



**TESTIMONY OF  
THE DEPARTMENT OF THE ATTORNEY GENERAL  
KA 'OIHANA O KA LOIO KUHINA  
THIRTY-THIRD LEGISLATURE, 2026**

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**ON THE FOLLOWING MEASURE:**  
S.B. NO. 3077, RELATING TO HEALTH CARE.

**BEFORE THE:**  
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

**DATE:** Friday, February 13, 2026      **TIME:** 1:00 p.m.

**LOCATION:** State Capitol, Room 225

**TESTIFIER(S):** Anne E. Lopez, Attorney General, or  
Erin N. Lau, Deputy Attorney General

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Chair San Buenaventura and Members of the Committee:

The Department of the Attorney General supports this bill.

Currently, two separate chapters of the Hawaii Revised Statutes (HRS), chapters 327E and 327G, HRS, provide a legal framework for advance health-care directives. The purpose of this bill is to update and consolidate our current laws by repealing those outdated chapters and replacing them with a new chapter, which is a modified version of the Uniform Health-Care Decisions Act (2023), as promulgated by the Uniform Laws Commission. The proposed changes reflect a modern understanding of capacity and reduce barriers to creating advance directives for both general health care and mental health.

The bill includes several key updates:

- 1. Simplifying the requirements to execute a power of attorney for health care:** The bill reduces the number of witnesses required to create a power of attorney instruction from two witnesses or a notarization to one witness.
- 2. Clarifying and safeguarding an individual's right to receive treatment during a psychiatric or psychological event:** The bill explicitly permits an individual to include an enforceable instruction in their advance mental health-care directive. While current law allows an individual to create an advance mental health-care directive, it does not clearly address the enforceability of treatment instructions contained in the advance mental health-care directive

during psychiatric or psychological events, nor does it provide any safeguards to ensure that the individual instructed such treatment. This bill provides those safeguards missing in the current law to ensure the instruction was consented to by the individual by requiring the signatures of two in-person witnesses in the advance mental-health care directive. Those safeguards make the treatment instructions enforceable during psychiatric or psychological events, even if the individual refuses treatment due to the individual's medical condition.

**3. Expanding the pool of qualified providers who may determine capacity:**

The bill allows an advance practice registered nurse (APRN) with advanced education and specialized clinical training to determine whether an individual has capacity. Under current law, only a physician or a licensed psychologist can make that determination. The addition of APRNs will enhance accessibility to timely capacity assessments while maintaining high professional standards.

- 4. Making it easier for sample forms to be updated:** The bill shifts the responsibility of creating and updating sample forms for advance health-care directives from statutory inclusion to the Department of Health (in consultation with the Department of the Attorney General). This change ensures that the sample forms can be updated promptly to address evolving community needs. The current statutory forms, based on the previous Uniform Health-Care Decisions Act (1993), do not reflect a modern understanding of capacity, treatment options, or accessibility, creating unnecessary barriers for individuals seeking to create an advance health-care directive.

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

- 1. Default surrogate as an authorized Medicaid representative:** In 2018, chapter 327E, HRS, was amended to allow a default surrogate to act as an authorized representative for Medicaid purposes. The bill preserves this authority to ensure continuity in health-care decision making for individuals relying on Medicaid.

- 2. Default surrogate selection process:** When Hawaii adopted the Uniform Health-Care Decisions Act (1993), it created a process for choosing a default surrogate by requiring a physician, or the physician's designee, to locate interested persons and have those persons choose a default surrogate from among themselves. This process has been effective, as reported by medical providers, and reflects Hawaii's unique cultural context, including the recognition of "hanai" relationships.

We believe this bill provides significant and meaningful updates to the laws that will clarify and simplify the process to execute advance health-care directives and advance mental health-care directives. These changes will make it easier for individuals and their families to use advance directives to ensure autonomous decision-making and obtain appropriate care. Thank you for the opportunity to provide testimony.



**STATE OF HAWAII**  
**KA MOKU'ĀINA O HAWAII**  
**STATE COUNCIL ON DEVELOPMENTAL DISABILITIES**  
**'A'UNIKE MOKU'ĀPUNI NO KA NĀ KĀWAI KULA**

PRINCESS VICTORIA KAMĀMALU BUILDING  
1010 RICHARDS STREET, Room 122  
HONOLULU, HAWAII 96813  
TELEPHONE: (808) 586-8100 FAX: (808) 586-7543

February 13, 2026

The Honorable Joy A. San Buenaventura, Chair  
Senate Committee on Health and Human Services  
The Thirty-Third Legislature  
State Capitol  
State of Hawai'i  
Honolulu, Hawai'i 96813

Dear Chair San Buenaventura and Committee Members:

**SUBJECT:** SB3077, Relating to Health Care

The Hawai'i State Council on Developmental Disabilities is in **support** of SB3077, which adopts the Uniform Health Care Decisions Act (2023), as modified, to replace existing chapters related to advance health care directives and advance mental health care directives.

The State Council on Developmental Disabilities supports this measure because it strengthens recognition of Supported Decision-Making and modernizes Hawai'i's advance health care directive laws in a way that better protects the rights, autonomy, and dignity of people with disabilities. The bill appropriately recognizes that individuals may have capacity to make health care decisions with supports, technology, and reasonable accommodations, a key principle of disability civil rights and person-centered practice.

SB3077 clarifies that capacity includes the ability to communicate decisions independently or with supported decision making and other reasonable accommodations. This is a critical safeguard for people with intellectual and developmental disabilities and people with mental health disabilities, who may require assistance to understand information or communicate choices but nonetheless retain the right to direct their own health care. By modernizing definitions and consolidating advance health care and advance mental health care directives into a unified statutory framework, the bill reduces confusion and strengthens continuity across systems. These updates align Hawai'i law with contemporary standards and reflect a person-centered approach consistent with federal disability rights principles.

For these reasons, the Hawai'i State Council on Developmental Disabilities **supports** SB3077.

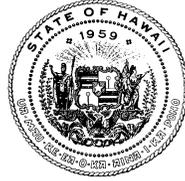
Thank you for the opportunity to submit testimony.

Sincerely,

A handwritten signature in blue ink that reads "Daintry Bartoldus". The signature is written in a cursive style with a large initial 'D'.

