Response to February 10, 2012 Letter Outlining Concerns with SB 172

This legislation is consistent with current law. The intent is to clarify ambiguities within the Health Care Decisions Act – AS 13.52. We appreciate the opportunity to review this legislation with you.

Sectional Analysis & Health Care Decisions Act – AS 13.52

A legal review of the Sectional Analysis of Senate Bill 172 (SB172), and of the current law (Health Care Decisions Act) pertaining to end of life decisions in AS 13.52, are provided along with this response and will be helpful to understanding the specifics of the legislation.

1. Providence – *These bills attempt to mandate that aggressive potentially hazardous interventions be performed on every patient who requests it, no matter what the underlying disease, injury or illness (Sec. 2, pg 2, lines 2 -6; Sec. 3, pg 2, lines 11-15).*

   Response – This is a broad overstatement. Sec. 2, pg 2, lines 2 -6; and Sec. 3, pg 2, lines 11-15, restates more clearly what AS 13.52 already states. See October 28, 2011, State of Alaska, Legislative Legal opinion attached.

   Note: On p. 2, line 13, the term "advanced health care directive" will be amended to "individual instruction", to be consistent with the more narrow focus of limiting the health care provider's right to decline to comply with a patient request that cardiopulmonary resuscitation be provided.

2. Providence – *If the patient is not capable of decision making, a surrogate decision maker can mandate that potentially hazardous interventions be performed EVEN if the patient's advance health care directive states otherwise (Sec. 3, pg 2, lines 11-15; Sec. 6, pg 2, lines 29-31 and pg 3, line 4; and Sec. 12, pg 19, lines 18-19).*

   Response – This is not correct. An advanced health care directive indicating a patient's choice for a DNR order or choice not to prolong life must be adhered to (see 13.52.030(g)) and this legislation does not change that. Rather, it reiterates the authority of patient advance health care directives in Sec. 6, pg 3, lines 2-3 which states in part, *under this paragraph, the consent (to a DNR order) may be provided by an advance health care directive.* Further, the rights of health care providers and institutions not to comply with a decision of a surrogate who the provider observes is not abiding by the wishes, values and best interests of a patient are protected under 13.52.030(g-h) *Surrogates*, and under 13.52.140 *Judicial relief*.

3. Providence – *It agrees that health care providers can identify medical futility (when procedures or interventions will not help a patient condition) but it further mandates that health care providers cannot refuse to apply potentially harmful interventions to patients if they or their*

families demand it. This is true even when the procedures are deemed to be medically ineffective (Sec. 3, pg 2, lines 7-18).

Response – Much of this section is current law, not new law. Only lines 11 – 15 contain new language, which clarifies that a health care provider, health care institution or facility may not decline to comply with an individual instruction or health care decision that requests CPR or other resuscitative measures be provided.

4. Providence – *In short, it mandates that providers batter patients, by performing painful and potentially harmful procedures that are in direct contrast to generally acceptable medical practice (Sec. 3, pg 2, lines 7-18).*

   Response – See response to #3.

5. Providence – *It mandates that under certain circumstances health care providers may not adhere to their medical creed to "first do no harm". It mandates that providers harm patients (Sec. 3, pg 2, lines 7-18).*

   Response – See response to #3.

6. Providence – *It does not encourage or support the input of medical providers or collaborative efforts to determine the best course of care by weighing all of the care options with clear understanding and discussion of risks vs. benefits (Sec. 3, pg 2, lines 7-18).*

   Response – See response to #3; also, the authority to issue or make ineffective DNR orders is, unfortunately, often viewed as a zero sum game. If the physician gains decision making authority, the patient loses. If the patient gains decision making authority, the physician loses. This legislation does nothing to discourage the dialogue surrounding these difficult decisions. Ideally, agreement will be reached. But in the end, if there is an impasse between the patient (or surrogate) and the physician with respect to a DNR order, the law says the presumption is in favor of life, and with that of patient consent to a DNR order being required.

   With respect to parents of a child patient, sometimes they cannot accept, even after long and painful discussions that their child will not survive. They will not "give up". May CPR be done long enough (not prolonged) for the parents looking on to demonstrate its futility? The health care provider is also treating the family, even though the child is beyond saving. Public safety and critical care personnel with substantial service in the profession know the relevancy of this argument.

7. Providence – *It encourages individuals to direct hospitals and health care providers to perform potentially harmful interventions on patients who will not benefit from these interventions (Sec. 3, pg 2, lines 7-18; Sec. 2, pg 2, lines 2-6). It negates individual freedom to choose.*

   Response – see response to #3 and #6; also, with respect to DNR orders, this legislation most certainly supports the patient's individual freedom to choose, and protects them from becoming subject to a DNR order against their will. Determinations of when to discontinue efforts at life-saving interventions fall to the purview of physicians, the policies of the health care institutions, and the accepted standards of medical practice.

8. Providence - *It allows surrogate decision makers to reverse decisions made by individuals who have completed advance health care directives (Sec. 2, pg 2, lines 2-6; Sec. 3, pg 2, lines 7-18; Sec. 6, pg 3, line 4; Sec. 13.52.300, pg 7, lines 6-11, and 15 and 16).*

   Response – this is not correct. See response to #2; also, a real misunderstanding occurs here with respect to what is current law, and what is being proposed in the legislation. The reference to Sec. 13.52.300, pg 7, lines 6-11, and 15 and 16, <u>is all current law</u> as stated in the sample Advance Health Care Directive form. None of this is new or amended language that is being proposed. Rather, the language in question on the form is merely giving the explanation that Part 1 of the form is a durable power of attorney for health care and advising the reader that they may appoint an agent, limit or not limit the agent's authority to make health care decisions for the patient, and if they choose not to limit the agent's authority, a careful description of the specific actions an agent make take on their behalf is identified.

