prescribed order of priority: local, statewide, regional, and national. Unique exceptions are authorized, including "status one" patients (the most critically ill) and a six-antigen kidney match.

If an organ donor is near death and the organs are suitable for donation and there is a known organ donation status, the hospital notifies the organ procurement organization and the organs are harvested. *See* s. 732.922, F.S., If there is no known organ donation status, the hospital administrator or a designee then proceeds to request any of the persons in the specified classes to consent to donation of organs.

The Panel for the Study of End-of-Life Care

End-of-life care has emerged as a significant item on the national health care agenda. In 1997, the Legislature established the "Panel for the Study of End-of-Life Care." *See* ch. 98-327, L.O.F. The Panel was directed to consider three major areas and submit an interim report by January of 1999. The Panel traveled the state accepting public testimony on the topics and studied pain management, advance directives, and fiscal and regulatory barriers to good end-of-life care.

The Panel's recommendations emphasized the need for reeducation of virtually all segments of society to improve understanding of "what constitutes good end-of-life care and the opportunity to experience a quality life until the very end." The panel endorsed the following goals for pursuing such an objective:

- the right to refuse treatment and the patient's right to make decisions about his or her care and his or her surrogate's right to carry out the patient's wishes when he or she is no longer capable of decision making;

- the right to die without aggressive curative treatment does not equal an obligation to die at any age or with any disability, this right is about supporting an individual's right to make choices along the life continuum in the context of their values, their beliefs, and their situations;

- the realignment of existing financial resources to appropriately reimburse for palliative care;

- the right of all persons, regardless of insurance status, to be provided access to good end-of-life care.

The panel adopted 11 recommendations relating to good end-of-life care education for all people practicing in health care, human services, and related areas. These recommendations propose, in part, that: continuing education in end-of-life care may be substituted for other required continuing education courses, if the courses have been previously taken; the Legislature encourage ongoing development of innovative end-of-life educational programs for all health care providers; the Legislature recommend that professional organizations representing health care professionals develop strategies to promote and provide incentives for participation in end-of-life training and incorporate such training in organizational activities; the Legislature provide for the portability of advance directives, including DNRO forms; the Legislature institute a legislative

proposal that encourages excellence in end-of-life care; and the Legislature extend the Panel's existence until August 1, 2000.

III. Effect of Proposed Changes:

Section 1 creates yet unnumbered sections.

Subsection (1) provides legislative findings relating to demographic characteristics of the state; the recommendations of the Panel for the Study of End-of-Life Care (Panel); patient access to effective pain management and palliative care; a person's experience of death and dying, and preferences about end-of-life care based on ethnic and cultural values and beliefs; cross-cultural training of social, health, and education practitioners, measurement of pain as a "fifth vital sign" to aid health care providers assessing and managing pain; freedom from fear of blame or discipline of health care providers for using adequate medication to effectively manage pain; and the constitutional right to privacy as it relates to an incompetent adults' expression of their wish to receive, refuse, withhold, or withdraw any medical treatment.

Subsection (2) authorizes the Secretary of the Department of Health (DOH) 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.

Subsection (3) requests that the Chancellor of the State University System 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.

Sections 2, 3, 4, 5, 6 and 7 amend, respectively, the following sections to allow the personnel and facilities acting under the respective sections, to withhold or withdraw CPR pursuant to a do-not-resuscitate order issued under chapter 401, F.S., and to provide liability protection for them when acting pursuant to such orders:

- s. 395.1041, F.S. (Supp.1998), relating to access to hospital emergency services and care.
- s. 400.142, F.S., relating to nursing home staff.
- s. 400.4255, F.S., relating to assisted living facility staff.
- s. 400.487, F.S., relating to home health agency personnel.
- s. 400.6095, F.S., to relating to members of the hospice care team.
- s. 400.621, F.S. (Supp.1998), relating to adult family-care home providers.

Section 8 amends s. 401.45, F.S., relating to denial of emergency treatment and civil liability for emergency medical services providers, to:

(1) Strike language authorizing emergency medical services personnel to withhold or withdraw life-prolonging techniques;
(2) Direct DOH, in consultation with the Department of Elderly Affairs, and the Agency for Health Care Administration, to develop a standardized DNRO identification system with devices that indicate that a patient has a DNRO, and to permit DOH to charge a fee to cover the cost of producing and distributing such devices; and

(3) Direct DOH to develop and enforce rules to implement this section.

