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 1890

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

SUBJECT: End-of-Life Care

DATE: April 13, 2000 REVISED: _____ _____ _____ _____

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

I. Summary:

The committee substitute for committee substitute for Senate Bill 1890 amends a number of provisions relating to the end-of-life care, as follows:

- Extends authority to withhold or withdraw cardiopulmonary resuscitation based on a do-not-resuscitate order (DNRO) to all hospital personnel in lieu of emergency services personnel and extends immunity from liability for those persons;
- Clarifies that the authority of a physician to issue a DNRO is not affected by specified statutory provisions relating to validly executed DNROs in hospitals, nursing homes, assisted living facilities, or hospice scenarios;
- Requires use of official department form for a validly executed DNRO which must be signed by the patient's physician and the patient, or alternatively his or her health care surrogate or proxy, court-appointed guardian or attorney in fact acting under a durable power of attorney;
- Revises the licensure renewal requirements for specified health care professionals to provide option to take continuing education courses in end-of-life care and palliative care in lieu of course on domestic violence under specified circumstances;
- Adds legislative intent language in chapter 765, F.S., to allow someone to plan for incapacity either through a written document or through an oral statement, to encourage health care professional regulatory boards to adopt standards on end-of-life care and pain management, and to encourage educational institutes to implement professional training curricula on end-of-life care;
- Directs the Department of Elderly Affairs, the Agency for Health Care Administration, and the Department of Health to conduct a statewide end-of-life care public education campaign;
- Creates a new section in chapter 765, F.S., relating to pain management and palliative care;
- Revises the suggested statutory form for designation of a health care surrogate to include reference to the requirement for a separately executed declaration for surrogate's authority to make an anatomical gift,
- Revises the prerequisites upon which a health care surrogate may consent to health care decisions, and expands authority to include consent to a physician's DNRO;
- Revises the suggested statutory form of living wills relating to the incapacity of the person before the will takes effect;

- Revises the basis upon which a health care proxy may exercise authority to consent to withhold or withdraw life-prolonging procedures to require such authority to be exercised in accordance with specified sections of chapter 765, F.S.; and
- Creates an 18-member End-of-Life Care Workgroup.

This bill amends the following sections of the Florida Statutes: 395.1041, 400.142, 400.4255, 400.6095, 401.45, 455.597, 765.102, 765.203, 765.204, 765.205, 765.303, 765.305, 765.306, and 765.401, and creates s. 765.1103 and one undesignated section of law.

II. Present Situation:

Federal and state statutory and case laws provide that each legally competent adult has the right to make decisions about the amount, duration, and type of medical treatment he or she wishes to receive, including the right to refuse or to discontinue medical treatment.[*] However, the Florida Supreme Court has recognized four state interests that may override, on a case-by-case basis, a person's constitutionally recognized right to make health care decisions that would result in the person's death: (1) preservation of life, (2) the protection of innocent third parties, (3) the prevention of suicide, and (4) maintenance of the ethical integrity of the medical profession. *See In re Guardianship of Browning*, 568 So.2d 4 (Fla. 1990)

The concept of the "substituted judgment" provides for a person to act on behalf of a person who lacks capacity to make health care decisions, particularly regarding consent to withhold or withdraw extraordinary life-sustaining measures on the belief that the terminally ill and incapacitated patient, while competent, would have wanted or done the same under the circumstances. *See John F. Kennedy Hosp. v. Bludworth*, 452 So.2d 921 (Fla. 1984).

Through health care advance directives, a mentally capacitated person can plan and make health care arrangements for when they become incapacitated. *See* ch. 765, F.S. They may be written instruments or oral expressions regarding any aspect of the principal's health care and may involve the designation of a health care surrogate, delegation of authority to an attorney in fact pursuant to a durable power of attorney, the execution of a living will, the execution of do-not-resuscitate order (DNRO), or the execution of some other lawfully executed instrument as authorized under another state's law.

Health Care Surrogate and Proxy

Florida law provides for the designation of a health care surrogate to make health care decisions for a principal. See Part II, ch. 765, F.S. *See* ss. 765.203 and 765.303, F.S., respectively. A written designation of a health care surrogate must be witnessed by two adults and signed by the principal or alternatively, another person to sign on the principal's behalf if the principal is unable sign the instrument. *See* s. 765.202, F.S. A suggested form is provided in statute. *See* s. 765.203, 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 Hosp., 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).

