



**WRITTEN TESTIMONY OF  
THE DEPARTMENT OF THE ATTORNEY GENERAL  
KA 'OIHANA O KA LOIO KUHINA  
THIRTY-THIRD LEGISLATURE, 2025**

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**ON THE FOLLOWING MEASURE:**

S.B. NO. 1323, S.D. 1, RELATING TO HEALTH CARE.

**BEFORE THE:**

SENATE COMMITTEE ON JUDICIARY

**DATE:** Thursday, February 20, 2025      **TIME:** 10:01 a.m.

**LOCATION:** State Capitol, Room 016

**TESTIFIER(S):**      **WRITTEN TESTIMONY ONLY.**  
(For more information, contact Erin N. Lau,  
Deputy Attorney General, at 808-587-3050)

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Chair Rhoads and Members of the Committee:

The Department of the Attorney General supports this bill. We also suggest amendments at the end of this testimony.

Currently, two separate chapters of the Hawaii Revised Statutes (HRS), chapters 327E and 327G, HRS, provide a legal framework for advance health care directives. The purpose of this bill is to update and consolidate our current laws by adopting a modified version of the Uniform Health-Care Decisions Act (2023), as promulgated by the Uniform Laws Commission, which reflects a better understanding of capacity and reduces barriers to creating advance directives relating to general health care and mental health.

Key updates in this bill include:

1. **Recognizing the nuances of capacity:** The bill acknowledges that an individual may have the capacity to make certain decisions related to their health care, even if they lack the capacity to make specific health care decisions. For example, a person might not be able to make an informed decision about whether to undergo surgery but could competently identify who should make that decision on their behalf. By addressing these subtleties, the bill respects an individual's ability to participate in their care to the extent possible. In contrast,

the current law defines capacity narrowly as the ability to make a health care decision and communicate that decision.

2. **Simplifying the requirements to execute a power of attorney for health care:** The bill reduces the number of witnesses required to create a power of attorney instruction from two witnesses or a notarization to one witness.
3. **Clarifying and safeguarding an individual's right to receive treatment during a psychiatric or psychological event:** The bill explicitly permits an individual to include an enforceable instruction in their advance mental health care directive. While current law allows an individual to create an advance mental health care directive, it does not clearly address the enforceability of treatment instructions contained in the advance mental health care directive during psychiatric or psychological events, nor does it provide any safeguards to ensure that the individual instructed such treatment. This bill provides those safeguards missing in the current law to ensure the instruction was consented to by the individual by requiring the signatures of two in-person witnesses in the advance mental health care directive. Those safeguards make the treatment instructions enforceable during psychiatric or psychological events, even if the individual refuses treatment due to their medical condition.
4. **Streamlining capacity determinations:** The bill reduces the requirement for determining an individual's capacity from two separate examinations by health care providers to a single examination conducted at the same time the determination of capacity is made. Under current law, two health care providers must conduct separate examinations to determine capacity without a requirement that those examinations occur when the patient presents with the same symptoms. The bill streamlines this process, requiring only one contemporaneous examination while allowing for additional examinations by another provider if needed. If the individual disagrees with the initial determination of incapacity, an examination by another provider may be conducted to confirm or reassess the determination of incapacity.

5. **Expanding capacity determination health care providers:** The bill allows an advance practice registered nurse (APRN) with advanced education and specialized clinical training to determine whether an individual has capacity. Under current law, only a physician or a licensed psychologist can make that determination. The addition of APRNs will enhance accessibility to timely capacity assessments while maintaining high professional standards.
6. **Making it easier for sample forms to be updated:** The bill shifts the responsibility of creating and updating sample forms for advance health care directives from statutory inclusion to the Department of Health (in consultation with the Department of the Attorney General). This change ensures that the sample forms can be updated promptly to address evolving community needs. The current statutory forms, based on the previous Uniform Health-Care Decisions Act (1993), do not reflect a modern understanding of capacity, treatment options, or accessibility, creating unnecessary barriers for individuals seeking to create an advance health care directive.

