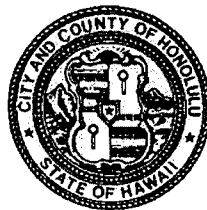


HONOLULU EMERGENCY SERVICES DEPARTMENT
CITY AND COUNTY OF HONOLULU

3375 KOAPAKA STREET, SUITE H-450 • HONOLULU, HAWAII 96819-1869
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MUFI HANNEMANN
MAYOR

ELIZABETH A. CHAR, M.D.
DIRECTOR

April 3, 2009

The Honorable Brian T. Taniguchi, Chair
and Members
The Honorable Dwight Y. Takamine,
and Members
Committee on Judiciary and Government Operations
The Senate
Twenty-Fifth Legislature
Hawaii State Capitol
415 South Beretania Street
Honolulu, HI 96813

Re: HB1379, HD2, SD1, Relating to Physician Orders for Life Sustaining Treatment

Dear Chair Taniguchi, Vice Chair Takamine and Committee Members:

HB 1379, HD2, SD1 seeks to clarify and amend HB 3126, which was passed in 2006. The Honolulu Emergency Services Department, City and County of Honolulu, is in favor of this bill as it will allow people to make their wishes known and die a natural death with measures to ensure comfort care if they so choose.

Currently, Emergency Medical Services (EMS) personnel are mandated to attempt resuscitation unless the person has a state issued comfort care only; do not attempt resuscitation (CCO-DNAR) bracelet or necklace. The difficulty with this is that in order for the person to obtain one of these bracelets, the person must have a terminal condition and apply through the State Department of Health, via the State EMS office, with a form filled out by their physician. POLST will be a form that can be obtained in a multitude of locations or even via the internet and the form can be signed after a discussion with one's physician.

Many members in our community mistakenly think that having a living will is enough to prevent an unwanted attempt at resuscitation by emergency responders. POSLT will help to ensure that if the person prefers to die a natural death, comfort care can be given by EMS personnel and that person's wishes can be respected.

Thank you for the opportunity to testify on this bill.

Sincerely,

A handwritten signature in black ink, appearing to read "Elizabeth A. Char".

Elizabeth A. Char, M.D., Director
Honolulu Emergency Services Department

April 2, 2009

TO: SENATE COMMITTEE ON JUDICIARY AND GOVERNMENT OPERATIONS
Senator Brian T. Taniguchi, Chair
Senator Dwight Y. Takamine, Vice Chair and
Members

From: Becki Kulm
68-3824 Manu Aihue Pl.
Waikoloa, HI 96738

Testimony in Support of HB 1379, HD 2, SD 1: Relating to Physicians Orders for Life Sustaining Treatment

This bill seeks to allow the use of a standardized physician order form specifically relating to a person's wishes for life sustaining treatment at the end-of-life. This order would be effective in all pre-hospital and health care settings.

I am a Masters of Social Work Student; Distance Education program at University of Hawaii at Mānoa. I am also a practicing social worker in a medical setting in West Hawaii. It is my duty and obligation as a social worker to support the rights and inherent dignity of those I seek to serve. This is true, regardless of where I may practice – whether in a school, an office, or in a health care setting. The most basic way in which to support and maintain a person's dignity is to allow them to make choices about those things of importance to them. This includes choices regarding how they want to die. This has been an uncomfortable topic for many, individuals, family members, and the medical community alike. There have been incremental steps taken since the late 1990s in effort to codify a person's wishes regarding the care they wish to receive at the end of their lives.

In 1999, HRS Chapter 372E, the Uniform Health-Care Decisions Act (Modified) created a specific format for this discussion, namely the Advance Health Care Directive. In 2006, the legislature passed §321-23.6, allowing for CCO/DNR bracelets.

While admirable, neither of these pieces of legislation comprehensively address all areas of end-of-life care. The CCO/DNR bracelet is only available to a patient that is terminally ill and expected to die within a short period. It is silent on care during the period before the person's heart or lungs stop functioning, but activates during that split second in which the person dies.

