

2007

SUMMARY OF HEALTH CARE DECISION STATUTES ENACTED IN 2007

In 2007, states adopted the following legislation creating, modifying and amending rights and procedures affecting health care decision-making. The statutes affect advanced directives, including Do Not Resuscitate Orders, anatomical gifts, advanced directive registries, default surrogate laws, and public education.

Georgia and Utah became the latest states to enact a major rewrite of their advance directive laws to combine and simplify advance directives and surrogate decision-making into a single compilation. Utah, along with North Carolina, also authorized the use of their versions of “Physician’s Orders for Life-Sustaining Treatment” (POLST). Maryland and Oregon made minor amendments to their POLST programs. POLST documents are not advanced directives. Instead, these protocols are similar to out-of-facility or portable DNRs and are designed to convey a patient’s wishes for end-of-life medical care in a language that health care systems understand. Such protocols become a set of doctor’s orders enumerating a patient’s wishes regarding medical care as an illness advances – such as resuscitation, hospitalization, nutrition and hydration, ventilation, and antibiotics. The forms do not replace other advanced directives and are completed by a patient with his or her doctor.

Each piece of legislation is coded to indicate the potential areas of health care decision making affected by the statute. The coding system is:

AD = Advanced Directives

DNR = Do Not Resuscitate Orders

DS = Default Surrogate

POLST = Physician’s Orders for Life Sustaining Treatment, or its variants (e.g. MOLST, POST, and MOST).

Registry = State electronic registry for Advance Directives or POLST

Health Care Decision Statutes

Georgia – AD

- 2007 Georgia Laws Act 48 (H.B. 24), approved May 16, 2007, and effective July 1, 2007, repeals the former “Durable Power of Attorney for Health Care Act” and “Living Will” Act replaces them with a comprehensive “Georgia Advance Directive for Health Care Act,” codified at Ga. Code Ann. §§ 31-32-1 to -8.

Idaho – AD and POLST

- S.L. 2007, ch. 196, § 11 amending I.C. § 39-4510, effective July 1, 2007 modified the statutory form HCPOA and Living Will so that the principal can indicate whether he or she has discussed scope of treatment with a physician and completed a Physician Orders for

Scope of Treatment (POST) form and wishes to incorporate the POST provisions to the HCPOA and Living Will.

Maryland - POLST

- 2007 Maryland Laws Ch. 70 (H.B. 214), amending MD Health Gen § 5-602, effective October 1, 2007, renamed the “Patient’s Plan of Care” to “Instructions on Current Life-Sustaining Treatment Options”.

Maryland - DNR

- 2007 Maryland Laws Ch. 251 (H.B. 682) amending MD Health Gen. § 5-608, effective October 1, 2007, clarifies options for a health care provider caring for a patient with a DNR. The statute now provides that prior to cardiac or respiratory arrest, a health care provider *may* withhold, provide or withdraw treatment in accordance with the DNR; and after cardiac or respiratory arrest, the provider *shall* withhold, provide or withdraw treatment in accordance with the DNR.

Missouri - DNR

- V.A.M.S. 190.600 – 621, codified as MO ST § 190.600 – 621, “Outside the Hospital Do-Not-Resuscitate Act” adopted provisions and penalties concerning outside the hospital DNRs.
 - Outside the hospital DNRs are only affective when the declarant is not admitted to a hospital, is to be maintained as the first page of the declarant’s medical charts and should be transferred with the patient if he or she moves between facilities.
 - Contains a pregnancy exception.
 - Compliance with the outside the hospital DNR at health care facilities is permissive, but transfer is mandatory if the physician or facility is unable or unwilling to comply with the order.
 - The statutes also include a variety of criminal penalties for knowing concealment, defacement, destruction, falsification or forgery of another person’s outside the hospital DNR.

Nevada – AD Registry

- Laws 2007, c. 473, § 6 and §7, amending Nev. Rev.Stat. §§ 449.920 and 449.925, effective July 1, 2007 appropriated \$200,000 to establish and maintain the Registry of Advance Directives for Health Care on the Secretary of State’s website and provides the following procedural requirements for accessing the Advanced Directives Registries:
 - A person who wishes to register an advance directive must submit to the Secretary of State: an application in the form prescribed by the Secretary of State, a copy of the advance directive; and the fee, if any, established by the Secretary of State.
 - Once properly submitted, the advanced directive will be posted to the registry, assigned a registration number and password and the registrant will receive a registration card.

