In 2019, twelve states adopted substantive amendments to their health decisions laws, creating, modifying, and amending rights and procedures affecting health care decision-making. The statutes affect advance directives, Physicians’ Orders for Life-Sustaining Treatment (POLST), default surrogates, physician aid-in-dying legislation, and state electronic registries. These summaries are intended to offer selected highlights and do not fully describe the laws in their entirety.

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

- **AD** = Advance Directives
- **DS** = Default Surrogate
- **POLST** = Physician Orders for Life Sustaining Treatment, or its variants (e.g. MOLST, POST, MOST, and others)
- **Registry** = State electronic registry for Advance Directives and/or POLST
- **PAD** = Physician aid-in-dying legislation

---

**Arizona**

**(Registry)**


Under prior Arizona law, the secretary of state was required to establish and maintain a health care directives registry. Pursuant to amended section 36–3291, the department of health services is now required to designate a qualifying health information exchange organization to operate a health care directives registry. A “qualifying health information exchange organization” is a nonprofit health information organization that is designated by the department of health services to operate the health care directive registry.

Prior to amendment, section 36-3292 limited the documents a person could submit to the registry to a health care power of attorney, a living will, and a mental health care power of attorney. Under the amended section, a person may submit health care directives, including prehospital medical care directives and any amendments to or revocations of these documents. Additionally, instead of requiring the person who submits a document to provide a return address, the amended...
section mandates the qualifying health information exchange organization to establish a process for authenticating the identity of the person who submits a document.

In regards to registration of materials, amended section 36–3294 shifts responsibility from the secretary of state to the qualifying health information exchange organization to ensure the security of the registry documents and to remove and distinguish documents that have been revoked or replaced by more recent documents. Additionally, the qualifying health information exchange organization is required to provide a person who submits a document with a viewable record of the information entered into the registry, allow the person to submit corrected information, and establish a process to allow persons who submit documents to review, retrieve, revoke, and replace documents. The qualified health information exchange organization will activate the entry of the submitted document into the health care directives registry only after receiving confirmation that the information submitted is correct.

Under prior Arizona law, the registry was accessible only by entering a file number and password on the internet website. However, under amended section 36–3295, the registry information is considered confidential and not to be disclosed except as allowed by state or federal law. A person who submits documents to the registry may access the document in the registry in a manner prescribed by the qualifying health information exchange organization. Additionally, if the person who submits a document so requests, the qualifying health information exchange organization may transmit the information received regarding the document to the registry system of another jurisdiction.

Finally, the amendment repeals Section 36-3297, which established the health care directives registry fund.

**Colorado**

**(AD)**


The amendment adds part 2 to article 18.7 of title 15. Part 2 (§§ 15–18.7–201-07) provides guidelines for directives concerning “behavioral health orders for scope of treatment” for adults. While the terminology refers to the document as “orders,” it is a psychiatric advance directive and not a medical order and is defined as a “written instruction, created pursuant to section 15–18.7–202, concerning behavioral health treatment, medication, and alternative treatment decisions, preferences, and history to be made on behalf of the adult who provided the instruction.” It must be signed by the individual and two “disinterested witnesses” as defined. The directive can also include the appointment of an agent. § 15–18.7–202 describes the information a behavioral health orders form must include. § 15–18.7–203 provides that an adult may amend or revoke all or part of his or her behavioral health orders form at any time and describes how the adult may do so. The form is effective for only two years following the date that the adult signed the form. § 15–18.7–204 describes how to address a conflict between a
behavioral health orders form and an adult’s advance medical directive. While the form can be revoked at any time, the statute provides that if there is a conflict between the adult’s behavioral health orders form and the adult’s request for behavioral health treatment, medication, or alternative treatment decision or preference, the form controls for the treatment decision or preference at issue. This is sometime referred to as a Ulysses clause, because it locks in the expressed instructions. § 15–18.7–205 describes the duty to comply with behavioral health orders for scope of treatment and immunity for complying with such orders. § 15–18.7–206 mandates that a health care facility or provider shall not require an adult to have executed a behavioral health orders form as a condition of receiving treatment. § 15–18.7–207 mandates that a health insurer may not refuse to insure or continue to insure an individual solely because the individual executed a behavioral health orders form or has not yet execute a behavioral health orders form.