An advance directive clarifies various choices the person has made regarding care prior to death, as well as the point of implementing life-sustaining treatment. It includes provisions for appointing another to make end-of-life decisions if the person is unable, the use of life support machines, pain medication, tube feedings, the appointment of a single physician to oversee the person's care, and body/organ donation. The most concerning issue with AHCD's is that they do not mandate that the wishes expressed be carried out. While an AHCD is easy for anyone to draft, it is not an official physician order and not legally binding on physician or first responders. For instance, when a person calls for an ambulance in an emergency, or brings a patient to the emergency department, AHCD's are out of force. The default action for first responders and Emergency Department personnel is to provide full resuscitation efforts, to cease them only if it becomes clear that they are futile, or the person is "stable" enough to transfer to an Intensive Care Unit. Stable in this context means only that the person's life signs are maintained. Rather than meaning that the person is "better", it usually means that the person is no longer in immediate danger of dying – because of life sustaining machines and medications. Once the patient leaves the ED, if there is a conflict between the wishes of a Power of Attorney for Health Care, and the person's AHCD, the course of treatment is murky. Although the AHCD is in effect "the voice" of the person, it is a silent voice from the past. At times, when the voices of family are louder and in the present, an ethics committee must clarify the best interest of a patient who remains on life support, most commonly for those with artificial tube feedings.

The Physicians Orders for Life Sustaining Treatment (POLST) form replaces neither a CCO/DNR bracelet, nor an AHCD, but compliments and completes both. It does provide a written distillation of a patient's wishes regarding end-of-life care, regardless of whether they are in the community, in a hospital setting, or in a long-term facility, with the force of a physician order. It is a complimentary part of the continuum of end-of-life care that allows for treatment in some instances, while directing that care not be initiated in others. It is a written order from the physician, drafted only after a comprehensive discussion with the patient or their designee, initiated only when the person is elderly or medically frail, has a terminal condition, or a chronic disease expected to end in death. Research done in states where POLST is recognized, such as Oregon, Washington, New York, and California, indicates that in 85% of cases, if there is a POLST available to first responders, whether EMS or ED staff, it is honored. This is clearly a more effective mechanism to impart end-of-life decisions, and to ensure that patients receive only the treatment they choose, at the end of their lives.

Your actions in passing HB 1379, HB2, SB1, will ensure that Hawaii citizens be supported in the difficult decisions they have made regarding health care; which will allow them to die in a dignified manner in the way they have chosen.

Thank you for allowing me to testify on this important bill.



SENATE COMMITTEE ON JUDICIARY AND GOVERNMENT OPERATIONS
Senator Brian Taniguchi, Chair

Conference Room 016
April 6, 2009 at 10:00 a.m.

Testimony in support of HB 1379 HD 2 SD 1.

The Healthcare Association of Hawaii advocates for its member organizations that span the entire spectrum of health care, including acute care hospitals, two-thirds of the long term care beds in Hawaii, as well as home care and hospice providers. Thank you for this opportunity to testify in support of HB 1379 HD 2 SD 1, which creates a Physician Orders for Life Sustaining Treatment (POLST) that describes an individual's wishes regarding end-of-life care.

In recent years various types of advance health care directives have been developed so that individuals can make known to health care providers the kind of medical care they desire. For example, many people now have a living will that describes what kind of medical care they want at the end of their lives.

In 2006 a bill was sponsored by advocates who intended to establish a POLST system. The bill was enacted, but a subsequent legal review limited its authority to the creation of a "comfort care only – do not resuscitate" (CCO-DNR) document.

A CCO-DNR document is simply a "yes or no" answer to the question of whether resuscitation should be initiated by a health care provider if a person is found to be without a pulse or breathing. A POLST document is much more detailed, distilling orders of a person's advance directives and representing a discussion between the patient and the patient's physician. As such, the POLST document typically goes far beyond the question of whether or not to resuscitate if there is no pulse or breath and more comprehensively details the individual's wishes.

For the foregoing reasons, the Healthcare Association supports HB 1379 HD 2 SD 1.

