HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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House Bill 96

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House Judiciary Committee
Task Force on Guardianships, Trusts and Estates

Main Capitol Building
Room 60, East Wing
Harrisburg, Pennsylvania

Monday, March 22, 1999 - 10:10 a.m.

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BEFORE:

Honorable Patrick M. Browne
Honorable Patrick E. Fleagle
Honorable Stephen Maitland
Honorable Peter Daley

ALSO PRESENT:

David Bloomer
Majority Research Analyst

Beryl Kuhr, Esquire
Office of Minority Chief Counsel

Jane Mendlow
Minority Research Analyst

Judy Sedesse
Majority Administrative Assistant

C O N T E N T S

CHAIRPERSON BROWNE: Good morning. I apologize. I'm suffering from a slight cold, and change in the temperature always does it. I'd just like to call the hearing for the Task Force on Guardianship, Trusts and Estates to order under the Judiciary Committee.

This hearing -- the purpose of this hearing is to gather testimony on House Bill 96 sponsored by Representative Patrick Fleagle that amends the advance directives for the Health Care Act to provide guidance and direction for EMS personnel in the field in honoring advance directives and DNR orders.

This bill was subject to a very formative hearing last term under the Health and Human Services Committee. It's a bill that has very important implications on emergency medical service personnel's actions in the field and also the decisions of individuals and whether they should or should not be able to have their opinions taken into account and their wishes taken into account in regards to DNR and advance directives in the field.

To get started, I'd like to recognize the prime sponsor of the bill, Patrick Fleagle, for testimony and comments. Representative Fleagle.

REPRESENTATIVE FLEAGLE: Thank you, Mr. Chairman. I want to personally thank you, Mr. Chairman,

and members of this Task Force for allowing me to testify on House Bill 96. I have been working on this legislation since 1996 and thought it would be helpful to give you some brief background on the need for and the evolution of the statutory language that we have in this bill.

In 1996, I was approached by members of an ethics committee of a hospital in my district who, in conjunction with local emergency medical services personnel, outlined a prehospital care scenario which resulted in traumatic experiences to a patient, a prehospital care giver and the patient's family.

At present, when EMS personnel are dispatched on a call to a patient who has a legal DNR order, the personnel are forced into a position where they must ascertain if the DNR order is legal and legitimate while at the same time delivering care due to a life-threatening condition even if an individual's family presents EMS personnel with a written DNR order.

The EMS personnel have no way of knowing if it is a legitimate legal document. We do have some attorneys who are EMS care givers. But for the most part, you're not going to have a -- an attorney show up to give you prehospital care.

It's been my experience that this situation dictates a "proceed with resuscitation" course of action

giving the benefit of the doubt to life-sustaining measures. Ironically, complicating this scenario is the advent of automatic defibrillation equipment or AED's, automated external defibrillation equipment, which fortunately in most situations provides immediate cardiac resuscitation.

Instructions from medical command, usually back -- remotely based at a hospital setting, places such command in a position no better than the immediate care giver; i.e., whether the DNR orders are legitimate.

HB 96 would provide terminally ill patients with a form of identification either as a bracelet or card issued by the Pennsylvania Department of Health and certified by the patient's personal physician immediately showing to the emergency medical personnel the presence of a DNR order.

Upon arrival at a scene, emergency medical service personnel, after making initial assessments, would preclude, per the patient's orders and desires, any cardiopulmonary resuscitation. Such resuscitation is defined on page two of the bill. The presence of such an indicator would not preclude any treatment for pain alleviation or other measures of comfort for the patient.

This legislation also encompasses a so-called conscience clause which gives emergency medical service

personnel protection from civil or criminal liability for failing to comply with an EMS DNR order.

On August 27th, 1998 -- you have alluded to this, Mr. Chairman. -- the House Health and Human Services Committee held a hearing on a similar piece of legislation introduced by me and assigned to their committee. The issues of this meeting revolved mainly around medical and ethical issues.

I provided the Executive Director of the House Judiciary Committee, Brian Presci, with information and testimony from that hearing, which I believe he has passed on to you, Mr. Chairman. I have worked with a wide variety of emergency medical personnel on amendments to this legislation and have incorporated many of the concerns as the bill presently exists.

I owe, Mr. Chairman, a tremendous amount of thanks to a working group consisting of emergency medical personnel and in particular to Mr. Douglas Wolfberg, an attorney here in Harrisburg who has been very helpful in many of the legal aspects of this legislation and who will be speaking next, I believe, on your agenda.

Mr. Wolfberg has been very active in EMS issues and was involved in the drafting of the advance directive language of Chapter 54 of Title 20, which I believe passed in the early '90s, Mr. Chairman. Like a lot

of other issues that require technical expertise, I would readily refer to Mr. Wolfberg and have learned to appreciate his ability to combine both medical and legal expertise that are required in addressing the more technical portions of this advance directive issue.

I'd also like to take this time to -- to personally thank Janette Kearney who is, I believe, the Assistant Director of the Pennsylvania Emergency Health Services Council. She was very helpful and was very loyal through what has been a very tedious process. And you legislators will understand that, certainly can appreciate that. And that's good because a good legislation takes time.

Since I began addressing this particular issue involving DNR orders, I have found that what started as a rather local issue has developed into a nationwide concern that's been addressed by several other states. As an example, I have with me today a bracelet from New Jersey which would be very similar to that envisioned in this legislation.

Now, I'll let you -- if I can have this back, I'll let you look at this after I'm done. This is the only one I have. You will notice that the language in this bill is restricted to physician certified terminally ill patients.

Now, granted, from the day we were born, I guess you could argue that we are terminally ill and will eventually die. However, I found it necessary to limit this type of identification system to terminally ill patients for several reasons.

Obviously, terminally ill patients would be the first group of people who would want to avail themselves of such a system. But this limit of scope is also out of practical legislative necessity since the broadening of the eligibility or any eligibility for such a bracelet or card brings into play several complicating factors such as resuscitation of suicide victims.

I look forward to any constructive ideas that I'm sure will emanate from this Task Force and from the Judiciary Committee as a whole. My broad-based work group has been responsive and accepting of any and all ideas to make this legislation better and protect the quality of life for terminally ill patients, their families, and emergency medical personnel who respond to their needs.

I'd be happy to answer any questions you might have of a general nature. And I look to my colleague, Mr. Wolfberg, for any technical or legal assistance that you might have that may go a little bit over my head. Thank you again, gentlemen, for giving me this opportunity to speak on behalf of this legislation.

CHAIRPERSON BROWNE: Thank you, Representative Fleagle, for your comments on a very important bill. I just have just one point of clarification I guess that relates to just the general substance of the bill. And that is, what type of individual would an EMS DNR order apply to? You're saying that somebody that is healthy that has an existing living will who has --

REPRESENTATIVE FLEAGLE: Yes. And as I mentioned before, it would be a person who was certified by their physician as having a terminal condition.

CHAIRPERSON BROWNE: So this is another step in addition to the actual living will?

REPRESENTATIVE FLEAGLE: Yes, I would say that accurately describes it.

CHAIRPERSON BROWNE: Do you know if -- about going forward further than what you had done in this bill, do you know if the other states that you've done your research on, New Jersey, I think Montana was another one, go further than what you have provided?

REPRESENTATIVE FLEAGLE: I'm not sure if they go further. And of course, I didn't ask that of them. My chief concern was that -- one good thing about having a working group is they bring up scenarios that -- that could possibly be problems after -- after a bill has -- has passed. And I like to air on the side of conservatism

here.

And if any -- if they have been successful in other states, I will be glad to expand upon this language at a future date. But this is a very critical issue. I mean, you're talking about life and death here. And I'd like to go -- proceed very slowly on the legislation to -- to make sure that it's -- it's tight and not just based on what other states have done.

We have not heard any negatives from any of the other states who have -- have similar language.