The amendment also expands the scope of § 15–18.7–109: an insurer may not refuse to insure, refuse to continue to insure, or limit the amount, extent, or kind of coverage available for life insurance, health insurance, or within an annuity to an individual, or charge an individual a different rate for the same coverage solely because such individual has or has not executed a medical orders for scope of treatment form.

(Registry)


The amendment adds article 54 to title 25, which creates a statewide registry for advanced directives. § 25–54–102 enumerates the duties and powers the department of public health and environment has with respect to the statewide electronic system. For example, the department has the ability to contract with health information organization networks for the creation, administration, and maintenance of the registry; establish criteria for qualified individuals to access the system; create procedures by which individuals may add or remove advance medical directives to or from the registry; and create procedures and safeguards to ensure the confidentiality and security of the registry.

If an individual or authorized surrogate decision-maker so requests, a qualified provider that has an agreement with the health information organization network may upload the individual’s advance health care directive to the registry after consulting with the individual. A “qualified provider” is defined as a person or entity that may use or disclose protected health information for treatment purposes.

Prior to uploading the advance health care directive, the individual or authorized surrogate decision-maker shall sign an electronic affidavit in the presence of the qualified provider affirming the advance health care directive is appropriately executed, current, and accurate. Signing the electronic affidavit revokes any prior advance health care directives of the same type previously uploaded to the system. The individual or authorized surrogate decision-maker is responsible for ensuring that the advance health care directive uploaded to the system is appropriately executed, current, and accurate.
Connecticut

(AD)


The amendment adds subdivisions (87) to (97), inclusive, to subsection (a) of section 10-29a of the general statutes. Subdivision (96) states that the Governor shall proclaim April sixteenth of each year to be Advance Directive Awareness Day to raise public awareness of the importance of planning ahead for health care decisions and to encourage the use of advance directives.

Illinois

(AD, POLST, Registry)


After amendment, the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois, Section 2310–600(b-5) allows an electronic version of the Uniform POLST form to be created, signed, or revoked electronically. Under Section 2310–600(b–10), the Department of Public Health is mandated to study the feasibility of creating a statewide registry of advance directives and POLST forms.

The Illinois Living Will Act and the Mental Health Treatment Preference Declaration Act are both amended by expanding the definition of “declaration” to include a witnessed document in electronic format. In both acts, a written declaration in electronic format functions in the same way as a declaration in hard copy format in that the electronic declaration may be revoked in whole or in part at any time by deleting in a manner indicating the intention to revoke. A declaration may also be signed electronically. Overall, the amendments to these acts clarify that the documents, writing, forms, and copies referenced in the acts may be in hard copy or electronic format.

Similarly, the Health Care Surrogate Act is amended by adding Section 70, which provides that the affidavit, medical record, documents, and forms referenced in the Act may be in hard copy or electronic format, and further, such documents may be populated with electronic data.

The amendments to Article 45 of the Illinois Power of Attorney Act also take into account electronic transactions. The definition of “health care agency” notes that a patient’s power of attorney may be in either hard copy or electronic format. Moreover, the documents, writings, forms, and copies referred to in the Article may be in electronic format, and the revocation and signature requirements set forth in the Article may be satisfied electronically. Finally, Section 4–9, which is designated to penalties, provides that any person shall be civilly liable who, without
the principal’s consent, enters information in an electronic system under the persona of the principal.

**Maine**

**(PAD)**


The amendment enacts the Maine Death with Dignity Act, which allows a competent, adult resident of Maine to make an oral and written request to obtain a prescription for medication that the adult may self-administer to end his or her life in a humane and dignified manner. The adult’s attending physician must ensure that the adult is making an “informed decision,” meaning the decision is made after being fully informed by the attending physician of the patient’s medical diagnosis and prognosis, the potential risks associated with taking the medication to be prescribed, the probable result of taking the medication, and the feasible alternatives to taking the medication. The attending physician’s diagnosis and prognosis, as well as whether the patient is making an informed decision, shall be confirmed by a consulting physician. An adult does not qualify under the Act solely because of age or disability.

