SCHOLARLY ARTICLE

The Need for a Family Medical Decision Making Statute in Oklahoma

By Tracy A. Cinocca

I. INTRODUCTION

Imagine you and your family are returning home from vacation in Florida. Around dusk you decide to look for a hotel. You glance at a hotel sign on the side of the road, then a car crosses the highway median and collides into the front of your vehicle. Everyone in the car besides you–your spouse, your 18 year old daughter, and your mother–is unconscious. At the hospital you quickly recover. The rest of your family does not. Each of them is in a coma. Physicians at the local hospital perform emergency procedures for your family, but you discover you are unable to make any health care decisions for them. No one in your family has ever issued an advance directive. You and your family incorrectly presumed that the medical custom of deference to family members would prevail in this type of situation. You must initiate expensive and timely guardianship proceedings to act as a surrogate decision maker for your spouse, your adult child and your mother.

Most people believe they can consent for their family members' medical care in the event of such a disaster, but legally they cannot. Oklahoma is one of only 12 states that does not have a family medical decision making statute in effect.[1] Ironically, the Oklahoma legislature has determined family-decision making is allowed for experimental treatments or procedures, but not medically accepted ones. [2] The legislature should amend Title 63 to allow family-decision making for all health care decisions – not just "experimental" ones.

Current Oklahoma laws on surrogate consent for medical care for incompetent individuals.

The Uniform Durable Power of Attorney Act authorizes a person to appoint another as his or her attorney-in-fact.[3] Such an attorney-in-fact may acquire "complete or limited authority with respect to the principal's person, including, but not limited to, health and medical care decisions on the principal's behalf."[4] Also, the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act sets forth the requirements for appointment of a proxy. Such a proxy may make medical treatment decisions, including decisions regarding life-sustaining treatment, through a health care proxy appointment in an advance directive conforming to the requirements of 63 O.S. § 3101.4.[5] Finally, under Oklahoma's present laws, a family's only option is the initiation of expensive and time-consuming guardianship proceedings to gain the right to make medical treatment decisions. The necessity to obtain a guardianship appointment absent appointment as an attorney-in-fact or a health care proxy could be alleviated by a change in Oklahoma law.

Current laws may not sufficiently safeguard a person's interest in directing his or her health care. The Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act provides that any "individual of sound mind and 18 years of age or older may execute at any time an advance directive governing the withholding or withdrawal of life-sustaining treatment."[6] Through the advance directive a declarant may appoint a health care proxy to make treatment decisions only if the patient is "terminally ill" or "persistently unconscious," as defined in the Act. A durable power of attorney must also be executed in order for a surrogate decision maker to authorize routine medical treatments or procedures, if the

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patient is not terminally ill or persistently unconscious. Only eight percent of the population has executed an advance directive.[7] Moreover, many durable powers of attorney do not take effect until a physician states in writing that the principal is incompetent.[8] Oklahomans need a statute that specifically authorizes family-decision making for routine health care decisions without the expense of hiring a lawyer.

Most state legislatures and experts across the United States approve of family-decision making statutes.

Many legal and medical experts and 38 state legislatures across the country support family-decision making statutes.[9] In 1971 the Missouri legislature passed the first family-decision making law.[10] In 1982, after six states had already adopted family-decision making statutes,[11] the National Conference of Commissioners on Uniform State Laws approved the Uniform Model Health-Care Consent Act.[12] Then four more states passed family-decision making statutes.[13] In 1985 and 1989 the Uniform Laws Commission approved the Uniform Rights of the Terminally Ill Act.[14] This act only allowed surrogate family-decision makers to decide whether to withhold or withdraw life-sustaining procedures from an incompetent family member.[15] Between 1985 and 1993, 20 additional states passed family-decision making statutes.[16] In 1993, the Uniform Law Commissioners approved the Uniform Health Care Decisions Act (UHCDA).[17] The UHCDA provides the most up to date guidance on the construction of family-decision making statutes.

The UHCDA, like 63 O.S. § 3102A, provides if a patient is incompetent and has not designated a surrogate decision maker, then a spouse, unless legally separated; adult child; a parent; or an adult brother or sister in descending order of priority may act as a surrogate.[18] However, the UHCDA grants family-decision making authority for all health care decisions[19] unlike the Oklahoma law that only applies to experimental treatments. **Most states have agreed with the experts that drafted the UHCDA that family-decision making statutes are needed.**

Family-decision Making Statutes Protect a Patient's Right to Self-determination.