This bill maintains two key aspects of Hawaii's current law that are not found in the Uniform Health-Care Decisions Act (2023):

1. **Default surrogate as an authorized Medicaid representative:** In 2018, chapter 327E, HRS, was amended to allow a default surrogate to act as an authorized representative for Medicaid purposes. The bill preserves this authority to ensure continuity in health care decision making for individuals relying on Medicaid.
2. **Default surrogate selection process:** When Hawaii adopted the Uniform Health-Care Decisions Act (1993), it created a process for choosing a default surrogate by requiring a physician, or their designee, to locate interested persons and have those persons choose a default surrogate from amongst themselves. This process has been effective, as reported by medical providers, and reflects Hawaii's unique cultural context, including the recognition of "hanai" relationships.

After discussion with Hawaii Health Systems Corporation (HHSC), the Department respectfully requests that the Committee make the following changes to address the issues the HHSC raised in its testimony before the Senate Committee on Health and Human Services:

1. On page 12, lines 17-20, remove the word "signed" from section -4(b)(3), HRS, so that the sentence reads as follows:
  - (3) Documented in a record by the health care professional making the finding that includes an opinion of the cause, nature, and probable duration of the lack of capacity.

This change would be consistent with modern electronic health records that do not have a signature block but link the health care professional to the records through the health care professional's account.

2. On page 28, lines 7-15, add a new paragraph (7) to section -12(f) (including technical amendments to paragraphs (5) and (6)), as follows:
  - (5) If the person is not a family member or cohabitant, a statement describing how the person exhibited special care and concern for the individual who lacks capacity and is familiar with the individual's personal values; ~~and~~
  - (6) Affirmation that the person understands that the health care professional will reasonably rely on the person's representations in the declaration to assist in providing medical treatment[-]; and
  - (7) A statement that the declaration was provided under the penalty of law.

This change would explicitly authorize a health care professional to require a person assuming the role of a default surrogate to affirm, under penalty of law, the accuracy of their signed declaration.

We believe this bill introduces significant and meaningful updates to the laws regarding advance health care directives and advance mental health care directives. These changes will make it easier for individuals and their families to use these tools to provide appropriate care and decision-making. We respectfully ask the Committee to pass this bill. Thank you for the opportunity to provide testimony.

**TESTIMONY OF THE  
COMMISSION TO PROMOTE UNIFORM LEGISLATION**

**on SB1323, SD1**

**RELATING TO HEALTH CARE** (Adopts the Uniform Health-Care Decisions Act (2023) with amendments to replace chapters 327E and 327G, HRS. Effective 12/31/2050.)

**BEFORE THE SENATE COMMITTEE ON JUDICIARY**

**DATE:** Thursday, February 20, 2025, at 10:01 a.m.

**PERSON SUBMITTING TESTIMONY:**

PETER HAMASAKI, Commission to Promote Uniform Legislation

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Chair Rhoads, Vice-Chair Gabbard and Members of the Committee on Judiciary:

My name is Peter Hamasaki, and I am a member of the State of Hawai'i Commission to Promote Uniform Legislation. Thank you for this opportunity to provide written testimony in support of Senate Bill No. 1323, Senate Draft 1.

Hawai'i previously adopted the Uniform Law Commission's ("ULC") 1993 version of Uniform Health-Care Decisions Act ("UHCDA"). Senate Bill No. 1323, Senate Draft 1, replaces the 1993 UHCDA with the updated version of the UHCDA which was approved by the ULC in 2023.