To receive a prescription for medication, a qualified patient must first make an oral request to his or her attending physician. At least fifteen days later, the qualified patient must make and sign a written request and reiterate the oral request to his or her attending physician. At the time the patient makes the second oral request, the attending physician must offer the patient an opportunity to rescind the request. A prescription for medication may not be written unless the attending physician has offered the patient an opportunity to rescind the request. A patient may rescind his or her request at any time and in any manner regardless of the patient’s mental state.

At least 48 hours must elapse between the date the patient signs the written request and the writing of a prescription. Subsection 24 provides the form of the written request. The form must be signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, is acting voluntarily, and is not being coerced to sign the request. At least one witness must be a person who is not a relative of the patient by blood, marriage, or adoption; a person who at the time the request is signed would be entitled to any portion of the qualified patient’s estate upon death, under any will, or by operation of any law; or an owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

Any provision in a contract, will, or other agreement, whether written or oral, that affects whether a person may make or rescind a request for medication to end the person’s life in a humane and dignified manner, is not valid.

It is important to note that a physician’s participation in the Act is voluntary; if a physician is unable or unwilling to carry out the qualified patient’s request, the physician shall transfer any relevant medical records for the patient to a new health care provider upon request by the patient.
Additionally, the Act does not authorize a physician or any other person to end a patient’s life by lethal injection, mercy killing, or active euthanasia. The actions taken in accordance with the Act do not constitute suicide, assisted suicide, mercy killing, or homicide under the law. State reports must refer to acts committed under the Act as “obtaining and self-administering life-ending medication.”

**Nevada**

(AD)


This bill designates April 16 of each year as “Healthcare Decisions Day in the State of Nevada.” The Governor’s annual proclamation of this day must call upon the news media, state and local officers, hospitals, nursing homes, assisted living facilities, continuing care retirement communities, hospice facilities, private nonprofit groups and foundations, and other public and private entities to bring attention to the importance of discussing the manner in which they would like to have their health care wishes carried out and of using an advance directive to express those wishes.

(AD)

**2019 Nevada Laws Ch. 79 (S.B. 223).** Approved May 16, 2019. Effective October 1, 2019. An Act relating to persons in need of care or assistance; revising provisions relating to the power of an agent, acting pursuant to a power of attorney, to consent to the placement of a principal in certain facilities.

Chapter 162A.450 now includes the provision that an agent under a power of attorney may not consent to placement of the principal in an assisted living facility, a facility for skilled nursing, or a secured residential long-term care facility unless the power of attorney expressly grants the agent that authority. The power of attorney form in 162A.620 now includes options where the power of attorney may designate that he or she wishes to grant the agent this authority.

(AD)

**2019 Nevada Laws Ch. 296 (S.B. 121).** Approved June 1, 2019. Effective October 1, 2019. An Act relating to adopting a power of attorney for health care decisions for persons with any form of dementia and revising provisions relating to the authority of a principal under a power of attorney.

The amendment adds a section to Chapter 162A providing a form for a power of attorney for health care decisions for an adult with any form of dementia. It also includes an addendum form to indicate specific wishes regarding treatment. The power of attorney form emphasizes the agent’s obligation to provide decision support to the principle to the extent possible to enable the
principal to make decisions. Additionally, both Chapter 162.460 and Chapter 162A.620 now contain specific provisions clarifying that a principal has the authority to act on his or her own behalf even after executing a power of attorney, and any decision or instruction given by the principal supersedes any inconsistent decision or instruction given by an agent pursuant to a power of attorney.

(AD)

2019 Nevada Laws Ch. 352 (A.B. 299). Approved June 3, 2019. Effective October 1, 2019. An Act relating to powers of attorney; defining the term “nondurable” for certain purposes relating to powers of attorney; revising provisions relating to powers of attorney for certain financial matters and health care; and revising provisions relating to the Nevada Lockbox.

The bill adds to Chapter 162A the definition of “nondurable,” which is a power of attorney that terminates upon the incapacity of a principal. The bill also revises the term “incapacity” to provide that incapacity must be determined by a court of competent jurisdiction or, if an instrument executed pursuant to Chapter 162A specifically provides a different method for determining incapacity, by the method set forth in that instrument.