CHAIRPERSON BROWNE: Okay. I think one of the things that was made very clear at your hearing at the Health and Human Services Committee was the application of this bill was mostly not in a public environment. It's more in a home environment.

REPRESENTATIVE FLEAGLE: That's correct. And perhaps in the future we could expand it. But there are just so many scenarios that are rather frightening to me in -- in a public area for a regular citizen to be wearing one of these, that I would prefer and my working group has preferred to keep it into a terminally ill condition in a private setting.

CHAIRPERSON BROWNE: Thank you. I know that based on the testimony received at the hearing last term, the amount of pressure that's put on EMS personnel in the

field without further guidance and clarity on this issue, it seems like it was -- it's tremendous in terms of response for family and neighbors with somebody who has this type of problem.

REPRESENTATIVE FLEAGLE: And I will add that as technology proceeds, these type of issues are going to be coming before us as legislators. And they're tough issues. We have gotten to a point where these automated external defibrillators have basically, well, come into play immediately or practically immediately when the EMS personnel come into your home.

So there's not a lot of time there. And I know from practical experience that in -- the EMS community constantly strives to get to the patient with an automatic defibrillator as quickly as possible. And I know you say, Well, CPR can keep them going.

Well, when a heart goes into fibrillation, unless that AED is used, CPR can't keep them alive indefinitely.

CHAIRPERSON BROWNE: Okay. Thank you very much.

REPRESENTATIVE FLEAGLE: Thank you.

CHAIRPERSON BROWNE: Any other questions by members? Thank you, Representative Fleagle.

REPRESENTATIVE FLEAGLE: Thank you, Mr.

Chairman. I'll let this with you.

CHAIRPERSON BROWNE: Okay. Great. Pat, do you want to join us at the table?

REPRESENTATIVE FLEAGLE: Okay.

CHAIRPERSON BROWNE: I'd like to mention that Representative Daley and Representative Maitland have joined us. Next I'd like to recognize Douglas Wolfberg, Esquire from Duane, Morris & Heckscher. Thank you, Mr. Wolfberg, for your time and your testimony.

MR. WOLFBERG: My pleasure. Thank you, Mr. Chairman, for the invitation to testify today regarding House Bill 96. As Mr. Chairman noted, my name is Doug Wolfberg. And I'm an attorney with the Law Firm of Duane, Morris and Heckscher, LLP based here in our Harrisburg office.

In my practice, among other things, I represent numerous EMS organizations and ambulance services across the Commonwealth. Prior to attending law school, I worked in EMS full time for about 15 years, including on the staff of the Pennsylvania Emergency Health Services Council which Representative Fleagle mentioned and has done a tremendous service in moving this legislation forward.

I was first asked by Representative Fleagle to assist him in drafting this legislation back in '96 or '97. And I just first want to say that Representative -- I think

EMS in Pennsylvania owes Representative Fleagle a tremendous debt of gratitude for his hard work and commitment to EMS not only on this issue but beyond that.

I don't know if this is for broadcast. But I did it a week or two ago. I'll do it again. Representative Fleagle is currently taking an EMT course, which I understand puts him among a small handful of legislators that have this background both as a provider and as a legislator. And I think that's further evidence of his interest and dedication in this issue.

Also, just briefly to mention the efforts of Jack Weinrauch who is an attorney with the Legislative Reference Bureau here in the Capitol who is also a paramedic who has been a sounding board at least for me on this legislation, also PEHSC and the Ambulance Association of Pennsylvania whose council is here today, Ellie Frazier, and who it's also been my privilege to work with on this legislation.

House Bill 96 would permit EMS providers to withhold CPR and other resuscitative measures when a patient expresses such a desire through his advance directive and when that patient is in a terminal condition and incompetent or permanently unconscious.

The current Advance Directive Act does address EMS providers but has some limitations, which I'll briefly

discuss. The current law permits EMS providers to withhold unwanted resuscitation based only on a patient's advance directive document.

EMS providers must therefore examine this legal document in the field and make rapid judgments under stressful conditions. Advance directives are not standardized, as you know, under current law. And therefore, there's not a single place on an advance directive form that an EMT or a paramedic can actually look to and determine rapidly a patient's no code or DNR status.

After taking the time to review this legal document, the EMT or paramedic must then by radio contact a medical command physician. And that's a physician who works in a hospital emergency department that is given authority under the state EMS Act to give prehospital personnel instructions over the radio.

So the EMS provider has to contact that doctor by radio and explain the situation to them, review the advance directive. And it's important to remember that this medical command physician has never before had any patient relationship with the person, with the victim, with the patient.

And many are understandably reluctant to give a DNR order over the radio based only on what a paramedic or an EMT is telling them about a form that the doctor has

never seen and about a patient they've never before examined. So I would submit that the law's practical effect is somewhat limited as it currently stands.

Nevertheless, despite these limitations, family members who are often present at the scene of these emotional incidence don't understand these legal limitations. They don't understand why EMS providers have to put their loved one through -- through the often violent process of resuscitation.

And it is a very violent process. To paint somewhat of a picture for you, as I've done in my written testimony, CPR often involves audible fracturing of ribs because you have to exert great pressure on the chest, forcing a breathing tube down somebody's throat, shocking them with electrical stimulation and defibrillator to bring their heart back to some sort of life-sustaining rhythm.

This is a violent process. And when a patient decides to forego that, they've made a reasoned judgment to do that. And when an EMS crew shows up and starts doing it anyway, there's significant pressure placed on them to balance those wishes of the patient and the family member saying, Now wait, you know, my loved one didn't want any of this.

But they say, Well, sorry. That's just what we have to do. Some doc on the radio told us. And it's

very hard for the family to understand that. Therefore, the main benefit of this bill is that it would create a standardized mechanism for EMS personnel to be able to identify patients who have DNR orders in the field.

The bill would provide for EMS DNR forms, cards and bracelets which would be made available by the Department of Health to physicians throughout the Commonwealth. Physicians would in turn control these documents much like they would a prescription blank in their office.

They would in turn issue it to their patients if the patient meets the criteria under the living will; i.e., they're permanently unconscious or incompetent and terminally ill, and only when that patient has indicated a desire to forego CPR, defibrillation, intubation.

When all of those things apply, the patient would be eligible for a DNR order and the physician would issue one. EMS providers then would therefore be able to recognize in mere seconds an EMS DNR order, which is a medical document, rather than having to interpret a living will, which is a legal document.

And just as importantly, this standardized mechanism would permit the efficient training of Pennsylvania's thousands of EMS providers to know what a DNR order looks like when they see one. Without this

specific legislation, not only are EMS providers placed in a difficult situation, but as I've discussed, so are the patients.

It's also important to mention what this bill will not do. This bill will not increase the number of people whose advance directives are operative under Pennsylvania law. Under this bill, EMS DNR orders could be issued only to those patients whose advance directives have already taken effect under the law as it currently exists; that is, those who are permanently unconscious or terminally ill and incompetent.

This bill merely provides a way that EMS providers can identify these DNR patients with greater certainty, and it also provides universal meaning and definition to what the term "do not resuscitate" means. So EMS providers know that when they see a DNR order, it would mean withhold CPR, defibrillation, intubation and other related treatments that are spelled out in the bill.

Some, particularly at last summer's hearings and informally, have indicated a desire to see this legislation go further. And the Chairman asked some questions about do other states take this concept further. An answer to that is yes, other states do, particularly Virginia.

However, Virginia started out with this very

approach, limiting their DNR orders to patients who had valid living wills that were operative under law. And only after several years of implementing this and educating providers in their state did they expand the concept.

I spoke with the former EMS Director of Virginia who is now working for the federal government in the Federal EMS Program. And she indicated that they don't think it would have been as successful and as well accepted if they would have tried to bite off the whole, you know, the whole apple at once. So I thought I'd pass that along to you.

