AN ACT TO PROVIDE THAT AN ORGAN DONATION MADE BY WILL, BY A DURABLE POWER OF ATTORNEY, BY A LIVING WILL OR PURSUANT TO THE UNIFORM ANATOMICAL GIFT ACT SUPERCEDES ANY DECISION BY THE FAMILY OF THE ORGAN DONOR; TO AMEND SECTION 41-41-209, MISSISSIPPI CODE OF 1972, TO PROVIDE THE FORM FOR SUCH DECLARATION BY AN ORGAN DONOR; TO AMEND SECTION 41-39-15, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT NO PROTOCOL FOR POTENTIAL ORGAN DONORS SHALL SUPERCEDE A VALID GIFT OF AN ORGAN; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. A gift of all or part of the body made (a) by will, (b) under a Durable Power of Attorney for Health Care declaration pursuant to Section 41-41-209, (c) under a Withdrawal of Life-saving Mechanism (Living Will) declaration pursuant to former Section 41-41-107, or (d) under a Uniform Anatomical Gift Act declaration pursuant to Section 41-39-39, will supercede and have precedence over any decision by the family of the individual making the organ donation.

SECTION 2. Section 41-41-209, Mississippi Code of 1972, is amended as follows:

41-41-209. The following form may be used to create an advance health-care directive. Sections 41-41-201 through 41-41-207 and 41-41-211 through 41-41-229 govern the effect of this or any other writing used to create an advanced health-care directive. An individual may complete or modify all or any part of the following form:

ADVANCE HEALTH-CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make
health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

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

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

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

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

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

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

Part 4 of this form lets you authorize the donation of your organs at your death, and declares that this decision will supersede any decision by a member of your family.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

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

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

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

__________________________________________________________________
(name of individual you choose as agent)

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

__________________________________________________________________
(home phone)           (work phone)
OPTIONAL: If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

__________________________________________________________________

(name of individual you choose as first alternate agent)

__________________________________________________________________

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

__________________________________________________________________

(home phone)                                (work phone)

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

__________________________________________________________________

(name of individual you choose as second alternate agent)

__________________________________________________________________

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

__________________________________________________________________

(home phone)                                (work phone)

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

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

(Add additional sheets if needed.)

(3) WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE: My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's
authority to make health-care decisions for me takes effect immediately.

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

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

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

[ ] (a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

[ ] (b) Choice To Prolong Life
I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

__________________________________________________________________
__________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________

(Add additional sheets if needed.)

PART 3

PRIMARY PHYSICIAN

(OPTIONAL)

(10) I designate the following physician as my primary physician:

__________________________________________________________________

(name of physician)

__________________________________________________________________

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

(phone)
OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

__________________________________________________________________
(name of physician)
__________________________________________________________________
(address)       (city)       (state)      (zip code)
__________________________________________________________________
(phone)

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

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

_______________________________     ______________________________
(date)                          (sign your name)
_______________________________     ______________________________
(address)                        (print your name)

_______________________________
(city)        (state)

PART 4
CERTIFICATE OF AUTHORIZATION FOR ORGAN DONATION

(OPTIONAL)
I, the undersigned, this__________day of __________, 20__, desire that my__________organ(s) be made available after my demise for:

(a) Any licensed hospital, surgeon or physician, for medical education, research, advancement of medical science, therapy or transplantation to individuals;

(b) Any accredited medical school, college or university engaged in medical education or research, for therapy, educational research or medical science purposes or any accredited school or mortuary science;
(c) Any person operating a bank or storage facility for
blood, arteries, eyes, pituitaries, or other human parts, for use
in medical education, research, therapy or transplantation to
individuals;

(d) The donee specified below, for therapy or transplantation
needed by him or her, do hereby donate my ________ for said
purpose to __________(Name) at _________(Address).

I hereby authorize a licensed physician or surgeon to remove and
preserve for use my ________for said purpose.

I specifically provide that this declaration shall supercede and
take precedence over any decision by my family to the contrary.

Witnessed this________day of_____,20__.  