A family-decision making law in Oklahoma would not supersede the authority of a patient to make his or her own decisions, if he is able, or to appoint someone else to do so. The proposed Oklahoma statute would protect all prior expressions of patient intent. A patient would only need to rely on a family-decision maker if he or she were incompetent, had not appointed a health care proxy or attorney-in-fact, or the court had not appointed a guardian.[20] Oklahoma law places a high priority on self determination as expressed through statutes authorizing living wills, advance directives or durable powers of attorney. Many other states have incorporated this value into their laws authorizing family-decision making.[21] "The decisions made in a living will, or by the agent appointed by the durable power of attorney prevail over the [surrogate] family member's decisions."[22] This allows family-decision making only if the incompetent

patient or court has not previously appointed a decision maker. Thus, any concerns an individual may have about entrusting health care decisions to a family member are easily addressed by specifically nominating a health care proxy or attorney-in-fact.

A family-decision maker is usually the best decision maker.

Family members are typically the best surrogates for patients because, in most cases, no one knows more or cares more about the personal and religious beliefs of an incompetent individual than his or her family.[23] People generally prefer to have family members make their decisions instead of judges, even if the family-decision maker did not decide as they would have wanted.[24]

> Public surveys indicate that patients prefer to have family members, rather than physicians, judges or others make their medical treatment decisions for them...Moreover, many patients seem to prefer that their surrogates choose in accordance with the surrogate's view of the patient's best interests, rather than the surrogate's view of the patient's preferences.[25]

Unlike a judge who is unfamiliar with the patient, family members are more intimately concerned about the welfare of the patient and must live with the decision they make.[26] Many people recognize this and prefer family-decision making to the expense and delay associated with court intervention.

Most states require surrogate decision makers to substitute the incompetent's judgment for their own[27] and base their decisions on what the patient would have wanted.[28] This is the substituted judgment standard. These statutes frequently provide that if the substituted judgment standard cannot be used for some reason then the decision maker should use the best interests standard. The best interests standard should apply when a surrogate decision maker does not know the patient's intentions, personal values or religious beliefs.[29] Some states only require the best interests of the patient be considered.[30] In Oklahoma, health care proxies must make decisions based upon known intentions, personal views and their view of the patient's best interests.[31] Further, if a health care proxy cannot do this, his or her decisions should be based "on reasonable judgment about the individual's values and what the individual wishes would be based upon those values."[32]

Family members rather than physicians or judges are generally more capable of applying the best interests standard since they usually know more about the patient and the patient's values.[33] Only people who know the incompetent patient can properly ascertain what the patient would have wanted, and then act in that patient's best interests.

What is unclear to a judge about a patient's beliefs and preferences may be patently clear to family members.[34] Judges often inadvertently impose their values upon their treatment decisions for patients instead of the patient's values.[35] Further, the physicians' values also often take precedence over patient preferences.[36] Many studies demonstrate the predominance of physicians' values in end-of-life decisions.[37] Although, hopefully uncommon, a physician's interest in his research and training may also conflict with the patient's interest.[38] Hospitals, nursing homes and doctors may have financial interests that could induce them to continue treatment for a patient beyond all hope of retaining cognitive abilities when an insurance provider pays all the costs.[39] Neither physicians nor the courts are in a better position than a patient's family to judge what the patient would have wanted since under most circumstances neither the physician nor the judge knows the patient better.

Health care providers should receive immunity from criminal prosecution, civil liability and disciplinary action for following the medical custom of deference to family members.

Family-decision making statutes clarify case law that legitimizes the customary medical practice of family-decision making for incompetents.[40] According to David Orentlicher,

> "Ordinarily, when the patient has not left an advance directive, family members are relied upon to make decisions for the patient. Indeed, physicians have historically turned to family members for medical decisions when patients are mentally

> incompetent, and courts generally have recognized the authorities of families to make life-sustaining treatment decisions for incompetent patients....because in the overwhelming majority of cases there is no advance directive, uncertainty about family authority could have a profound effect on end-of-life decision making."[41]