But I do agree that this -- that eventually there should be some provision in law for even people who do not have operative living wills to be able to go to their doctor and get a DNR order. But again, I think that this is a valid incremental approach to that solution.

And other states, as I've indicated, have said that that was a preferable way to go for them. Other states, as Representative Fleagle testified, like Virginia, Florida, New Jersey and Montana, have used EMS DNR forms and bracelets for several years.

In fact, Montana calls its program "Comfort One" which is, you know, short, catchy. It allows them to do a statewide education system that has been supported by the Hospital Association of Montana. And attached to my

testimony I did provide a copy of this for you.

But this is an example of the education materials that they use to give to the physicians, to patients, to providers, to hospitals so everyone knows exactly what this program provides. I've also brought today a copy of Virginia's first DNR form and bracelet. The bracelet is similar to New Jersey's.

And the form goes through and allows the physician to just check off those -- those things that apply. And then the bottom of it tears off, slides right into the bracelet, and there's surefire identification for the providers. It's a great system. It's worked very well.

I too would be glad to let you take a look at this as long as I get it back. Just a final thought here. I'm often asked -- I teach subjects for EMTs and paramedics and other attorneys on this issue. And I'm often asked why DNR patients even call for EMS in the first place and whether or not this is really just an education problem that could be solved by going to the families and saying, This isn't what EMS is for. Don't call them.

Well, my answer to this is always, Do not resuscitate does not mean do not treat. I hate to lace a statement with so many double negatives or triple negatives. But EMS is more than just about saving lives.

And a lot of people see the lights and sirens and defibrillators and get all caught up in it.

But it's also about caring for patients. It's about easing their breathing or lessening their pain. And an EMS provider or any health care provider, for that matter, shouldn't take a hands-off approach to a patient just because they have one of these bracelets on and say, Well, there's nothing for me to do here.

There's still a great deal to be done for that patient short of the unwanted heroic measures. Terminally ill patients have the same right as anyone else to call for an ambulance and I submit may be much more in need of one.

As most of you probably know, this legislation was first introduced by Representative Fleagle in 1998 and received widespread support from this chamber. In fact, last session's version of a nearly identical bill as House Bill 96 passed the House 201 to zero prior to the expiration of the session.

And last summer, as you know, there was testimony at a hearing by hospitals, hospices, emergency physicians and medical ethicists at last summer's hearing. And I interpreted it as being overall very supportive of the concept.

Therefore, the time seems right for the General Assembly to assist Pennsylvania's EMS providers and

give them a DNR law that would permit them to do their jobs with greater efficiency and compassion.

Thank you again for the opportunity to testify. And I'd be happy to address any questions.

CHAIRPERSON BROWNE: Thank you, Mr. Wolfberg, for your testimony. I just have a couple concerns or questions. You had mentioned the difficulty that the EMS personnel have under the current system to honor an advance directive.

What circumstances based on your experience would somebody have the ability to honor? What's under the current law, or what is standard form right now?

MR. WOLFBERG: Two -- two ways that it would be honored under current law. One is if after explaining the circumstances of the incident to the medical command physician, that doctor gives an order by radio that says it's okay to withhold resuscitation, you know, do these other things, transport them and bring them into the hospital.

The second way would be is if the physician who has prior knowledge of the patient's advance directive being operative would instruct the EMS personnel about that. So it's fairly limited.

CHAIRPERSON BROWNE: And in terms of percentages, is there any way you can put a -- when this

situation occurs in the field, if you had to take a guess of what percentage that an EMS -- an EMS personnel can honor a DNR order, what would that be?

MR. WOLFBERG: That they can honor a living will under the law as it stands now?

CHAIRPERSON BROWNE: Yeah.

MR. WOLFBERG: I would say -- if you're talking about percentages of patients who are in cardiac arrest and who don't want the resuscitation, how many of them have to get it despite the living will?

CHAIRPERSON BROWNE: Right.

MR. WOLFBERG: I would probably say a majority. I couldn't really give a percentage. But I -- just from my own experience, I would -- and from what I hear from my clients and working in the field, that it would be -- it would be greater than the majority, perhaps even 75 percent.

CHAIRPERSON BROWNE: Okay. The bill mentions a good faith exception for a conscience -- for conscience reasons that EMS personnel cannot honor an EMS DNR order. What legal implications does that present as far as the ability of EMS personnel to avoid honoring the EMS DNR order through the identification through the bracelet?

MR. WOLFBERG: Right. It -- it offers really no implications beyond what is currently in the law for any

provider who believes in good conscience he can't execute the provisions of a living will. The current law allows doctors and any other health care provider to transfer the care of that patient if in good faith they can't comply for matters of conscience.

This bill would simply do exactly that same thing for EMS personnel who in good conscience can't comply with the DNR order. The reality, though, is under the current law there's a provision that you can transfer the care of that patient if you're unwilling to comply. In the prehospital system, there's very little time to do that.

Most likely, that would result in resuscitation. But importantly, we have to recognize that some EMS providers may have a conscience, you know, objection to that sort of withholding care. And importantly, I think this would immunize those providers, provide immunity from civil prosecution and immunity from retribution by their employer from making that decision as long as it was made in good faith.

And remember, the result of that is the patient gets resuscitated and if they're successful, is delivered to the emergency department as a viable patient. And the decision could be made at some point once the patient's in a controlled environment like the hospital.

CHAIRPERSON BROWNE: Okay. And lastly, you

had mentioned how Virginia had expanded the circumstances under which someone could execute an EMS DNR order. Do you know what circumstances; that is, did they expand it beyond the scope of this bill?

MR. WOLFBERG: Yes. They would expand it -- my understanding is that they would expand it -- they have expanded it to patients -- beyond patients who have operative living wills. Basically, that would mean anyone who, like you or I, who is -- who is competent, healthy, could say, for whatever reason, I don't want to -- I don't want to be resuscitated, talk it over with their doctor and get -- get a bracelet or an order to be able to accomplish that.

They've also, I think, retooled the bracelets a little bit in the form so other providers other than just EMTs and paramedics will -- will be able to recognize and act on the bracelets and forms.

CHAIRPERSON BROWNE: Somebody -- just one thing had come to me based on what you had just mentioned. Under the circumstances -- regarding liability of the EMS personnel, EMS personnel or another medical provider. And you had a bracelet that was transferred to another person. The bracelet doesn't provide any identification through any type of photograph or anything like that?

MR. WOLFBERG: Correct.

CHAIRPERSON BROWNE: What would be the -- under the circumstances of the bill, what would be the liability to the provider?

MR. WOLFBERG: Well, the -- that's a good question. We could probably talk all day about that. I mean, there would be enough liability to go around for everybody in that case. But first off, the person who would transfer that bracelet to someone else with the intent of causing their death could be prosecuted under criminal statutes.

That's the case under the current law. That would not change under this legislation. The liability of the provider for honoring that, as long as the provider has no knowledge that this isn't the patient, that provider would be protected as long as he acted in good faith.

Essentially, what happens under this proposed legislation is that the presence of a bracelet or a card or a form would really kind of be prima facie evidence of a valid declaration and a valid DNR order and relieves the provider of a duty to have to call the doctor and have to do all those other things to confirm it because time really doesn't permit it under those circumstances. But that's an excellent question.

CHAIRPERSON BROWNE: Thank you. Any other questions by members? Yes, Representative Daley.

REPRESENTATIVE DALEY: Take me through the process -- I -- tell me how an advance medical directive becomes operative.

MR. WOLFBERG: Under current law?

REPRESENTATIVE DALEY: Under current law.

MR. WOLFBERG: A person at any time of sound mind, you or I or our family members or anyone else, goes to an attorney or gets a form from an association or wherever, a hospital, a nursing home, and fills one out at any time, being of sound mind.