Daintry Bartoldus  
Executive Administrator

JOSH GREEN, M.D.  
GOVERNOR OF HAWAII  
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAII



KENNETH S. FINK, M.D., M.G.A., M.P.H.  
DIRECTOR OF HEALTH  
KA LUNA HO'OKELE

STATE OF HAWAII  
DEPARTMENT OF HEALTH  
P. O. Box 3378  
Honolulu, HI 96801-3378  
doh.testimony@doh.hawaii.gov

**Testimony in SUPPORT of SB3077  
RELATING TO HEALTH CARE**

SENATOR JOY SAN BUENAVENTURA, CHAIR  
SENATOR ANGUS L.K. MCKELVEY, VICE CHAIR  
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Hearing Date: Friday, February 13, 2026 1:00 p.m. Room Number: 225 & Video

1 **Fiscal Implications:** Undetermined.

2 **Department Position:** The Department of Health (“Department”) supports this measure.

3 **Department Testimony:** The Adult Mental Health Division offers the following testimony on  
4 behalf of the Department.

5 The Department supports SB 3077, which seeks to adopt the Uniform Health-Care  
6 Decisions Act (2023) with amendments to replace HRS chapters 327E and 327G. The State of  
7 Hawaii previously adopted the 1993 version of the Uniform Health-Care Decisions Act as HRS  
8 chapter 327E. The 2023 revision of the Uniform Health-Care Decisions Act and accompanying  
9 modifications designed for our State intend to improve flexibility, ease-of-implementation, and  
10 individual preferences for decisions involving guardianship, surrogacy, and advance health care  
11 or mental health care directives.

12 The Department appreciates the ongoing collaborative effort to improve the system of  
13 mental health care on our islands.

14 **Offered Amendments:** None.

15 Thank you for the opportunity to testify on this measure.

**SB-3077**

Submitted on: 2/11/2026 6:54:01 PM

Testimony for HHS on 2/13/2026 1:00:00 PM

<b>Submitted By</b>	<b>Organization</b>	<b>Testifier Position</b>	<b>Testify</b>
Louis Erteschik	Testifying for Hawaii Disability Rights Center	Oppose	In Person

Comments:

We oppose the so called Ulysses clause just as we did last year when a similar measure was heard. It is nothing more than an attempt to get people to waive their legal and constitutional rights. Aside from being bad policy, we question its validity and legality. If the individual changes their mind at the moment it would otherwise occur, we believe it may be unenforceable and would still require a Court order. We also question if the person who would administer the medication is really going to want to follow through without legal intervention. We remain concerned that this will be utilized as a way to make it easier to involuntarily medicate people under the guise of individual choice.

Beyond that, it is not really clear what purpose this bill serves. The current law is not particularly "broken". While this is supposedly modeled on the Uniform Law, our understanding is only two other states have adopted this. This is a lengthy bill with a lot of different parts to it, that was developed mostly by the Administration without a lot of stakeholder engagement. We would prefer to see the Legislature designate a work group to meet in the Interim if it feels that this issue is significant enough to warrant further discussion.



**February 13, 2026 at 1:00 pm**  
**Conference Room 225**

**Senate Committee on Health and Human Services**

To: Chair Joy A. San Buenaventura  
Vice Chair Angus L.K. McKelvey

From: Paige Heckathorn Choy  
VP, Government Affairs  
Healthcare Association of Hawaii

Re: **Testimony in Support**  
**SB 3077, Relating to Health Care**

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

Thank you for the opportunity to provide **comments** on this measure, which seeks to update the Uniform Health Care Decisions Act. This bill represents a significant departure for current laws around advanced health care directives, affecting some of the most sensitive and complex moments in health care and governing how decisions are made when individuals may be seriously ill, incapacitated, or nearing the end of life. Any changes to this framework must operate seamlessly across different care settings, clinicians, patients, and families, often under urgent and emotionally charged circumstances. For that reason, even well-intended statutory changes can have wide-ranging operational and clinical consequences if they are not carefully aligned with how care is actually delivered.

The provider community believes there is a meaningful opportunity for deeper engagement on these proposed changes. Broad stakeholder engagement would help ensure that revisions promote clarity and consistency, avoid unintended conflicts, and reflect the realities of modern care delivery, including interdisciplinary teams, overlapping physical and mental health conditions, and evolving care settings. At the same time, we recognize that updating the UHCDA is a priority for some stakeholders, and we understand the desire to move this effort forward during this legislative session.

With that in mind, we are offering targeted amendments intended to make the proposed changes workable in practice. These amendments are not about altering the underlying goals of

the measure, but about ensuring clarity in statutory language, reducing unnecessary administrative and clinical burdens, and better aligning the law with real-world decision-making and patient care workflows.

While our strong preference remains the establishment of a formal working group to fully vet and refine these issues, the proposed amendments represent a good-faith effort to bridge that gap. They are designed to support patients, families, and providers alike by creating a clearer, more practical framework that can be consistently applied across care settings, while preserving the integrity and intent of the UHCDA.

Below, please find the suggested amendments:

1. We request that the committee add a new subsection (d) into the new Section 7 of the UHCDA, starting on page 14 to read:

*“(d) A health care instruction, whether oral or written, shall not revoke, suspend, or otherwise invalidate an advance health-care directive unless the individual expressly states an intent to revoke or modify, in whole or in part, the advance health-care directive and is determined to have capacity to make health care decisions as described in this section at the time the revocation or modification is made.”*

This addition would provide clarity by expressly stating how and when an advance health care directive (AHCD) may be revoked or modified. Specifically, the proposed language makes clear that a health care instruction—whether oral or written—does not override an existing AHCD unless the individual clearly expresses an intent to revoke or modify that directive and is determined to have capacity to make health care decisions at the time the change is made.

This clarification is necessary because the statute, as currently written, may be read to allow instructions given at any time to supersede a valid AHCD. Further, the instructions as laid out in this section may not be portable among care settings and providers. By directly referencing AHCDs and tying any revocation or modification to both express intent and decisional capacity, this amendment helps preserve the integrity of advance planning and provide clearer guidance for providers.

2. We also support modifying the section governing how disagreements between an AHCD and an AMHCD are resolved (in the new Section 10). The way this section is currently written makes it difficult to interpret and creates uncertainty for providers at the point of care. As written, it is not always clear which directive should control when the documents appear to conflict, particularly in situations where a patient has both medical and behavioral health needs, and treatment decisions must be made quickly.

