
Frequently Asked Questions (and Answers) About Hawaii's New Uniform Health Care Decisions Act (Modified)

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Abstract:

The Hawaii Uniform Health Care Decisions Act (Modified) became law, effective July 1, 1999. The Act makes major changes the law pertaining to Advance Directives and surrogate decision-making. While some of the changes seem to be confusing, most practitioners should find the new law helpful in attempting to assure that the rights of their patients to self-determination and autonomy are preserved and their wishes are followed. Using a question and answer format, this article will provide a basic guide to the new law. The "frequently asked questions" and the answers follow a brief overview of the Uniform Health Care Decisions Act. For busy practitioners, a conclusion summarizes key points.

Overview of the New Uniform Health Care Decisions Act (Modified)

There is a new law that makes major changes to Hawaii's laws pertaining to health care decision-making, including advance health care directives and surrogate decision-making. The 1999 Hawaii Session Laws Act 169, effective July 1, 1999, is called the Uniform Health Care Decisions Act (Modified)¹. It repealed Hawaii Revised Statutes (HRS) Chapter 327D (Medical Treatment Decisions) in its entirety and it significantly modified the provisions under HRS Chapter 551D pertaining to the durable power of attorney for health care decisions. Hawaii's version of the Uniform Health Care Decisions Act (UHCDCA) was adapted from the Uniform Act approved by the National Conference on Uniform Laws and by the American Bar Association House of Delegates. The text of Act 169 is included in this edition of the journal.

Even with certain limitations added by the legislature, the act:

1. Acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances.
2. Is comprehensive and enables Hawaii to replace its existing legislation on the subject with a single statute.
3. Is designed to simplify and facilitate the making of advance health care directives

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4. Seeks to ensure that an individual's decisions about health care are governed by the individual's own desires concerning the issues to be resolved.

5. Addresses compliance by health care providers and institutions.
6. Includes procedures for the appointment of a surrogate, if needed, and for resolution of disputes, specifically through initiation of guardianship proceedings.

Limitations in the law include the imposition of special rules for decisions by "non-designated" surrogates to withhold or withdraw artificial nutrition and hydration and the inapplicability of the act to a patient diagnosed as pregnant by the attending physician.²

Anecdotal evidence suggests that many health care professionals still do not have a good understanding of the new law and that several specific provisions are problematic. This article is intended to help answer some of the most frequently asked questions. Readers may submit additional questions to the author through the journal for possible inclusion in future editions of the journal.

Frequently Asked Questions

QUESTION # 1

Why was the law changed and why was the Uniform Health Care Decisions Act model used?

Answer

In 1997 the Governor established a Blue Ribbon Panel on Living and Dying With Dignity to explore the issues relating to living and dying in Hawai'i. The panel found that dying has not been managed as well as it could and in 1998 submitted seven recommendations to the governor.³ One of the recommendations was that the content of Advance Directives for Healthcare including Living Wills be made more specific, their use more widespread and their provisions more binding. With respect to patient self-determination, the panel found that most people do not make Advance Directives and even when they are made, a significant percentage of Advance Directives is ignored or not followed by health care providers.⁴ The report went on to indicate that several factors contributed to this situation:

- 1) Existing statutes provide few incentives to execute advance directives;
- 2) They contain few sanctions to encourage compliance; and
- 3) There is no mechanism to determine whether the provisions of the law are being met.

Despite the fact that Advance Directives possess legal status, physicians and health care facilities continue to be influenced by their own

opinions of what is in the best interest of the patient or by the demands and desires of family members or other third parties. Too often the patient's own expressed instructions are not reflected in end of life care. Further, the panel found that another difficulty was that statutes regarding end of life care (Medical Treatment Decisions, Durable Power of Attorney for Health Care, Do Not Resuscitate necklaces and bracelets, Surrogate Decision-Makers, Brain Death) are scattered throughout state law."⁵

The 1997 Health Care Decisions By Legal Surrogate Act⁶ created a two-year demonstration project that the legislature felt would protect the health and safety of a person who: (1) Previously had the ability, but who no longer had the ability, to understand the significant benefits, risks, and alternatives to proposed health care, and to make and communicate health care decisions; (2) Resided in a skilled nursing or intermediate care facility; and (3) Had not executed a health care directive for health care decisions which addressed the specific health care decisions presented, at the time, by or to the facility or health care provider; or whose agent was unavailable and whose whereabouts could not be ascertained within a reasonable period of time. This act was incorporated into HRS Chapter 327D and "sunsetted" effective June 30, 1999. The enabling legislation created a task force to study the implementation of the act and to make recommendations for new legislation regarding surrogate decision-making.

