

JAN 20 2023

A BILL FOR AN ACT

RELATING TO HEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. Section 327E-2, Hawaii Revised Statutes, is
2 amended as follows:

3 1. By adding two new definitions to be appropriately
4 inserted and to read:

5 "Electronic prescription" has the same meaning as in
6 section 329.1.

7 "Pharmacist" has the same meaning as in section 329.1."

8 2. By amending the definition of "health care" to read:

9 ""Health care" means any care, treatment, service, or
10 procedure to maintain, diagnose, or otherwise affect an
11 individual's physical or mental condition, including:

12 (1) Selection and discharge of health-care providers and
13 institutions;

14 (2) Approval or disapproval of diagnostic tests, surgical
15 procedures, programs of medication, and orders not to
16 resuscitate; [and]



1 (3) Direction to provide, withhold, or withdraw artificial
 2 nutrition and hydration; provided that withholding or
 3 withdrawing artificial nutrition or hydration is in
 4 accord with generally accepted health care standards
 5 applicable to health-care providers or
 6 institutions[-]; and

7 (4) Refusal of the administration of any opioid
 8 medication."

9 SECTION 2. Section 327E-9, Hawaii Revised Statutes, is
 10 amended to read as follows:

11 "[-] §327E-9 [+] **Immunities.** (a) A health-care provider or
 12 institution acting in good faith and in accordance with
 13 generally accepted health-care standards applicable to the
 14 health-care provider or institution shall not be subject to
 15 civil or criminal liability or to discipline for unprofessional
 16 conduct for:

17 (1) Complying with a health-care decision of a person
 18 apparently having authority to make a health-care
 19 decision for a patient, including a decision to
 20 withhold or withdraw health care;



1 (2) Declining to comply with a health-care decision of a
2 person based on a belief that the person then lacked
3 authority; [øx]

4 (3) Complying with an advance health-care directive and
5 assuming that the directive was valid when made and
6 has not been revoked or terminated[-]; or

7 (4) Revoking or overriding, in good faith, a voluntary
8 non-opioid directive in an emergency situation.

9 (b) An individual acting as agent, guardian, or surrogate
10 under this chapter shall not be subject to civil or criminal
11 liability or to discipline for unprofessional conduct for
12 health-care decisions made in good faith.

13 (c) A prescription presented or electronically transmitted
14 to a pharmacy shall be presumed valid for the purposes of this
15 chapter and a pharmacist shall not be subject to civil or
16 criminal liability or to discipline for unprofessional conduct
17 for dispensing a controlled substance in contradiction of a
18 patient's advance health-care directive that refuses the offer
19 or administration of any opioid medication."

20 SECTION 3. Section 327E-16, Hawaii Revised Statutes, is
21 amended to read as follows:



1 "§327E-16 Optional form. The following sample form may be
2 used to create an advance health-care directive. This form may
3 be duplicated. This form may be modified to suit the needs of
4 the person, or a completely different form may be used that
5 contains the substance of the following form.

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"ADVANCE HEALTH-CARE DIRECTIVE

8

9

Explanation

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You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health-care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

18

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21

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those



1 decisions for you now even though you are still capable. You
2 may name an alternate agent to act for you if your first choice
3 is not willing, able, or reasonably available to make decisions
4 for you. Unless related to you, your agent may not be an owner,
5 operator, or employee of a health-care institution where you are
6 receiving care.

7 Unless the form you sign limits the authority of your
8 agent, your agent may make all health-care decisions for you.
9 This form has a place for you to limit the authority of your
10 agent. You need not limit the authority of your agent if you
11 wish to rely on your agent for all health-care decisions that
12 may have to be made. If you choose not to limit the authority
13 of your agent, your agent will have the right to:

- 14 (1) Consent or refuse consent to any care, treatment,
15 service, or procedure to maintain, diagnose, or
16 otherwise affect a physical or mental condition;
- 17 (2) Select or discharge health-care providers and
18 institutions;
- 19 (3) Approve or disapprove diagnostic tests, surgical
20 procedures, programs of medication, and orders not to
21 resuscitate; and



1 (4) Direct the provision, withholding, or withdrawal of
2 artificial nutrition and hydration and all other forms
3 of health care.