The bill also distinguishes between a court appointed guardian’s effect on a nondurable power of attorney versus a durable power of attorney: if, after a principal properly executes a nondurable power of attorney, a court appoints a guardian of the principal’s estate or person, the nondurable power of attorney is terminated. On the other hand, if, after a principal properly executes a durable power of attorney, a court appoints a guardian of the principal’s estate or person, the durable power of attorney is suspended and the agent’s authority is not exercisable unless the court orders the termination of the guardianship or the court issues an order allowing the agent to retain specific powers conferred by the power of attorney.

The bill revises the form for a durable power of attorney for health care decisions in two ways. First, the form now notifies the principal that he or she may request a copy of the document be stored in the Nevada Lockbox to allow access by authorized providers of health care. Second, the bill adds to the statement of desires section an option regarding the principal’s desire that his or her attending physician administer medication to alleviate suffering if the principal has an incurable or terminal condition.

The bill also adds to 449A.433 (a section in the state’s separate living will statute) the provision that a durable power of attorney for health care, executed pursuant to existing law, constitutes a valid declaration governing the withholding or withdrawal of life-sustaining treatment.

New Jersey

(PAD)

The bill amends the state’s Medical Aid In Dying for the Terminally Ill Act by adding a provision to 2A:62A–16 clarifying that licensed psychologists, psychiatrists, medical practitioners, nurses, clinical social workers, and marriage and family therapists do not incur a duty to warn and protect when a qualified terminally ill patient requests medication that the patient may choose to self-administer in accordance with New Jersey law. Additionally, the bill adds a provision to 2C:11–6 clarifying that any action taken in accordance with New Jersey’s Medical Aid in Dying for the Terminally Ill Act shall not constitute suicide or assisted suicide.

(POLST)


Oklahoma

(AD)


An adult patient may authorize another person to make health care decisions for the patient if the patient is unconscious, incompetent, or otherwise mentally or physically incapable of communicating. However, the bill adds a provision to Title 63, Section 3102.4 mandating that before the authorized person makes a health care decision for the patient, the person shall provide the health care provider with a signed copy of the following statement to be entered into the patient’s medical record:

“I hereby certify that:

I have not been convicted of, pleaded guilty to or pleaded no contest to the crimes of abuse, verbal abuse, neglect or financial exploitation by a caregiver; exploitation of an elderly person or disabled adult; or abuse, neglect, exploitation or sexual abuse of a child;
I have not been found to have committed abuse, verbal abuse or exploitation by a final investigative finding of the State Department of Health or Department of Human Services or by a finding of an administrative law judge, unless it was overturned on appeal; and

I have not been criminally charged as a person responsible for the care of a vulnerable adult with a crime resulting in the death or near death of a vulnerable adult.”

Moreover, a health care provider will not be held liable for following in good faith the instructions of an authorized person who submits this statement.

Oregon

(AD)


The bill amends § 127.635, regarding surrogate decision-makers, by clarifying that an election for hospice treatment is included in the range of life-sustaining procedures for which both designated surrogates (“designated health care representative”) and a default surrogate decision-maker under the statute (“health care representative”) are authorized as decision-makers under the procedures set forth in statute. The bill defines “hospice treatment” as treatment that focuses on palliative care, including care for acute pain and symptom management, rather than curative treatment, provided to a principal with a terminal condition.

(DS)


This bill applies supported decision-making principles to individuals with an intellectual or developmental disability and who have been deemed by a court or treating physician to be incapable of making health care decisions. The bill permits an “individualized written service plan team”—which is a group consisting of the individual, the individual’s legal or designated representative, the individual’s case manager, and other individuals who may be chosen by the individual, such as care providers or family members—to appoint a health care advocate for the individual. A “health care advocate” is defined as a person who is authorized to make health care decisions on behalf of an individual if the individual does not have a guardian or a health care representative. The individualized written service plan team must inform the individual of the team’s decision to seek a health care advocate for the individual prior to the appointment of the advocate. The healthcare advocate must then be approved by at least two-thirds of the individualized written service plan team, including the individual. The health care advocate is appointed for a one-year term, subject to reappointment or revocation.