The legal issues focus group of the Governor's Blue Ribbon Panel ultimately recommended that Hawai'i consider adopting a version of the Uniform Health Care Decisions Act (UHCDA) which was adapted from the Uniform Act approved by the National Conference on Uniform Laws and by the American Bar Association House of Delegates. After many months of hearings and deliberations, the Health Care Decisions By Legal Surrogate task force which has been meeting during the same period of time, agreed that utilizing the UHCDA format was the best approach to the issue, in essence following the recommendations that came from the work of the Blue Ribbon Panel. The task force ultimately agreed, however, to recommend significant changes to the surrogate provisions of the UHCDA in order for the bill to go forward. A modified version of the Model UHCDA was submitted to the legislature in the fall of 1998 as part of the Governor's legislative package.

QUESTION # 2

What "Advance Directives" are covered under the UHCDA, what can they include, and is there a standard form?

Answer

The term "Advance Medical Directive," "Advance Health care Directive" or more simply "Advance Directive" (AD), in the broadest sense, applies to all directives, instructions, or even desires that a person may communicate in writing, orally or in some other fashion concerning decisions about one's body. In a stricter sense, ADs can be defined as written documents directing the consent or non consent, application, withdrawal or withholding of medical treatment, or the appointment of a surrogate decision maker. Hawaii law has never required written advance directives although they have been preferred. Each state or territory has different laws on the subject it is often questionable whether an AD executed in one jurisdiction will be recognized in another jurisdiction. (One version

of an AD must, by federal law, be recognized by all states. The Military Advance Medical Directive, if properly executed in accordance with military legal assistance guidelines, must be recognized in every U.S. jurisdiction⁷) There has been some movement toward creating uniformity among the states as is evidenced by enactment of the UHCDA in several jurisdictions, including Hawai'i.

Under the new UHCDA an adult or emancipated minor may make advance health care directives⁸ by giving an "individual instruction"⁹ orally or in writing and/or by executing a power of attorney for health care, which may authorize the agent to make any health care decision the principal could have made while having capacity. The term "living will" is not used in the UHCDA. Copies of a written advance health care directive have the same effect as the original.¹⁰ The new advance directives should be more "portable" than those executed under the old law, especially in jurisdictions that adopt the UHCDA.¹¹

Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity.¹² An individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider¹³ but an individual may revoke all or part of an advance health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.¹⁴

The new law includes an optional sample form (and explanation) which may be duplicated or modified to suit the needs of the person, or a completely different form may be used that contains the substance of the sample form found in the statute.¹⁵ A sample form with an explanation is found in the copy of the UHCDA which is included in this edition of the journal. The sample optional form was written with the intention that consumers utilize the form without having to seek the assistance of an attorney but the University of Hawai'i Elder Law Program (UHELP)¹⁶ has received numerous comments from clients, physicians and attorneys. Many indicate that the new optional sample form is too long and too complicated, especially for individuals with diminished capacity or limited education. UHELP has developed its own forms for clients with diminished capacity or limited education.

The UHCDA does not include all of the types of advance directives. There are some health care decisions that were not ordinarily addressed by traditional advance directives or by surrogates. Traditional AD's were not very useful or applicable under circumstances where a patient suffers cardiac or respiratory arrest. Of course, surrogate decision-making at the time of such a medical emergency can be difficult. In 1995 a law¹⁷ was passed in Hawai'i which allows a terminally ill person to state in advance that he or she does not want to be resuscitated in an emergency if he or she:

(A) Has been certified in a written "comfort care only" document by the person's physician to be a terminally ill patient of that physician; and

(B) Has certified in the same written "comfort care only" document that the person directs emergency medical services personnel, first responder personnel, and health care providers not to administer chest compression, rescue breathing, electric shocks, or medication, or all of these, given to restart the heart if the person's breathing or heart stops, and directs that the person is to receive care for

comfort only, including oxygen, airway suctioning, splinting of fractures, pain medicine, and other measures required for comfort; and

(C) Has been prescribed by a physician a "comfort care only—do-not-resuscitate" (CCO-DNR) identifying bracelet or necklace. The written document containing both certifications must be signed by the patient with the terminal condition, by the patient's physician, and by any one other adult person who personally knows the patient.