In the absence of an advance directive or a designated health care surrogate or the unavailability of a health care surrogate, a proxy may be appointed from a list of specified persons who know the patient or may be a court-appointed guardian to make health care decisions. *See* s.765.401, F.S. A proxy must comply with the same provisions that a health care surrogate must. However, the proxy's decision to withhold or withdraw life-prolonging procedures must either be supported by a written declaration evidencing the patient's desire for such an action. In the absence of a written declaration, the patient must have a terminal condition, have an end-stage condition, or be in a persistent vegetative state. When authorizing the withholding or withdrawing of life-prolong procedures, a proxy's decision must be supported by clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent.

Durable Powers of Attorney

In Florida, powers of attorney and similar instruments conferring legal authority are governed by chapter 709, F.S. The power of attorney must be in writing and executed in accordance with the statutory formality associated with conveyance of real property. Florida recognizes fully the general power of attorney and the durable power of attorney.

The powers delegable to a power of attorney can include, but are not limited to, unless otherwise provided in law: 1) Every act authorized and specifically enumerated in the durable power of attorney, 2) Authority to execute stock, security and other related powers, and 3) Authority to convey or mortgage property. *See* s. 709.08(7)(a), F.S. Additionally, the durable power of attorney may include the power to make health care decisions, *if such authority is specifically granted in the durable power of attorney,* including those set forth in chapter 765, F.S., relating to health care advance directives. *See* s. 709.08(7)(c), F.S.

Living Wills

Part III of chapter 765, F.S., governs the execution of a living will regarding the withholding or withdrawing of life-prolonging procedures in the event a person has a terminal condition, has an end-stage condition or is in a persistent vegetative state. The living will serves as persuasive evidence of the subsequently incapacitated person's intent and is given great weight by the surrogate or proxy since it 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 capacity so that the right can be directly exercised by the patient (person determined to be incapacitated); and (2) Any limitations or conditions expressed orally or in the living will have been carefully considered and satisfied.

Some health care professionals view and have acted on living wills as self-executing documents 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, the professional is placed in the position of carrying out the patient's instructions as expressed in the living will, and relieving the family members of the difficulties surrounding such decision when they are not emotionally able to direct the discontinuation of life-support despite the patient's clear instructions. However, families and others may intervene in a decision by the surrogate, proxy or health care professional through an expedited judicial intervening process to "swiftly resolve claims when nonlegal means prove unsuccessful." *See* s. 765.105, F.S.; Fla. Prob. R. 5.900 (1991). Similarly, if a health care provider is unwilling to carry out the patient's instructions

regarding treatment including the withdrawal or withholding of life-prolonging procedures, the health care provider may transfer the patient to another health care provider. *See* s. 765.308, F.S.

Do-Not-Resuscitate Orders (DNROs)

In 1992, the Legislature provided statutory recognition of do-not-resuscitate orders (DNROs) by emergency medical services personnel to honor the wishes of those who wanted to die at home, or in another setting other than a hospital, without being subjected to extraordinary resuscitation measures in the event of an emergency call. Emergency medical technicians (EMT) and paramedics are immune from liability when acting on a physician's DNRO. *See* s. 401.45(3), F.S. In the absence of a DNRO, emergency services personnel are 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. Pursuant to department rule, DNROs must be executed and properly witnessed on a standard yellow-colored form entitled,"*Prehospital Do Not Resuscitate Order Form, DH 1896." See Fla. Admin. Code* R 64E-2.031. The form must also include the signatures of the person's attending physician who must attest to consultation with another physician as to the person's terminal condition and of the patient or the patient's surrogate, proxy, or guardian. The department in consultation with the Department of Elderly Affairs and the Agency for Health Care Administration was also directed to develop a standardized do-not-resuscitate identification system with devices to signify, when carried or worn, that the possessor is a patient for whom a physician has issued a DNRO. *See* s. 401.45(c), F.S.

Court-Appointed Guardian

Under chapter 744, F.S., in any guardianship proceeding, the court is required to determine if a health care advance directive has been executed and whether a health care surrogate has been designated. *See* §744.3115, F.S. If a health care advance directive was executed and a health care surrogate designated, the court can modify or revoke the health care surrogate's authority as provided under the directive and to the extent governed by chapter 765, F.S., by redelegating the authority to a guardian.