To: **Senator Brian T Taniguchi, Chair**
Senator Dwight Y. Takamine, Vice-Chair
Senate Committee on Judiciary and Government
Operations

From: Daniel Fischberg, MD, PhD

Subject: **Support of HB 1379, Relating to Physicians Orders for Life Sustaining Treatments**

My name is Daniel Fischberg, and I am a physician specializing in pain management and palliative care. In this capacity I care for hundreds of terminally ill patients each year, mostly in the acute hospital setting. **I am testifying in strong support of HB 1379, Relating to Physicians Orders for Life Sustaining Treatments**, which would replace an ineffective “comfort care only” bracelet system with a standard document that clearly states the wishes of the person cared for by emergency medical personnel, first responders and health care providers throughout the state.

I respect that the committee members likely already recognize the shortcomings of the current Comfort Care Only/Do Not Resuscitate bracelet: after all, legislation to improve this system with a rapid communication document was passed and signed into law two years ago. The current measure is designed to correct inconsistencies found in the prior legislation and to bring our practice into compliance with the standard approved by the National POLST Workgroup.

While an advance directive can be a useful tool to summarize a person’s values, beliefs and preferences for possible changes in future health, a POLST document provides real-time instructions for first-responders, emergency room personnel and other health care providers. Unlike a living will these instructions are clear and actionable not requiring an evaluation of whether certain terms have been met. From daily experience, I can assure you that interpreting a living will is not always a straight-forward affair, often requiring the interpretation of an Ethics Committee. First line responders require absolute clarity so that they can immediately act to resuscitate or initiate comfort measures. National data show that POLST documents provide this kind of clarity.

Another major advantage of POLST over the current bracelet system is that the latter only allows for a binary decision: resuscitate or don’t resuscitate. POLST documents allow for finer shades of gray. Patients can designate comfort measures only, full aggressive measures, or choose which interventions they would accept and which they would refuse. POLST documents even allow patients to request a trial of certain treatments, such as tube feedings, to see if meaningful improvements in health might occur and instructions to stop these treatments if and when these improvements do not occur. I assure you that these choices are very clinically meaningful and clarifying

these choices respects the patient's autonomy to a much greater extent than current practice permits.

I urge the committee to pass HB 1379. The current bracelet system has been proven to be ineffective in honoring people's wishes, and it needs to be replaced. A uniform document written as physician's orders will clearly articulate a person's choices and allow healthcare providers across the medical spectrum—from EMS to ERs to ICUs to nursing homes—to quickly and unambiguously honor these choices and improve the delivery of healthcare in Hawai'i.

Thank you for this opportunity to testify and for your serious and thoughtful consideration of this bill and submitted testimony. Please do not hesitate to contact me for additional information or questions.

Sincerely,

Daniel Fischberg, MD, PhD

TO : SENATE COMMITTEE ON JUDICIARY AND GOVERNMENT RELATIONS
Senator Brian T. Taniguchi, Chair
Senator Dwight Y. Takamine, Vice chair

FROM: Eldon L. Wegner, Ph.D.
Policy Advisory Board for Elder Affairs (PABEA)

SUBJECT: **HB1379 HD2 SD1, Relating to Physician Orders for life Sustaining Treatment**

HEARING: 10:00 am on Monday, April 6, 2009
Conference Room 016, Hawaii State Capitol

PURPOSE: Creates a process for a patient to direct end-of-life treatment in a standardized physician orders for life sustaining form.

POSITION: **PABEA supports HB1379 HD2 SD1.**

RATIONALE:

The Policy Board for Elder Affairs has a statutory obligation to advocate on behalf of the senior citizens of Hawaii. While we advise the Executive Office on Aging, we do not speak on behalf of the Executive Office of Aging.

Advances in medical technology have resulted in procedures which can prolong life but sometimes carry severe compromises in quality of life. We believe that it is important that patients be given control over end-of-life treatment decisions. The current provision of Health Care Directives is one measure which enables patients to express their desires. However, this bill proposes supplementing Health Care Directives with physician orders which would give patients even more control over their actual treatment and would also pertain to emergency personnel.

Thank you for allowing me to testify.

To: COMMITTEE ON JUDICIARY AND GOVERNMENT OPERATIONS
Senator Brian T. Taniguchi, Chair
Senator Dwight Y. Takamine, Vice Chair and
Members

From: Kenneth Zeri, RN, MS
President Kokua Mau
President, Hospice Hawaii

**Testimony in support of HB 1379 HD2 SD1 relating to
Physicians Orders for Life Sustaining Treatment**

Thank you for considering this bill in decision making today. This is the companion bill to SB 516, which has passed successfully out of this committee.