The 2023 UHCDA enables individuals to appoint agents to make health care decisions for them should they become unable to make those decisions for themselves, to provide their health-care professionals and agents with instructions about their values and priorities regarding their health care, and to indicate particular medical treatment they do or do not wish to receive. It also authorizes certain people to make health-care decisions for individuals incapable of making their own decisions but who have not appointed agents, thus avoiding the need to appoint a guardian or otherwise involve a court in most situations. In addition, it sets forth the related duties and powers of agents and health-care professionals, and provides protection in the form of immunity to both under specified circumstances

Like the 1993 version adopted previously adopted by Hawai'i, the 2023 UHCDA's

goals include: (1) acknowledging the right of a competent individual to make decisions about the provision, withdrawal or withholding of health care; (2) providing a single statute to govern both the appointment of a health-care agent and the recording of an individual's wishes regarding their health care; (3) simplifying and facilitating the making of an advance health-care directive; (4) ensuring that decisions about an individual's health care will be governed, to the extent possible, by the individual's own desires; (5) addressing compliance with an individual's instructions by health-care institutions and professionals; and (6) providing a procedure for resolution of disputes.

Some of the key benefits of the 2023 UHCDA are that it:

- ***Reduces unnecessary barriers to the execution of advance directives:*** By making it easier to create an advance directive, the 2023 UHCDA seeks to reduce the number of Americans who lack an advance directive. The 2023 UHCDA also authorizes the use of mental health care, or psychiatric, advance directives in a way that helps resolve conflicts between competing advance directives.
- ***Clarifies when agents may act:*** The 2023 UHCDA adds provisions clearly indicating when a surrogate's power commences and addresses what happens if a patient objects to a surrogate making a decision for them. It also allows an individual to specifically authorize their appointed agent to obtain health information while the individual has capacity, thus allowing the agent to assist the individual in making health-care decisions.
- ***Clarifies agents' powers and gives individuals the option to authorize special powers.*** For example, to reduce the likelihood that an individual's health-care needs will go unmet due to financial barriers, the 2023 UHCDA authorizes a surrogate to apply for health insurance for a patient who does not have another fiduciary authorized to do so. It also provides that an agent has only those powers that are expressly authorized in the power of attorney that appointed the agent.
- ***Modernizes default surrogate provisions:*** The 2023 UHCDA updates the priority list in the 1993 version to reflect a broader array of relationships, family structures, and living arrangements.

- ***Brings the definition of capacity and approaches to capacity determinations in line with modern practice:*** A surrogate’s authority to make health-care decisions for a patient typically commences when the patient lacks capacity to make decisions for themselves. The 2023 UHCDA modernizes the definition of capacity to focus on an individual’s *functional* abilities and clarifies that an individual may lack capacity to make one decision yet retain capacity to make others. The 2023 UHCDA also expands the list of health-care professionals who may determine that an individual lacks capacity.

The commission also offers the following comments on Senate Bill No. 1323, Senate Draft 1, for the committee’s consideration.

- Section -2 contains a definition for “advance practice registered nurse”; we note that “advance practice registered nurse” also is defined in section 457-2, HRS, and the committee may wish to have a single, consistent definition.
- Section -11 provides for the Department of Health, in consultation with the Department of the Attorney General, to develop model forms. We note that the 2023 UHCDA contains an optional form, and we hope that this form will be considered in developing forms for Hawai‘i.

A summary of the UHCDA prepared by the ULC is attached for the committee’s additional information and reference.

Thank you very much for this opportunity to offer written testimony in support of this measure.



## **UNIFORM HEALTH-CARE DECISIONS ACT (2023)**

The Uniform Health-Care Decisions Act (“UHCDA”) was promulgated by the Uniform Law Commission (“ULC”) in 2023, reflecting a multiyear collaborative and non-partisan process to modernize and expand on the Uniform Health-Care Decisions Act approved by the ULC in 1993 (“1993 Act”). This Act enables individuals to appoint agents to make health-care decisions for them if they cannot make those decisions for themselves, provide their health-care professionals and surrogates with instructions about their values and priorities regarding health care, and indicate particular medical treatment they do or do not wish to receive. It also authorizes certain people to make health-care decisions for those incapable of making their own decisions who have not appointed an agent, thus avoiding the need to appoint a guardian or otherwise involve a court in most situations. In addition, it sets forth the related duties and powers of surrogates and health-care professionals, and provides protection in the form of immunity to both under specified circumstances. The Act seeks to improve upon the 1993 Act by drawing on decades of experience and knowledge about how people make health-care decisions and about the challenges associated with creating and using advance directives.