Physicians and other health care providers who follow the custom of deference to family members without specific legal authority should be concerned about civil liability and disciplinary action for doing so. Where the decisions involve life-sustaining treatment, criminal prosecution may also be a concern. "If an incompetent patient has not left an advance directive, a surrogate [decision making] act increases the likelihood that physicians will feel comfortable relying on the patient's family members to make life-sustaining treatment decisions."[42]

> Those surrogate decision making provisions that are part of a living will, health care power of attorney, combined advance directive, or DNR legislation partake of the statutory immunity provided by those statutes. Some of the free standing surrogate decision making statutes confer on physicians and other health care providers immunity from civil and criminal liability and from professional discipline if they act in conformity with the surrogate decision making statute. Some also confer immunity on surrogates.[43]

Oklahoma law currently provides immunity for physicians from criminal prosecution, civil liability and disciplinary action for following Advance Directives for Health Care,[44] Advance Directives for Mental Health Care Treatments,[45] and Do Not Resuscitate Orders.[46] Likewise, if a family-decision making act were approved, Oklahoma should grant the same immunities to health care providers found in these other laws. Without a family-decision making statute in Oklahoma, guardianship proceedings are often a necessity for hospitals and physicians to provide health care without fear of liability where no surrogate decision maker has been appointed.[47]

A family-decision making statute in Oklahoma will save patients, their families and health care providers money through avoidance of guardianship proceedings.

Judicial intervention into medical decision making is costly and unnecessarily intrusive.[48] The vast majority of Americans have not made any formal advance directive.[49]

> Despite considerable publicity about advance directives, most people do not use them. Surveys find that only between four and 17 1/2 percent of adult Americans have completed an advance directive. Accordingly, many states have enacted statutes giving authority to family members or close friends to make end-of-life decisions for patients who have not completed advance directives.[50]

Without an advance directive or durable power of attorney, guardianship proceedings must be held to determine who the surrogate decision maker will be.

The burdens of litigation heavily weigh upon families and hospitals with limited funds.[51] For many families, a court order is an overwhelming and complex obstacle. [52] Surrogate decision makers should not have to deal with the complexities of litigation when they have to deal with an incapacitated loved one.

Family-decision making statutes protect a family's financial interests from the legal fees involved in a guardianship proceeding.[53] The Oklahoma legislatures recognized the need for avoidance of court proceedings if possible in the Do-Not-Resuscitate Act: "[D]ecisions concerning one's medical treatments involve highly sensitive, personal issues that do not belong in court, even if an individual is incapacitated."[54] A family-decision making statute in Oklahoma would allow patient families and health care providers to avoid complex, timely and expensive guardianship proceedings.

Conclusion

When an individual cannot make his or her own health care decisions, Oklahoma law should allow family-medical decision making for all treatment decisions – not just those decisions that involve experimental treatments. Individuals who wish to name a particular surrogate decision maker may still do so with such a law in effect using the current law. By allowing surrogate decision making for families, Oklahoma can further protect an incom-

petent patient's interest in receiving appropriate health care since usually no one else knows more or cares more about the patient. Most states and the UHCDA have legislatively codified the medical custom of deference to family-decision making for all health care decisions that are not prohibited by law.[55] Oklahoma should as well. This will protect physicians and hospitals from criminal prosecution, civil liability and professional discipline and allow families to avoid the costs and complexities of guardianship proceedings. Oklahomans should urge their state legislators to enact a law incorporating these important values.

1. *In the Matter of Kathleen Farrell*, 108 N.J. 335, 343; 529 A.2d 404, 408 (Lexis through 1997)(Contains cites to 38 state statutes and the District of Columbia regarding provisions of the Terminally Ill Act on "living wills" that have been adopted in part); See also n. 9.

2. 63 O.S.Supp. §3102A (1998).

3. 58 O.S. § 1072.1 (B)(1).

4. *Id.*

5. 63 O.S.Supp. § 3101.1, 3101.3 (1998). (Oklahomans may also appoint an attorney-in-fact through an Advance Directive for Mental Health Treatment. 43A O.S.Supp.§ 11-106(B)(1998).)

6. 63 O.S. § 3101.4(A).

7. Barry R. Furrow et al., *Health Law* §17-23 (2d ed.1995)(Roughly 8% of Americans have a written advance directive).

8. 63 O.S. §3101.7 (Two physicians must determine patient is a qualified patient); 63 O.S. §3101.3 (10) (A patient is qualified if she is over 18 years of age, has executed an advance directive, and two physicians have determined her to be in a terminal condition or persistently unconscious state).