But that declaration -- so any of us in the room could have one as we sit here right now. But that declaration doesn't become effective, it doesn't kick in until under the law one of two things happens. First is that the person is in a chronic vegetative state or what's called permanently unconscious under the current law.

The second option is if the person is terminally ill and incompetent. So the patient has to be in pretty dire straights for the advance directive to even kick in under the law as it is written right now. This wouldn't expand that universe at all.

The second thing that has to happen under the current law is the attending physician, the person's regular doctor, has to make the determination that those -- one of those two conditions exist, meaning that they're

permanently unconscious or terminally ill and incompetent, put that in writing in the chart and then has a duty to have a second physician confirm that diagnosis.

So there's really three steps under current law: The diagnosis, the written declaration of that diagnosis, and the confirmation of that diagnosis by a second physician.

REPRESENTATIVE DALEY: So under current law, it's the duty of the physician to confirm that terminal condition or the chronic vegetative state?

MR. WOLFBERG: Correct. EMS providers nor medical command physicians would be making those determinations.

REPRESENTATIVE DALEY: They would not be making those determinations?

MR. WOLFBERG: Correct. It would just be the person's attending physician and -- who knows them and who has treated them.

REPRESENTATIVE DALEY: Now, my question then goes to the next step. If a patient directs that even if a cardiac or respiratory arrest, that cardiopulmonary resuscitation not be initiated, doesn't the attending physician first have to make a determination that the patient's either incompetent or in a terminal condition or state of permanent unconsciousness --

MR. WOLFBERG: Yes.

REPRESENTATIVE DALEY: -- for that to happen?

MR. WOLFBERG: Yes. The doctor wouldn't even give the patient the bracelet until those things had happened. So that's kind of the safety net there.

REPRESENTATIVE DALEY: Yeah. I have no other questions.

CHAIRPERSON BROWNE: Any other questions by members? Thank you, Mr. Wolfberg.

MR. WOLFBERG: Thank you.

CHAIRPERSON BROWNE: Next we have Jessie Rohner, Executive Administrator, Pennsylvania State Nurses Association. Thank you, Ms. Rohner, for your time and testimony today. You may begin.

MS. ROHNER: Thank you. Good morning, Mr. Chairman and members of the Committee. My name is Jessie Rohner. I'm the Executive Administrator of the Pennsylvania State Nurses Association. This is Susan -- to my right is Susan Shanaman.

VIDEO TECHNICIAN: Is your microphone on? Is your red light on?

MS. ROHNER: Yes.

VIDEO TECHNICIAN: Okay. Could you pull it a little closer?

MS. ROHNER: Okay. Is that better?

VIDEO TECHNICIAN: As long as they can hear. I can hear.

MS. ROHNER: Susan Shanaman is Pennsylvania State Nurses Association's lobbyist. I wish to thank you for the opportunity to speak today regarding House Bill 96, which if enacted will provide for advance directives for non-hospital emergency medical services health care.

The nurse is one of several health professionals who has a responsibility for ensuring that advance care directives initiated by the patient are current and reflective of the patient's choices. Facilitating patients with respect to making end-of-life decisions is a process that includes evaluating changes and the patient's perspective and health care state.

The nurse has a responsibility to facilitate informed decision-making including but not limited to advance directives. Advance medical directives are of two types: Treatment directives, often referred to as living wills, and appointment directives, often referred to as power of attorney or health proxies.

PSNA, as an advocate for the development of a process that will allow patients outside of institutional settings to use advance directives, supports legislative action that clarifies the roles and responsibilities of health care providers in the implementation and execution

of advance directives.

The trend for the past ten years, a trend which shows no signs of slowing, is for patients to be hospitalized only when they are acutely ill. In addition, the availability of new technologies in non-hospital settings allows many patients to receive their care outside of the hospital, in clinics or at home in a manner that was not possible before. It is, therefore, more critical than ever that legislation such as House Bill 96 is enacted now.

As indicated by the position statement of the American Nurses Association, concerns exist regarding the nursing role in implementing DNR orders. As a result of these dilemmas concerning confusing or conflicting DNR orders, the Pennsylvania State Nurses Association and the American Nurses Association support the following ten principles regarding the implementation of DNR decisions.

These principles are applicable to both hospital and non-hospital settings. The choices and values of the competent patient should always be given highest priority, even when those wishes conflict with those of health care providers and families.

In the case of the incompetent or never competent patient, any existing advance directives or the decisions of surrogate decision-makers acting in the patient's best interest should be determinative. The DNR

decision should always be a subject of explicit discussion among the family, the patient, any designated surrogate decision-maker acting in the patient's best interest, and the health care team and should include consideration of the efficacy and desirability of CPR, a balancing of benefits and burdens to patients and therapeutic goals.

Nurses need to be aware of and have an active role in developing DNR policies. DNR orders must be clearly documented, reviewed and updated periodically to reflect changes in the patient's condition. A DNR order is separate from other aspects of a patient's care, and there should be no implied or actual abandonment of other types of care for patients with DNR orders.

Nurses have a duty to educate patients and their families about all types of termination of treatment decisions and should encourage patients and families to think about these decisions before admission to health care facilities. Nurses have a responsibility to educate patients and their families about the various forms of advance directives.

There should be clear mechanisms within each health care facility for the resolution of disputes among health care professionals or among patients, families and health care professionals concerning DNR orders. If it is the nurse's personal belief that her moral integrity is

compromised by her professional responsibility to carry out a particular DNR order, she should transfer the responsibility for the patient's care to another nurse.

The appropriate use of advance directives can prevent suffering for many patients who choose to engage in end-of-life decisions, decisions which are part of a *self-determination process, evaluating changes in the* patient's perspective and health state.

We, as nursing professionals and as an organization, firmly believe that all persons should have the right to a peaceful death without medical intervention if they so choose. About 32 states have enacted similar legislation or have adopted attorney general opinions that provide the option of utilizing DNR orders in noninstitutional settings.

While we are working towards this legislative remedy, nurses are moving forward with other initiatives which we hope will increase the health and safety of patients and which PSNA believes should be recognized in this legislation. Let me explain.

The nursing profession as a whole is moving toward increasing the educational level of registered nurses. More and more individuals are earning a baccalaureate degree in nursing before entering the profession. As patient acuity levels continue to increase

and new technologies are introduced, nurses need to maintain a higher level of education to keep up with the needs of their patients.

Nurses recognize the need for lifelong learning and are taking advantage of advanced education opportunities. A growing number of nurses are continuing their education and becoming advanced practice nurses who use their knowledge and education to serve as primary care providers.

Advanced practice nurses include the following specialties: Certified registered nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists. All these specialties have been practicing in this Commonwealth for an extended period of time.

Over the years, these nurses have proven themselves to be capable and accomplished providers of health care to patients of all ages. Their practice has enhanced access to quality, affordable, comprehensive care for citizens of the Commonwealth, particularly those who live in medically underserved areas.

These nurses work in health care settings such as community health centers, hospitals and hospital clinics, school and college student health clinics, physician offices, HMOs, nursing homes and hospices,

business and industrial health care settings, home health agencies, schools of nursing, nurse-run centers, and military and Veteran Administration facilities.

There are approximately 6,000 advanced practice nurses in this Commonwealth providing services in all 67 counties. In fact, this General Assembly recognized the work of the advanced practice nurses in passage of Act 68 of 1998 by including certified registered nurse practitioners as primary care providers.

And this year Medicaid and Medicare have acknowledged the valuable contributions of advanced practice nurses by permitting direct payment for services. PSNA therefore believes that one minor change should be made to this legislation to assure the recognition of the nurse's role as the health care professional who will probably attend the patient at the time of death and the health care practitioner best able to make judgments related to the patient's condition.

Nurses have the authority to make declarations of death, yet the role of the nurse is incorporated into the general role of the health provider under this legislation. PSNA believes that the nurse should have special designation in the legislation associated with that role and the role as continuous provider to most terminally ill, homebound or hospice patients.