Our proposed amendment seeks to better clarify how decisions should be made by focusing on the primary condition being treated at the time care is delivered. This added clarity is critical for

providers who must navigate these directives in real time while ensuring safe, timely, and patient-centered care.

The suggested amendment is below:

*“(a) If a direction in an advance mental health care directive of an individual conflicts with a direction in another advance health care directive of the individual, the later direction shall control and revoke the earlier direction to the extent of the conflict; provided that the existence of a conflict shall be determined based on the specific health care decision at issue, rather than on whether the individual’s condition is characterized as mental or physical.*

*(b) An agent appointed to make health care decisions other than mental health care decisions has authority over all other health care decisions, including decisions relating to medical or surgical treatment, palliative care, life-sustaining treatment, and care for physical conditions, even when such conditions are comorbid with a mental or behavioral health condition.*

*(c) An agent appointed to make decisions only for mental health care has authority over decisions primarily relating to the diagnosis, treatment, or management of a mental or behavioral health condition, including decisions regarding psychiatric treatment and admission to or discharge from a mental health facility, to the extent authorized by the advance mental health care directive.*

*(d) When a proposed course of treatment addresses both mental and physical health aspects, the agents shall, to the extent practicable, consult with one another. If the agents disagree, authority shall be determined by the primary purpose of the specific decision at issue, as determined by the attending health care provider acting in good faith.*

*(e) A health care provider who relies in good faith on a determination under subsection (f) shall not be subject to civil or criminal liability or professional discipline for acting in accordance with that determination.*

3. We request a change to the new Section 12(c) to make it more clear about when a provider should search for a surrogate decision-maker, especially by adding language around determining lack of capacity:

*“(c) ~~Unless the individual has an advance health care directive that indicates otherwise or the person identified by the individual under subsection (b) is designated as a default surrogate]~~ If the individual has not appointed an agent, lacks capacity to identify a default surrogate, and there are no instructions on identifying a default surrogate, the responsible health care professional or the responsible health care professional's designee shall make reasonable efforts to locate as many interested*

*persons as practicable, and the responsible health care professional or the responsible health care professional's designee may rely on the interested persons to notify other family members or interested persons. Upon locating interested persons, the responsible health care professional or the responsible health care professional's designee shall inform the interested persons of the individual's lack of capacity and that a default surrogate should be selected for the individual."*

4. We believe that amendments need to be made to the new Section 13(a). As written, it is problematic because it allows an individual who has been determined to be incapacitated to disqualify a decision-maker who was appointed prior to the incapacitation. This is unworkable and the exact type of situation that an advance healthcare directive or instruction is meant to avoid. However, there are varying levels of capacity. Individuals may lack capacity to make some decisions while maintaining the capacity to make others, including the appointment of someone to make decisions on their behalf, and it is important to preserve such autonomy when it exists. Below is the suggested amendment:

*(a) An individual for whom a health care decision would be made may disqualify a person from acting as default surrogate for the individual by expressing the wish to disqualify that person. The disqualification shall be in a record signed by the individual or communicated verbally or nonverbally by the individual to the person being disqualified, another person, or a responsible health care professional. If the individual has expressed that the individual did not want a particular person to make health care decisions for the individual, that person shall be disqualified from being a default surrogate. Disqualification under this subsection shall be effective only if made by an individual who retains capacity under section 3(a)(1) and 2(C). ~~[Disqualification under this subsection shall be effective even if made by an individual who is found under section 4(b) or by a court to lack capacity to make a health care decision if the individual clearly communicates a desire that the person being disqualified not make health care decisions for the individual.]~~*

5. We also request removing Section 13(b)(4), that would automatically disqualify an ex-partner from serving as a surrogate decision-maker. Many clinicians have found that families may choose an ex-partner as the best person to make decisions—and that, in fact, they can serve in the role successfully and respectfully. As a result, we believe that these individuals should not be disqualified outright. We do, however, agree that an ex-partner's appointment as an agent should be revoked if the standards outlined in Section 14 are met.

6. We respectfully request the removal of the new Section 18(f) on page 35, as it is unclear what problem it is intended to address or how it would improve current practice. In the absence of a clear policy rationale or demonstrated need for prohibiting a decision to place an individual for more than what seems to be an arbitrary number of days (100), we believe this section would be better omitted.

7. We request the removal of the section authorizing co-agents (on pages 36-37) to better reflect how health care decisions are made in practice. The statute already establishes a clear hierarchy and framework for surrogate decision-making, but the inclusion of co-agents will likely create uncertainty about who has final authority, particularly in urgent or time-sensitive clinical situations where providers need to act quickly and decisively.

When multiple agents are named with equal authority, disagreements or delays can arise, placing clinicians in the difficult position of trying to interpret intent rather than focusing on the patient's best interests. We understand that an AHCD could name multiple agents—but in that case, a clear decision-maker would be named, unlike in the situation this co-agent section imagines. We would also request that the definitions related to co-agents be removed.

8. We also request an amendment in the new Section 21(g)(2) on page 41 to better reflect current statute for AHCDs and add clarity. Further, these amendments are important in the rare case a transfer may not be feasible.

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

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

*(2) Provide continuing care to the patient while the patient remains under the refusing provider or institution's care; and*

*(3) ~~2~~ Immediately make a reasonable effort to transfer the individual to another health care professional or health care institution that is willing to comply with the instruction or decision and provide life-sustaining care and care needed to keep or make the individual comfortable, consistent with accepted medical standards to the extent feasible. ~~[-until a transfer is made.]~~*

9. The new Section 21 appropriately recognizes that health care providers may decline to comply with an instruction when doing so would be inconsistent with generally accepted health care standards. To ensure that this principle is fully and consistently reflected in the statute, we recommend adding corresponding immunity language in Section 23. Specifically, we suggest amending Section 23(a) to include a new subsection (7) that provides clear protection for providers who, acting in good faith, do not follow an instruction that conflicts with accepted standards of care. Aligning these sections will help avoid ambiguity, provide reassurance to clinicians making difficult decisions in real time, and support the safe and appropriate delivery of care.

*“(7) Refusing to comply with an advance health care directive if the directive requires care that is contrary to generally accepted health care standards applicable to the health care professional or health care institution.”*

10. We also believe a clarifying amendment is necessary in the new Section 24(d)(1) to eliminate a potential loophole for emergency responders. As currently drafted, the statute

could be read to allow POLST instructions to be applied or disregarded in ways that are inconsistent with their intended use, creating uncertainty for EMS personnel who must make rapid, high-stakes decisions in the field. By addressing this gap, the proposal provides clearer guidance for EMS providers, supports uniform practice across care settings, and helps ensure that POLST forms function as intended to guide emergency care decisions.