- The Secretary of State shall establish procedures for updating an advance directive or removing an advanced directive that has been revoked.
- The Secretary of State shall not provide access to a registrant's advance directive unless: the person requesting access provides the registration number and password of the registrant; the Secretary of State determines that providing access to the advance directive is in the best interest of the registrant; access to the advance directive is required pursuant to the lawful order of a court of competent jurisdiction; or access to the advance directive is requested by the registrant or his personal representative.
- A registrant or the personal representative of a registrant may access the registrant's advance directive for any purpose. A provider of health care to the registrant may access the registrant's advance directive only in connection with the provision of health care to the registrant.
- The registration of an advance directive does not establish or create a presumption that the contents of the advance directive are accurate or the execution or issuance of the advance directive complies with the requirements necessary to make the advance directive valid.
- Failure to register an advance directive does not affect the validity of the advance directive.
- Failure to notify the Secretary of State of the revocation of a registrant's advance directive does not affect the validity of the revocation.

New Jersey – DS (Medical Research)

- 2007 NJ Sess. Law Serv. Ch. 316, codified as NJ St. § 26:14-1 – 5, Access to Medical Research Act, effective January 13, 2008, provides a list of procedures for persons with cognitive impairments, limited capacity, or serious physical or behavioral conditions and life-threatening illnesses to consent to participate in medical research. The statute defines how an approved research institution can obtain informed consent and provides the following priority list of persons authorized to consent on behalf of a person with diminished capacity: 1) the guardian; (2) the health care representative under an advance directive for health care; (3) the spouse or civil union partner; (4) the domestic partner, as defined in state law; (5) adult son or daughter; (6) a custodial parent; (7) adult brother or sister; (8) adult grandchild; (9) an available adult relative with the closest degree of kinship to the subject.

North Carolina – AD

S.L. 2007-502, § 6(a) and (b), repealing NCGS § 32A-25 and adding NCGS § 32A-25.1, effective October 1, 2007 and S.L. 2007-502, § 12, amending NCGS § 90-322, effective October 1, 2007 amend the HCPOA and living will statutory forms.

- The statutory living will form now define three situations for the declarant to choose to withhold treatment; all three situations may be selected.
 - The phrase “terminal and incurable” has been replaced with “incurable or irreversible condition that will result in death within a relatively short period of time.”

- “Persistent vegetative state” is now “unconscious and, to a high degree of certainty, will never regain consciousness.”
- A third triggering standard was added to the Living Will: “suffers from advanced dementia or any other condition resulting in the substantial loss of cognitive ability and that loss, to a high degree of medical certainty, is not reversible.” This standard previously was included HCPOA.
- The statutory living will now allows the declarant to choose whether the health care agent or the wishes expressed in the living will are controlling, and whether in the three above situations, the physician *may* or *shall* withhold or withdraw treatment.
- The statutory HCPOA now includes:
 - reimbursement of reasonable expenses incurred by the agent,
 - states that if a physician is not named to determine that the principal is unable to make or communicate health care decisions, or if the named physician is not available, then the attending physician may make such a determination,
 - a method for the principal to clearly indicate a wish to make anatomical gifts and authorizes the agent to make decisions about autopsy, anatomical gifts, and disposition of remains
 - a provision recognizing out-of-state directives.

North Carolina – DS

S.L. 2007-502, § 12, amending NCGS § 90-322, effective October 1, 2007, provides the following list, in order of priority, of persons who must concur in the decision to stop treatment *when there is no advanced directive*, replacing the previous generic list of spouse, parent, guardian, nearest relative or other authorized person:

- The general guardian or guardian of the person if clerk has revoked the health care agent’s authority
- Health care agent
- Attorney in fact with powers to make health care decisions
- Spouse
- Majority of the patient’s reasonably available parents and children who are at least 18 years of age
- Majority of patient’s reasonably available siblings who are at least 18 years of age
- An individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient’s wishes

North Carolina – POLST

- 2007 North Carolina Laws S.L. 2007-502 (H.B. 634), amending NCGS § 90-21.17, effective October 1, 2007, establishes “Medical Orders for Scope of Treatment: (MOST).

- The protocol which includes a form, completed by a patient with a terminal illness or other advanced conditions, clarifies the patient’s wishes regarding high probability medical decisions, including CPR, full versus limited medical interventions (including whether to transfer to a hospital), antibiotics, and artificial nutrition and hydration.
- Sample form, designed to travel with the patient across treatment settings, is available at <http://www.ncdhhs.gov/dhsr/EMS/pdf/ncmostform.pdf>

Oregon – AD and POLST Registry

- 2007 Oregon Laws Ch. 697 (S.B. 329), effective January 1, 2008 established the Oregon Health Fund program to, among other initiatives, create and maintain a registry of advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms and a process for assisting a person who chooses to execute an advance directive or a POLST form.

