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/SB 2228

SPONSOR: Health, Aging and Long-Term Care Committee and Senator Klein

SUBJECT: End-of-Life Care

DATE: March 30, 1999 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Carter	Wilson	HC	Favorable/CS
2.			JU	
3.			FP	
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 2228 provides legislative findings related to end-of-life care. The bill 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), reporting to the Legislature by January 30 of each year on project results, and authorizes the department to apply for grants and accept donations. Language in the bill requests the chancellor of the State University System to convene a working group to review available curricula for end-of-life care and make recommendations through the respective health-related professional regulatory boards for content and materials to be included in the curriculum of each medical, social work, and allied health discipline's school.

Furthermore, the bill adds liability protection relating to honoring do-not-resuscitate orders for nursing homes, assisted living facilities, home health agencies, and adult family-care home providers. It authorizes health care providers to substitute a continuing education course on end-of-life care, for purposes of licensure or certification renewal, for the AIDS/HIV course, if this course has been taken in a previous licensure cycle. Another provision in the bill requires hospital administrators to 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. The bill clarifies 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. Effective July 1, 1999, the bill extends the existence of the Panel for the Study of End-of-Life Care 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.

This bill amends ss. 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, Florida Statutes (F.S.); ss. 395.1041, 400.621, 455.604, 458.319, 459.008, 732.912, and 732.914, F.S., 1998 Supplement; creates s. 765.404, F.S.; and creates three undesignated sections of law.

II. Present Situation:

Florida law authorizes individuals to plan and make arrangements, while they have the mental capacity, for health care once they have become incapacitated. Certain legal documents must be used to effect implementation of such plans or arrangements, generally, known as advance directives.

Chapter 765, F.S., provides guidelines for legally binding advance directives. Such directives must be witnessed. The person creating (executing) the directive is referred to as the *principal*. The directives may be written instruments or oral expressions concerning any aspect of the principal's health care. Such directives may: (1) provide for designation of a health care surrogate, (2) be a living will, (3) be a do-not-resuscitate order (DNRO), (4) be a power of attorney, or (5) some other lawfully executed instrument or expressions as authorized under another state's law. An individual may be designated as a health care surrogate to make health care decisions on behalf of the principal who designates him or her.

Advance Directives and Health Care Surrogates

In 1992, the Legislature enacted chapter 92-199, *Laws of Florida* (L.O.F.), which significantly updated Florida's statutory provisions relating to advance directives. Provisions of chapter 765, F.S., were revised to incorporate most of the provisions of the 1990 Florida Supreme Court decision, *In re Guardianship of Browning*, 568 So.2d 4 (Fla. 1990), relating to living wills and the discontinuation of life-prolonging procedures. The 1992 revisions to the law:

- integrated provisions of chapter 745, F.S. (1991), relating to health care surrogacy, into chapter 765, F.S., and renamed the chapter "Advance Directives" in order to have all provisions relating to a person's arrangements for the management of medical care during incapacity or incompetency in one chapter;

- amended s. 709.08, F.S., to direct that a person with a durable power of attorney over medical care be governed by chapter 765, F.S.;

- created a new section relating to "proxies," which allows for the appointment of someone to make health care decisions in the absence of a surrogate and without seeking court intervention;

- incorporated 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;

- provided for the recognition of do-not-resuscitate orders by paramedics and emergency medical technicians (EMTs); and

- amended chapter 744, F.S., relating to guardianship, to accommodate the designation of a health care surrogate.

Patient Autonomy, Self-Determination & Advance Planning

Federal and state law, interpreted and supported by case law, 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 State Supreme Court has 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. Bludworth*, 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 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).

Do-Not-Resuscitate Orders (DNRO)

The 1992 revisions to the law provided for the recognition of DNROs by emergency medical services personnel. Many elderly ill individuals want to be able to die at home without fear of being subjected to extraordinary resuscitation measures should an ambulance be called. What was needed was some sort of statutory directive that permitted emergency medical technicians (EMTs) and paramedics to respect this wish, since paramedics and EMTs are under a legal obligation to make every effort to maintain life. Section 765.307, F.S., was added to the law to authorize emergency medical personnel to honor a DNRO written on a form adopted by the Department of Health (DOH or department).

The Legislature also enacted chapter 92-78, L.O.F., which addressed the sunset of Part III of chapter 401, F.S., relating to medical transportation services. Section 401.45(3), F.S., provides

that an EMT or paramedic may withhold resuscitation or life-prolonging treatment from a patient if evidence of a physician's order not to resuscitate is presented. The statute also provides liability protection to personnel who act on the basis of such orders. Without the statute and the DNRO, emergency personnel are considered to be under a duty to administer cardiopulmonary resuscitation (CPR). Section 401.35(4), F.S., directs the Department of Health to establish rules with regards to the circumstances and procedures for honoring orders not to resuscitate. The department, which is responsible for regulation and procedures relating to emergency services, has developed a form, *"Prehospital Do Not Resuscitate Order Form, DH 1896,"* which is printed on yellow-colored paper only and 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 personnel will honor the form only if it is on yellow paper. This was found to be a problem by the Panel for the Study of End-of-Life Care. The Panel heard from state residents about their anger and confusion, or someone they knew of being angry and confused, because a DNRO presented was a photocopy of the form on white paper. Though appropriately signed, it was not honored by paramedics or EMTs.