4 Part 2 of this form lets you give specific instructions
5 about any aspect of your health care. Choices are provided for
6 you to express your wishes regarding the provision, withholding,
7 or withdrawal of treatment to keep you alive, including the
8 provision of artificial nutrition and hydration, as well as the
9 provision of pain relief medication. Space is provided for you
10 to add to the choices you have made or for you to write out any
11 additional wishes.

12 Part 3 of this form lets you give specific instructions
13 with regard to the donation of organs at death.

14 Part 4 of this form lets you designate a physician to have
15 primary responsibility for your health care.

16 After completing this form, sign and date the form at the
17 end and have the form witnessed by one of the two alternative
18 methods listed below. Give a copy of the signed and completed
19 form to your physician, to any other health-care providers you
20 may have, to any health-care institution at which you are
21 receiving care, and to any health-care agents you have named.



1 You should talk to the person you have named as agent to make
2 sure that he or she understands your wishes and is willing to
3 take the responsibility.

4 You have the right to revoke this advance health-care
5 directive or replace this form at any time.

6

7

PART 1

8

DURABLE POWER OF ATTORNEY FOR HEALTH-CARE DECISIONS

9

10 (1) DESIGNATION OF AGENT: I designate the following
11 individual as my agent to make health-care decisions for me:

12

13

14

(name of individual you choose as agent)

15

16

17

(address) (city) (state) (zip code)

18

19

20

(home phone) (work phone)

21



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1 _____

2 (address) (city) (state) (zip code)

3

4 _____

5 (home phone) (work phone)

6

7 (2) AGENT'S AUTHORITY: My agent is authorized to make all
8 health-care decisions for me, including decisions to provide,
9 withhold, or withdraw artificial nutrition and hydration, and
10 all other forms of health care to keep me alive, except as I
11 state here:

12

13 _____

14

15 _____

16

17 _____

18 (Add additional sheets if needed.)

19

20 (3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's
21 authority becomes effective when my primary physician determines



1 that I am unable to make my own health-care decisions unless I
2 mark the following box. If I mark this box [], my agent's
3 authority to make health-care decisions for me takes effect
4 immediately.

5 (4) AGENT'S OBLIGATION: My agent shall make health-care
6 decisions for me in accordance with this power of attorney for
7 health care, any instructions I give in Part 2 of this form, and
8 my other wishes to the extent known to my agent. To the extent
9 my wishes are unknown, my agent shall make health-care decisions
10 for me in accordance with what my agent determines to be in my
11 best interest. In determining my best interest, my agent shall
12 consider my personal values to the extent known to my agent.

13 (5) NOMINATION OF GUARDIAN: If a guardian needs to be
14 appointed for me by a court, I nominate the agent designated in
15 this form. If that agent is not willing, able, or reasonably
16 available to act as guardian, I nominate the alternate agents
17 whom I have named, in the order designated.

18

19

PART 2

20

INSTRUCTIONS FOR HEALTH CARE

21



1 If you are satisfied to allow your agent to determine what
2 is best for you in making end-of-life decisions, you need not
3 fill out this part of the form. If you do fill out this part of
4 the form, you may strike any wording you do not want.

5 (6) END-OF-LIFE DECISIONS: I direct that my health-care
6 providers and others involved in my care provide, withhold, or
7 withdraw treatment in accordance with the choice I have marked
8 below: (Check only one box.)

9 [] (a) Choice Not To Prolong Life

10 I do not want my life to be prolonged if (i) I
11 have an incurable and irreversible condition that
12 will result in my death within a relatively short
13 time, (ii) I become unconscious and, to a
14 reasonable degree of medical certainty, I will
15 not regain consciousness, or (iii) the likely
16 risks and burdens of treatment would outweigh the
17 expected benefits, OR

18 [] (b) Choice To Prolong Life

19 I want my life to be prolonged as long as
20 possible within the limits of generally accepted
21 health-care standards.



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1 (7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial
 2 nutrition and hydration [~~must~~] shall be provided, withheld or
 3 withdrawn in accordance with the choice I have made in paragraph
 4 (6) unless I mark the following box. If I mark this box [],
 5 artificial nutrition and hydration [~~must~~] shall be provided
 6 regardless of my condition and regardless of the choice I have
 7 made in paragraph (6).

8 (8) RELIEF FROM PAIN: If I mark this box [], I direct
 9 that treatment to alleviate pain or discomfort should be
 10 provided to me even if it hastens my death.