South Dakota – AD

- SL 2007, ch 193, § 2, amending SD ST § 34-12D-3 revised the statutory living will wording regarding scope of desired treatment to the following three options, *replacing* previous four options of “no life-sustaining treatment”, “treatment for restoration”, “treatment unless permanently unconscious” and a desire for “maximum treatment”:
 - If death is imminent or the declarant is permanently unconscious, the declarant chooses not to prolong life. If life sustaining treatment has been started, stop it, but keep the declarant comfortable and control pain.
 - Even if death is imminent or the declarant is permanently unconscious, the declarant chooses to prolong life.
 - The declarant chooses neither of the above instructions and can offer personalized instructions if the declarant is terminally ill, death is imminent or is permanently unconscious
- The same legislation revised the statutory living will wording regarding scope of desired treatment related to artificial nutrition and hydration to the following two options, *replacing* the previous indications of whether or not the declarant included artificial nutrition and hydration within the scope of desired treatment section described above:
 - If death is imminent or the declarant is permanently unconscious, suspend artificial nutrition and hydration. If it has been started, stop it.
 - Even if death is imminent or the declarant is permanently unconscious, continue artificial nutrition and hydration

South Dakota – DS

- 2007 South Dakota Laws Ch. 192 (SB 74), amending SD ST § 34-12C-1 and 3, adds “adult cousin” and “close friend” as a potential designated surrogate when there is no advanced directive or the health care agent or guardian is not available to provide consent. “Close friend” is defined as “any adult who has provided significant care and exhibited concern for the patient, and has maintained regular contact with the patient so as to be familiar with the patient's activities, health, and religious or moral beliefs.”

Utah – AD, DS, and POLST

- 2007 Utah Laws Ch. 31 (S.B. 75), codified as UT ST § 75-2a-1101 – 1123, effective January 1, 2008 is a major revision of the health decision laws, combining into one form what were three forms under the old Personal Choice and Living Will Act and requiring only one witness. Among its provisions, the statute:
 - Allows written or oral directives.
 - Assumes a presumption of capacity and provides a list of factors for physicians to consider making a determination regarding capacity to consent to medical procedures. Separately defines “capacity to appoint an agent” as meaning “the adult understands the consequences of appointing a particular person as agent” (§75-2a-103); additional factors to consider in assessing capacity are provided in §75-2a-105.
 - Provides the following expanded list of surrogates who may consent when the designated health care agent is not available to provide consent: (1) spouse (unless divorced, legally separated, or a court finds reason to preclude the spouse from acting); (2) child; (3) parent; (4) sibling; (5) grandparent; (6) grandchild; or (7) a person who
 - (a) has exhibited special care and concern for the patient;
 - (b) is familiar with the patient's personal values; and
 - (c) is reasonably available to act as a surrogate.
 - Allows individuals to choose whether their agent can disregard their documented preferences.
 - Gives the individual broad authority to disqualifying an appointed agent or health care surrogate, even if the individual lacks capacity to make a health care decision.
 - Provides compliance requirements for physicians providing medical care for a person with an advanced directive.
 - Recognizes a “physician order for withhold life-sustaining treatment,” applicable to emergency medical personnel and subject to rules to be established by the Department of Health.

Washington – DS

- 2007 Wash. Legis. Serv. Ch. 156 (S.S.B. 5336), effective July 22, 2007, provides that:
 - state registered domestic partners are authorized to provide informed consent for health care on behalf of a patient who is not competent to consent (WA ST § 7.70.065);
 - a health care provider or health care facility may disclose health care information about a patient to the patient’s state registered domestic partner without the patient's authorization to the extent a recipient needs to know the information (WA ST § 70.02.050);
 - an appointment of a principal's state registered domestic partner, as attorney in fact, including appointment as successor or co-attorney in fact, under a power of attorney shall be revoked upon entry of a decree of dissolution or legal separation or

declaration of invalidity of the state registered domestic partnership of the principal and the attorney in fact, unless the power of attorney or the decree provides otherwise (WA St §11.94.080).

States Adopting the Revised Uniform Anatomical Gifts Act (2006)

Several states adopted provisions of the Revised Uniform Anatomical Gifts Act (2006). Several provisions of the Revised Uniform Act are relevant to the use of HCPOAs and Living Wills.