9. Ariz.Rev.Stat. § 36-3231(Lexis through 1996 Sess.); Ark.Code Ann. § 20-17-214(Lexis through 1995 1st Special Sess.); D.C. Code Ann. § 21-2210 (Lexis through 1996 Supp.); Fla. Stat. ch. 765.401 (Lexis through 1996 Sess.); Ga. Code Ann. § 31-39-2, § 31-39-4 (Lexis through 1996 Sess.); Haw. Rev. Stat. Ann. § 327D-21 (Michie, Lexis through 1996 Sess.); 755 Ill. Comp. Stat. 40/25 (West, Michie, Lexis through Pub. Act 89-679); Ind. Code Ann. § 16-36-1-5 (Michie, Lexis through 1996 Sess.); Idaho Code § 39-4303 (Michie, Lexis through 2d Sess. of 53rd legislature); Iowa Code § 144A.7 (Lexis through all 1995 legislation); La. Rev. Stat. Ann. § 1299.53 (West, Lexis through 1995 Sess.); Md. Code Ann., Health-Gen. I. § 5-605 (Lexis through 1996 Sess.); Miss. Code Ann. § 41-41-3 (Lexis through 1996 Sess.); Mo. Rev. Stat. § 431.061 (Lexis through 1995 Sess.); Model Health Care Consent Act § 4 (West 1988); Mont. Code Ann. § 50-9-106 (Lexis through 1995 Sess.); Nev. Rev. Stat. Ann. § 449.626 (Michie 1995); N.M. Stat. Ann. § 24-7-8.1 (Michie, Lexis through 1996 Supp.); N.Y. Pub. Health Law § 2965 (Consol., Law. Co-op., Lexis through Ch. 254, 9/1/96); N.C. Gen. Stat. § 90-322 (Michie, Lexis through 1996 Sess.); N.D. Cent. Code § 23-12-13 (Michie, Lexis through 1995 54th Sess.); Ohio Rev. Code Ann. § 2133.08 (Anderson, Lexis through 10/10/96 Sess.); Or. Rev. Stat. § 127.635 (Lexis through 1995 Sess.); S.C. Code Ann § 44-66-30 (Law Co-op., Lexis through 1996 Sess.); S.D. Codified Laws § 34-12C-3 (Michie, Lexis through 1996 71st Sess.); Tex. Health & Safety Code Ann. § 313.004, § 672.009 (West, Lexis through 1996 Sess.); Wash. Rev. Code Ann. § 7.70.065(Michie, Lexis through 1996 Sess.); W. Va. Code § 16-30B-7(Michie, Lexis through all 1996 legislation); Wyo. Stat. Ann. § 3-5-209 (Michie, Lexis through 1996 Sess.); Unif. Rights of the Terminally Ill Act § 7 (West 1987 & Supp 1996); Utah Code Ann.§ 78-14-5 (Michie, Lexis through all 1996 legislation); Va. Code Ann. § 54.1-2986 (Michie, Lexis through 1996 Sess.).

10. Mo. Rev. Stat. § 431.061 (Lexis through 1995 Sess.)(effective 1971).

11. Ga. Code Ann. § 31-39-2, § 31-39-4 (Lexis through 1996 Sess.)(effective 1981)(DNR has substituted judgement but best interests on others); Idaho Code § 39-4303 (Michie, Lexis through 2d Sess. of 53rd legislature) (effective 1975); La. Rev. Stat. Ann. § 1299.53 (West, Lexis through 1995 Sess.)(effective 1975); Mo. Rev. Stat. § 431.061; N.C. Gen. Stat. § 90-322 (Michie, Lexis through 1996 Sess.)(effective 1977); Utah Code Ann.§ 78-14- 5 (Michie, Lexis through all 1996 legislation) (effective 1976).

12. Model Health Care Consent Act § 4 (West 1988)(effective 1982).

13. Iowa Code § 144A.7 (Lexis through all 1995 legislation)(effective 1985); Miss. Code Ann. § 41-41-3 (Lexis through 1996 Sess.)(effective July 1, 1984); N.M. Stat. Ann. § 24-7-8.1 (Michie, Lexis through 1996 Supp.)(effective 1984); Va. Code Ann. § 54.1-2986 (Michie, Lexis through 1996 Sess.)(effective 1983).