Thus, we believe that the legislation should be amended to allow advanced practice nurses in collaboration with physicians to make the determination when the declaration becomes effective.

Borrowing from the state of Ohio's statute, the authority and qualified immunity for a nurse practitioner who participates in the DNR process could be stated as follows: A person who holds a certificate of authority to practice as a certified nurse practitioner or clinical nurse specialist under state law may take action that may be taken by an attending physician under DNR identification and do-not-resuscitate orders and has the immunity provided by statute if the action is taken pursuant to a standard care arrangement with a collaborating physician.

Again, I thank you for the opportunity to appear today and commend your consideration of this very important and needed legislation that will provide for self-determination rights of the terminally ill who wish to die at home or in a noninstitutional setting.

I would be pleased to try to answer any questions that you might have.

CHAIRPERSON BROWNE: Thank you, Ms. Rohner, for your testimony. I just have, I guess, several questions or concerns. One of the things that was

mentioned in the prior hearing that was a potential conflict that might exist in the field now or is something that is separate in the bill is the difference between resuscitation and comfort care.

And you had mentioned about -- Mr. Wolfberg had mentioned the same thing regarding the ability of providers to provide care even though it's not resuscitation. Do you have any specific concerns or experience in terms of when that conflict comes into play or doesn't come into play with regards to a situation where someone is -- a DNR order is being executed and a provider wants to give comfort care but there might be potential liability that would be considered resuscitation? Is there a conflict like that in the field?

MS. ROHNER: I do not believe that there is. I think that it's fairly straightforward. And I think it has -- well, I shouldn't say straightforward. But I think particularly where nurses have had experience with the comfort care is really in a hospital setting where the patient might need some comfort, might want a drink of water, might want to be turned, might need some oxygen.

So I think we have the experience from the hospital setting that will transfer to a home setting. I think for nurses, it's relatively clear what constitutes artificial means of sustaining a patient and what is merely

comfort care.

CHAIRPERSON BROWNE: So there's enough delineation in the practice in terms of protocols for each one that if somebody has a DNR order and you provide comfort care, there's no liability to the nurse?

MS. ROHNER: I believe that that is correct, yes.

CHAIRPERSON BROWNE: Okay. You had mentioned about clear mechanism within each health care facility regarding conflicts between families and providers. Do those things, based on your experience, exist right now? Is that rare to see that?

MS. ROHNER: I think it's becoming -- I think it is rare. I think that early on when we were beginning to look at advance orders -- or advance directives, that there were health care providers who were perhaps not as comfortable or there were patients -- families who were not as comfortable.

But I think in the last decade, we've moved -- we've made tremendous strides in decreasing the conflict so that most often now, if it is done in an appropriate fashion with the patient, with the family or with a surrogate or with the ethics committee and everyone is part of that decision-making, I think the decisions are much better decisions that individuals -- all the individuals

involved in the team can live with and are comfortable with.

CHAIRPERSON BROWNE: It seems like that would be very important for this bill to work in the field probably.

MS. ROHNER: Yes.

CHAIRPERSON BROWNE: And the last concern -- and it's probably the most important thing you mentioned. -- was the expansion of the bill regarding the allowance of a nurse practitioner to be the one to make a determination in collaboration with a physician.

How would that work? How would -- give me a specific example of how that would work.

MS. ROHNER: Well, I think it would probably work as it currently works with our advanced practice nurses who are functioning in counties in the Commonwealth right now. We do have APRNs or certified nurse practitioners primarily and clinical nurse specialists who are providing care very often to the elderly, very often to children, where particularly in medically underserved areas they have a collaborative agreement with the physicians.

They see the patient. The physician is not on the premise. They have -- whatever that collaborative arrangement is is determined between the APRN and the physician, I mean, if they meet once a week, if they meet

once a month and review cases.

And I -- I would expect that this would work no differently, that when the advanced practice nurse finds a patient or has a patient or a family in her -- that she is seeing in a clinic or wherever she is seeing the patient, that the same discussion would go on as it would with the physician.

She would then discuss that with the physician. And a determination would be made that yes, this patient does meet the criteria or does not meet the criteria.

CHAIRPERSON BROWNE: You're saying -- you mentioned Ohio's statute. Is that the only state that you know of that's allowed that?

MS. ROHNER: No. I believe both Maryland and Oklahoma I believe have nurse providers in their act. Yes. And we can provide those to you if you would like. I believe we have them coming today.

CHAIRPERSON BROWNE: Thank you. Thank you very much. Any questions from members?

REPRESENTATIVE DALEY: No, no.

CHAIRPERSON BROWNE: Thank you very much for your testimony. Larry Frankel from American Civil Liberties Union. Mr. Frankel.

MR. FRANKEL: Good morning, Representative

Browne, Daley and Fleagle and members of the staff. I am Larry Frankel, Executive Director of the American Civil Liberties Union of Pennsylvania. With me today is Robyn Martin-Wall, a student who's been an intern in our office this last academic year. She has some prepared testimony she will present first, and then I have a couple comments after that.

MS. MARTIN-WALL: Good morning. Again, my name is Robyn Martin-Wall, and I am currently completing my Master's of Law and Social Policy Practicum at the American Civil Liberties Union of Pennsylvania. I would like to thank the members of the Task Force on Guardianships, Estates and Trusts for extending this opportunity to testify on House Bill 96 and the subject of advance directives and do-not-resuscitate orders in emergency medical service health care.

The ACLU believes that all persons are entitled to decide whether to receive or continue medical treatment or to have such treatment withheld or withdrawn consistent with their express wishes or best interests. The ACLU thinks that this right is based upon the fundamental civil liberty principles of autonomy and self-determination, privacy, and the freedom of thought and religion.

Current health care practices direct emergency

medical service professionals to use extreme measures, if necessary, to stabilize persons who are in a medical emergency. However, without prior knowledge afforded by family members or advance directive documents, emergency medical service personnel may inadvertently and unintentionally defy do-not-resuscitate orders secured by the patient through a physician.

By adopting this proposed amendment to Title 20 of the Pennsylvania Consolidated Statutes, the Pennsylvania General Assembly can take an important step by joining at least 27 states who currently have prehospital DNR programs to insure that autonomy and self-determination of all persons will be protected.

By extending the advance directive to emergency medical services of the health care system and by providing a bracelet reminiscent of the medical alert bracelet and a wallet-sized card to make emergency medical service health care professionals aware of existing do-not-resuscitate orders, declarants will be provided the autonomy they requested and deserve at a time when such decisions are most significant.

By amending Title 20, the Pennsylvania General Assembly can reduce the misplaced heroic efforts of emergency medical service workers, limit the undue stress on patients who do not wish to be resuscitated, and permit

emergency medical service workers to honor the most important decisions of declarants. House Bill 96 will allow for a simple procedure that can be an easy solution to a potentially heart-wrenching situation.

Thank you again for your time and interest in this issue. And I will be happy to answer any questions you may have.

MR. FRANKEL: I would now like to address what I found -- and I think others who I asked of -- a little bit confusing about the bill itself. And if you turn to page 9 which contains some of the language about the proposed form. And I understand -- and something that's become clear today and made it, you know -- from being here today made my own thinking, I guess, a little clear on this, that it isn't the intention of expanding the universe; that it has to be somebody who is incompetent and terminally ill or in a permanent unconscious state.

But if you look down to the bottom of the patient, starting at line 22, the form would allow for the signature of a patient. And it would be my testimony that if the doctor has to find the person incompetent, that the patient would have no practical or legal capacity to sign this form, that I find -- and I remember last week I had a brief conversation with Representative Fleagle that there was something that was confusing to me. And I think I

understand my confusion a lot better.