The major stakeholders of this bill and the companion bill have worked together to craft this policy in a manner that allows for the voluntary adoption of the Physician's Order for Life Sustaining Treatment. The actual document has been in development by health care leaders committed to this issue for the past few years, as well as in consultation with the National POLST Work Group, of which Hawaii has become a member.

We urge the committee to pass this piece of legislation.

I may be reached at 924-9255 for additional questions.

(signed)
Kenneth Zeri

TO: Senate Judiciary and Government Operations Committee
Senator Brian Taniguchi, Chair

From: Jackie Mishler, RN, BSN, PCCN
Telephone: (808) 878-8987

Re: HB 1379 HD1 SD 1, Physicians Orders for Life Sustaining Treatment (POLST)
Decision-Making on Monday April 6, 2009 10:00 AM

Honorable Senator Taniguchi,

Thank you for this opportunity to **express serious reservations** about a bill I would otherwise not oppose. The objections raised in these comments are in the interest of improving this legislation not in arguing against the need for it. Unfortunately, HB1379 can have serious, unintended consequences as written.

Please consider:

- Any order not to provide full emergency care should be unambiguous and clearly and deliberately made.
- In the circumstances dealt with by the bill a **non-designated surrogate** should **not** have the power to sign the form in question authorizing DNR (do not resuscitate) orders, withholding antibiotics, withholding food and fluids, etc.
- The legislation is being approved before the key Orders form is issued by the DOH. This creates the potential problem that the Orders form may not fully reflect the intention of the legislation but may be implemented without further comment.
- There is no legislative oversight in this bill. While this may reflect the fact that the bill's proponents are known and trusted, this legislation will be used in circumstances we cannot foresee. In a life-and-death matter some oversight and review seems appropriate.
- The effect of legislation should include that the vulnerable not receive less protection than they do now.

A **non-designated surrogate** is a surrogate decision maker that was never chosen by the patient. This legislation as written creates a new situation where full decision-making authority can be granted to someone unknown to the patient. While this might work out fine in many cases, it presents clear potential for abuse.

Allowing non-designated surrogates authority to act on behalf of incapacitated patients is a problem that casts a shadow over this entire legislation. It results in the vulnerable being afforded less protection in this bill than under current law.

Why is that the case? It is because this bill provides for pre-hospital DNR orders. A hospital has numerous safeguards in place-- by virtue of its internal procedures, State and Federal oversight, and the fact that any DNR order has to be authorized by a physician recognized and awarded privileges by the hospital. This bill unwittingly casts aside all of these internal and external safeguards provided by the healthcare setting.

This legislation allows a "surrogate," who could be a next door neighbor, to go to the DOH, fill out a form, and sign someone up for a DNR order with

- 1) NO proof the patient is incapable of making medical decisions
- 2) NO proof of surrogacy except a statement they signed themselves
- 3) NO witness to the signature or witness who states he knows who the person is; and
- 4) NO protective language that would ensure surrogate or witnesses do not have an interest in the patient's estate.

This is an unprecedented and uncontrolled situation. One can argue that most people wouldn't do anything untoward. But hospitals have accrued safeguards over the years precisely because unexpected and untoward things happen.

Important safeguards provided in the Uniform Health Care Decisions Act Modified (UHCDAM) are missing. Hawaii's mechanism for selecting surrogates is a piece of paper that is filled out by the surrogate stating how they came to be selected by the consensus of interested parties or how they came to select themselves to be the surrogate. When this happens in a hospital or care home there is oversight by the physician, social worker, nurses and other caregivers. Out of a hospital setting, there is none of this oversight. With this proposal to expand surrogate authority to pre-hospital DNR orders, we are in uncharted waters and great care needs to be taken.

Proponents may feel they can adequately address these concerns but how and where? Without the safeguards integral to an in-hospital setting, legislative oversight is needed as part of the bill.

While it may not be the intent of this legislation, this bill allows a person to walk into the DOH with a piece of paper, filled out at home, containing purported witnesses' signatures, and declaring themselves to be the surrogate for a patient identified only by the name on the paper. This situation may not be likely; however, it is not only possible, it would be completely legal under the provisions of this bill.