The advocate is authorized to access the health records of the individual and consult with the individual’s medical providers in order to make health care decisions on behalf of the individual,
but the advocate must inform the individual of all health care decisions made or considered. Additionally, the advocate may not make health care decisions on behalf of an individual with respect to convulsive treatment, psychosurgery, sterilization, abortion, withholding or withdrawing of a life-sustaining procedure, withholding or withdrawing artificially administered nutrition and hydration other than hyperalimentation, testing for HIV unless testing is necessary for obtaining treatment or care for the individual, a request for medication for the purpose of ending the individual’s life, euthanasia, an experimental procedure unless the procedure has been approved by an institutional review board and is determined by the treating physician to be in the best interest of the individual, an experimental drug that has not been approved for use by the United States Food and Drug Administration unless the drug is part of an approved clinical trial and the individual’s treating physician has determined that it is in the best interest of the individual, or the use of seclusion or physical or chemical restraints unless an imminent risk of harm to the individual or others exists, but only for as long as the imminent risk continues except in the case of an emergency.

Further, a health care decision made by a health care advocate regarding a significant medical procedure or treatment must be approved by a majority of the individualized written service plan team at an in-person meeting. The individual must participate in the meeting unless the individual declines to participate or is unable to participate due to the individual’s medical condition.

An individual has the right to protest any health care decision made by a health care advocate. If the individual protests a health care decision by a health care advocate, the health care decision is revoked, the health care advocate’s authority is withdrawn with respect to the health care decision that is revoked, and the individualized written service plan team or the health care advocate shall notify the provider whose recommendation is the subject of the health care decision that is revoked.

Finally, the bill mandates the Department of Human Services to ensure that appropriate training is made available to at least two members of the individual’s individualized written service plan team before the team appoints a health care advocate to the individual.

(PAD)


Under prior Oregon law, a patient with a qualifying medical condition must make two oral requests for medication to end his or her life at least 15 days apart before the attending physician may write the prescription for medication. The patient must also make a written request according to the procedures in the statute at least 48 hours before the physician may write the prescription for medication. This amendment provides that if the qualified patient’s attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request, the qualified patient may reiterate the oral request to his or her attending physician at any time after making the initial oral request, and the prescription for medication may be written at any time following the later of the
qualified patient’s written request or second oral request. The physician must still offer the patient an opportunity to rescind the request at the time of the patient’s second oral request.

South Carolina

(POLST)


An Act to amend the code of laws of South Carolina to enact the “Physician Orders for Scope of Treatment (POST) Act” by adding Chapter 80 to Title 44 so as to enable certain persons to execute a POST form signed by a physician that sets forth the patient’s wishes as to health care where the patient has been diagnosed with a serious illness or may be expected to lose capacity within twelve months; to require health care providers and health care facilities to accept a POST form as a valid medical order and to comply with the order, with exceptions; to require the Department of Health and Environmental Control to perform certain duties with respect to overseeing post forms; to provide immunity from civil and criminal liability and from disciplinary action for certain persons acting in accordance with provisions of the chapter; to allow a POST form to be revoked by the patient or patient’s legal representative.

The bill creates § 44–80, or the “Physician Orders for Scope of Treatment (POST) Act.” Under the Act, a POST form is defined as a designated document to be used only in situations where a patient may be expected to die or lose capacity within twelve months. The form consists of a set of medical orders signed by the patient’s physician addressing key medical decisions consistent with the patient’s goals concerning treatment at the end of life. A POST form is portable and valid across health care settings.

The POST form must be a uniform document based on the National Physician Orders for Life-Sustaining Treatment (POLST) paradigm; the form must include the patient’s name and contact information, date of birth, effective date of the form, diagnosis, treatment plan, health care representative or health care agent contact information, CPR preference, medical intervention preferences, preferences for antibiotics, and assisted nutrition and hydration preferences. A copy, facsimile, or electronic version of a completed POST form is considered legal. Additionally, a similar form executed in another jurisdiction in compliance with the laws of that jurisdiction will be deemed a valid expression of a patient’s wishes regarding health care.

A POST form may be revoked at any time by an oral or written statement by the patient or a patient’s legal representative, but a revocation is only effective upon communication to the health care provider or health care facility by the patient or the patient’s legal representative. The execution of a POST form by a patient or the patient’s legal representative automatically revokes any previously executed POST form.