*(d) An emergency department of a health care institution or health care professional who is an emergency medical services personnel or first responder personnel shall not be liable under subsection (c) for a violation of section -21(e) if:*

*(1) The violation occurs in the course of providing care to an individual experiencing a health condition for which the professional reasonably believes the care is appropriate to avoid imminent loss of life or serious harm to the individual or providing care, provided that the emergency medical services personnel or first responder personnel were not aware in advance of a provider order for life-saving treatment;*

11. We also request an amendment to the definition of “legally authorized representative” on page 58, line 4 to include the term “default surrogate” to make it consistent with Hawaii Revised Statutes.

12. Lastly, we are requesting a deferred implementation date of three years (an effective date of July 1, 2029) in order for a working group (which we’ve outlined below) to work through the material changes this bill makes. We believe a formal working group is an important feature to ensure these statutory changes are implemented thoughtfully and effectively. Advance care planning is complex, and even well-intended amendments can create operational challenges if providers, EMS, patients, and families do not share a common understanding of how the law is meant to function in real-world settings.

A working group would provide a structured forum to identify remaining ambiguities, surface unintended consequences, and ensure that the statute aligns with clinical practice, patient expectations, and existing workflows across care settings. In addition, a working group would allow time for education and consensus-building before further changes are made. Clear guidance, training, and consistent interpretation are essential for providers who must rely on advance health-care directives, advance mental health care directives, and POLST forms in time-sensitive situations.

For these reasons, we suggest the following:

*SECTION 15. (a) The Attorney General, in consultation with the Department of Health, shall convene and facilitate a working group to review, discuss, and provide recommendations regarding the implementation of the Uniform Health-Care Decisions Act, as amended by this Act. The working group shall include:*

*(1) One representative from the Department of Health;*

- (2) One representative from the Office of the Attorney General;
- (3) At least six (6) providers representing hospice, palliative, hospital, or any other type of related care;
- (4) One representative from Kokua Mau;
- (5) Two representatives from the Healthcare Association of Hawaii; and
- (6) Any other stakeholders deemed appropriate by the Attorney General to ensure balanced and informed participation.

(b) The purpose of the working group shall be to:

- (1) Identify any implementation issues, ambiguities, or unintended consequences arising from the amendments to the Uniform Health-Care Decisions Act;
- (2) Evaluate the impact of the Act on existing advance health-care directive practices, including those used by hospice and palliative care providers;
- (3) Develop recommendations to ensure clarity, consistency, and workability in implementation;
- (4) Identify whether statutory, regulatory, or administrative changes are necessary to support effective implementation; and
- (5) Partner with relevant stakeholders to mount an education campaign for residents and providers to ensure a comprehensive understanding of the changes within the law and to provide guidance where needed.

The working group shall submit a written report of its findings and recommendations to the legislature at least twenty (20) days prior to the start of any legislation session until the Act takes effect.

Thank you for your attention to this important matter and for your consideration of our amendments.



February 12, 2026

Dear Chair Senator San Buenaventura, Vice-chair McKelvey and members of the committee,

I am writing today to express my concern about **SB3077** that would make changes to the Uniform Healthcare Decisions Act. This bill makes substantive changes to how medical decisions are made for some of the most vulnerable in our society, those who are too sick to speak for themselves. We recognize that work has been done to update existing law through this bill and we are ready to work with the administration and other key stakeholders on changes to improve existing statutes.

Kōkua Mau is a 26-year-old non-profit, and I have served as the Executive Director for the past 16 years. We are one of the lead agencies statewide for educating professionals and the public about Advance Directives and decision making when we are unable to speak for ourselves. Over the years, we have educated thousands of professionals and members of the public and our website is “go-to” site for background information, advance directives form, including in 13 languages, and other tools and resources to help people understand these decisions.

This bill directly impacts the work that we do daily as well as hundreds of doctors, nurses, social workers, case managers, elder care attorneys and other professionals who care for people with serious illness. These frontline workers should be included in conversations on proposed changes as they have direct experience with what works and what could be improved. Currently, our system for Advance Directives is working well, although there is always room for improvement.

A very similar bill was re-committed last year at the end of the session. The Healthcare Association identified this topic as a legislative priority in August, and we were ready to create a working group to address, with the administration, the issues raised. Unfortunately, that has not happened yet. We are ready to work on the issues raised in the bill as they are core to the work that we do in serious illness care.

This is a complicated bill. It combines the statutes for Advance Directive and the Mental Health Directives and makes changes in a number of different areas. Some of these changes could be improvements, others we see as problematic. Four areas of concern:

1. Appointment of independent co-agents of equal status will not work. This is universally seen as a bad idea by those who work with Advance Directives and Healthcare Agents, including a variety of providers I have spoken with in the last month in Hawaii. Providers need to know who is in charge and who is the back up.

Imagine Mrs. K has appointed her two sons as her healthcare agents but has not talked to them about her wishes. The doctor calls the first son, who is in a meeting and unavailable,



so he calls the second son for guidance. The first son gets out of the meeting and now there are two people with equal decision-making power.

What if they do not agree on the course of action? An all-too-common scenario if people have not talked with each other or the person they are making decisions for. The provider would not know how to proceed. Care could be delayed. Patients could linger in the hospital or ICU until the dispute was resolved by someone from the hospital or even by an ethics committee. Family dissension is very common in these scenarios, and it is crucial to have a clear lead decision maker.

2. Reducing the number of witnesses needed on an Advance Directive to only one allows for potential misuse and removes a patient safeguard. The bill also allows for the witness to be a health care professional at an institution where they are getting care. This removes another important patient safeguard. I have not heard that lack of a second witness is an issuing in completing Advance Directives.
3. Resolving issues between agents appointed in Advance Directives and Mental Health Directives is unclear. This bill sets up a system for potentially three agents with the most recent agent as having decision making status and can easily delay care. What is the mechanism for resolving these issues? Again, dissension and disagreement is very common in serious illness decision making, which is why it is crucial to have discussions ahead of time with all involved. And have good social workers, chaplains and others with mediation skills to gain clarity.
4. POLST (Provider Orders for Life Sustaining) will be negatively impacted. This bill must be amended to be in keeping with current POLST legislation (327K) as this bill would allow EMS to ignore a POLST, a portable medical order that is the only document EMS can honor in an emergency situation. POLST is a very successful, statewide program that was enacted in 2009. Kōkua Mau is the lead agency for POLST in Hawai'i, and I serve on the National POLST Board.