The RUAGA:

1. Honors the choice of an individual to be or not to be a donor and strengthens the language barring others from overriding a donor's decision to make an anatomical gift (Section 8);
2. Facilitates donations by expanding the list of those who may make an anatomical gift for another individual during that individual's lifetime to include health-care agents and, under certain circumstances, parents or guardians (Section 4);
3. Empowers a minor eligible under other law to apply for a driver's license to be a donor (Section 4);
4. Facilitates donations from a deceased individual who made no lifetime choice by adding to the list of persons who can act as default decision-maker and make a gift of the deceased individual's body or parts the following persons: the person who was acting as the decedent's agent under a power of attorney for health care at the time of the decedent's death, the decedent's adult grandchildren, and an adult who exhibited special care and concern for the decedent (Section 9) and defines the meaning of "reasonably available" which is relevant to who can make an anatomical gift of a decedent's body or parts (Section 2(23));
5. Permits an anatomical gift by any member of a class where there is more than one person in the class so long as no objections by other class members are known and, if an objection is known, permits a majority of the members of the class who are reasonably available to make the gift without having to take account of a known objection by any class member who is not reasonably available (Section 9);
6. Creates numerous default rules for the interpretation of a document of gift that lacks specificity regarding either the persons to receive the gift or the purposes of the gift or both (Section 11);
7. Encourages and establishes standards for donor registries (Section 20);
8. Enables procurement organizations to gain access to documents of gifts in donor registries, medical records, and the records of a state motor vehicle department (Sections 14 and 20);
9. Resolves the tension between a health-care directive requesting the withholding or withdrawal of life support systems and anatomical gifts by permitting measures necessary to ensure the medical suitability of organs for intended transplantation or therapy to be administered (Sections 14 and 21);
10. Clarifies and expands the rules relating to cooperation and coordination between procurement organizations and coroners or medical examiners (Sections 22 and 23);
11. Recognizes anatomical gifts made under the laws of other jurisdictions (Section 19); and
12. Updates the [act] to allow for electronic records and signatures (Section 25).

States adopting the RUAGA in 2007:

- Arizona, AZ ST § 36-859
- Colorado, CO ST § 12-34-101 – 125
- Indiana, IN ST § 29-2-16.1-1 to 21
- 2007 Kansas Laws Ch. 127 (H.B. 2010)
- Minnesota, MN ST § 525A.01 - .25
- Montana , MT ST 72-17-101 – 214

- 2007 New Mexico Laws Ch. 323 (H.B. 1276)
- 2007 Oregon Laws Ch. 681 (H.B. 3092)
- Rhode Island, RI ST § 23-18.6.1-1 – 25
- 2007 South Dakota Laws Ch. 197 (SB 197)
- Tennessee, TN ST § 68-30-101 – 120
- Virginia, VA ST § 32.1-291.21 – 25

Other Notable Changes

Connecticut – Persons under Conservatorships, i.e. guardian of the person and/or property

- 2007 Conn. Legis. Serv. P.A. 07-116 (S.S.B. 1439), amending Conn. Gen. Stat. § 45a-656, effective October 1, 2007 is a major reform to the guardianship provisions.

Subpart (b) of the statute was added to specify the duties of the conservator as relates to the health care of the conserved person. Such duties include carrying out the following in a manner that is the least restrictive means of intervention: ascertaining the conserved person’s views and making decisions in conformance with the conserved person’s reasonable and informed expressed preferences, making all reasonable efforts to ascertain the health care instructions and other wishes of the conserved person, and making decisions in conformance with the conserved person’s expressed health care preferences, including a health care power of attorney or living will. A health care decision of a health care representative under a power of attorney takes precedence over that of a conservator, except in limited circumstances or where the court orders otherwise. Finally, the conservator must afford the conserved person the opportunity to participate meaningfully in decision-making in accordance with the conserved person’s abilities.

Connecticut – Health care authority not included in statutory short form DPA.

- 2007 Conn. Legis. Serv. P.A. 07-252, amending Conn. Gen. Stat. § 1-55, effective October 1, 2007 clarifies that a statutory short form power of attorney permits the principal to authorize the agent to act with respect to any matters and affairs not enumerated in Conn. Gen. Stat. §§ 1-44 to 1-54 (property matters), but not for health care decisions, for which the principal must use a Living Will or a statutory Combined Form Health Care Document.

New York – Advance Directive Public Education

- 2007 Sess. Law News of N.Y. Ch. 471, adding N.Y. Public Health Law § 207 – Health Care and Wellness Education – Outreach Program, effective August 1, 2007 creates a program within the Department of Public Health to, among other initiatives, educate the public about the need and importance for consumers and patients to have an advance directive, particularly a health care proxy, and the need and importance for health care providers to play a leadership role in discussing end-of-life care preferences and values with patients, and to provide patients with health care proxy forms.

New York – DS

- 2007 Sess. Law News of N.Y. Ch. 105 (A. 3583-B) (McKINNEY'S), approved July 3, 2007, and effective December 30, 2007, amends N.Y. Surr. Ct. Pro. Act § 1750-b, authorizing family default surrogates to make health care decisions for persons with mentally retardation or developmental disabilities under regulations to be established by the Commissioner of Mental Retardation and Developmental Disability.

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