Sections 9-11 amend ss. 455.604, 458.319, and 459.008, F.S. (Supp.1998), to provide continuing education requirements for health care professionals relating to licensure and certification renewal, to allow licensed health care professionals to substitute a continuing education course on end-of-life care for the AIDS/HIV course, provided these professions took the AIDS/HIV course in a previous licensure cycle.

Section 12 amends s. 732.912, F.S. (Supp.1998), relating to anatomical gifts, to provide that, if a decedent has executed an agreement concerning organ and tissue donation, then his or her surrogate may give all or part of the decedent's body as an anatomical gift. If the decedent has not expressed his or her wishes about organ and tissue donation and has not designated a surrogate, current law governing anatomical gifts controls.

Section 13 amends s. 732.914, F.S. (Supp.1998), relating to the manner of executing anatomical gifts, to conform a cross reference.

Section 14 amends s. 732.917, F.S., relating to rights and duties at death under the Anatomical Gift Act, to conform a cross reference.

Section 15 amends s. 732.922, F.S. (Supp. 1998), relating to duties and the liability of hospital administrators pertaining to organ procurement, to require that hospital administrators request consent for organ or tissue donation from the decedent's health care surrogate then, if the decedent has not designated a health care surrogate, a person listed in the priority list of persons who may consent to an anatomical gift under chapter 732, F.S., when the decedent has not executed a donor card or document.

Section 16 amends s. 765.101, F.S., to revise or add the following definitions as indicated:

- "advance directive" to add anatomical gifts, and to delete DNROs;
- "health care decision" to add making an anatomical gift;
- "incapacity" or "incompetent" to include a patient who is deceased for the purpose of making an anatomical gift;
- "informed consent" to provide clarification;
- "life-prolonging procedure" to specify that it includes artificially provided sustenance and hydration, and to delete reference to 'terminal condition';
- "end-stage condition" (new)
- "persistent vegetative state"; and
- "terminal condition."

Specifically, the phrase "terminal condition" is revised to exclude reference to "persistent vegetative state." The phrase "persistent vegetative state" is given its own standalone definition but still defined as existing law. The definition for "end-stage condition" is created to distinguish from "terminal condition" and "persistent vegetative state." It is based on Maryland law. *See* Md. Code Ann. Health-General §5-601 (1994) "End-stage condition" is defined in the bill as "a condition caused by injury, disease, or illness which has resulted in severe and permanent deterioration, indicated by incapacity and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective."

Section 17 amends s. 765.102, F.S., providing legislative intent relating to advance directives, to change references from "terminal condition" to "incapacity."

Section 18 amends s. 765.103, F.S., to clarify that directives made prior to October 1, 1999, must be given effect as executed.

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

Section 20 amends s. 765.107, F.S., to clarify that the provisions of chapter 765, F.S., providing for advance directives, do 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 the 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's or provider's forms, and requires 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 DOH, AHCA, and the Department of Children and Families, 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, to make a technical change.

Section 23 amends s. 765.205, F.S., to clarify that the surrogate may authorize the admission, discharge, or transfer of a principal to any facilities or programs 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 conform cross references.

Section 25 amends s. 765.302, F.S., relating to the procedure for making a living will, to expand those scenarios in which a person's living will may direct the provision, withholding or withdrawal of life-prolonging procedures. The person may either have a terminal condition, an end-stage condition, or be in a persistent vegetative state.

Section 26 amends s. 765.303, F.S., to add to the suggested form for a living will that the principal of the will must be mentally and physically incapacitated for the will to trigger the directives for life-prolonging procedure in those cases where the principal has a terminal condition, has an end-stage condition or is in a persistent vegetative state.

Section 27 amends s. 765.304, F.S., providing the procedure for execution of a living will, to revise language to change reference to "competency" to "capacity" and to expand the scenarios in which a person's living will be given effect to include if the person has an end-stage condition or if the person is in a persistent vegetative state. It also revises the phrase "reasonable probability" to provide for the uniform use of the phrase "reasonable medical probability."

Section 28 amends. s. 765.305, F.S., providing the procedure for a health care surrogate in the absence of a living will to consent to withholding or withdrawal of treatment, to change reference from "competency" to "capacity," and to require that the surrogate be satisfied that the patient is both mentally and physically incapacitated with no reasonable medical probability of recovery or the patient has a terminal condition, has an end-stage condition, or is in a persistent vegetative state. It also revises the phrase "reasonable probability" to provide for the uniform use of the phrase "reasonable medical probability."