I do not work with mental health directives and hope that people who work with those with mental health issues will be included in discussions moving forward.

This law is not seen as best practice nationally and only two states, Utah and Delaware, have adopted it. Other states that are at the forefront of serious illness care have not moved to adopt it.

We hope that more time can be taken, with input from all stakeholders in Hawai'i, if changes are needed to this important legislation and are ready to work with our colleagues to make that happen.

Thank you for your consideration.

Jeannette Kojane, Executive Director, Kōkua Mau

Website: [kokuamau.org](http://kokuamau.org) , Phone 808 585-9977

Testimony of  
Jonathan Ching  
Head of Government Relations

Before:  
Senate Committee on Health and Human Services  
The Honorable Joy A. San Buenaventura, Chair  
The Honorable Angus L.K. McKelvey, Vice Chair

February 13, 2026  
1:00 p.m.  
Conference Room 225  
Via Videoconference

**Re: SB 3077, Relating to Healthcare.**

Chair San Buenaventura, Vice Chair McKelvey, and committee members, thank you for this opportunity to provide testimony on SB 3077, which amends the Uniform Health-Care Decisions Act.

**Kaiser Permanente submits COMMENTS and requests AMENDMENTS on SB 3077.**

**Kaiser Permanente Hawai'i supports the amendments submitted by the Healthcare Association of Hawaii (HAH)** and appreciates their efforts in working with providers, including ours, who work with patients with varying degrees of capacity and their families everyday.

Kaiser Permanente Hawai'i is one of the nation's largest not-for-profit health plans, serving 12.6 million members nationwide and more than 271,000 members in Hawai'i. In Hawai'i, more than 4,600 dedicated employees and more than 650 Hawai'i Permanente Medical Group physicians and advance practice providers work in our integrated health system to provide our members coordinated care and coverage. Our team includes providers dedicated to continuing care for patients, which typically includes managing care for patients with long-term conditions whose physical and mental health may fluctuate and/or need to be moved between facilities, including non-Kaiser facilities.

Kaiser Permanente Hawai'i understands the desire to update our laws on advanced health care directives, advanced mental health care directives, and decision-making processes for individuals with compromised capacity. However, it is important to stress that the situations where these directives are utilized and where the law may be relied upon by parties involved are complex. These situations can be difficult to navigate due to a variety of factors, including: 1) patient's specific conditions – they may retain some level of capacity or their capacity may wax and wane

(especially in situations such as delirium), 2) potential and consequential disagreements between decision-makers or potential decision-makers, and sometimes, 3) time-sensitivity.

Our providers aim to keep patients at the center of our care, and in cases where capacity is in question, we seek to preserve as much patient autonomy as possible, to the extent patients are capable of understanding and making decisions. These situations can be fluid and highlight the critical role of the provider(s) in these situations.

With that in mind, **Kaiser Permanente Hawai'i respectfully requests more time to consider the bill's impact on individuals, their loved ones, and providers, and to identify and mitigate any unintended consequences. We appreciate HAH's suggestion of a delayed implementation date and the formation of a working group.**

Mahalo for the opportunity to testify on this important measure.



**Submitted Online: February 12, 2026**

**TO:** Senate Committee on Health & Human Services  
Senator Joy San Buenaventura, Chair  
Senator Angus McKelvey, Vice Chair

**FROM:** Eva Andrade, President

**RE:** Opposition to SB3077 Relating to Healthcare

Hawaii Family Forum is a non-profit, pro-family education organization committed to preserving and strengthening families in Hawai'i. We respectfully oppose SB 3077.

While SB 3077 is presented as a modernization and consolidation of existing law, it represents a sweeping rewrite of how deeply personal medical decisions are made for individuals who can no longer speak for themselves. These are not minor adjustments. This is a structural change affecting families at some of the most vulnerable moments of their lives.

Advance health care directives are built on trust — trust that our wishes will be honored, that our families will be respected, and that appropriate safeguards exist when we cannot speak for ourselves. Any major revision to that framework must proceed carefully, transparently, and with broad community input.

One concern is the expansion of surrogate decision-making authority through the proposed “default surrogate” structure. Under this framework, decision-makers may be identified from a potentially broad group of “interested persons.” For many families, this raises understandable questions: Who ultimately has authority? How are disagreements resolved? What safeguards protect against confusion or misuse?

Medical crises are already emotionally charged. The law should reduce uncertainty — not create additional layers of ambiguity.

The bill also authorizes advance mental health directives that may become temporarily irrevocable during a specified psychiatric or psychological event. While intended to provide continuity of care, provisions that limit a person’s ability to revoke a directive during a mental health crisis raise serious concerns about autonomy, dignity, and due process. These are complex ethical issues that deserve deliberate public discussion.



**SB3077**  
**Page Two**

Additionally, the bill repeals Hawai‘i’s current advance directive statutes and replaces them with a modified version of the 2023 Uniform Health-Care Decisions Act. Yet there has been little evidence presented that the current system is fundamentally broken. Stakeholders engaged in serious illness care have indicated that improvements may be possible, but there is no urgent crisis requiring wholesale replacement.

Another significant concern raised by practitioners is the potential conflict between several provisions of this proposal and federal privacy law under HIPAA. The bill contemplates health care professionals reaching out to and sharing information with broad categories of “interested persons” to identify or select a default surrogate. Our understanding is that federal HIPAA standards strictly regulate disclosure of protected health information without written authorization. Where state law requires or encourages broader disclosure, federal law may preempt conflicting provisions.

At a minimum, if we read this correctly, this could possibly create legal uncertainty for providers who must comply with federal privacy rules. The Legislature should proceed cautiously before enacting provisions that could expose providers to compliance conflicts or litigation risk.

When laws govern life-and-death medical decisions, clarity and stability matter. The standard should not simply be uniformity with a national model, but careful alignment with Hawai‘i’s existing legal framework, medical practices, and community values.