11 (9) VOLUNTARY NON-OPIOID OPTION: If I mark this box
 12 [], I refuse at my own insistence the offer or administration
 13 of any opioid medications.

14 [+9+] (10) OTHER WISHES: (If you do not agree with any of
 15 the optional choices above and wish to write your own, or if you
 16 wish to add to the instructions you have given above, you may do
 17 so here.) I direct that:

18
 19 _____
 20
 21 _____



1 (Add additional sheets if needed.)

2

3

PART 3

4

DONATION OF ORGANS AT DEATH

5

(OPTIONAL)

6

7 [~~10~~] 11 Upon my death: (mark applicable box)

8 [] (a) I give any needed organs, tissues, or parts,

9

OR

10 [] (b) I give the following organs, tissues, or parts

11

only

12

13 [] (c) My gift is for the following purposes (strike any

14

of the following you do not want)

15

(i) Transplant

16

(ii) Therapy

17

(iii) Research

18

(iv) Education

19

20

PART 4

21

PRIMARY PHYSICIAN



1 (OPTIONAL)

2

3 [~~11~~] (12) I designate the following physician as my
4 primary physician:

5

6

7 (name of physician)

8

9

10 (address) (city) (state) (zip code)

11

12

13 (phone)

14

15 OPTIONAL: If the physician I have designated above is not
16 willing, able, or reasonably available to act as my primary
17 physician, I designate the following physician as my primary
18 physician:

19

20

21 (name of physician)



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1

2

3

(address) (city) (state) (zip code)

4

5

6

(phone)

7

8

~~[-(12)]~~ (13) EFFECT OF COPY: A copy of this form has the same effect as the original.

9

10

~~[-(13)]~~ (14) SIGNATURES: Sign and date the form here:

11

12

13

(date)

(sign your name)

14

15

16

(address)

(print your name)

17

18

19

20

(city) (state)

21

22

~~[-(14)]~~ (15) WITNESSES: This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your



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1 signature; or (b) acknowledged before a notary public in the
2 State.

3

4

ALTERNATIVE NO. 1

5

6

Witness

7

I declare under penalty of false swearing pursuant to

8

section 710-1062, Hawaii Revised Statutes, that the principal is

9

personally known to me, that the principal signed or

10

acknowledged this power of attorney in my presence, that the

11

principal appears to be of sound mind and under no duress,

12

fraud, or undue influence, that I am not the person appointed as

13

agent by this document, and that I am not a health-care

14

provider, nor an employee of a health-care provider or facility.

15

I am not related to the principal by blood, marriage, or

16

adoption, and to the best of my knowledge, I am not entitled to

17

any part of the estate of the principal upon the death of the

18

principal under a will now existing or by operation of law.

19

20

21

(date)

(signature of witness)



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23

(address)

(printed name of witness)

(city) (state)

Witness

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

(date)

(signature of witness)

(address)

(printed name of witness)



1 _____

2 (city) (state)

3

4 ALTERNATIVE NO. 2

5

6 State of Hawaii

7 County of _____

8 On this _____ day of _____, in the year

9 _____, before me, _____ (insert name of notary

10 public) appeared _____, personally known to me (or

11 proved to me on the basis of satisfactory evidence) to be the

12 person whose name is subscribed to this instrument, and

13 acknowledged that he or she executed it.

14

15

16 Notary Seal

17

18 _____

19 (Signature of Notary Public)"

20 SECTION 4. Statutory material to be repealed is bracketed

21 and stricken. New statutory material is underscored.

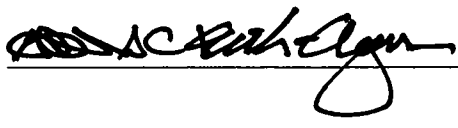
22



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1 SECTION 5. This Act shall take effect upon its approval.

2

INTRODUCED BY: 



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Report Title:

Advance Health-Care Directive; Voluntary Non-Opioid Option

Description:

Adds a voluntary non-opioid option to the sample advance health-care directive form. Establishes that a prescription presented or electronically transmitted to a pharmacy shall be presumed valid and grants pharmacists immunity from civil, criminal, and professional liability for dispensing an opioid in contravention of a patient's non-opioid directive.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