Because chapter 401, F.S., 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 reissued each time a patient moves between a hospital and a nursing home.

The public testimony received by the Panel 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. The testimony revealed that many in the public do not understand why their living will, which specified that they do not want to be resuscitated, does not govern in all situations. Further compounding the problem, is the plight of people who live in non-medical facilities such as assisted living facilities and adult family-care homes. 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.

Guardians & Surrogates

Court appointment of a guardian has long been the traditional arrangement for providing decision-making authority for a person who has become incapacitated. Unfortunately, the process of appointing a guardian is cumbersome, time-consuming, and expensive. It is for this reason that the concept of health care surrogacy has emerged. Health care surrogacy permits a person, prior to incapacity, to designate someone of his or her own choosing 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). A guardian, on the other hand, may, if so authorized by a court, make all decisions for a ward, including health care decisions, and may do so on the basis of the *ward's best interest*.

Section 765.205, F.S., provides that a surrogate shall take priority over a later appointed guardian. Section 744.3115, F.S., on the other hand, appears to give a court, in a guardianship proceeding, the authority to revoke the authority of a surrogate at the court's discretion. The procedure that a guardian must follow under chapter 744, F.S., before consenting to the termination of life-support conflicts with the procedure provided in chapter 765, F.S. Under s. 744.3215, F.S., a limited guardian may not consent without first seeking court approval. The court must be persuaded by clear and convincing evidence that such a decision is in the best interest of the incapacitated person. Section 765.401, F.S., permits a guardian with authority to consent to medical treatment to make such a 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 does not have to seek court approval. The latter procedure is in keeping with the State Supreme Court's decision in *Browning*, which saw the court's role as one of resolving conflicts and ambiguities rather than as decision maker.

Surrogate as Decision-Maker

The State Supreme Court in *John F. Kennedy Hosp. v. Bludworth*, 452 So.2d 921 (Fla. 1984), addressed the situation of withholding life-prolonging procedures from an incompetent person and adopted the doctrine of "substituted judgment." "Substituted judgment" means that an authorized person may exercise the patient's right to refuse extraordinary life-sustaining measures, substituting their judgment for what they believe 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 incompetent person's intention and should be given great weight by the person who substitutes their judgment on behalf of the terminally ill incompetent. In 1990, the State Supreme Court reaffirmed this position and held in *Browning* that when a patient is incompetent a person's right to refuse medical treatment may be exercised by close family members or friends, as well as guardians. Again, the person must make the medical choice that the patient, if competent, would have made. A living will would provide a presumption of clear and convincing evidence of the patient's wishes. In addition, the court provided conditions that the surrogate must meet before exercising the incompetent person's right to forego treatment. Included in these conditions are: (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, s. 394.4598, F.S., 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.

Some health care providers have taken the position that a living will is "self-executing" and that the attending physician can carry out the patient's instructions as stated in the living will without having to consult with the patient's family, guardians, or close friends. Indeed, they claim that not only is it unnecessary and inconvenient to have to locate someone to act on the patient's behalf (surrogate or proxy), but it puts the person who is acting for the patient in the position of "approving" the instructions of the patient, as expressed in the living will. In addition, they claim that a family member is often not emotionally able to direct that life-support be discontinued, despite an incompetent patient's clear instructions. They do not want to have to seek expedited

judicial intervention *via* Florida Probate Rule 5.900 in order to challenge the surrogate or proxy's decision. This rule was put in place in 1991 at the direction of the court in *Browning* in order to "swiftly resolve claims when nonlegal means prove unsuccessful." Section 765.308, F.S., provides a "transfer clause" which requires health care providers who do not wish to carry out the treatment decisions of a patient to either transfer the patient to another health care provider or comply with the wishes of the patient.

Anatomical Gifts or Organ Donations

Chapter 69-88, L.O.F., created the Florida “Uniform Anatomical Gift Act.” Modeled after the national Uniform Anatomical Gift Act, Florida's law established the process by which individuals or their families may donate organs and tissues. 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. These provisions are currently contained in part X of chapter 732, F.S., consisting of ss. 732.910-732.922, F.S.

Section 732.912, F.S., provides that any person who can make a will may donate all or part of his or her body for the purposes of transplantation, therapy, medical research, or education. 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 petition heard ex parte filed by any person.

Section 732.914, F.S., provides that 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. An anatomical gift may be made either to a specified donee or without specifying 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. Section 732.915, F.S., requires these registration cards to be placed in a central registry developed by the Agency for Health Care Administration (AHCA or agency) and DHSMV.

Current practice is for DHSMV to send the donor documents to AHCA where they are stored in a central location. 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. The agency is requesting that other funds in the trust fund be made available on a one-time basis for these purposes. If this fund authorization is granted, the agency proposes to make the organ donor registry available to hospitals across the state via the Internet. Security codes will be used to prevent the disclosure of private medical records to the public.