The Act requires the South Carolina Department of Health and Environmental Control to oversee the POST form and its future iterations; display a printable sample of the POST form currently being used by the department on a publicly accessible website; develop a statewide, uniform process for identifying a patient who has executed any advance directive, a POST form, or a combination of advance directives and a POST form; and develop a process for collecting...
feedback to facilitate the periodic redesign of the POST form in accordance with current health care best practices.

An advanced practice registered nurse (APRN) may create, execute, and sign a POST form if authorized to do so by his or her practice agreement. However, the POST form must be for a patient of the APRN, the physician with whom the APRN has entered into a practice agreement, or both. A physician assistant (PA) may also create, execute, and sign a POST form if authorized to do so by his or her scope of practice guidelines. The POST form must be for a patient of that PA, the PA’s supervising physician, or both. Any physician who is responsible for the creation and execution of a POST form shall make reasonable efforts to periodically review and update the POST form with the patient at least once per year.

If a health care provider or health care facility is unwilling to comply with an executed POST form based on policy, religious beliefs, or moral convictions, he or she shall contact the patient’s health care representative, health care agent, or other authorized person, and the health care provider or facility shall allow the transfer of the patient to another health care provider or health care facility.

In regards to criminal or civil liability, the Act specifies that any individual acting in good faith as a legal representative who executes a POST form on behalf of an incapacitated patient is not subject to criminal prosecution or civil liability for executing the form. Moreover, a health care provider who in good faith complies with a POST form is not subject to criminal prosecution, civil liability, or disciplinary penalty for complying with the POST form. Additionally, a health care provider, health care facility, or other person who has not received actual notice of the revocation of a POST form and complies with the wishes stated in the POST form is not subject to civil or criminal liability or professional disciplinary action for actions taken that are in accordance with reasonable medical standards. Death resulting from the withholding or withdrawal of life-sustaining procedures pursuant to an executed POST form does not constitute a suicide, homicide, or vulnerable adult abuse or neglect.

The Act also provides that the execution of a POST form is voluntary, meaning a health care provider, health care facility, health care service plan, insurer issuing disability insurance, self-insured employee benefit plan, or nonprofit hospital plan may not require any person to execute a POST form as a condition of being insured for, or receiving, health care services. Additionally, the execution of a POST form does not modify the terms of an existing life insurance policy or affect the sale, procurement, or issuance of any life insurance policy.

The Act clarifies that the absence of a POST form does not allow health care providers or facilities to make presumptions about a patient’s intent with respect to the consent to or refusal of life-sustaining procedures. A health care provider or health care facility must be guided by the patient’s stated wishes, or if the patient is unable to communicate, the wishes as stated by the patient’s surrogate decision maker. Nothing in the Act may be interpreted to interfere with the right of an individual to make decisions regarding use of life-sustaining procedures or to supersede any right or responsibility that a legal representative has to order the withholding or withdrawal of medical care.
South Dakota

(POLST)


An Act to establish certain provisions regarding advance care planning.

The bill creates Chapter 34–12, South Dakota’s statute addressing advance care planning for patients with a terminal condition. Under the bill, a patient may execute a medical order for scope of treatment (MOST), which is a document other than an advance health care directive executed by a patient who has been diagnosed with a terminal condition and the patient’s medical provider and entered in the patient’s medical record. The MOST provides direction to health care providers about the patient’s goals and preferences regarding life-sustaining treatment. A patient’s authorized representative may execute a MOST only if the patient lacks decision-making capacity; the patient’s lack of capacity shall be recorded in the patient’s medical record.

The chapter mandates the secretary of the Department of Health to develop a standardized MOST form and instructions for completion of the form and to make the form available to the public on the department’s website.

The chapter also specifies that a completed form shall include the name and date of birth of the patient; a statement that the patient either has or does not have an advance health care directive; information regarding the patient’s diagnosis of a terminal condition; information indicating the preference of the patient or the patient’s authorized representative regarding the use of cardiopulmonary resuscitation, specified medical interventions, and the intensity of treatment for each intervention, and if there is no such indication of the patient or authorized representative’s preference, a directive to health care providers to use all necessary and appropriate medical interventions; a provision directing the administration of artificial nutrition and hydration; a statement confirming that the medical provider and the patient or the patient’s authorized representative had a discussion about the patient’s medical condition, treatment goals, and use of medical intervention; a statement confirming that the execution of the MOST by the patient or the patient’s authorized representative is based on informed consent; a statement advising the patient that if there is a conflict between the MOST and the patient’s written directives in any previously executed and unrevoked durable power of attorney or living will, the health care provider will treat the patient in accordance with the instructions in the MOST; the signature and date of signing of the patient or the patient’s authorized representative; the signature and date of signing of the medical provider; and a statement that the duty of medicine is to care for patients even when they cannot be cured, that health care providers and their patients must evaluate the use of technology at their disposal based on available information, that judgments about the use of technology to maintain life must reflect the inherent dignity of the patient and the purpose of medical care, and that everyone is to be treated with dignity and respect.