The solution may be to eliminate that portion of the bill so no one -- if you're incompetent, you cannot have a legal capacity to sign this form. Now, as a policy matter, the ACLU probably believes that it shouldn't be limited to only those who are incompetent and terminally ill. But I understand the explanation about doing this incrementally.

But as it is written, this does create some confusion about what really can trigger it. Could a patient sign this and have it be recognized? So I think that in some senses, that's a policy decision for you to be making.

But as someone who has read the bill a number of times and listened to the testimony today, unless someone can enlighten me, I don't think having that provision in the form is going to help make it effectively carried out.

And that's really the only intent. But we support the bill; we support the concept of the bill. We'd just like to see that clarified so there is no confusion out there. And if at some later point, years down the road, there's an effort to expand it so that those who are competent but terminally ill wish to make these declarations as well, have these orders in effect, we

certainly would support that also.

CHAIRPERSON BROWNE: Thank you both for your testimony. Any questions from members?

REPRESENTATIVE DALEY: No. I understand where Larry's coming from and that's why I raised the question.

MR. FRANKEL: And your questions earlier helped me understand that it's why --

REPRESENTATIVE FLEAGLE: Mr. Chairman, I just --

CHAIRPERSON BROWNE: Yes.

REPRESENTATIVE FLEAGLE: Just to comment, the -- I mean, you're getting way over my head on the legal issues in this. But it's my understanding that this document must be signed by a competent person but only becomes active when the person becomes incompetent.

Certainly they will not be -- I mean, an incompetent or unconscious person cannot sign a document.

MR. FRANKEL: I understand that the living will declaration has to be signed by a competent person. The way I understand this form and the bill, the doctor comes in, certifies one that they've signed a living will. But now they are both incompetent and terminal; and therefore, the order can go in effect.

This provision also allows the surrogate for the patient to sign, which perfectly makes sense. And I'd

be happy to sit down with you, Representative Fleagle, the attorney from Duane, Morris. And maybe I'm missing something. But I read it.

I showed it to another attorney. And I said, If you're incompetent, you can't sign a form. And it's the living will that is the important form to be signed when they're competent. This takes into effect when they become incompetent so that that next step can be carried forward.

REPRESENTATIVE FLEAGLE: Mr. Chairman, I'd be glad to work with Mr. Frankel. If it's confusing to him, why, I want to make sure there's no doubt about that.

CHAIRPERSON BROWNE: Okay. As far as the -- a regular DNR order can be signed, a regular DNR order, is that -- I would figure that's done when -- in combination with the living will. You sign it when you are -- is that like when you are competent?

MR. FRANKEL: This, as I understand it, is for the DNR order that would not be in the hospital record, the prehospital or even after the hospital. And it could be certainly in the medical records at the hospital. It could be a form you sign when you go into the hospital.

This is for those people who are not hospitalized and not have it in those records. I mean, obviously, based on what I heard today from those people who have actually been in the field, do-not-resuscitate

requests contained in the living will are carried out even without these orders now where they are known about.

My understanding of the legislation is to make it so that you don't have to look at the living will to determine whether or not it is effected. And if the intent of the legislation is to be able to carry out on the dictates of a living will that has kicked in -- and they can only kick in under present law by incompetence.

That's in the statute. I looked at it again today. I heard the testimony. So we're talking about somebody who probably has been in the hospital, released back home because they and their family decided they would rather spend their last few months at home.

But they certainly -- it's only a matter of confusion. I don't think it changes the bill at all. But if somebody who read this -- and I thought the idea behind the bill was to clear up any confusion. You can't have a competent person signing a -- an incompetent person signing a document.

CHAIRPERSON BROWNE: You had mentioned -- you had mentioned in your testimony regarding some of the reasons why this makes sense in terms of the rights of individuals. With these still you have concerns about Pennsylvania going forward with this similar to what Virginia did in terms of extending it beyond terminally

ill?

MR. FRANKEL: We would certainly be supportive of it. But I -- again, I think we understand that incrementalism is probably the way to go.

CHAIRPERSON BROWNE: Okay. Thank you very much. Appreciate your testimony. Charles Artz and Dr. Todd Sagin. Are they here? Thank you, gentlemen, for your time. Pennsylvania Academy of Family Physicians. You may proceed. Thank you.

DR. SAGIN: Mr. Chairman, Members of the House Judiciary Committee's Task Force on Guardianships, Estates and Trusts, good morning. My name is Todd Sagin. I'm here with Charlie Artz, Counsel to the Pennsylvania Academy of Family Physicians. And I'm here today to express support for House Bill 96 on behalf of our state economy.

I'm pleased to have the opportunity to promote this bill because I have a long-standing professional interest in ethical issues surrounding medical intervention at the end of life. I have practiced family medicine and geriatrics for 20 years in Pennsylvania, and I helped thousands of patients plan for the onset of debilitating or terminal illness.

In the 1970's, I founded and was president of the Delaware Valley Ethics Committee Network, a group which promoted the establishment and training of medical ethics

committees in hospitals throughout southeastern Pennsylvania. It was a group that worked to educate professionals about the importance of living wills.

Every day throughout our Commonwealth, family physicians are working with patients and their families to assure that the health care each patient receives is consistent with his or her personal values and wishes regarding specific medical interventions.

They do so recognizing that patients have statutory, constitutional and common law rights to refuse unwanted medical treatment. Doctors encourage patients to exercise these rights by executing living wills and durable power of attorney documents.

These tools provide important guidance to health care professionals when patients are not able to communicate their wishes directly. Unfortunately, they are frequently not available for immediate review when an unanticipated health crisis strikes.

In urgent situations, health professionals must act quickly and definitively; and there is little time to engage in an effort to discover and confirm the health care wishes of a noncommunicative or an incompetent patient. The resulting medical intervention, though well intentioned, may be unwanted by the patient.

Where the intervention involves

cardiopulmonary resuscitation, the process is an unavoidably painful and frightening assault on the ailing individual. When this happens, the patient suffers a violation of her legal rights as well as the associated fear, pain and potential trauma, cost and uncertainty regarding her future state of health.

The intention and effect of House Bill 96 to allow select patients an opportunity to avoid this circumstance is commendable and will be a relief to thousands of Pennsylvania's citizens who fear unwanted resuscitation in the event of cardiopulmonary arrest.

This bill will help remove the Catch-22 faced by patients who fear that if they call for an ambulance, they may be subjected to unwanted interventions; but if they do not call for help, they must suffer unnecessarily in extremis where the professional administration of comfort measures could be of benefit.

Several modifications to the language of the bill will enhance its ability to meet the needs of Pennsylvania's citizens. The first recommended change is found in Section 5413 (g) and concerns the language of the do-not-resuscitate order to be executed by the patient's attending physician. And this is the issue Mr. Frankel just raised.

The physician is asked to affirm in this order

that the patient is incompetent. There is no logical reason to require a patient be incompetent in order to possess the proposed EMS DNR order. The purpose of the order is to give direction when they become incapacitated or incompetent as the result of a sudden medical crisis.

I note that in hospitals throughout the Commonwealth, it's common practice for physicians to write do-not-resuscitate orders after discussions with competent patients. Under the current language of this proposed bill, a terminally ill patient could present to a physician and request that an EMS DNR be executed.

As I understand the language of this bill, the physician would have to respectfully decline and ask the patient to return at a time when he is incompetent and of course at that time bring his duly authorized surrogate with him.

The language as presently written appears to unintentionally deprive competent terminally ill patients the rights this bill intends to give them. It's also unclear in the language whether the physician and the patient and/or surrogate must sign the EMS DNR order for it be valid. It certainly appears reasonable to require two signatures on this document, and the bill -- and that's a typo there. -- the bill should expressly so state.