This Act shares the key goals of the 1993 Act, including: (1) acknowledging the right of a competent individual to make decisions about the provision, withdrawal or withholding of health care; (2) providing a single statute to govern the appointment of a health-care agent and the recording of an individual’s wishes regarding the individual’s own health care; (3) simplifying and facilitating the making of an advance health-care directive; (4) ensuring that decisions about an individual’s health care will be governed, to the extent possible, by the individual’s own desires; (5) addressing compliance with an individual’s instructions by health-care institutions and professionals; and (6) providing a procedure for resolution of disputes.

The new Act reflects substantial changes in how health care is delivered, increases in non-traditional familial relationships and living arrangements, the proliferation of the use of electronic documents, the growing use of separate advance directives exclusively for mental health care, and other recent developments.

A state enacting it would repeal any statute governing the issues addressed in this Act, including the 1993 Act. Below are several key improvements of the Uniform Health-Care Decisions Act:

- This Act incorporates approaches designed to facilitate the use of advance directives. This is important because, although all states have enacted statutes enabling the use of advance directives, many adult Americans have never made one. Without an advance directive, individuals’ wishes are less likely to be honored. In addition, their health-care professionals, family, and friends may struggle to determine how to make health-care decisions for them and to identify what decisions to make. The Act therefore seeks to reduce the number of Americans who lack an advance directive by reducing unnecessary barriers to execution of these documents.
- This Act adds clarity around when a surrogate may act by specifying when the surrogate’s power commences. Patients, surrogates, and health-care professionals are all disadvantaged when it is unclear

whether a surrogate has authority to make decisions. In addition, it addresses an issue on which state statutes are typically silent: what happens if patients object to a surrogate making a decision for them.

- This Act adds provisions to guide determinations of incapacity, which is important because a surrogate's authority to make health-care decisions for a patient typically commences when the patient lacks capacity to make decisions. The Act modernizes the definition of capacity so that it accounts for the functional abilities of an individual and clarifies that the individual may lack capacity to make one decision but retain capacity to make other decisions. In addition, recognizing the growth of allied health professions, and that a variety of health-care professionals may have training and expertise in assessing capacity, the Act expands the list of health-care professionals who are recognized as being able to determine that an individual lacks capacity.
- This Act authorizes the use of advance directives exclusively for mental health care. Since the 1993 Act, many states have authorized such advance directives, sometimes called "psychiatric advance directives." Among other things, these allow individuals with chronic mental health challenges to provide specific instructions as to their preferences for mental health care and to choose to allow those instructions to be binding in the event of an acute mental health crisis.
- This Act modernizes default surrogate provisions that allow family members and certain other people close to a patient to make decisions in the event the patient lacks capacity and has not appointed a health-care agent. The new default surrogate provisions update the priority list in the 1993 Act to reflect a broader array of relationships and family structures. They also provide additional options to address disagreements among default surrogates who have equal priority.
- This Act clarifies the duties and powers of surrogates. For example, to reduce the likelihood that an individual's health-care needs will go unmet due to financial barriers, the Act authorizes a surrogate to apply for health insurance for a patient who does not have another fiduciary authorized to do so. It also provides that an agent only possesses those powers expressly authorized in the power of attorney that appointed the agent.
- This Act includes an optional model form that is designed to be readily understandable and accessible to diverse populations. The form gives individuals the opportunity to readily share information about their values and goals for medical care. Thus, it addresses a common concern raised by health-care professionals in the context of advance planning: that instructions included in advance directives often focus exclusively on preferences for particular treatments, and do not provide health-care professionals or surrogates with the type of information about patients' goals and values that could be used to make value-congruent decisions when novel or unexpected situations arise. The form addresses these concerns by providing options for individuals to indicate goals and values, in addition to specific treatment preferences.