For these reasons, Hawaii Family Forum respectfully urges the Committee to defer SB 3077 and allow for a more deliberate, community-centered review that includes medical professionals, mental health providers, privacy law experts, disability advocates, elder care practitioners, faith communities, and families.

Thank you for the opportunity to testify in opposition.



1011 Waiianue Avenue  
Hilo, Hawaii 96720-2019  
Phone: (808) 969-1733  
Fax: (808) 961-7397

care@hawaiicarechoices.org  
www.hawaiicarechoices.org

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COMMITTEE ON HEALTH AND HUMAN SERVICES

Senator Joy A. San Buenaventura, Chair  
Senator Angus L.K. McKelvey, Vice Chair

**RE: Testimony in Opposition to SB 3077 – Uniform Health Care Decisions Act (Modified); Advance Health Care Directives, Advance Mental Health Care Directives**

Hearing: Friday, February 13, 2026, at 1:00 p.m.

Dear Chair San Buenaventura, Vice Chair McKelvey, and Members of the Committee:

My name is Brenda S. Ho, CEO of Hawai'i Care Choices, a nonprofit palliative and hospice care provider serving the Big Island community for over 40 years. Our mission is to improve the lives of those we touch by offering support, guidance, and compassionate care of body, mind, and spirit.

Thank you for the opportunity to submit written testimony on the proposed inclusion of the Advance Mental Health Care Directive (AMHCD) within the existing Advance Health Care Directive (AHCD) under a single statutory framework, as outlined in SB 3077. While both instruments promote the patient's right to self-governance and to make informed decisions about their own medical care, they address fundamentally different legal, ethical, and clinical circumstances.

AHCD is primarily designed to guide decisions regarding end-of-life care, life-sustaining treatment, and long-term medical conditions. In contrast, AMHCD addresses treatment preferences during periods of temporary incapacity resulting from mental health crises. Mental health directives involve unique issues such as fluctuating capacity, crisis stabilization, involuntary treatment standards, medication choices, and coordination with behavioral health providers. These issues require specific statutory language to ensure clarity, enforceability, and alignment with existing mental health care laws.

Combining these directives risks creating confusion for patients, families, and providers by merging two complex areas of health care decision-making into a single, potentially lengthy and overwhelming document. Such consolidation may inadvertently undermine the autonomy these directives are meant to protect, especially if individuals are discouraged from completing the form or if critical mental health provisions are overlooked in emergency situations. Hawaii's current AHCD offers a clear, socialized, and trusted framework that supports end-of-life decision-making and ensures families and providers understand patients' wishes.

Separately, AHCD and AMHCD provide clear guidance for end-of-life and mental health patients; combining the two would create confusion and introduce risk without benefit. Thank you for your time and consideration.

Respectfully,

Brenda S. Ho, MS, RN  
Chief Executive Officer

Senator Joy A. San Buenaventura, Chair  
Senator Angus L.K. McKelvey, Vice Chair  
Senate Committee on Health and Human Services

**SB 3077 Relating to Health Care  
COMMENTS ONLY**

Friday, February 13, 2026; 1:00 PM  
State Capitol, Conference Room 225 & Videoconference

I am testifying on SB 3077 relating to health care. Please table this bill until the local professional community most impacted by this bill is afforded adequate opportunity to discuss its concerns and resolve the problems identified in the legislation.

My name is Dr. Linda Axtell-Thompson. I am an instructor in health care administration at the University of Hawaii West Oahu, but I submit my testimony as a concerned individual and trained bioethicist. I have a doctorate degree in bioethics from the Neiswanger Institute for Bioethics, Stritch School of Medicine, Loyola University Chicago. I have worked for 30+ years in the Hawaii healthcare sector and volunteered for 20+ years in local policy/advocacy for aging, end-of-life, and dementia, with emphasis on ethical issues.

While it is understandable to consider adopting nationwide model legislation, my great concern is that such sweeping national recommendations do not adequately consider the unique circumstances of our Hawaii community and healthcare landscape. One size does not fit all. My concerns mirror those identified by Kokua Mau, the statewide coalition to improve care for serious illness and end-of-life. Several concerns have been identified that merit more time for thoughtful deliberation **and input** by the local professional community most knowledgeable about the issues and most impacted by the proposed legislation:

- Conflicts between Advance Directive Agents and Mental Health Directive Agents
- Co-Agents and conflict resolution
- Implications of the Ulysses Clause
- Potential issues with EMS
- Conflicts with POLST law
- Capacity and surrogacy
- Verbal designation if the patient has capacity
- Statute changes concerning Artificial Nutrition

Please table SB 3077 until the local professional community, along with relevant State agencies, are provided sufficient time to thoughtfully discuss and resolve the identified concerns and problems. Thank you for the opportunity to provide testimony.

Linda M. Axtell-Thompson, DBE  
[laxtell@hawaii.edu](mailto:laxtell@hawaii.edu); 808-226-6865

Chair Buenaventura, Vice Chair McKelvy

My name is Marilyn Seely and I was appointed as director the Executive Office on Aging under Governor Benjamin Cayetano. During his term he created the Governor's Blue Ribbon Panel on Living and Dying with Dignity to address the issues of end of life care. I was asked to organize and support this group of distinguished community members headed by Hideto Kono. Discussion and debate on all aspects of living and dying with dignity was called for by Mr Kono and the Governor agreeing that these issues could no longer be ignored. The Executive Office on Aging was to convene meetings for public discussion, assist interested parties in obtaining speakers and maintaining a resource library and assisting individuals and groups working for legislative consideration of our proposals. The governor's proclamation stated "The public debate now begins. Furthermore, according to the Governor "Society has a vital interest in protecting life and safeguarding the ability of health care providers to cure and care for the ill, and individuals must be able to control every moment of their lives up to the final days".

From December 1996 to June 9, 1998, the 18 member Panel met regularly and conducted nine public hearings state wide deliberating on recommendations from five focus groups. There were six key points of agreement in the panel recommendations and disagreement on one. A Model Act adapted from the Harvard Journal of Legislation was presented. The result of this work was passage of the Uniform Health Care Decisions Act which after much debate, was passed and is still in use today with minor amendments. The Act has served us well.

The introduction of SB 3077 was a surprise to the many palliative care and hospice workers and in my ongoing discussions with these front line practitioners, I have not heard any desire or need to change the current Act.