Finally, the value brought by House Bill 96

should not be limited to those of Pennsylvania's citizens who are terminally ill or permanently unconscious. The legal, ethical and medical consensus that individuals have a right to refuse unwanted medical treatment applies to everyone, not just to a limited group of patients; and therefore, the ability to advise emergency medical workers of a wish to avoid resuscitation should be applicable to all.

Recent experience in Oregon where physician assisted suicide is legal shows that most who choose this option do so because of a fear of a loss of autonomy; that is, they fear that decisions regarding medical interventions will be determined by others or by the circumstances under which they become acutely ill.

The EMS DNR order provides a way to retain autonomy for patients and retain control over medical events. And in doing so, it should deter individuals from seeking more desperate courses of action such as those offered by Dr. Kevorkian in Michigan. This peace of mind should be available to all and not just to the terminally ill or to the permanently unconscious to whom it can offer no solace.

There is an opportunity for this bill to clarify the rights of all Pennsylvanians who wish to refuse emergency resuscitation, and I encourage the Committee to

expand the language of the bill accordingly. Thank you for your consideration of these comments.

Family physicians will continue to serve their patients and help them accomplish their personal health goals. House Bill 96 will help both doctors and patients to this end, and we welcome its passage.

CHAIRPERSON BROWNE: Thank you very much for your testimony. The thing I guess you mentioned that was the most important in terms of the substance of this bill is your opinions that the -- the people who should be able to execute this should not only be the terminally ill; it should include everyone, including people who are I guess per se healthy.

Do you foresee any legal implications to the medical profession by allowing an expansion of this type of situation to everyone outside of terminally ill patients? Is it something that the medical profession might be concerned of in regards to legal liability?

DR. SAGIN: Well, if you put the terms medical profession and legal liability in the same sentence, there always are concerns. But I think there is a very clear and well-established consensus in the legal, medical and ethical communities that there's an absolute right to refuse treatment on the part of all patients, not just the two classes currently enumerated in this bill and the

living will statute.

So the answer to your question is no, physicians should not have a concern about liability with an expansion of language.

CHAIRPERSON BROWNE: So in -- in the field -- just to give an example how this would work. If somebody, when they execute a living, could get a card that has a DNR order on it and they get in a car accident and as a result of the car accident they're permanently unconscious or they're in a situation where they can't be revived, that's -- in that circumstance, the EMS personnel, if they see that card, they just decide not to give treatment.

Is that what you -- that type of situation you would foresee that?

DR. SAGIN: Yes. If there is some kind of legally authorized statement that expresses their wishes not to be resuscitated, EMS personnel would have -- should have the mandate to respect and honor that.

CHAIRPERSON BROWNE: I guess -- I guess that one of the concerns of expanding it beyond this bill does provide is that it opens up situations that are a lot more -- will be a lot more common, a lot more numerous. And the possibilities of making mistakes, even though it's not, you know, not something that we want to happen, making mistakes would be a lot more possible.

So that's something that in terms of Representative Fleagle's approach, doing it incrementally might be, at least from my perspective, might be more prudent in terms of where this would apply. But I know where --

DR. SAGIN: And we certainly respect that in incremental advances and advance nevertheless. I would point out that the living will statute as currently passed in this state is in practice largely irrelevant because -- that because we have this consensus and general appreciation that patients have a right to refuse treatment, medical personnel act in accordance with that.

That's common medical practice. And so those constraints, although they're written into the language from living will statute, the practice are not true constraints on what's going on every day in this state. I'm not aware that we've had as a result a lot of mishaps.

Perhaps you've suggested we might have if we expanded the opportunity here for EMS personnel to also respect patients' rights to refuse treatment.

CHAIRPERSON BROWNE: I just have one -- just one further question that relates back to testimony on protocols within hospitals in terms of procedures when it comes to conflicts between families and practitioners and providers in regards to living wills and DNR orders.

Is it your experience that that is pervasive in the field, or is it something that needs to be worked on in combination with this bill as far as having those type of protocols?

DR. SAGIN: I'm not sure I'm entirely -- protocols that address where conflicts occur such as language that would specify who, when there's not a designated surrogate and there's a conflict in the family, could speak for patients?

Yes, that kind of clarity generally is helpful. Although, I'd have to say that in most institutions, the resulting struggle that takes place in trying to work through the conflicts generally is productive and ends up in some kind of a resolution that doesn't require the issue to go to court, for example.

And there are ethics committees in virtually all of our hospitals in the state now that assist in that process. So although it would be helpful to have some clarity written into the law there, I don't think it's essential.

CHAIRPERSON BROWNE: Okay. Thank you. Thank you very much. Representative Fleagle?

REPRESENTATIVE FLEAGLE: No.

CHAIRPERSON BROWNE: Thank you very much. Appreciate it. The last testifier is James Jordan. He's

here. Deputy Secretary of Health, Department of Health. Thank you. You may begin when you're ready.

MR. JORDAN: Good morning, Mr. Chairman, members of the House of Representatives Task Force on Guardianships, Estates and Trusts, members of the Judiciary Committee. I am James Jordan, Deputy Secretary for Health Planning and Assessment, Department of Health.

I oversee the Emergency Medical Services Office which has primary lead agency responsibilities for the state's emergency medical services system such as EMS training and certification of providers, technical assistance, quality assurance and preparation of the state EMS plan.

I have with me this morning Caroline Bowes. Ms. Bowes is a registered nurse and EMS program specialist. She's worked extensively on this bill and is also responsible for training programs within the EMS office. Thank you for giving us the opportunity to speak to you today on this very important topic. We applaud the efforts of Representative Fleagle and yourselves for the interest on this issue.

When faced with a terminal disease, many persons would want to have all the care available rendered to them that might help them to survive. But once all possible therapies and life-extending treatments have been

exhausted, many of us would not want the natural process of death to be interfered with, especially if such interferences were clearly futile and may result in more suffering and emotionally devastating situations for our family and friends.

There is a well-recognized and well-accepted practice in the hospital setting where individuals already have the right to establish advance directives which waive futile attempts at resuscitation and unnecessary protraction of their pain and suffering when terminal illness or injury is about to end their lives.

Currently, such protections do not clearly exist in the out-of-hospital setting when EMS personnel are called in good faith to assist those of us in need. Many times EMS personnel are called to administer care to terminally ill or injured patients because family members are unaccustomed to the dying process or suddenly become uncomfortable with their loved one's condition.

In such circumstances, they call for immediate help. However, immediate help usually means calling 911 or its equivalent. EMS providers arrive because the family wants comfort or advice for themselves at this terrible moment in their lives, but EMS personnel generally have an altogether different primary focus.

They have been trained to focus on providing

procedures to save lives. When in doubt, they are instructed that it is their legal obligation to act under transfer and medical treatment protocols and to provide the most aggressive interventions possible to save a life.

But in the case of an individual who has, in consultations with his or her physician and family, established that he or she has an irreversible and life ending disease and has also executed an advance directive that no one shall now interfere with the natural process of death, it presents a dilemma if the EMS providers believe they still have a legal obligation to attempt resuscitation efforts.

Simply stated, if EMS providers come into a situation where they have no legal tool or evidence that they would not be held for neglecting to act, they must act. Even if the family objects and states unequivocally that it was the dying person's wishes to avoid unnecessary interventions and procedures, the family are strangers unknown to the EMS personnel.

Thus, when in doubt, EMS providers must attempt resuscitation. House Bill 96 provides a mechanism for an individual who has been determined by a physician to have an irreversible terminal illness or injury to receive an easy to recognize bracelet or wallet card that directs EMS personnel to forego resuscitation attempts.

House Bill 96 attempts to remove the doubt of whether to provide lifesaving measures by providing a legal, easy to identify tool and mechanism to alert EMS providers that they are legally relieved of their usually sworn duty to act.

In turn, it provides a level of comfort that EMS providers are complying with the individual's final wishes. It is also structured to allow EMS personnel to administer interventions without interfering with the natural processes of death and provides penalties for those who knowingly abuse the process.