The UHCDA does not specifically cover the decision to accept or refuse the administration of psychotropic drugs by a health care provider for a psychotic condition. A person suffering from a psychotic condition, but who is competent and in a state of remission at the time of execution may execute a written declaration directing that medical treatment, including the administration of psychotropic drugs, be provided at a time when the person has lapsed and "lacks sufficient understanding to make or communicate responsible medical treatment decisions."¹⁸

QUESTION # 3

Are Advance Directives executed under the old law still "valid?"

Answer

Yes, but the old documents may impose unnecessary limitations on the choices available to patients and may be less clear than advance directives executed under the UHCDA. Health care providers should encourage patients to consider making new advance directives under the new law.

The old "living will" law¹⁹ provided that any competent person who had attained the age of majority could execute a declaration directing the provision, continuation, withholding, or withdrawal of life-sustaining procedures under certain conditions, such as a terminal condition or where the patient had a permanent loss of ability to communicate with others due to irreversible brain injury or coma. An attending physician who was notified of the existence of such a declaration had a duty to make a determination of whether the patient's condition corresponded to the directions in the declaration and, if so, to make a written certification of such a finding in the patient's medical record.²⁰ Under the old law, physicians were sometimes reluctant to certify that the patient was in such a condition and had "no reasonable chance of regaining this ability."

The old durable power of attorney for health care law.²¹ had numerous limitations and was difficult for many people to execute. A competent person who had attained the age of majority could execute a durable power of attorney authorizing an agent to make any lawful health care decisions that could have been made by the principal at the time of election.²² The execution requirements for making a durable power of attorney for health care under the old law were, however, somewhat restrictive.²³

The old law also included a provision which stated that "a durable power of attorney for health care decisions is presumed not to grant authority to decide that the principal's life should not be prolonged through surgery, resuscitation, life-sustaining medicine or procedures, or the provision of nutrition or hydration unless such authority is explicitly stated."²⁴ It was not sufficient under the old law to use a phrase such as "I grant all powers relating to my health care." The new UHCDA permits such a broad grant of powers. The old law specifically mentioned that a durable power of attorney for health

care decisions was only effective during the period of incapacity of the principal as determined by a licensed physician.²⁵ As discussed in question # 2, this, too, is changed under the UHCDA.

QUESTION # 4

How is a "surrogate" appointed and what powers do they have when a patient no longer has the ability to make health care decisions and there is no guardian or agent under a health care power of attorney?

Answer

Under the UHCDA a surrogate may make a health care decision for a patient if the patient lacks capacity²⁶ and no agent or guardian has been appointed or the agent or guardian is not available. A patient may designate or disqualify any individual to act as a surrogate by personally informing the supervising health care provider.²⁷ How the patient is to personally inform the supervising health care provider is not spelled out in the act. It is obvious that a patient may orally inform the supervising health care professional. The designation or disqualification may be made in writing. Section 7 of the act requires a supervising health care provider who knows of the existence of an advance health care directive, revocation of an advance health care directive, or designation or disqualification of a surrogate to "promptly record its existence in a patient's health care record and, if it is in writing, (emphasis added) shall request a copy and if one is furnished shall arrange for its maintenance in the health care record. Further, Section 12 of the act provides that "a copy of a written advance health care directive, or designation or disqualification of a surrogate (emphasis added) has the same effect as the original."