________________
DONOR

________________
ADDRESS

________________
TELEPHONE

________________
WITNESS

________________
WITNESS_______

(13) WITNESSES: This power of attorney will not be valid
for making health-care decisions unless it is either (a) signed by
two (2) qualified adult witnesses who are personally known to you
and who are present when you sign or acknowledge your signature;
or (b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

I declare under penalty of perjury pursuant to Section
97-9-61, Mississippi Code of 1972, that the principal is
personally known to me, that the principal signed or acknowledged
this power of attorney in my presence, that the principal appears
to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

______________________________      ______________________________
(date)                       (signature of witness)

______________________________      ______________________________
(address)                     (printed name of witness)

_____________________________       _____________________________
(city)      (state)

Witness

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

_____________________________       _____________________________
(date)                        (signature of witness)

_____________________________       _____________________________
(address)                       (printed name of witness)

_____________________________2
(city)      (state)

ALTERNATIVE NO. 2

State of ________________

County of ________________
On this _____ day of ________, in the year ____, before me, _______________ (insert name of notary public) appeared _______________, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Seal

____________________________
(Signature of Notary Public)

SECTION 3. Section 41-39-15, Mississippi Code of 1972, is amended as follows:

41-39-15. (1) For the purposes of this section:

(a) "Potential organ donor" means a patient with a severe neurological insult who exhibits loss of cranial nerve response or who has a Glasgow Coma Scale score of five (5) or less.

(b) "Potential tissue donor" means any patient who dies due to cardiac arrest.

(c) "Organ procurement organization" means the federally designated agency charged with coordinating the procurement of human organs in the State of Mississippi for the purpose of transplantation and research.

(d) "Tissue bank" or "tissue procurement organization" means a not-for-profit agency certified by the Mississippi State Department of Health to procure tissues, other than solid organs, in the State of Mississippi.

(2) Before November 1, 1998, each licensed acute care hospital in the state shall develop, with the concurrence of the hospital medical staff and the organ procurement organization, a protocol for identifying all potential organ and tissue donors. The protocol shall include a procedure for family consultation.
This protocol shall not be applicable in cases where a declaration
by the organ donor (a) by will, (b) under a Durable Power of
Attorney for Health Care declaration pursuant to Section
41-41-209, (c) under a Withdrawal of Life-saving Mechanism (Living
Will) declaration pursuant to former Section 41-41-107 (now
repealed), or (d) under the Uniform Anatomical Gift Law pursuant
to Section 41-39-39, has been provided to the attending physician.

(3) The protocol shall require each hospital to contact the
organ procurement organization by telephone when a patient in the
hospital becomes either a potential organ donor or potential
tissue donor as defined in this section. The organ procurement
organization shall determine the suitability of the patient for
organ or tissue donation after a review of the patient's medical
history and present condition. The organ procurement organization
representative shall notify the attending physician or designee of
its assessment. The hospital shall note in the patient's chart
the organ procurement organization's assessment of suitability for
donation. The organ procurement organization representative shall
provide information about donation options to the family or
persons specified in Section 41-39-35 when consent for donation is
requested.

(4) If the patient becomes brain dead and is still suitable
as a potential donor, the organ procurement organization
representative shall approach the deceased patient's legal next of
kin or persons specified in Section 41-39-35 for consent to donate
the patient's organs. The organ procurement organization
representative shall initiate the consent process with reasonable
discretion and sensitivity to the family's circumstances, values
and beliefs.

To discourage multiple requests for donation consent, the
organ procurement organization representative shall make a request
for tissue donation during the organ donation consent process.
When the possibility of tissue donation alone exists, a tissue bank representative or their designee may request the donation.

(5) The option of organ donation shall be made to the deceased patient's family upon the occurrence of brain death and while mechanical ventilation of the patient is in progress. The protocol shall require that the decision to donate be noted in the patient's medical record. The organ procurement organization shall provide a form to the hospital for the documentation. The form shall be signed by the patient's family pursuant to Sections 41-39-31 through 41-39-51. The form shall be placed in each deceased patient's chart documenting the family's decision regarding donation of organs or tissues from the patient.

(6) Performance improvement record reviews of deceased patients' medical records shall be conducted by the organ procurement organization for each hospital having more than ninety-five (95) licensed acute care beds and general surgical capability. These reviews must be performed in the first four (4) months of a calendar year for the previous calendar year. If the organ procurement organization and hospital mutually agree, the performance improvement record reviews may be performed more frequently. Aggregate data concerning these reviews shall be submitted by the organ procurement organization to the State Department of Health by July 1 of each year for the preceding year.

(7) No organ or tissue recovered in the State of Mississippi may be shipped out of the state except through an approved organ sharing network or, at the family's request, to an approved organ transplant program.

(8) Any hospital, administrator, physician, surgeon, nurse, technician, organ procurement organization, tissue procurement organization or donee who acts in good faith to comply with this section shall not be liable in any civil action to a claimant who alleges that his consent for the donation was required.
(9) Nothing in this section shall be construed to supersede or revoke, by implication or otherwise, any valid gift of the entire body to a medical school.

SECTION 4. This act shall take effect and be in force from and after July 1, 2001.