House Bill 96 relieves EMS personnel who are always trying to do what is best to serve the public from being held liable if they act in good faith to resuscitate such persons simply because they are unsure of the situation. This bill also allows them to stop such efforts if clear documentation becomes available after interventions are started.

House Bill 96 also provides two different options for individuals who wish to alert EMS personnel of their wishes: First, an easy to identify and accessible bracelet to be worn on the wrist; next, a wallet-sized card that EMS personnel would seek and identify.

It also allows a person to have a specific, easily recognized order with which all state EMS personnel

will become readily familiar. This would help avoid the unacceptable and untimely delays. The Department would be charged with the responsibilities of supplying the bracelets, wallet cards and EMS DNR order form that meet standards defined in the bill.

The development of these tools must be accomplished with the advice of the statewide EMS advisory council and with the assistance of the regional councils. This process will use the best input from stakeholders so that the results will be consensus based.

Because of the impact on practice and protocols, the State Emergency Medical Services Office's lead agency responsibilities mandate that implementation be supported by training of EMS personnel and development of regional and state protocols.

The House Bill 96 also requires the Department of Health to include the requirements of the amending act as part of the curricula it provides to EMS personnel under the EMS Act. In Pennsylvania, this information could easily be incorporated into the medical/legal sections of the existing curricula for initial first responder, EMT, EMT paramedic, and health professional training. The information could also be presented and offered as a state-approved continuing education program.

One consideration is that under the

Department's proposed EMS regulations, the Department will endorse education provided in other jurisdictions if it is the equivalent to that provided in programs directly approved by the Department.

Out-of-state programs would not include a component dealing with Pennsylvania law relating to EMS personnel following the DNR orders. Therefore, the Department regulations may need to be revised on final adoption to require DNR education at some point.

In summary, we support the concept of House Bill 96 which recognizes the position with which EMS personnel are confronted. This bill addresses the issue of how to deal with advance directives for terminally ill and injured patients who are at home or in a place outside of the hospital setting where EMS personnel may arrive as the most immediate available health care providers.

It provides a simple and workable mechanism to ensure that a dying person's wishes are honored and yet also provides for appropriate liability protection for EMS personnel. It facilitates the kind of service that we should always try to provide to the citizens of the Commonwealth.

Thank you again for allowing us to testify today. If there are any questions, I will be happy to take them at this time.

CHAIRPERSON BROWNE: Thank you very much for your testimony. I just have maybe two questions based on your testimony. One thing that you mentioned was regarding training for EMS personnel under the EMS Act with the amendments provided in this bill.

When EMS personnel are now trained, how are they instructed in terms of what they should do in these circumstances given that the law currently exists?

MR. JORDAN: The law is very specific. There are specific directives in terms of establishing an advance directive, and the EMS personnel are familiarized with that training. Beyond that, I'm going to ask Caroline Bowes to speak about the specifics of the training.

MS. BOWES: Yeah. They're basically instructed to -- that they have to adhere to the regional treatment and transfer protocols that are approved by the Department. Each of the regions have treatment and -- medical treatment protocols that are actually developed and adopted at the regional level and then forwarded to the state for approval.

So they're taught that they have to follow those protocols and also contact medical command physicians.

MR. JORDAN: EMS processes the direct interaction with the medical command. And in the proposed

legislation, that no longer does exist so retraining would be necessary. An additional responsibility does fall on the shoulders of the EMT or EMT paramedic; however, the guidelines are very specific about the role.

CHAIRPERSON BROWNE: Okay. I guess under the bill, the Department of Health will have the responsibility of setting up the identification process, if I'm correct. I think I'm correct in saying that the cards and/or bracelets will be put together by the Department of Health.

MR. JORDAN: The cards, the bracelet and the form, the DNR form itself, will be the responsibility of the Department within 180 days after the bill becomes effective.

CHAIRPERSON BROWNE: Do you see the process used by other states in terms of the bracelets they're using, the cards that they're using are sufficient to provide the protections that are necessary under this -- under this measure with the additional responsibilities for EMS personnel? Do you foresee that the Department of Health would use the same process?

MR. JORDAN: Well, I can't say that every state is totally consistent. We have been looking at practices in other states, and we will learn from those experiences and take what we feel is best for Pennsylvania. We'll do that in consultation with the statewide advisory

council and with the regional councils.

And then I think the final part is yes to your question. Every effort will be taken to assure that safeguards are in place to prevent abuse.

CHAIRPERSON BROWNE: Okay. One last question that was in regards to -- this is something that has been curious to me about current -- the current statute and what's in the bill regarding is there a legal obligation to act in the field. And the bill provides for the exception of good faith in conscience.

How often is that -- does that come into play in terms of honoring a DNR order in the field? Is that something that provides for a loophole of any kind in terms of the ability of EMS personnel or medical providers just not to regard the substance of this bill as any different than what's out there now?

MR. JORDAN: I believe that this bill provides -- it's an excellent tool. It helps the paramedic or the EMT at the scene. It better defines their role because they're confronted with very complicated situations. The EMTs and paramedics take very seriously their responsibilities.

We monitor their carrying out of those responsibilities. I don't see a loophole. If a -- I mean, there is always an opportunity for abuse. We want to

minimize that. But because they are so serious about their responsibility and preserving life and also meeting -- honoring the wishes of the family and the individual who is being cared for, with special training, I believe we will address most of the concerns that you may have and that you're voicing here.

Concerning how often we expect a paramedic or an EMT to invoke the part of this bill that says they have a right not to implement because of conscience, we can't say without exact direct experience. I think that that would be done -- that's a very difficult decision.

And I don't think that responsibility would be taken lightly. And that's the kind of thing we would stress in the training and have discussions with individuals on in the course itself. It's not something that any EMT or paramedic will take very lightly at all.

CHAIRPERSON BROWNE: So that's something that's not discussed in training right now and how that's legally implemented, good faith exception?

MR. JORDAN: No, that -- that is not. Not the way it's written here, no.

CHAIRPERSON BROWNE: I'm not concerned about how EMS personnel perceive their role. That's not my concern. My concern is how a broad-based statement like that is applied legally. Once you get something out of the

field into something -- into the legal interpretations of it, it -- it can lose or -- it loses meaning or becomes something you don't want it to, you didn't expect it to become based on the intent of the bill. So --

MR. JORDAN: Exactly.

CHAIRPERSON BROWNE: Thank you very much. Representative Fleagle.

REPRESENTATIVE FLEAGLE: Just a comment that during meetings on this bill, informal meetings at least that I had, most of the members there were very adamant about putting in an appropriation not so much for the paperwork and the -- and the cards but -- and I believe it was Janette Kearney of the Emergency Health Service Federation was very adamant about putting money in for education.

And there's -- the statutory language I believe is $50,000 to provide that education. So your comment about putting it in the curriculum and adding it to those who -- to the curriculum of those who have already attained EMT status is well-taken. And that's appreciated by everybody that's been involved in this process.

MR. JORDAN: Thank you.

CHAIRPERSON BROWNE: Thank you both for your time and your testimony. I appreciate it.

MR. JORDAN: Thank you.

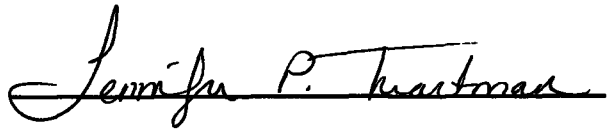
MS. BOWES: Thank you.

CHAIRPERSON BROWNE: That being our last testifier, this hearing is adjourned. Thank you very much.

(Whereupon, at 11:36 a.m., the hearing adjourned.)

* * * *

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me during the hearing of the within cause and that this is a true and correct transcript of the same.



JENNIFER P. TROUTMAN

Registered Professional Reporter

My Commission Expires:
April 30, 2001

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