If no directive was executed and no surrogate designated, the court can delegate to a guardian the power to "consent to medical and mental health treatment" on behalf of the incapacitated person (or ward). *See* s. 744.3215(3)(f), F.S. It appears that the decision to direct, withdraw or withhold life-prolonging procedures may not automatically fall within that power as other extraordinary decisions impacting the incapacitated person requires the court to undergo a special review process prior to the delegation of such authority.[*] Alternatively, one must refer to chapter 765, F.S., relating to health care advance directives. In the absence of a health care advance directive

[2]Notably, under a separate statutory provision, specific authority relating to commitment to a facility, consent to experimental biomedical or behavioral procedures, consent to dissolution of marriage, consent to termination of parental rights, and consent to sterilization or abortion can not be exercised by the guardian until the court appoints an independent attorney to present evidence and act on the ward's behalf, receives medical, psychological and social evaluations, visits personally with the ward and confirm the ward's incapacity to make this decision, and finds by clear and convincing evidence, that the procedure or participation is in the ward's best interest. *See* s. 744.3215(4)(a), F.S., and s. 744.3725, F.S. Moreover, section 744.3725, F.S. states that no new or independent right to or authority over the termination of parental rights, dissolution of marriage, sterilization, abortion or the termination of life support systems is established by the purely procedural aspect of the relevant sections.

or designated health care surrogate, a judicially appointed guardian (if already previously authorized to consent to medical treatment) as a proxy may make health care decisions including the decision to withdraw or withhold life-prolonging procedures. *See* ss. 765.401 and 765.404, F.S. However, if the health care decision to be made is the decision to withdraw or withhold life-prolonging procedures, such proxy's decision must be based on either:

- A written declaration, or
- Clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent [the patient must have a terminal condition, have an end-stage condition or be in a persistent vegetative state, for this provision to apply].

In addition, a court-appointed guardian (with pre-existing authority to consent to medical treatment) may exercise the decision to withhold or withdraw life-prolonging procedures if the person in a persistent vegetative state, there is no advance health care directive or family or friend is available to act as proxy, and there is no evidence indicating what the person would have wanted under such conditions. *See* s. 765.404, F.S. The guardian and the person's attending physician must consult with the medical ethics committee and conclude that the condition is permanent, that there is no reasonable medical probability for recovery and that withholding or withdrawing is in the patient's best interest.

III. Effect of Proposed Changes:

Section 1 amends s. 395.1041, F.S., relating to DNROs applied to persons in hospitals. It extends authority to withhold or withdraw cardiopulmonary resuscitation based on a do-not-resuscitate order (DNRO) to all hospital personnel in lieu of emergency services personnel and extends immunity from liability for those persons. In addition, this section clarifies that the absence of a DNRO executed pursuant to s. 401.45, F.S., relating to denial of emergency treatment does not affect the authority of a physician to issue a DNRO.

Section 2 amends s. 400.142, F.S., relating to DNROs applied to persons in nursing homes, to clarify that the absence of a DNRO executed pursuant to s. 401.45, F.S., relating to denial of emergency treatment does not affect the authority of a physician to issue a DNRO in a nursing home.

Section 3 amends s. 400.4255, F.S., relating to DNROs applied to persons in assisted living facilities, to clarify that the absence of a DNRO executed pursuant to s. 401.45, F.S., relating to denial of emergency treatment does not affect the authority of a physician to issue a DNRO in such facility.

Section 4 amends s. 400.6095, F.S., relating to DNROs applied to persons in hospice care, to clarify that the absence of a DNRO executed pursuant to s. 401.45, F.S., relating to denial of emergency treatment does not affect the authority of a physician to issue a DNRO for a patient under hospice care.

Section 5 amends paragraph 401.45(3)(a), F.S., relating to the authority of emergency medical technicians and paramedics to act on a DNRO. It codifies the administrative rule regarding prerequisites for a validly executed DNRO. The DNRO must be executed on the Department of Health's standard DNRO form which must be signed by the patient's physician and the patient, or

the patient's health care surrogate, proxy, or court-appointed guardian, or attorney in fact pursuant to a durable power of attorney.