Federal law provides that states cannot certify an entity for organ procurement unless the entity is designated as such by the Secretary of the federal Department of Health and Human Services. In order for an organ procurement organization (OPO) to be so certified, 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 the following 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.

Currently, as specified under s. 732.922, F.S., 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. If there is no known organ donation status, the hospital administrator or his 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 enacted chapter 98-327, L.O.F., to establish the "Panel for the Study of End-of-Life Care." 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 it was charged with studying. The Panel studied:

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

The Panel's recommendations emphasize the need for re-education 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. Provides legislative findings related to demographic characteristics of the state; the recommendations of the Panel for the Study of End-of-Life Care (Panel); that all persons should have access to effective pain management and palliative care; that a person's experience of death and dying, and preferences about end-of-life care are rooted in ethnic and cultural values and beliefs; that social, health, and education practitioners 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 for using adequate medication to effectively manage pain; and 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 Secretary of the Department of Health (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.

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.

Section 2. Amends s. 395.1041, F.S., 1998 Supplement, relating to access to emergency services and care, to permit hospital emergency services personnel to withhold or withdraw CPR pursuant to a do-not-resuscitate order issued under chapter 401, F.S., and to provide liability protection for facility staff and facilities when acting pursuant to such orders.

Section 3. Amends s. 400.142, F.S., relating to requirements for nursing home emergency medication kits, to permit nursing home staff to withhold or withdraw CPR pursuant to a do-not-resuscitate order issued under chapter 401, F.S., and to provide liability protection for facility staff and facilities when acting pursuant to such orders.

Section 4. Amends s. 400.4255, F.S., relating to assisted living facility use of licensed personnel, to permit assisted living facility staff to withhold or withdraw CPR pursuant to a

do-not-resuscitate order issued under chapter 401, F.S., and to provide liability protection for facility staff and facilities when 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., and to provide liability protection for home health personnel and agencies when 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., and to provide liability protection for hospice staff when acting pursuant to such orders.

Section 7. Amends s. 400.621, F.S., 1998 Supplement, relating to adult family-care homes, to permit adult family-care home providers to withhold or withdraw CPR pursuant to a do-not-resuscitate order issued under chapter 401, F.S., and to provide liability protection the provider when acting pursuant to such orders.

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., 1998 Supplement, providing 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, if these courses have been taken in a previous licensure cycle.

Section 12. Amends s. 732.912, F.S., 1998 Supplement, 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., 1998 Supplement, 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., 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., 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 the definition of "health care decision" to add making an anatomical gift;
3. Amend the definition of "incapacity" or "incompetent" to include a patient who is deceased for the purpose of making an anatomical gift;
4. Amend the definition of "informed consent" to provide clarification;
5. Amend the 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., providing legislative intent relating to advance directives, to change references from "terminal condition" to "incapacity."

Section 18. Amends s. 765.103, F.S., relating to the effect of statutory changes on existing advance directives, to clarify that directives executed prior to the effective date of this act 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., relating to statutory construction, 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., relating to the responsibility of a surrogate, 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 delete the condition that a person suffer from a "terminal condition" as a restriction on a competent adult's living will or written declaration directing the providing, withholding, or withdrawal of life-prolonging procedures.

Section 26. Amends s. 765.303, F.S., providing a suggested form for a living will, to revise the form to add, as the basis for acting on an executed living will, determination that the executor of such will is *both mentally and physically incapacitated*.

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 delete the requirement that a person be terminally ill as a prerequisite to acting on the directions contained in a living will.

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 to "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's condition is terminal.

Section 29. Amends s. 765.306, F.S., relating to determination of a patient's condition, to delete the requirement that a patient's attending physician or treating physician and at least one consulting physician examine the patient *separately* to determine whether the patient may recover *mental or physical* capacity or whether a medical condition or limitation referred to in an advance directive exists.

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

- renumber s. 765.308, F.S., as s. 765.1105, F.S., and make authority to transfer a patient applicable 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 directives.

Section 32. Amends s. 765.401, F.S., relating to health care proxies, to require a proxy's decision to withhold or withdraw life-prolonging procedures to be supported by a written declaration or the patient must be terminally ill or in a persistent vegetative state.

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. 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. Effective July 1, 1999, repeals subsection (6) of s. 3 of chapter 98-327, *Laws of Florida*, providing for the termination of 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:

None.

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, and will incur some cost related to development and implementation of the DNRO identification system, as required by section 8 of the bill. Effective July 1, 1999, the Panel for the Study of End-of-Life Care is appropriated $100,000 to fund the work and activities of the panel through January 31, 2000.

VI. Technical Deficiencies:

In section 32 of the bill references are made to terminal condition that should be deleted to conform this section to the remainder of the bill.

On page 32, line 23, the section designation for the bill should be “36” instead of “35.”

VII. Related Issues:

None.

VIII. Amendments:

None.