In the absence of a designation by the patient of a surrogate, or if the designee is not reasonably available, a surrogate may be appointed to make a health care decision for the patient.²⁸ Unlike the Model Act approved by the National Conference on Uniform Laws, Hawaii's version of the UHCDA does not provide for a common family hierarchy of decision makers for a decisionally incapacitated patient but, rather, provides for decision-making by surrogates selected from a group of "interested persons."²⁹ Under the new law "interested persons" means the patient's spouse, unless legally separated or estranged, a reciprocal beneficiary, any adult child, either parent of the patient, an adult sibling or adult grandchild of the patient, or any adult who has exhibited special care and concern for the patient and who is familiar with the patient's personal values.³⁰ The UHCDA places a big burden on health care providers with respect to the selection of a surrogate. This seems to be the most difficult area for families and physicians, especially when there is family dissension. To make certain that the practitioner knows the process Section 5 of the Act is set out below::

"...Upon a determination that a patient lacks decisional capacity to provide informed consent to or refusal of medical treatment, the primary physician or the physician's designee shall make reasonable efforts to notify the patient of the patient's lack of capacity. The primary physician, or the physician's designee, shall make reasonable efforts to locate as many interested persons as practicable, and the primary physician may rely on such individuals to notify other family members or interested persons.

(c) Upon locating interested persons, the primary physician, or the

physician's designee, shall inform such persons of the patient's lack of decisional capacity and that a surrogate decision-maker should be selected for the patient.

(d) Interested persons shall make reasonable efforts to reach a consensus as to who among them shall make health care decisions on behalf of the patient. The person selected to act as the patient's surrogate should be the person who has a close relationship with the patient and who is the most likely to be currently informed of the patient's wishes regarding health care decisions. If any of the interested persons disagrees with the selection or the decision of the surrogate, or, if after reasonable efforts the interested persons are unable to reach a consensus as to who should act as the surrogate decision-maker, then any of the interested persons may seek guardianship of the patient by initiating guardianship proceedings pursuant to chapter 551. Only interested persons involved in the discussions to choose a surrogate may initiate such proceedings with regard to the patient..."

There have already been suggestions is to change the UHCDA and adopt provisions recommended by the legal aspects focus group of the Governor's Blue Ribbon Panel and originally considered by the surrogate decision committee.³¹

Since the patient can designate or disqualify a surrogate, "interested persons" can be "trumped" by an orally designated surrogate. In the same manner a patient may orally disqualify someone who otherwise would be entitled to make decisions on behalf of the patient. Under Hawai'i's version of the UHCDA, whether the surrogate is "designated" or "non-designated" the supervising health care provider must require a surrogate to provide a written declaration under the penalty of false swearing stating facts and circumstances reasonably sufficient to establish the claimed authority.³²

There are restrictions on decisions by "non-designated surrogates. Artificial nutrition and hydration may be withheld or withdrawn upon a decision by the surrogate only when the primary physician and a second independent physician certify in the patient's medical records that the provision of artificial nutrition or hydration is merely prolonging the act of dying and that the patient is highly unlikely to have any neurological response in the future."³³ This particular provision should encourage practitioners to emphasize the importance of personally designating an agent or surrogate.

QUESTION # 5

Are there any general parameters or limitations set out under the new law?

Answer

Yes. Section -13—Effect of this chapter—provides overall guidance. First of all, the UHCDA does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance health care directive.

Death resulting from the withholding or withdrawal of health care in accordance with the UHCDA does not for any purpose constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity to the contrary.

The UHCDA does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this State.

The UHCDA does not authorize or require a health care provider or institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or institution.

The UHCDA does not authorize an agent or surrogate to consent to the admission of an individual to a psychiatric facility as defined in chapter 334, unless the individual's written advance health care directive expressly so provides.

The UHCDA does not affect other statutes of this State governing treatment for mental illness of an individual involuntarily committed to a psychiatric facility.

What seems to be an unfortunate placement of a provision states that the UHCDA does not apply to a patient diagnosed as pregnant by the attending physician. Such an overall inapplicability would probably be found to be unconstitutional. Pregnant women continue to have a constitutional right to make health care decisions.

QUESTION # 6

Are there penalties for not following the law and are there immunities for following the directions of authorized decision-makers when there is a conflict?