Section 29 amends s. 765.306, F.S., relating to determination of a patient's condition, to solely require one attending or treating physician to examine the patient to determine whether the patient has a terminal condition, has an end-stage condition, is in a persistent vegetative state, or has a medical condition or limitation referred to in an advance directive, or whether the patient may recover *mental or physical* capacity.

Section 30 renumbers s. 765.308, F.S., as 765.1105, F.S., and revises the provisions relating to the transfer of a patient, to:

- authorize the transfer of a patient when the health care provider or facility refuses to comply with the advance directive or treatment decision of the patient's surrogate, and clarify that the chapter does not obligate a health care provider or facility to act contrary to its moral or ethical beliefs relating to all treatment decisions, not just decisions to forego life-prolonging procedures;

- change reference from "declaration of patient" to a "patient's advance directive"; and

- provide that a health care provider that is unwilling to carry out the *treatment decision of a patient's surrogate* must take certain specified actions.

Section 31 amends s. 765.310, F.S., relating to falsification or destruction of an advance directive, to renumber s. 765.310, F.S., as s. 765.1115, F.S., to make it applicable to all advance directives, including amendments and revocations of an advance directive.

Section 32 mends s. 765.401, F.S., to require a health care proxy's decision to withhold or withdraw life-prolonging procedures to be supported by a written declaration. In the absence of such declaration, the proxy's decision must be supported by clear and convincing evidence that

the patient who is determined to have a terminal condition or end-stage condition, or is in a persistent vegetative, would have made the proxy's decision when competent.

Section 33 creates s. 765.404, F.S., relating to persons in a persistent vegetative state who have no advance directives, made no indication of their desires in such state, or have no family or friends willing to serve as proxies. It creates a procedure for withdrawing or withholding life-prolonging procedures in those cases, provided the person has a court-appointed guardian and the guardian and the attending physician, in consultation with the facility's medical ethics committee conclude that the condition is permanent and there is no reasonable medical probability of recovery.

Section 34 directs the Department of Elderly Affairs to convene a workgroup to develop model advance directive forms and to make the forms available to the public, and authorizes the department to reconvene the workgroup as necessary.

Section 35 repeals subsection (6) of s. 3 of chapter 98-327, *Laws of Florida*, effective July 1, 1999. Instead it provides for continuation of the term for the Panel for the Study of End-of-Life Care and continues the Panel's existence until January 31, 2000, provides an appropriation of $100,000 from the General Revenue Fund to the Pepper Institute on Aging and Public Policy at Florida State University, and requires the Panel to submit its final report to the Legislature by January 31, 2000.

Section 36 provides an effective date of October 1, 1999, except as provided in section 35 of the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill may make it easier for a health care provider or residential facility to honor a person's medical treatment decisions as expressed through a DNRO, an advance directive, a health care surrogate or proxy upon the person becoming incapacitated.

The bill may also clarify the process for making an anatomical gift under part X of chapter 732, F.S., and encourage health care professionals to take courses on end-of-life care.

C. Government Sector Impact:

The Department of Health may incur costs for which state-appropriated funds may be expended relating to the two demonstration projects that the Secretary of the department is authorized to develop and implement in Section 1 of the bill; however, the department is authorized to apply for grants, accept special grant money, services, gifts or donations to support the demonstration projects. The department may also incur costs in the development and implementation of the do-not-resuscitate orders (DNRO) identification system, as required by Section 8 of the bill, and the development of a standardized and portable DNRO form. The bill authorizes charging a reasonable fee to cover the cost and distribution of these identification devices to offset any fiscal impact on the department.

Effective July 1, 1999, the Panel for the Study of End-of-Life Care is appropriated $100,000 from the General Revenue Fund to fund the work and activities of the panel through January 31, 2000.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

#1 by Fiscal Policy:
Removes language that continues the existence of the Panel for the Study of End-of-Life Care until January 31, 2000, removes language that required a final report to be submitted to the Legislature by January 31, 2000, and deletes the appropriation of $100,000 from the General Revenue Fund to the Pepper Institute on Aging and Public Policy at Florida State University to support the work of the panel.