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February 14, 2012



Senator Fred Dyson
State Capitol, Room 121
Mailstop 3100
Juneau, AK 99801-1182

Dear Senator Dyson:

I recently became aware that in a letter dated January 18, 2012 from you to Senator Bettye Davis, and subsequently made part of the public record for Senate Bill 172, there are statements attributed to the "Chief Operating Officer" and the "Chief Medical Officer" of an area hospital in reference to a specific patient and family. For a number of reasons, I believe that the "chief operating officer" referenced in your letter may be me, and the "chief medical officer" would then be Roy Davis, MD. I wish to clarify a statement attributed to Providence executives in order to avert misunderstanding among interested parties who are neither familiar with the case referenced in your letter nor the mechanisms and laws for physician prescriptions, including "Do Not Resuscitate" ("DNR") orders.

While I presently serve as the chief executive officer of Providence Health & Services Alaska, at the time referenced in your letter, I served as the chief operating officer. You and I spoke on at least two occasions about the case in question. I explained that these cases are almost always highly complicated and emotionally demanding for all parties. Physicians do an outstanding job of considering each patient's needs and of determining the appropriateness for such orders under these challenging circumstances.

Roy Davis, MD, our chief medical officer, indicates that he never spoke with you about the patient matter. However, you did speak with Richard Mandsager, MD. Dr. Mandsager serves as chief executive officer for Providence Alaska Medical Center, and he recalls speaking with you about certain details of the case. We suspect that your reference to the "chief medical officer" was in fact to Dr. Mandsager in his role as chief executive officer.

The specific clarification we wish reflected in the public record is that neither Dr. Mandsager nor any other executive of Providence Health & Services represented to you that the DNR order would be removed from the referenced patient's medical record. Such an action is inconsistent with policy, bylaws and community practice. As such, removal of the DNR was never considered.

I respectfully request that you correct the official record on this important matter.

Sincerely,

A handwritten signature in cursive script that reads "Bruce Lamoureux".

Bruce Lamoureux
Sr Vice President/Chief Executive Alaska Region

BL:lb

Cc: ~~Senator Bettye Davis~~
✓ Senator Hollis French
Representative Bob Lynn

Providence Health & Services Alaska
Review of Senate Bill 172 and House Bill 309
Prepared by Providence Physician Leadership - February 10, 2012 and
Unanimously Endorsed by the Providence Alaska Medical Center's (PAMC)
Medical Executive Committee, elected representatives of physicians who hold
medical privileges at PAMC – February 13, 2012

At first glance, Senate bill # 172 and its partner bill #309 in the House, appear to empower patients to make decisions about their health care at the end of life (Sec. 1 pg 1 lines 3-7). However, on further review these bills contain language involving a very complex decision making process that normally occurs between a patient and his or her physician.

These bills attempt to legislate a complex decision making process and make a "one size fits all" model for end-of-life care. Specifically, these bills are concerned with advanced health care directives which may be made independently or may accompany a will or estate planning. The advanced health care directive is designed to give direction to your family, loved ones and health care providers about care choices if you become critically ill and cannot make decisions for yourself. Ideally, every individual would make this directive ahead of time, when they are clear of mind and not under stress or distracted in any way. In reality, fewer than 1 in 5 individuals arriving to a hospital have an advanced directive(Halpern NA, Pastores SM, Chou JF, Chawla S, Thaler HT, Palliat Med. 2011 Apr;14(4):483-9. Epub 2011 Mar 18; . Knott CI, Psirides AJ, Young PJ, Sim D., Crit Care Resusc. 2011 Sep;13(3):167-74).

These bills also address requests by patients or health care providers to use or not to use advanced medical procedures in an attempt to keep them alive. New terminology adopted by several states terms these issues as "Allow Natural Death," (AND). In Alaska, the terminology utilized is called DNR (do not resuscitate) orders and advanced resuscitative measures. A DNR order can be initiated with or without an advance health care directive. Historically, A DNR is a written agreement that is made between a physician and a patient after discussion about a patient's medical condition. A DNR can answer questions about whether a patient wants CPR (chest compressions or cardiopulmonary resuscitation), wants artificial breathing applied (also called intubation) or some assistance with breathing if an individual needs assistance on a temporary or long term basis. It addresses artificial nutrition if an individual is temporarily or permanently unable to swallow or eat. It addresses the use of antibiotics for infection and other medications to support blood pressure. It addresses the use of electricity/shocking of the heart to reset or restart the heart if the heart stops.

The decisions made by an individual about how they want to spend their end days are complex and personal. Each person has their own set of circumstances that guide their decision making. The decision may be based on what types of illnesses an individual has or how long they have had these illnesses. It may have to do with their ability or inability to tolerate pain and suffering. It may be directly or indirectly related to religious or cultural beliefs. It may reflect a preference to allow all bodily processes to occur

naturally and not be artificially supported. It may have to do with a desire not to be a burden to family or loved ones if circumstances alter one's ability to care for themselves. It may reflect financial concerns.

The list of reasons why people make decisions is lengthy and unique to each individual. These decisions should be discussed at length with family and loved ones and preferably with a physician who can communicate the degree and prognosis of illnesses with the individual and their loved ones. Ideally, everyone knows and understands the choices and why they are made.