For further information about the Uniform Health-Care Decisions Act, please contact Legislative Counsel Haley Tanzman at (312) 450-6620 or [htanzman@uniformlaws.org](mailto:htanzman@uniformlaws.org).



**February 20, 2025 at 10:01 am**  
**Conference Room 016**

**Senate Committee on Judiciary**

To: Chair Karl Rhoads  
Vice Chair Mike Gabbard

From: Paige Choy  
AVP, Government Affairs  
Healthcare Association of Hawaii

Re: **Submitting comments**  
**SB 1323 SD 1, Relating to Health Care**

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high-quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 30,000 people statewide.

Thank you for the opportunity to provide comments on this measure, which seeks to update the Uniform Health Care Decisions Act. While we appreciate efforts to clarify the decision-making framework for incapacitated patients, our members have concerns that some of the proposed changes could create confusion, delay necessary treatment, and increase liability risks for healthcare providers.

Under the proposed amendments, a patient is presumed to have capacity unless a physician makes a documented determination otherwise. However, if the patient objects to the finding of incapacity, providers must then treat them as if they have capacity, regardless of medical judgment. This structure introduces ambiguity into clinical decision-making, potentially requiring providers to act against their professional assessments of a patient's ability to make informed choices.

Additionally, the exceptions outlined in the amendments may create more issues than they resolve. Specifically, one exception allows providers to disregard a patient's objection to an incapacity determination only when:

1. The patient has a health condition requiring prompt treatment to avoid imminent loss of life or serious harm; and

2. A second healthcare professional confirms the lack of capacity.

This requirement for a second physician's confirmation could be impractical in urgent care settings and may lead to unnecessary delays in providing lifesaving or stabilizing treatment. In many scenarios, obtaining a second opinion in a timely manner is not feasible, particularly in rural or resource-limited settings. Requiring an additional medical determination in these cases may prevent providers from acting in a patient's best interest when time is of the essence.

Furthermore, the exception itself could expose providers to legal risk. The language requiring treatment only in cases of "imminent loss of life or serious harm" is subjective and may invite litigation. If a provider determines that urgent treatment is necessary and overrides a patient's objection, they could later face claims that the condition was not actually "imminent" or that the patient's objections should have been honored. This uncertainty places an undue burden on providers who are simply trying to act in accordance with medical best practices and protect patient well-being.

Lastly, we have concerns regarding the penalties, which can include a \$50,000 fee for violations of certain sections. This seems like a particularly onerous penalty for healthcare providers who often work under zero or negative margins. We would suggest that penalties be removed or significantly lowered in this measure.

While we support efforts to ensure patient autonomy, these proposed changes could make clinical decision-making more cumbersome. We urge reconsideration of those particular amendments to ensure that providers can act in the best interests of patients without undue procedural burdens or legal risk. Thank you for the opportunity to submit comments.



**HAWAII HEALTH SYSTEMS**  
C O R P O R A T I O N

"Quality Healthcare For All"

**LATE**

**COMMITTEE ON JUDICIARY**  
**Senator Karl Rhoads, Chair**  
**Senator Mike Gabbard, Vice Chair**

February 20, 2025  
10:01 AM  
Hawaii State Capitol  
Room 016 & Via Videoconference

**Testimony with Concerns on S.B. 1323, S.D.1**  
**RELATING TO HEALTH CARE**

Adopts the Uniform Health-Care Decisions Act (2023) with amendments to replace chapters 327E and 327G, HRS. Effective 12/31/2050. (SD1)

Edward N. Chu  
President & Chief Executive Officer  
Hawaii Health Systems Corporation

On behalf of the Hawaii Health Systems Corporation (HHSC) Corporate Board of Directors, thank you for the opportunity to present testimony **with a number of concerns on S.B. 1323, SD1, Relating to Health Care.**

- 1) Section -5, Page 14, A patient can object to a physician's clinical finding of incapacity.