The bill can be corrected simply.

On page 4, line 4--- Change the word 'or' to 'and'

Change line 5 to read (B) Has specifically designated the surrogate decision-maker that will be executing the form.

If it isn't possible to exempt the non-designated surrogate from signing this document **at the very least** the legislation should propose a more formal surrogate designation process before we lose all patient protection.

Legislation granting power of life and death must be looked at from a different perspective than what is immediately in front of us. What are the unintended consequences? That is the question the committee should weigh. What happens five years from now? The legislation will be an unexamined part of the law. There will be no accountability for the actions of any surrogate, well-intentioned or not. At the very least, we want to avoid an interested party who stands to inherit the estate telling EMS personnel not to resuscitate a patient.

Thank you for your consideration.

Should you want more detailed suggestions for changes in wording in the legislation and the reasons behind the recommendations for these changes, please refer to the following two pages.

There are other points at which the legislation can be improved. My testimony underscored the main objections. In making these further suggestions the primary interest is to avoid having the vulnerable receive less protection than they have now.

- Eliminate the words “or a health care provider” From line 21 and line 4.

Page 4, line 21, through page 5, line 5 basically says that someone other than the physician (a health care provider ---defined as being an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of the individual’s business or profession)--- can explain and prepare the form for the patient. Is there any medical physician order anywhere that is not written, signed, explained to the patient by the physician? I don’t think so. Physicians write orders based upon examination and consultation with the patient. It would be extremely important for them to do this with regards to such sensitive issues as DNR (Do Not Resuscitate) orders, withholding of antibiotics, withholding of food and fluids, and similar life-critical decisions. For instance, why would we have a nurse’s aide explain the form to a patient for signature? Does the aide know the medical treatment implications for that specific patient when she explains? Would a nurse or social worker?

- Eliminate the words “medically ineffective health care.” These are unnecessary, unclear, and contentious.

Page 5, lines 10-13 state that compliance shall not be required if the orders on the form request medically ineffective health care or health care that is contrary to generally accepted health care standards. Using the test of “generally accepted health care standards” makes sense. It is understood in the medical community. What is “medically ineffective health care” and who will judge it? Some treatments are medical decisions and don’t involve a patient decision and would be covered under generally accepted health care standards. Introducing an ambiguous and potentially contested phrase like “medically ineffective health care” may sound useful, but it creates a situation where a patient’s choice to have a certain treatment can be trumped by someone else’s opinion – without any review - that the treatment would be ineffective. It is an empty choice if it can be overruled without consent or review.

- Change the wording to say that anyone who has authority to sign a form may revoke the form at any time and in any manner that communicates the intent to revoke.

Page 5, Line 14. Why can a patient or a surrogate (if the patient doesn’t have capacity) fill out or change a form but only a patient with capacity can revoke one? If we assume surrogates are operating in the patient’s best interest why couldn’t they revoke the form if the patient’s circumstances change? If we agree a patient can designate someone to make decisions for her or him, why are we now limiting that authority? This is inconsistent.

The three changes recommended above would strengthen the bill. These can be combined with the recommendation to restrict the role of the non-designated surrogate. These changes together would largely correct the problems in the bill. To summarize the recommendation regarding the problems created by the authorization of non-designated surrogates, please consider the following three distinct options:

- Deleting surrogates from the legislation altogether; or
- Deleting non-designated surrogates from the legislation; or
- Defining the formal, legal process for obtaining surrogacy explicitly and requiring the document in question be notarized or for at least one of the witnesses not to have an interest in the estate.

The objections in this testimony are not an effort to derail the substantive intention of the bill. The EMS providers have a quandary and there is no objection to a document being used instead of or in addition to a bracelet for those patients who choose comfort care rather than resuscitation. There is no objection to this document following a patient to a health care facility. The problems this testimony seeks to highlight are those that occur outside the health care setting which is the environment this bill seeks to address. This legislation proposes to take a law grounded in the structured environment of the healthcare institution and transport it to the pre-hospital setting where multiple levels of oversight and safeguards, which we may take for granted, simply do not exist.