Section 6 amends s. 455.597, F.S., relating to the continuing educational requirements for health care professionals licensed or certified under chapter 458, F.S. (medical practice), chapter 459, F.S. (osteopathic medicine), chapter 464, F.S. (nursing), chapter 466, F.S. (dentistry), chapter 467, F.S. (midwifery), chapter 490, F.S. (psychological services), and chapter 491, F.S. (clinical and psychotherapy services). It provides a health care professional with the option to complete an end-of-life care and palliative health care course in lieu of a domestic violence course for licensure and licensure renewal, provided the health care professional has completed a domestic violence course in the immediately preceding biennium.[*]

Section 7 amends s. 765.102, F.S., relating to legislative findings and intent on health care advance directives. It clarifies legislative intent that the procedure for planning for one's own incapacity may be made either by executing a document or *orally designating* another person to direct the course of his or her medical treatment upon his or her incapacity. It adds legislative recognition for the need to educate health care professionals about end-of-life care and palliative health care. It also encourages professional regulatory boards to adopt appropriate standards and guidelines regarding end-of-life care and pain management and educational institutions who train health care professionals and allied health professionals to implement curricula on end-of-life care, including pain management and palliative care[*].

This section also directs the Department of Elderly Affairs, the Agency for Health Care Administration, and the Department of Health to conduct a joint campaign on end-of-life care to educate the public. The campaign should include culturally sensitive programs to improve understanding of end-of-life care issues in minority communities.

Section 8 creates s. 765.1103, F.S., relating to pain management or palliative care. It requires specified health care facilities, health care providers, and health care practitioners to comply, when appropriate, with a request for pain management or palliative care by a patient or an incapacitated patient's health care surrogate, proxy, court-appointed guardian, or attorney in fact under a durable power of attorney. This requirement applies when the person is a patient admitted to or a subscriber to and treated or serviced by specified facilities, providers and practitioners, as follows:

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[3]Existing law already allows a person licensed under chapter 457, F.S. (acupuncture); chapter 458, F.S. (medical practice); chapter 459, F.S. (osteopathic medicine); chapter 460, F.S. (chiropractice medicine); chapter 461, F.S. (podiatric medicine); chapter 463, F.S. (optometry); chapter 464, F.S. (nursing); chapter 465, F.S. (pharmacy); chapter 466, F.S. (dentistry and dental hygiene); part II, part III, part V, or part X of chapter 468, F.S. (nursing home administrators, occupational therapy, respiratory therapy, dietetics and nutrition practice); or chapter 486, F.S. (physical therapy) to take a course in end-of-life care and palliative health care in lieu of a course on AIDS/HIV as required for licensure and licensure renewal, provided such professional has completed an AIDS/HIV course in the preceding biennium. *See* s.455.604(9), F.S.; *See also* ss. 458.319(4), F.S. and 459.008(5), F.S.

[4]The terms "palliative care" and "palliative health care" are used interchangeably. In addition, neither pain management or palliative care is defined. "Palliative care" is defined statutorily in two chapters. In chapter 400, F.S., relating to nursing home and related health care facilities, the term "palliative care" means services or interventions which are not curative but are provided for the reduction or abatement of pain and human suffering. *See* s. 400.601(7), F.S. In chapter 440, F.S., relating to worker's compensation, the term "palliative care" is defined as noncurative medical services that mitigate the conditions, effects, or pain of an injury. *See* s. 440.13(1)(o), F.S.

hospitals, nursing homes, assisted living facilities, home health agencies, hospices, intermediate, special services, and transitional living facilities, prescribed pediatric extended care centers, intermediate care facilities for developmentally disabled persons; health maintenance organizations, prepaid health clinics, licensed medical and osteopathic physicians, and nurses. Information regarding pain management and palliative care must be provided to the patient or to the incapacitated patient's health care surrogate, proxy, court-appointed guardian or attorney in fact under a durable power of attorney.

Section 9 amends s. 765.203, F.S., relating to the statutory suggested form for designation of a health care surrogate. It adds language to the suggested form that authority to make health care decisions does not include the decision to donate organs unless a separate declaration is executed. This is consistent with the definition for "health care decisions" which includes the decision to make an anatomical gift as provided in Part X of chapter 732, F.S., relating to anatomical gifts. Specifically s. 732.912, F.S., conditions the authority of a health care surrogate to make an anatomical gift on the existence of some specific declaration by the person regarding an anatomical gift. This declaration may be indicated in a written agreement, an organ and tissue donor card, a living will, other advance directive, or a driver's license.