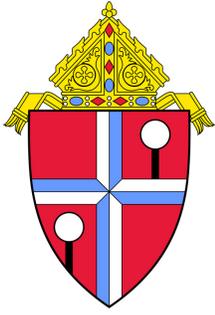
The new law as proposed has points with which we can agree. However, I have also listened to the objections for new requirements in SB3077 that would disrupt and or confuse how the law is implemented from the community of practitioners in the large community caring for the chronically ill and dying. We have heard the reasons for the mental health communities law now in place that could be amended to address their issues. My question is why not change that law without incorporating the many changes into the UHCDA which would require considerable effort to inform and explain new provisions to health care providers, patients and the public to assure compliance.

After the many years since the law has passed I have witnessed the amazing work, standards of care and compassion exhibited by those who sit at the bedside of chronically ill and terminally ill patients. They are without a doubt the experts in using the current law in carrying out their work. I recently heard one physician described by peers as the go to person who never turns away from the most difficult cases, but goes in no matter what with a calm compassionate demeanor and brings resolution to whatever issues confronting the patient and family. These are the kinds of carers who understand the issues and can be trusted to make the best decisions around our laws and practices. I urge you to listen to their concerns and see the value of wide spread community debate as was successfully used in the passage of the UHCDA.

In conclusion, we are not ready to pass this law but with conversation and time it can be resolved. However, for now let both existing laws stand until that happens or incorporate the changes suggested in SB 3077 into the mental health law only.

Thank you for your consideration of my testimony. We want the very best care for those who need it at critical times of their lives.

Marilyn Seely, former director of the Executive Office on Aging and participant for over 50 years in bettering the lives of older adults.



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**DIOCESE OF HONOLULU**  
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**LATE**

February 12, 2026

I am a Catholic priest who serves as Judicial Vicar and Director of Canonical Affairs for the Diocese of Honolulu. I have been involved in promoting the use of AHCDs for several years from a Catholic perspective, and I read through S.B. No. 3077 when I heard about it.

I did a comparison of the Hawaii bill with the national version of the 2023 Uniform Health-Care Decisions Act. Section 12 of the Hawaii bill about default surrogates diverges considerably from the national version. The national version includes a clearly defined hierarchy of individuals who are given preference to act as a default surrogate when no agent is chosen. The Hawaii version replaces this with an approach of the doctor relying on a perceived consensus of everyone interested — anyone who could be found. This seems potentially chaotic and fraught with conflict. Instead, a single person serving as the default surrogate could easily be fully informed with medical information, information about the patient's situation, and information from spiritual advisors regarding any moral implications, in order to make the best decision. The doctor deals with the one person who is closest to the patient, if the patient did not specify an agent, based on the defined hierarchy.

Related to this is the possibility of “co-agents” in Section 20. Again, the possibility of chaos and conflict is introduced in not having a single agent.

Also, adding a mental health directive to an AHCD appends something unrelated to the main purpose of an AHCD, which is primarily related to issues of life and death. Someone with a mental health crisis is not likely to be in such circumstances. A mental health directive might better be designed as a medical order, just as a POLST is a medical order, signed at a patient's request by a psychiatrist or equivalent provider.

I am opposed to this bill as drafted, especially considering the percentage of people who do not yet have an AHCD, the frequency of the default surrogate situation arising, and the resulting chaos, conflict and imprudent decisions that could take place.

Thank you.

Very Rev. Mark J. Gantley

**LATE**

## TESTIMONY IN OPPOSITION TO SB 3077

### RELATING TO HEALTH CARE DECISIONS

**Hearing Date:** February 13, 2026

**Committee:** Senate Committee on Health and Human Services

**Chair:** Senator Joy San Buenaventura

**Position:** Oppose

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#### Honorable Chair and Members of the Committee:

My name is Barbara Yamashita, and I am submitting testimony **in strong opposition to SB 3077**.

SB 3077 proposes a wholesale replacement of Hawai'i's existing advance health care directive statutes with a complex, 67-page framework modeled on the Uniform Health Care Decisions Act. While well-intentioned, this measure introduces unnecessary disruption to a system that currently works and has been recently improved through Act 98.

Hawai'i's existing advance directive process is effective and widely understood by providers and the public. Recent refinements have addressed administrative gaps without destabilizing the system. SB 3077 would discard these improvements and impose a sweeping overhaul without clear justification.

The bill introduces:

- Co-agent and surrogate conflict resolution mechanisms that are difficult to implement.
- Broad statutory amendments affecting EMS protocols, POLST forms, and guardianship laws.
- Significant training and compliance burdens for healthcare providers and state agencies.

This complexity risks confusion, delays in care, and inconsistent application across institutions.

SB 3077 adds provisions for advance mental health directives, including "Ulysses clauses," which allow individuals to set irrevocable instructions during future psychiatric crises. These clauses raise ethical and practical concerns:

- They may override patient autonomy during emergencies.
- They create ambiguity in decision-making during acute episodes.

The measure requires extensive system-wide changes—new forms, protocols, and public education—without clear funding or timelines. This could disrupt care and burden providers.

I respectfully urge the committee to:

1. **Defer SB 3077** until comprehensive stakeholder consultation occurs.
2. Pursue **incremental improvements** to mental health directives rather than a full statutory rewrite.
3. Ensure any changes align with existing EMS and POLST frameworks to avoid conflicts.

SB 3077 introduces more risk than benefit. Hawai'i's current system works. Let's strengthen it through targeted updates, not destabilize it with unnecessary complexity.

Thank you for the opportunity to testify.

**Respectfully submitted,**

Barbara Yamashita



**Kaua'i Hospice**  
*a special kind of caring*

**LATE**

February 12, 2026

**Committee on Health and Human Services**

**Re: Testimony in Opposition to SB3077**

Submitted by: **Kaua'i Hospice Inc.**

**SB3077 - Relating to the Uniform Healthcare Decisions Act—  
Chapter 327E and Chapter 327G, Hawaii Revised Statutes**

Dear Chair, Vice Chair, and Members of the Committee:

Kaua'i Hospice respectfully submits testimony in **opposition** to SB3077.

For more than forty years, Kaua'i Hospice has served individuals and families navigating serious illness and end-of-life decision-making. Advance health care directives (AHCDs) are central to our work. We support thoughtful modernization of statutes when clearly warranted. However, SB3077 represents an unnecessary and destabilizing overhaul of a system that is functioning well in Hawai'i.