In reality, fewer than 1 in 5 patients admitted to the hospital have made these decisions even though they may have very complicated advanced illnesses or injuries (Halpern, et.al. and Knott et.al.). In general, the American culture tends to not discuss death and dying and is generally unprepared to address these issues until they are forced to do so when confronted by a life altering or life threatening injury or illness. The decisions must then be made under stress. The worst case scenario presents when a patient is not able to make decisions and family members must make decisions while hoping they know what a patient may want. Often families do not know, are unsure, or simply are not present or cannot be found. Whenever possible, these decisions are made in advance. When they have not been made in advance, the medical team caring for the patient is faced with making the decisions together with available family members. Decisions are based upon what is known about the illness(es) or injuries, progression of disease, and benefits vs. harm of interventions. These decisions are crafted with input from family regarding patient preferences. It is a complex process and made with due diligence, generally with the input of many care providers, in addition to family wishes. They are not made lightly.

It is important to note that advanced interventions including CPR, artificial breathing techniques, artificial nutrition, shocking of the heart, etc. are helpful only in very specific medical circumstances. They are not applicable to each and every end of life illness or injury no matter what is portrayed on TV (references: code of Ethics of the American Medical Association (AMA), Opinions 2.035, 2.095). In fact, many of these interventions are painful and are rarely successful (Ebell & Alfonso; Family Practice 2011; 28:505-515). They are often associated with severe painful and sometimes persistent complications that leave the few who survive the procedures permanently impaired. CPR for example, was designed to be utilized in only a specific subset of heart patients (Kouwenhouen JAMA 1960 173: 1064-7). It was not recommended for other situations because the likelihood of survival is so low and the risks of complications are so high. For example, advanced cancer patients have not been shown to benefit from CPR. The procedure frequently causes broken ribs and a broken breast bone and collapsed lungs, to mention only a few of the potential complications. The benefits of the procedures should clearly outweigh the potential risks of the complications associated with these procedures. In end stage cancer, the benefits rarely outweigh the risks. When they do outweigh the risks, then CPR and other advanced aggressive procedures are performed. However, medical standards do not recommend doing advanced aggressive interventions in every case (references: code of Ethics of the American Medical Association (AMA), Opinions 2.035, 2.095). In these situations, the

recommendation is to provide full support for patients, but not to provide procedures that have a higher risk of injury than to provide benefit, irrespective of a DNR that may be in effect.

The House and Senate bills do not reflect the complexity of this decision making process. This legislation is inappropriate for a large portion of individuals by mandating the following:

1. 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).
2. 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. Pg2, lines 29-31and pg 3, line 4, Sec 12, pg 19, lines 18,19).
3. 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) .
4. 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 s (Sec 3. pg 2, lines 7-18) .
5. 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).
6. 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) ..
7. 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.
8. 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.)
9. 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. Pt 19, lines 23-27).

10. 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).
11. 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).
12. 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)
13. 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 3)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).
14. 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.
15. The new version of the advance health care directive form does not encourage graduated selection of interventions. It is an all or none proposition (Sec 13.52.300, pg 13, lines 2-10).

Page 19 simply needs to be deleted altogether.

Why the medical community has grave concerns

- It does not allow those individuals with the most expert understanding of health and disease and prognosis to exercise their expertise.
- It implies that DNR orders are made flippantly and without deep compassionate concern for the welfare of patients.
- It makes an assumption that doing potentially harmful and painful interventions are always in the patients’ best interests despite accepted medical standards that indicate otherwise.
- It ignores the Hippocratic Oath and that health care providers must first do no harm . It supports the battery of patients by mandating that harmful procedures be performed on patients without regard to the benefit vs. risk assessment of these interventions

- It does not support the time honored tradition of patient physician relationship in which these discussions should be made.
- It makes an assumption that every patient feels that the quantity of life trumps the quality of life
- It does not promote death with dignity
- It forces families and loved ones to reconsider the decisions of their loved ones and consider reversing decisions that may cause irreparable psychological and emotional damage in the long run.
- It assumes that physicians do not err on the side of over-utilizing CPR. It assumes that providers underutilize these aggressive procedures. This is untrue.

Considerations for Alaska citizens who do not want government intrusion into personal medical decision making

- It makes an assumption that each individual values the quantity of life over the quality of life without regard to the degree of suffering an individual may experience.
- It assumes that every individual wants artificial support even when it has been shown to not be helpful.
- It assumes that every person wants to have CPR and undergo potential pain and suffering from these procedures even when they have been shown not to be of any benefit.
- It allows other individuals to reverse your right to death with dignity because they are afraid to lose you. It implies that they may not value your life if they do not at least try the aggressive resuscitative measures.
- It forces others to ignore your choices and decide for themselves whether or not to honor your wishes.
- It mandates that every individual should be treated the same. It is a "cookie cutter approach" to medical care assuming that each person wants the same thing as proponents for the right to life.
- It has the potential to reverse a well thought out decision for end of life care that may have been made by you for reasons unknown to other individuals.
- It does not allow those who have not yet made advanced directives to have well thought out approaches to their medical care and instead defaults to the use of aggressive medical interventions

- It assumes that physicians do not make medical decisions incorporating acceptable medical standards of care.
- It assumes that a patient and their physician cannot tailor a unique care plan for each individual. Instead, a legislator with no medical experience whatsoever can mandate the procedures that will happen to you at the end of life.
- It mandates patients with extremely advanced medical conditions undergo these procedures simply because they do not have advance health care directives.
- It insists that all previously established advanced health directives and DNR orders be reconsidered and must be in compliance with the new standards established with this new bill.