14. Unif. Rights of the Terminally Ill Act § 7 (West 1987 & Supp 1996).

15. *Id.*

16. Ariz.Rev.Stat. § 36-3231(Lexis through 1996 Sess.)(effective 1992); Ark.Code Ann. § 20-17-214(Lexis through 1995 1st Special Sess.)(effective 1987); D.C. Code Ann. § 21-2210 (Lexis through 1996 Supp.)(effective 3/16/89); Fla. Stat. ch. 765.401 (Lexis through 1996 Sess.)(effective 4/10/92); Haw. Rev. Stat. Ann. § 327D-21 (Michie, Lexis through 1996 Sess.)(effective 1986); 755 Ill. Comp. Stat. 40/25 (West, Michie, Lexis through Pub. Act 89-679)(effective 9/26/91); Ind. Code Ann. § 16-36-1-5 (Michie, Lexis through 1996 Sess.)(effective 1993); Md. Code Ann., Health-Gen. I. § 5-605 (Lexis through 1996 Sess.)(effective 1993); Mont. Code Ann. § 50-9-106 (Lexis through 1995 Sess.)(effective 1991); Nev. Rev. Stat. Ann. § 449.626 (Michie 1995)(effective 1991); N.Y. Pub. Health Law § 2965 (Consol., Law. Co-op., Lexis through Ch. 254, 9/1/96)(effective 1987); N.D. Cent. Code § 23-12-13 (Michie, Lexis through 1995 54th Sess.)(effective 7/7/91); Ohio Rev. Code Ann. § 2133.08 (Anderson, Lexis through 10/10/96 Sess.)(effective 10/10/91); Or. Rev. Stat. § 127.635 (Lexis through 1995 Sess.) (effective 1993); S.C. Code Ann § 44-66-30 (Law Co-op., Lexis through 1996 Sess.)(effective 5/14/90); S.D. Codified Laws § 34-12C-3 (Michie, Lexis through 1996 71st Sess.)(effective 1990); Tex. Health & Safety Code Ann. § 313.004, N 672.009 (West, Lexis through 1996 Sess.)(effective 1993, 1989); Wash. Rev. Code Ann. § 7.70.065(Michie, Lexis through 1996 Sess.)(effective 1987); W. Va. Code § 16-30B-7(Michie, Lexis through all 1996 legislation)(effective 1993)(or best interests); Wyo. Stat. Ann. § 3-5-209 (Michie, Lexis through 1996 Sess.)(effective 4/1/92).

17. Unif. Health Care Decisions Act § 5 (effective 1993).

18. *Id.* at 5(b).

19. *Id.*

20. Unif. Health Care Decisions Act § 5 (effective 1993).

21. Ardath A. Hamann, *Family Surrogate Consent Laws: A Necessary Supplement to Living Wills, Durable Powers of Attorney*, 38 Villanova L. Rev. 103, 252 (1993).

22. Barry R. Furrow et al., *Health Law* §17-23 (2d ed.1995).

23. Hamann at 161-163.

24. David Orentlicher, *Symposium: Trends in Health Care Decision Making: The Limits on Legislation*, 53 Md. L. Rev. 1255, 1266-79 (1994).

25. *Id.* at 1279-80.

26. Hamann at 161.

27. Unif. Health Care Decisions Act § 5; Ariz.Rev.Stat. § 36-3231; Cal. Health & Safety Code § 1418.8; Colo. Rev. Stat. § 15-18.5-103; Del. Code Ann.tit.16, § 2507; D.C. Code Ann. § 21-2210; Fla. Stat. ch. 765.401; Haw. Rev. Stat. Ann. § 327D-21; Ind. Code Ann. § 16-36-1-5; Iowa Code § 144A.7; Md. Code Ann., Health-Gen. I. § 5-605; Mont. Code Ann. § 50-9-106; N.M. Stat. Ann. § 24-7-8.1; N.Y. Pub. Health Law § 2965; N.D. Cent. Code § 23-12-13; Ohio Rev. Code Ann. § 2133.08; S.C. Code Ann. § 44-66-30; S.D. Codified Laws § 34-12C-3; Tex. Health & Safety Code Ann. § 313.004, § 672.009; Va. Code Ann. § 54.1-2986; Wash. Rev. Code Ann. § 7.70.065; W. Va. Code § 16-30B-7(or best interests standard); Wyo. Stat. Ann. § 3-5-209.