Answer

The UHCDA requires health care providers to follow the instructions of patients, agents and surrogates. Unless otherwise specified in an advance health care directive, the guardian, agent or surrogate has the same right as the patient to request, receive, examine, copy and consent to the disclosure of medical or any other health care information.³⁴ Unless it requires medically ineffective health care or health care contrary to generally accepted health care standards, the UHCDA requires a health care provider or institution to comply with an individual instruction of a patient and with a reasonable interpretation of the instruction made by a person then authorized to make health care decisions for the patient.³⁵ The same section of the law requires that a health care provider to comply with a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.³⁶ A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience or stated policy but has certain continuing obligations to the patient³⁷.

The UHCDA includes both civil and criminal sanctions. A health care provider or institution that intentionally violates this chapter is subject to liability to the individual or the individual's estate for damages of \$500 or actual damages resulting from the violation, whichever is greater, plus reasonable attorney's fees.³⁸ Also, patients, agent's, guardians, surrogates and health care providers or institutions may seek judicial relief to enjoin or direct a health care decision or other equitable relief.³⁹ Proceedings are governed by part 3 of article V of chapter 560 (Guardians of the Person of Incapacitated Persons).

On the positive side, the UHCDA includes certain immunities. A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution will not be subject to civil or criminal liability or to discipline for unprofessional conduct for complying with a health care decision of a person apparently having

authority to make a health care decision for a patient, including a decision to withhold or withdraw health care; declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or complying with an advance health care directive and assuming that the directive was valid when made and has not been revoked or terminated.⁴⁰

Conclusion

The Uniform Health Care Decisions Act (Modified) has been in effect since July 1, 1999. It replaces existing legislation on medical treatment decisions, health care powers of attorney and health care decisions by legal surrogates. The UHCDA acknowledges the right of a competent individual to decide all aspects of his or her own health care, simplifies and facilitates the making of advance health care directives, authorizes the designation of surrogate decision-makers in the event that a patient lacks decisional capacity and does not have a guardian or health care agent, addresses compliance by health care providers and institutions and provides procedures for dispute resolution.

The UHCDA applies in all health care settings, including hospitals, nursing homes and other institutions, as well as community and outpatient settings. The new law includes safeguards to protect both patients and health care providers. The UHCDA places new responsibilities on health care providers to follow advance directives and to obtain documentation of claimed authority of surrogates.

The UHCDA makes it especially important for patients to consider executing written advance directives. These can include an "individual instruction" (formerly referred to as the "Living Will"), and a health care power of attorney. The new law makes it much easier to execute an advance directive. Copies of these documents should be filed in the patient's medical record.

For patients who have an "old" advance directive, they should check its currency, taking into consideration when was it executed, its clarity and whether it still reflects the patient's wishes. If a new advance directive is desired, health care providers may want to give them a copy of the sample optional form and explanation, and encourage them to individualize it.

In an emergency, in the absence of a formal document, supervising health care providers should ask patients to designate a surrogate and annotate this designation in the patient's medical record.