A health care provider who receives a valid MOST shall make the document part of the patient’s medical record. A document executed in another state or jurisdiction that meets the requirements
for a valid medical order for scope of treatment in that state or jurisdiction is valid in South Dakota.

If there is a conflict between a patient’s MOST and a patient’s oral directives or any written directives in an advance health care directive, the health care provider shall treat the patient in accordance with the most recent instruction.

The chapter provides that a patient with decision-making capacity may revoke a MOST at any time by destroying or defacing the MOST with the intent to revoke; with a written revocation of the MOST, signed and dated by the patient; or with an oral expression of the intent to revoke the MOST in the presence of a witness eighteen years of age or older who signs and dates in writing. An authorized representative may not revoke a MOST unless the MOST was executed by the authorized representative. The authorized representative shall make the revocation in writing. A revocation is effective upon communication to the health care provider, and the health care provider who is informed shall record the date and time of the notification of revocation in the patient’s medical record.

A health care provider who refuses to comply with the provisions of a MOST shall not prevent the transfer of the patient to another health care provider who is willing to comply with the MOST and must continue to provide care for the patient until the transfer is completed. Additionally, a health care provider may not require or prohibit the execution or revocation of a MOST as a condition for providing health care.

In regards to civil or criminal liability, a health care provider acting in good faith and in accordance with generally accepted health care standards is not subject to civil or criminal liability or to discipline for unprofessional conduct for complying with an apparently valid MOST; not complying with a MOST when it appears it was revoked or invalid when made; or not complying with a MOST due to the health care provider’s beliefs as a matter of conscience or the good faith belief that the patient has or lacks decision-making capacity.

**Washington**

(DS, POLST)


The bill amends § 7.70.065 by adding the following individuals to the list of persons who may provide informed consent to health care on behalf of a patient who is not competent to consent (after spouse or domestic partner; adult children; parents; adult brothers and sisters): adult grandchildren of the patient who are familiar with the patient; adult nieces and nephews of the patient who are familiar with the patient; adult aunts and uncles of the patient who are familiar with the patient; and an adult who has exhibited special care and concern for the patient, is familiar with the patient’s personal values, is reasonably available to make health care decisions, and is not a physician to the patient or an employee of the physician, the owner, administrator, or
employee of a health care facility, nursing home, or long-term care facility where the patient resides or receives care, or a person who receives compensation to provide care to the patient.

The adult in the last category, often referred to as a close friend, must also provide a declaration reciting facts and circumstances demonstrating that he or she is familiar with the patient and that he or she meets the requirements listed above; is a close friend of the patient; is willing and able to become involved in the patient’s health care; has maintained such regular contact with the patient as to be familiar with the patient’s activities, health, personal values, and morals; and is not aware of a person in a higher priority class willing and able to provide informed consent to health care on behalf of the patient. A person who knowingly provides a false declaration shall be subject to criminal penalties.

The declaration is effective for up to six months from the date of the declaration. A health care provider may, but is not required to, rely on such a declaration. Moreover, if the health care provider or health care facility relies on such a declaration, the health care provider or facility is immune from civil or criminal liability and from professional or other disciplinary action.

The amendment to § 7.70.065 also provides that no rights under Washington’s Death with Dignity Act may be exercised through a person authorized to provide informed consent to health care on behalf of a patient not competent to consent.

Finally, the bill amends § 70.122.030 by specifying that an adult’s directive regarding the withholding or withdrawal of life-sustaining treatment must be signed by the declarer and acknowledged before a notary public or other individual authorized by law to take acknowledgments. The notary or authorized individual must acknowledge that the adult has provided proof of identification.