28. *In re Quinlan*, 70 N.J. 10, 355 A.2d 649 (1976)(Definition of the substituted judgment standard.).

29. *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *In re Drabik*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

30. Model Health Care Consent Act § 4 (West 1988); Ga. Code Ann. § 31-39-2, § 31-39-4 (Lexis through 1996 Sess.)(except DNR orders use substituted judgment); Idaho Code § 39-4303 (Michie, Lexis through 2d Sess. of 53rd legislature)(effective 1975)(unless against expressed intentions); Ind. Code Ann. § 16-36-1-5; Ky.Rev. Stat. Ann.§311.631 (Michie, Lexis through 1996 Sess.); W. Va. Code § 16-30B-7(or substituted judgment).

31. 63 O.S.Supp. § 3101.16 (1998).

32. 63 O.S. § 3101.2.

33. Still another standard used by a few states requires good faith and that the decision not conflict with the expressed intentions of the patient prior to incompetency. Unif. Rights of the Terminally Ill Act §7 (West 1987 & Supp. 1996); Nev. Rev. Stat. Ann. § 449.626 (Michie 1995).

34. Hamann at 163.

35. *Id.*

36. Orentlicher at 1283.

37. Orentlicher at 1281-82 (Studies reveal that when a patient and physician are in disagreement regarding treatment 31.3%of a combined group of caregivers found the patient's right to choose only a moderate to moderately important or unimportant factor in end of life treatment decisions).
38. Hamann at 162.
39. Hamann at 152-53.
40. Alan Meisel, 2 *Right to Die* §10.18, 250 (2d ed. 1995).
41. Orentlicher at 1263.
42. Orentlicher at 1277.
43. Meisel at 267.
44. 63 O.S. §3101.10.
45. 43A O.S. §11-112.
46. 63 O.S. §3131.8.
47. Orentlicher at 1266 (1994) (Physicians often report that their fear of liability prevents them from following an advance directive's instruction to stop life sustaining procedures. Statutes may address this concern by providing physicians with immunity for civil and criminal liability if they carry out such an instruction in good faith according to statutory requirements.).
48. Hamann at 167.
49. Furrow at §17-23.
50. Orentlichter at 1260.
51. *Id.*
52. *Id.*
53. Hamann at 167.
54. 63 O.S. § 3101.2.
55. Model Health Care Consent Act §4; Unif. Health Care Decisions Act §5; Ariz.Rev.Stat. § 36-3231; Ark.Code Ann. § 20-17-214; Colo. Rev. Stat. §15-18.5-103; Del. Code Ann.tit.16, § 2507; D.C. Code Ann. § 21-2210; Fla. Stat. ch. 765.401; Haw. Rev. Stat. Ann. §327D-21; Idaho Code § 39-4303; Ind. Code Ann. § 16- 36-1-5; Ky.Rev. Stat. Ann. § 311.631; La. Rev. Stat. Ann. § 1299.53; Md. Code Ann., Health-Gen. I. § 5-605; Mass. Gen. Laws ch.201D, §16; Miss. Code Ann. § 41-41-3; Mo. Rev. Stat. § 431.061; N.M. Stat. Ann. § 24-7- 8.1; N.D. Cent. Code § 23-12-13; S.C. Code Ann § 44-66-30 (also in class adult sibling); S.D. Codified Laws § 34-12C-3; Tex. Health & Safety Code Ann. § 313.004, § 672.009; Utah Code Ann. § 78-14-5; Va. Code Ann. § 54.1-2986; Wash. Rev. Code Ann. §7.70.065; W. Va. Code § 16-30B-7(or best interests); Wyo. Stat. Ann. § 3-5-209.

NOTICE

MCLE 1998 Annual Reports of Compliance have been mailed and must be filed by ***ALL*** members age 65 or younger regardless of whether or not exempt from the educational requirements.

Deadline for earning the 12 hour education requirement is
December 31, 1998.

Deadline for filing the annual report is
February 15, 1999.

There is assessed a $50 expense charge for late filing or late compliance.

Duplicate 1998 Annual Reports of Compliance may be requested by contacting the MCLE Department, P.O. Box 53036, Oklahoma City, OK 73152, (405) 416-7009 or in Oklahoma (800) 522-8065. beverlyp@okbar.org