References

1. At the time this article was written, it appeared that the UHCDA (Modified) was to be designated as Chapter 327E of the Hawaii Revised Statutes.
2. Section 13 (g) Act 169, Hawaii State Legislature. Also see question # 5.
3. Final Report of the Governor's Blue Ribbon Panel on Living and Dying with Dignity, May 1998
4. Report and Recommendations-Advance Directives and Living Wills, Final Report of the Governor's Blue Ribbon Panel on Living and Dying with Dignity, May 1998
5. Report and Recommendations-Advance Directives and Living Wills, Final Report of the Governor's Blue Ribbon Panel on Living and Dying with Dignity, May 1998
6. Act 332, 1997 Hawaii State Legislature.
7. On February 10, 1996, President Clinton signed the "National Defense Authorization Act for Fiscal Year 1996." Section 749 of the Act requires states to recognize advance medical directives that are prepared by attorneys who are authorized to provide legal assistance for individuals who are eligible to receive legal assistance to the same extent as an advance medical directive "prepared and executed in accordance with the laws of the state concerned." This section is codified at 10 U.S.C. § 1044c.
8. Section 3, Act 169, Hawaii State Legislature
9. Section 2 Definitions: "Individual Instruction" means an individual's direction concerning a health care decision for the individual.
10. Section 12, Act 169, 1999 Hawaii State Legislature-Effect of copy.
11. Section 3(f), Act 169, 1999 Hawaii State Legislature An advance health care directive shall be valid for purposes of this chapter if it complies with this chapter, or if it was executed in compliance with the laws of the state where it was executed
12. Section 3(e), Act 169, 1999 Hawaii State Legislature
13. Section 4(a), Act 169, 1999 Hawaii State Legislature
14. Section 4(b), Act 169, 1999 Hawaii State Legislature
15. Section 16, Act 169, 1999 Hawaii State Legislature. Several different sample forms (and Explanations) have been developed by the University of Hawaii Elder Law Program (UHELP) to address specific concerns, needs and abilities of its diverse clients. The sample form in the statute seems to be difficult for many clients, and especially clients with limited education or limited ability to read or concentrate.
16. The University of Hawaii Elder Law Program (UHELP) now housed at the Law School has been in existence for eighteen years, first at the Legal Aid Society and for the past eight years, at the University of Hawaii. As part of the Law School, provides direct legal services, advocacy, education, training, research, and even proposing legislation to better the lives of older persons in Hawaii.
17. See Haw. Rev. Stat. 321-229.50. Rapid identification document.
18. See HAW. REV. STAT. § HRS 327F.
19. HAW. REV. STAT. CHAP 327D Medical Treatment Decisions (First enacted in 1986, amended periodically and subsequently repealed, effective July 1, 1999)
20. See HAW. REV. STAT. § 327D-10. (Repealed as of June 30, 1999)
21. See HAW. REV. STAT. § 551D-2.5(a). (Repealed as of June 30, 1999)
22. HAW. REV. STAT. § 551D-2.5(a) (Repealed as of June 30, 1999)
23. HAW. REV. STAT. § 551D-2.5(b) (Repealed as of June 30, 1999) The Durable Power of Attorney for Health Care :
 - (1) Shall be in writing;
 - (2) Shall be signed by the principal, or by another person in the principal's presence and at the principal's expressed direction;
 - (3) Shall be dated;
 - (4) Shall be signed in the presence of two or more witnesses who:
 - (a) Are at least 18 years of age
 - (b) Are not related to the principal by blood, marriage, adoption; and
 - (c) Are not, at the time that the durable power of attorney is executed, attending physicians, employees of the attending physician, or employees of a health care facility in which the principal is a patient; and
 - (5) Must have all signatures notarized at the same time.
24. HAW. REV. STAT. § 551D-2.5(c). (Repealed as of June 30, 1999)
25. HAW. REV. STAT. § 551D-2.5(d). (Repealed as of June 30, 1999)
26. Section 4(a), Act 169, 1999 Hawaii State Legislature defines "Capacity" as an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision
27. Section 5(a), Act 169, 1999 Hawaii State Legislature
28. Section 5(b), Act 169, 1999 Hawaii State Legislature
29. Section 5(b), Act 169, 1999 Hawaii State Legislature
30. Section 2, Act 169, 1999 Hawaii State Legislature
31. The original submission included the following wording:

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

 - (a) The spouse, unless legally separated;
 - (b) An adult child;
 - (c) A parent; or
 - (d) An adult brother or sister.

If none of the individuals eligible to act as surrogate under subsection (b) is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate.
32. Section 5(i), Act 169, 1999 Hawaii State Legislature
33. Section 5(g), Act 169, 1999 Hawaii State Legislature
34. Section 8, Act 169, 1999 Hawaii State Legislature-Health care information.
35. Section 7 Act 169, 1999 Hawaii State Legislature -Obligations of health care provider.
36. Section 1, Act 169 Hawaii State Legislature-Definitions. "Capacity" means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.
37. In Section 7 Act 169, 1999 Hawaii State Legislature -Obligations of health care provider. (e) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience. A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.
 - (f) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.
 - (g) A health care provider or institution that declines to comply with an individual instruction or health care decision shall:
 - (1) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient;
 - (2) Provide continuing care to the patient until a transfer can be effected; and
 - (3) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.
 - (h) A health care provider or institution may not require or prohibit the execution or revocation of advance health care directive as a condition for providing health care.
38. Section 10, Act 169, 1999 Hawaii State Legislature-Statutory damages.
39. Section 14, Act 169, 1999 Hawaii State Legislature-Judicial relief.
40. Section 9, Act 169, 1999 Hawaii State Legislature-Immunities