**Concern:** If the patient objects to the finding of incapacity, providers must then treat them as if they have capacity, regardless of medical judgment.

This introduces ambiguity into clinical decision-making, potentially requiring providers to act against their professional assessments of a patient's ability to make informed choices.

**Concern:** Allows providers to disregard a patient's objection to an incapacity determination when the patient has a health condition requiring prompt treatment to avoid imminent loss of life or serious harm.

On page 14, lines 17-20, there is an exception to taking a patient's objection to a clinical finding of incapacity where a health care provider can ignore the patient's objection if: "The individual is experiencing a health condition requiring a decision regarding health-care treatment to be made promptly to avoid imminent loss of life or serious harm to the health of the individual"

*Case Scenario:* Under the proposed bill, if a patient is clinically incapacitated, yet objects to that determination, the clinician must then follow the wishes of the patient. But if the patient then needs a blood transfusion promptly to avoid imminent loss of life or serious harm but the patient vocalizes that they do not want a blood transfusion, is the clinician supposed to ignore the patient's wishes and provide the life-saving blood transfusion?

The proposed bill creates vast opportunities for confusion and requires physicians to operate outside the realm of medical judgment and common standards of medical practice. The language requiring treatment **only** in cases of "imminent loss of life or serious harm" is subjective and may invite litigation. If a provider determines that urgent treatment is necessary and overrides a patient's objection, they could later face claims that the condition was not actually "imminent" or that the patient's objections should have been honored. This uncertainty places an undue burden on providers who are simply trying to act in accordance with medical best practices and protect patient well-being.

**Concern:** Allows providers to disregard a patient's objection to an incapacity determination **if** second healthcare professional confirms the lack of capacity.

**Concern:** The requirement for a second physician's confirmation could be impractical in urgent and emergent settings and may lead to unnecessary delays in providing lifesaving or stabilizing treatment.

In many scenarios, obtaining a second opinion in a timely manner is not feasible, particularly in rural or resource-limited settings. Requiring an additional medical determination in these cases may prevent providers from acting in a patient's best interest when time is of the essence. There is no existing law that requires two providers determination as to the lack of capacity except in the **rare** case where an individual has an advanced mental health care directive.

2) Section -19 (b) Page 39, a default surrogate cannot make health care decisions in certain situations that remain unclear

**Concern:** Page 41, lines 8 -13 reads:

- (b) "A default surrogate shall not make a health care decision if, under other laws of this State, the decision:
1. May not be made by a guardian; or
  2. May be made by a guardian only if the court appointing the guardian specifically authorizes the guardian to make the decision."

This language is vague and contradictory. It also fails to recognize that if a default surrogate is in place, that typically means that there is no guardian in place- which means there is no document that a health care provider or a default

surrogate can look to that would provide instructions what a guardian may and may not do. For decision making as serious as this, default surrogates,

providers, and individuals deserve clearly defined parameters dictating what a surrogate can or cannot do.

3) Establishes penalties, which can include a \$50,000 fee for violations of certain sections.

**Concern:** \$50,000 is an onerous penalty for healthcare providers who often work under zero or negative margins.

According to section 24, pages 48-49, the \$50,000 penalty is imposed if an institution or professional intentionally violates section 21, pages 42-43 of the bill.

§ -21 Duties of health care professional, responsible health care professional, and health care institution. (a) A responsible health care professional who is aware that an individual has been found under section -4(b) or by a court to lack capacity to make a health care decision shall make a reasonable effort to determine if the individual has a surrogate.

(b) If possible before implementing a health care decision made by a surrogate, a responsible health care professional as soon as reasonably feasible shall communicate to the individual the decision made and the identity of the surrogate.

(c) A responsible health care professional who makes or is informed of a finding that an individual lacks capacity to make a health care decision or no longer lacks capacity, or that other circumstances exist that affect a health care instruction or the authority of a surrogate, as soon as reasonably feasible, shall:

(1) Document the finding or circumstance in the individual's medical record; and

(2) If possible, communicate to the individual and the individual's surrogate the finding or circumstance and that the individual may object under section -5(c) to the finding under section -4(b).

