SENATE FILE NO. _____

Wyoming Health Care Decisions Act.

Sponsored by: Joint Labor, Health and Social Services Interim Committee

A BILL

for

AN ACT relating to the Wyoming Health Care Decisions Act; amending terminology relating to health care providers and physicians; adding persons who may not be witnesses for a power of attorney for health care as specified; amending the optional form for advance health care directives as specified; clarifying that a valid advance health care directive preempts decisions by a surrogate; amending provisions regarding decisions by a class of persons acting as health care surrogate; providing that a guardian's authority is as provided in existing guardianship statutes as specified; clarifying a health care providers duty to communicate with a patient as specified; amending civil and criminal immunity of agent and surrogates as specified; and providing for an effective date.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 35-22-402(a)(xx)(D), 35-22-403(b), (c) by creating a new paragraph (v) and (e), 35-22-404(c), 35-22-405(a), 35-22-406(a), (b)(intro), (e), (h) and (k), 35-22-407 by creating a new subsection (e), 35-22-408(a) through (c) and (e), 35-22-410(b) and 35-22-412(b) are amended to read:

35-22-402. Definitions.

(a) As used in this act:

(xx) "Surrogate" means an adult individual or individuals who:

(D) Are identified by the ~~supervising~~ primary health care provider in accordance with this act as the person or persons who are to make those decisions in accordance with this act.

35-22-403. Advance health care directives.

(b) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent

to make any health care decision the principal could have made while having capacity. The power must be in writing and signed by the principal or by another person in the principal's presence and at the principal's expressed direction. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. Unless related to the principal by blood, marriage or adoption, an agent may not be an owner, operator or employee of a residential or community care facility at which the principal is receiving care. The durable power of attorney must ~~either be sworn and~~ be acknowledged before a notary public or must be signed by at least two (2) witnesses, each of whom witnessed either the signing of the instrument by the principal or the principal's acknowledgement of the signature or of the instrument, each witness making the following declaration in substance:

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is ~~personally~~ known to me to be the principal, that the principal signed or acknowledged this document 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 attorney-in-fact by this document, and that I am not a treating health care provider, an employee of a treating health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility, nor an employee of an operator of a residential care facility.

(c) None of the following shall be used as a witness for a power of attorney for health care:

(v) The owner or employee of a health care institution.

(e) Unless otherwise specified in a written advance health care directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, shall be made by the primary physician, but ~~the supervising~~ a health care provider may make the decision if the primary physician is unavailable.

35-22-404. Revocation of advance health care directive.

(c) A health care provider, agent, guardian or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the ~~supervising~~ primary health care provider and to any health care institution at which the patient is receiving care.

35-22-405. Optional form.

(a) An advance health care directive may be substantially in the following form, but in addition may include other specific directions. The other sections of this act govern the effect of this or any other writing used to create an advance health care directive. If any of the other specific directions are held to be invalid, the invalidity shall not affect other directions of the directive that can be given effect without the invalid direction and to this end the directions in the directive are severable:

ADVANCE HEALTH CARE DIRECTIVE

Explanation

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 donation of organs and the designation of your ~~supervising~~ primary 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.

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 decisions for you now even though you are still capable.

You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a residential or community care facility at which you are receiving care.

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

(a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

(b) Select or discharge health care providers and institutions;

(c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and

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

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

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a ~~supervising~~ primary health care provider to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. This form must either be signed before a notary public or, in the alternative, be witnessed by two (2) witnesses. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make

sure that he or she understands your wishes and is willing to take the responsibility.

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

* *

Advance health care directive of (List Name):

_____

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(Not intended for financial matters)

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

_____

(name of individual you choose as agent)

_____

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

_____

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____

(name of individual you choose as first alternate agent)

_____

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

_____

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____

(name of individual you choose as second alternate agent)

_____

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

_____

(home phone) (work phone)

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

_____

_____

_____

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my ~~supervising health care provider~~ primary physician determines that I lack the capacity to make my own health care decisions. ~~unless I initial the following box. If I initial this box [ ], my~~

~~agent's authority to make health care decisions for me takes effect immediately.~~

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

~~(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, (please initial one):~~

~~[ ] I nominate the agent(s) whom I named in this form in the order designated to act as guardian.~~

~~[ ] I nominate the following to be guardian in the order designated:~~

_____

_____

~~[ ] I do not nominate anyone to be guardian.~~

PART 2

INSTRUCTIONS FOR HEALTH CARE

Please strike any wording that you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below:

[ ] (a) Choice Not To Prolong Life

I do not want my life to be prolonged if:

(i) I have an incurable and irreversible condition that will result in my death within a relatively short time;~~,~~ or

(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or

(iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

[ ] (b) Choice To Prolong Life

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

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I initial the following box.

If I initial this box [ ], I want artificial nutrition ~~must be provided~~ regardless of my condition and regardless of the choice I have made in paragraph (6).

If I initial this box [ ], I do not want artificial nutrition provided.

If I initial this box [ ], I want artificial hydration ~~must be provided~~ regardless of my condition and regardless of the choice I have made in paragraph (6).

If I initial this box [ ], I do not want artificial hydration provided.