9. Providence – *It mandates that all previously established health care directives become null and void if they were established previously but not in accordance with the new bill directives (Sec. 6, pg 3, lines 14 – 26; Sec. 14, pg 19, lines 23-27).*

   Response – this is an incorrect, overly broad statement. Rather, the bill language mentioned in Sec. 14, pg 19, lines 23 – 27 <u>speaks only to indicate how DNR orders made before the bill's effective date are to be treated in light of the bill.</u>

   Further, 13.52.150 *Do not resuscitate orders and identification of other jurisdictions* states that with respect to DNR orders or DNR identification executed, issued or authorized in another state or territory or possession of the United States - a health care provider or health care institution may presume, in the absence of actual notice to the contrary, that the DNR order or the DNR identification complies with the laws of this state, regardless of where or when it was executed, issued, or authorized, and that the patient is a qualified patient.

10. Providence – *It threatens litigation to providers who will not inflict harm on patients by refusing to perform medically ineffective harmful procedures and aggressive interventions when patients or their families request it (Sec. 8, pg 5, lines 12-14).*

    Response – the language of this section is consistent with current law liability for gross negligence or reckless or intentional actions, and states that immunities from liability do not apply to health care providers, institutions and facilities if the DNR order relied on by these entities was issued in violation of AS 13.52.065.

    The legislation protects health care providers from criminal liability by providing that a violation of 13.52.065 *Do not resuscitate protocol and identification requirements* does not, for any purpose, constitute a homicide (Sec. 9, pg 5, lines 20-21).

11. Providence – *It defaults automatically to doing aggressive painful potentially hazardous procedures on all patients who have not previously established written health care directives that specifically refuse to have CPR or other advanced aggressive interventions (Sec. 6, pg 3, lines 5-10; Sec. 4, pg 2, lines 19-22).*

    Response – this is not correct. This legislation allows patients (or surrogates) to make health care decisions with respect to DNR orders. Most patients do not have advanced health care directives, but defer making end of life decisions until they must be made.

    A misunderstanding occurs here in the sections of legislation identified. Sec. 6, pg 3, lines 5-10 speaks to when a physician may issue a DNR order without the express consent of the patient in various situations, one of which is when a patient has an advance health care directive which indicates the patient wants a DNR, and another situation in which a patient has an advance health care directive which is silent about the issuance of a DNR and another physician concurs in the decision to issue a DNR order.

12. Providence – *It mandates that a physician revoke DNR orders under any circumstance in which a patient, a family member or a surrogate decision maker demands it – even if the interventions demanded are medically ineffective (Sec. 2, pg 2, lines 2-6; Sec. 3, pg 2, lines 7-18).*

    Response – this is an incorrect, overly broad statement. See responses to #2, #6 and #7. True, the legislation protects patients from becoming subject to DNR orders against their will. However, the law clearly lays out process for determining who has standing to act on behalf of the patient, and who does not (13.52.030 *Surrogates).*

13. Providence – *It states that a physician who has "an individual relationship with the patient" may revoke a DNR. It does not specify what that relationship might be (Sec. 6, pg 3, line 31). It states that a physician who is employed by the health care institution where the patient is being treated may revoke a DNR order without establishing a professional patient-physician relationship (Sec. 6, pg 4, lines 1 and 2).*

    Response – we welcome proposed language from Providence. The central idea is to limit the number of uninvolved physicians who could raise objections to a DNR order. Sec. 6, pg 3, line 30 contains the key contextual language *arising out of the physician's* "individual relationship with the patient"; or "employment by the health care institution or health care facility where the patient is being treated". With respect to *individual relationship* – a patient could have close friends, who just happen to be physicians, who know much about the patient's medical situation, and personal values and wishes, but who are not the patient's primary care providers. With respect to *employment by the health care institution….where the patient is being treated* - the patient-physician relationship is implied, but not clearly stated.

14. Providence – *The advance health care directive form has been altered to indicate that any selection by an individual that does not ask for full resuscitation efforts must wish to die (Sec. 13.52.300, pg 11, lines 8-31, and pg 12, lines 1-11). It does not address or support an individual's right to request that their care be focused upon relief of pain and suffering, maximizing comfort and avoiding the prolonging of the dying process.*

    Response – a complete misunderstanding occurs here in the sections of legislation identified. The reference to Sec. 13.52.300, pg 11, lines 8-31, and pg 12, lines 1-11, is all current law as stated in the sample Advance Health Care Directive form. None of this is new or amended language that is being proposed. Further, the plain meaning of this form is clear - to enable patients to provide detailed instructions for health care concerning end-of-life decisions. The form covers the choice to prolong life, not to prolong life (and under what circumstances), additional instructions from patient, choices concerning artificial nutrition and hydration, and relief from pain.

15. Providence - *The new version of the advance health care directive form does not encourage graduated selection of interventions. It is an all or none proposition (13.52.300, pg 13, lines 2-10).* Response – This legislation incorporates the entirety of the current form, with one amendment (pg 13, lines 2-10) to provide an additional choice in the Alaska Health Care Directive form to allow patients to accept or refuse life-sustaining procedures. The current form under Part 2 – Instructions for Health Care, on pages 11 – 13 of the bill, give ample opportunities for graduated selection of interventions as stated in response to #14.