**1. Process Concerns**

During the 2025 legislative session, stakeholders raised substantial concerns and requested that this measure be recommitted for further discussion. We were assured that that meaningful engagement would occur during the interim.

Instead, the first stakeholder meeting occurred on December 30, 2025. That timing did not allow for genuine collaboration before the introduction of SB3077. The significant volume of amendments now being requested demonstrates that the bill was not sufficiently vetted.

Healthcare policy — especially policy affecting autonomy, capacity, and surrogate authority — requires careful, good-faith engagement with those who implement it daily.

**2. Addressing a Mental Health Crisis Without Undermining the Public**

We recognize that Hawai'i, like much of the nation, is facing a serious and visible mental health crisis. Homelessness, substance use disorder, and untreated mental illness are placing extraordinary strain on families, communities, and healthcare systems. These challenges are real and urgent.

However, even if SB3077 is in part an attempt to address perceived gaps related to mental health directives, we must be cautious not to broadly restructure advance health care directive law for the entire population in a way that could create unintended risk.

Advance health care directive statutes govern:

- Determinations of decision-making capacity
- Selection and authority of surrogates
- Execution and revocation of directives
- The legal protection of patient autonomy

These protections apply to every adult in Hawai'i — not solely to individuals experiencing acute mental health crises.

We cannot create sweeping statutory change that potentially jeopardizes capacity determinations, surrogate selection safeguards, or directive execution standards in an effort to simplify or “standardize” the law. Simplification must not come at the cost of clarity and guardrails.

While our community is in need of stronger mental health infrastructure, the solution is not to modify core healthcare decision-making law in a way that relies on the hope that systems will “do the right thing.” Laws governing surrogate authority and capacity must contain clear boundaries — not broad discretion — particularly when invoked on behalf of the most vulnerable.



Healthcare systems are complex. Providers operate under pressure. Without precise statutory protections, there is risk that expanded discretion could unintentionally overstep appropriate boundaries in determining incapacity or selecting surrogates. The answer to our mental health crisis lies in strengthening services, access, and coordination — not in loosening or restructuring the legal framework that protects every individual’s right to control their healthcare decisions.

### **3. A System That Is Already Working**

Hawai‘i is widely recognized as being at the forefront of advance health care directive policy. Our statutory framework has functioned effectively for patients, families, providers, and institutions for many years. SB3077 represents a substantial restructuring without evidence of systemic failure. In our experience delivering hospice and palliative care across Kaua‘i, the existing law supports patient autonomy and provides workable clarity in clinical practice.

Sweeping change should be reserved for demonstrated deficiency. No such deficiency has been established.

### **4. Legal Redesign Without Operational Grounding**

SB3077 is being advanced by the Attorney General’s office, which does not deliver direct healthcare services. The organizations that operationalize this law daily — hospices, hospitals, long-term care facilities, physicians, nurses, and community providers — were not meaningfully engaged prior to its reintroduction.

The number of amendments being requested signals unresolved operational concerns.

### **5. “Uniform” in Name, Not in Practice**

SB3077 is described as promoting uniformity. However, the proposal materially differs from the widely adopted Uniform Health-Care Decisions Act framework. Hawai‘i’s current law already reflects national best practices while preserving clarity and cultural appropriateness for our state.

*Uniformity should not come at the expense of stability, clarity, and patient protection.*

### **Conclusion**

Kaua‘i Hospice supports policies that protect autonomy, strengthen serious illness care, and address the very real mental health challenges facing our state. SB3077 does not accomplish these goals. Instead, it introduces uncertainty into a legal framework that is currently working.

We respectfully request that SB3077 be deferred and that any future revisions to Hawai‘i’s advance health care directive laws occur through a transparent, good-faith, stakeholder-driven process that prioritizes both patient protection and operational clarity.

Mahalo for the opportunity to testify.

Respectfully submitted,

**Tricia L. K. Yamashita MPH, MSPC**  
**Executive Director**  
**Kaua‘i Hospice, Inc.**

**Cc: Senate President, Ron Kouchi**  
**Representative, Nadine Nakamura**

**LATE**

**SB-3077**

Submitted on: 2/13/2026 7:28:55 AM

Testimony for HHS on 2/13/2026 1:00:00 PM

<b>Submitted By</b>	<b>Organization</b>	<b>Testifier Position</b>	<b>Testify</b>
J Emma Grote	Individual	Oppose	Written Testimony Only

Comments:

To whom in may Concern

I am writing to request to defer SB 3077 Uniform Health Care Decisions Act (Modified).

I am a hospice and palliative care physician practicing in Hawaii for the last 15 years and currently working at Navian Hawaii.

This is a complicated bill with many potential impacts on how we care for patients with serious illnesses, and needs further clarification and revision

Conflicts between AHCD agent and MHCD agent (p. 23): While the AHCD can encompass both physical and mental diseases, a separate MHCD would appoint a separate agent with power over mental health care and treatment choices. Separation of mental health concerns and physical disease diagnosis is difficult. In our patient population, particularly those suffering from neurologic diseases like dementia, or those on medications that may cause adverse reactions including changes to mental status it can be difficult to tease out if it is mental/physical illness leading to disease in this patient population. How will it be ascertained if it is a mental or physical illness that requires an agent’s input given mind/body are so closely intertwined? How is conflict between AHCD and MHCD agent to be handled if both are felt to mind/body are contributing to patient condition.

Selection of Co-agents (p. 41): This bill will allow individuals appoint co-agents in the AHCD who “may exercise independent authority.” For families and friends’ caring for patients with serious illness, it is not uncommon for there to be discord and conflict during this difficult time, especially around medical interventions. Having two agents who may have differing opinions about what should be done could effect timely delivery of care and make it more cumbersome for health care professionals to treat as co-agents try to come to a consensus.

EMS loophole (p. 49-50). There is a alarming loophole which allows EMS to not comply with the provisions of either the AHCD or MHCD if “the violation [their not complying] occurs in the course of providing care to an individual experiencing a health condition for which the professional reasonably believes the care is appropriate to avoid imminent loss of life or serious harm to the individual.” This does not respect patient autonomy especially in cases where they have elected to withhold life-sustaining or life “saving” treatment.

Given the serious questions and concerns this proposed bill has raised, I ask that it be deferred at the present time or give it a later start date to allow more community/provider feedback.

Respectfully

Dr J Emma Grote