(d) A responsible health care professional who is informed that an individual has created or revoked an advance health care directive, or that a surrogate for an individual has been appointed, designated, or disqualified, or has withdrawn, shall:

(1) Document the information as soon as reasonably feasible in the individual's medical record; and

(2) If evidence of the directive, revocation, appointment, designation, disqualification, or withdrawal is in a record,

request a copy and, on receipt, cause the copy to be included in the individual's medical record.

(e) Except as provided in subsections (f) and (g), a health care professional or health care institution providing health care to an individual shall comply with:

(1) A health care instruction given by the individual regarding the individual's health care;

(2) A reasonable interpretation by the individual's surrogate of an instruction given by the individual; and

(3) A health care decision for the individual made by the individual's surrogate in accordance with sections -17 and -18 to the same extent as if the decision had been made by the individual at a time when the individual had capacity.

(f) A health care professional or a health care institution may refuse to provide health care consistent with a health care instruction or health care decision if:

(1) The instruction or decision is contrary to a policy of the health care institution providing care to the individual and the policy was timely communicated to the individual with capacity or to the individual's surrogate;

(2) The care would require health care that is not available to the professional or institution; or

(3) Compliance with the instruction or decision would:

- (A) Require the professional to provide care that is contrary to the professional's religious belief or moral conviction and if other law permits the professional to refuse to provide care for that reason;
- (B) Require the professional or institution to provide care that is contrary to generally accepted health care standards applicable to the professional or institution; or
- (C) Violate a court order or other law.

(g) A health care professional or health care institution that refuses to provide care under subsection (f) shall:

(1) As soon as reasonably feasible, inform the individual, if possible, and the individual's surrogate of the refusal; and

(2) Immediately make a reasonable effort to transfer the individual to another health care professional or health care institution that is

willing to comply with the instruction or decision and provide life-sustaining care and

care needed to keep or make the individual comfortable, consistent with accepted medical standards to the extent feasible, until a transfer is made.

We suggest that penalties be removed or significantly lowered in this measure. The requirements are not definitive enough ("if possible" "reasonable effort") to elicit a \$50,000 penalty on health care providers.

We highly value patient autonomy and support efforts to ensure patient autonomy, however these proposed changes could create unnecessary risks and lead to confusion in clinical decision-making. We urge reconsideration of those particular amendments to ensure that providers can act in the best interests of patients without undue procedural burdens or legal risk.

We will continue to work with the Department of the Attorney General and the Healthcare Association of Hawaii on these outlined concerns. However, if these serious concerns cannot be adequately resolved, we respectfully request that this measure not be passed into law.

Thank you for the opportunity to provide testimony on this matter.

**LATE**

**SB-1323-SD-1**

Submitted on: 2/19/2025 5:43:39 PM

Testimony for JDC on 2/20/2025 10:01:00 AM

<b>Submitted By</b>	<b>Organization</b>	<b>Testifier Position</b>	<b>Testify</b>
Louis Erteschik	Testifying for Hawaii Disability Rights Center	Oppose	Written Testimony Only

Comments:

We oppose the so called Ulysses clause. It is nothing more than an attempt to get people to waive their legal and constitutional rights against involuntary medication. Aside from being bad policy, we question its validity and legality. If the individual changes their mind at the moment it would otherwise occur, we believe it may be unenforceable and would still require a Court order. We also question if the person who would administer the medication is really going to want to follow through without legal intervention.

At the Hearing before the Senate Health and Human Services Committee it was stated by the Deputy Attorney General that this was already current law and this bill merely provided additional procedural protections in the form of requiring witnesses. We have not been able to see that clearly in the current law and the testimony submitted by the Attorney General for this hearing seems to bear out our point of view that it is not the current law.

We continue to stand on our position and understand that this provision has been controversial in other jurisdictions and would urge caution before the Legislature incorporates this provision into Hawaii law.