(8) RELIEF FROM PAIN: ~~Except as I state in the following space,~~ I direct that treatment for alleviation of pain or discomfort be provided at all times, except as I state in the following space:

_____

_____

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

_____

_____

(Add additional sheets if needed.)

PART 3

DONATION OF ORGANS AND TISSUES AT DEATH

(OPTIONAL)

(10) Upon my death (initial applicable box):

[ ] (a) I have arranged to give my body ~~or,~~ to science

[ ] (b) I have arranged to give any needed organs~~,~~ or tissues ~~or parts, or~~ through the Wyoming donor registry

[ ] (c) ~~I give the following organs, tissues or parts only~~ I choose not to donate my body, tissues or organs

_____

_____

~~(d) My gift is for the following purposes (strike any of the following you do not want):~~

~~(i) Any purpose authorized by law;~~

~~(ii) Transplantation;~~

~~(iii) Therapy;~~

~~(iv) Research;~~

~~(v) Medical education.~~

Part 4

INFORMATION ABOUT MY HEALTH CARE PROVIDERS

(OPTIONAL)

(11) ~~I designate~~ [ ] The following physician ~~as~~ is my primary physician:

_____

(name of physician)

_____

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

_____

(phone)

If the physician I have ~~designated~~ named above is not willing, able or reasonably available to act as my primary physician, I designate the following as my primary physician:

_____

(name of physician)

_____

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

_____

(phone)

[ ] I choose not to designate a primary physician.

More information about my health care can be obtained through:

_____

(Institution/hospice)

* *

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) SIGNATURES: Sign and date the form here:

_____ (date)

(sign your name)

_____ (address)

(print your name)

_____

(city) (state)

~~(Optional)~~ SIGNATURES OF WITNESSES OR NOTARY PUBLIC:

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is known to me to be the principal, that the principal signed or acknowledged this document 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 attorney-in-fact by this document, and that I am not a treating health care provider, an employee of a treating health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a

residential care facility, nor an employee of an operator of a residential care facility.

First witness

_____ _____

(print name) (address)

_____

(signature of witness)

_____

(date)

Second witness

_____ _____

(print name) (address)

_____

(signature of witness)

_____

(date)

OR

Notary Public

The foregoing advance directive was acknowledged before me by _____, the principal, this _____ day of _____, 20__.

My commission expires: _____

_____

(Signature of notary public in lieu of witnesses)

_____

(date)

35-22-406. Decisions by surrogate.

(a) If a valid advance health care directive does not exist, a surrogate may make a health care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician or the ~~supervising~~ primary health care provider to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

(b) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the ~~supervising~~ primary health care provider. In the absence of a designation, or if the designee is not reasonably available, it is suggested that any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

(e) If more than one (1) member of a class assumes authority to act as surrogate, and ~~they~~ the other members of the class do not agree on a health care decision and the ~~supervising~~ primary health care provider is so informed, the ~~supervising~~ primary health care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. ~~If the class is evenly divided concerning the health care decision and the supervising health care provider is so informed, that class and all individuals having lower priority are disqualified from making the decision.~~

(h) The patient at any time may disqualify another, including a member of the individual's family, from acting

as the individual's surrogate by a signed writing or by personally informing the ~~supervising~~ primary health care provider of the disqualification.

(k) A ~~supervising~~ primary health care provider may require an individual claiming the right to act as surrogate for a patient to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

35-22-407. Decisions by guardian.

(e) A guardian's authority to make health care decisions for the ward shall be as provided in W.S. 3-2-201(a)(iii), subject to the restrictions in W.S. 3-2-202 and 35-22-407(b).

35-22-408. Obligations of health care provider.

(a) Before implementing a health care decision made for a patient who is able to comprehend, a ~~supervising~~ primary health care provider~~, if possible,~~ shall promptly communicate to the patient the decision made and the identity of the person making the decision.

(b) A ~~supervising~~ primary health care provider who knows of the existence of an advance health care directive, a revocation of an advance health care directive, or a designation or disqualification of a surrogate, shall promptly record its existence in the patient's health care record and, if it is in writing, shall request a copy and if one is furnished shall arrange for its maintenance in the health care record.

(c) ~~A supervising health care provider~~ The primary physician who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian or surrogate, shall promptly record the determination in the patient's health care record and communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patient.

(e) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience. A health care institution may decline to comply with an individual instruction or health

care decision if the instruction or decision is contrary to a written policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient. The provider or institution shall deliver the written policy upon receipt of the patient's advance directive that may conflict with the policy or upon notice from the ~~supervising~~ primary health care provider that the patient's instruction or decision may be in conflict with the health care institution's policy.

35-22-410. Immunities.

(b) An individual acting in good faith as agent or surrogate under this act is not subject to civil liability or criminal ~~liability~~ prosecution or to discipline by a licensing board for unprofessional conduct for health care decisions made in good faith.

35-22-412. Capacity.

(b) An individual is presumed to have capacity to make a health care decision, to give or revoke an advance

health care directive, and to designate or disqualify a surrogate unless the primary physician has certified that the patient lacks such capacity.

Section 2. W.S. 35-22-402(a)(xix), 35-22-405(b) and 35-22-407(a) through (d) are repealed.

Section 3. This act is effective July 1, 2007.

(END)