Section 10 amends s. 765.204, F.S., relating to the procedure for a physician's determination of a principal's incapacity to make health care decisions. It clarifies that the health care facility must notify the designated health care surrogate or attorney in fact with specified authority under the durable power of attorney that a determination of incapacity has been made by a physician. It adds cross references for the basis of authority of a health care surrogate or a person acting under a durable power of attorney. It also replaces the term "clinical record" with "medical record."

Section 11 amends s. 765.205, F.S., relating to the responsibilities of health care surrogates. It expands and clarifies that the health care surrogate must act in accordance with the principal's instructions unless otherwise limited, whether making health care decision, consulting with health care providers to provide consent, providing written consent including consent to a physician's DNRO, providing access to a principal's medical records, or applying for public benefits. It also replaces the term "clinical record" with "medical record."

Section 12 amends s. 765.303, F.S., relating to a suggested statutory form for a living will, to: (1) Correct scrivener's error regarding spelling of end-stage condition, (2) Replace the term "mentally and physically incapacitated" with "incapacitated" as it is already defined to mean being physically or mentally unable to communicate and willful health care decision, and (3) Make other technical changes.

Section 13 amends s. 765.305, F.S., relating to the procedure to forego treatment in the absence of a living will. It replaces the term "mentally and physically incapacitated" with "incapacitated" as it is already defined to mean being physically or mentally unable to communicate and willful health care decision.

Section 14 amends s. 765.306, F.S., relating to the procedure for determining whether a patient has a terminal condition, an end-stage condition, or is in a persistent vegetation state or otherwise has a medical condition or limitation provided in a health care advance directive. It replaces the term "mentally and physically incapacitated" with "incapacitated" as it is already defined to mean being physically or mentally unable to communicate a willful and knowing health care decision.

Section 15 amends s. 765.401, F.S., relating to authority of a proxy. It eliminates the provisions relating to the conditions under which a proxy may exercise authority to withhold or withdraw life-prolonging procedures on behalf of a patient. In its place, proxies must comply with the same provisions applicable to health care surrogates when making this particular decision but it must still be based on clear and convincing evidence that the decision would have been one that the patient would have chosen if the patient had been competent.[*] This section also specifies the statutory cross-references for the proxy's authority and responsibility, i.e., s. 765.205, F.S., relating to a health care surrogate's responsibilities, and s. 765.305, F.S., relating to the withholding or withdrawing of life-prolonging procedures in the absence of a living will.

Section 16 creates 18-member End-of-Life Workgroup within the Department of Elderly Affairs. The workgroup shall consist of the Secretary of the Department of Elderly Affairs (or designee; the Secretary of the Department of Health (designee); the Director of Health Care Administration or (designee); a Senate member, a House of Representative member, and one member from each of 13 named entities: Florida Hospital Association, the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Nurses Association, the Florida Acupuncture Association, the Florida Pharmacy Association, Florida Hospices and Palliative Care, Inc, the Florida Health Care Association, the Florida Assisted Living Association, the Florida Association of Homes for the Aging, the Florida Life Care Residents Association, the Florida Association of Insurance and Financial Advisors, and the Florida Association of Health Maintenance Organizations.

The workgroup is required to: (1) Examine reimbursement methodologies for end-of-life care, (2) Identify end-of-life care standards for purposes of developing a health care delivery system for end-of-life care, and (3) Develop recommendations for incentives for appropriate end-of-life care. The workgroup must a submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2000. The Department of Elderly Affairs is required to provide staff support to the workgroup within its existing resources. Members of the workgroup must serve without compensation. The term of the workgroup expires on May 1, 2001.

Section 17 provides for the act to take effect upon becoming a law.

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.

[5]Under Florida law, a written designation of a health care surrogate establishes a rebuttable presumption of clear and convincing evidence of the principal's designation. *See* s. 765.202(7), F.S.

C. Trust Funds Restrictions:

requirements of Article III, Subsection 19(f) of the Florida Constitution.

V.

A. Tax/Fee Issues:

B. Private Sector Impact:

- Clarifying a person's right to make health care decisions ranging from basic medical
- Educating the public through end-of-life care education campaigns regarding the issues
- Educating the health care professionals who serve the public to be better educated and

  regulatory boards develop standards and guidelines and educational institutes train health care professionals and allied health care professionals on these issues.

Government Sector Impact:

There is an indeterminate cost associated with the required joint public education campaign

Agency for Health Care Administration and the Department of Health. The bill does not appropriate an amount for this campaign.

Technical Deficiencies:

None.

Related Issues:

None.

Amendments:

None.