27-LS0991\D
Bannister
3/1/12

CS FOR SENATE BILL NO. 172( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DYSON, Davis, Coghill, McGuire, Olson

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care decisions, including do not resuscitate orders."

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

*** Section 1.** AS 13.52.045 is amended by adding a new subsection to read:

(b) A health care institution or health care facility may not interpret the issuance of a do not resuscitate order for a patient as preventing the health care institution or health care facility from providing life-sustaining procedures to the patient.

*** Sec. 2.** AS 13.52.060(e) is amended to read:

(e) A health care provider may decline to comply with an individual instruction or a health care decision for reasons of conscience, except **that a health care provider may not decline to comply with** [FOR] a do not resuscitate order **that is consistent with this chapter for reasons of conscience**. A health care institution or health care facility 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 or facility that 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. **Notwithstanding the other provisions of this subsection, this subsection does not, except as provided by AS 13.52.030(h), allow a health care provider, health care institution, or health care facility to decline to comply with an individual instruction or a health care decision that requests that a do not resuscitate order be made ineffective.**

*** Sec. 3.** AS 13.52.060(f) is amended to read:

(f) A health care provider, health care institution, or health care facility may decline to comply with an individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the provider, institution, or facility. **Notwithstanding the other provisions of this subsection, this subsection does not, except as provided by AS 13.52.030(h), allow a health care provider, health care institution, or health care facility to decline to comply with an individual instruction or a health care decision that a requests that do not resuscitate order be made ineffective.** In this subsection, "medically ineffective health care" means health care that according to reasonable medical judgment cannot cure the patient's illness, cannot diminish its progressive course, and cannot effectively alleviate severe discomfort and distress.

*** Sec. 4.** AS 13.52.065(a) is amended to read:

(a) A physician may issue a do not resuscitate order for a patient of the physician **only as provided in this section**. The physician shall document the grounds for the order in the patient's medical file.

*** Sec. 5.** AS 13.52.065(b) is amended to read:

(b) The department shall by regulation adopt a protocol, subject to the approval of the State Medical Board, for do not resuscitate orders that sets out a standardized method of procedure for the withholding of cardiopulmonary resuscitation by health care providers and health care institutions. **The protocol adopted by the department must comply with this section.**

*** Sec. 6.** AS 13.52.065 is amended by adding new subsections to read:

(g) Except as provided in (h) of this section, a physician may not issue a do not resuscitate order for a patient of the physician without the express consent of

(1) the patient, if the patient has capacity and is 18 years of age or older; under this paragraph, the consent may be provided by an advance health care directive; or

(2) a person authorized to make health care decisions for the patient.

(h) A physician may issue a do not resuscitate order for a patient of the physician without the express consent required by (g) of this section if the patient does not have capacity, no person is authorized to make health care decisions for the patient, and,

(1) if the patient has an advance health care directive, the directive indicates that the patient wants a do not resuscitate order;

(2) if the patient has an advance health care directive, the directive is silent about the issuance of a do not resuscitate order and another physician concurs in the decision to issue a do not resuscitate order; or

(3) if the patient does not have an advance health care directive, another physician concurs in the decision to issue a do not resuscitate order.

(i) A physician shall revoke a do not resuscitate order issued for a patient if

(1) the issuance of the do not resuscitate order violates (g) of this section;

(2) except as provided in (4) of this subsection, the patient has capacity and requests that the do not resuscitate order be revoked;

(3) the patient does not have capacity, the patient does not have an advance health care directive that indicates that the patient wants a do not resuscitate order, and a person authorized to make health care decisions for the patient requests the revocation of the do not resuscitate order; or

(4) the patient is under 18 years of age and the parent or guardian of the patient requests that the do not resuscitate order be revoked.

(j) A physician may revoke a do not resuscitate order issued by another physician for a patient, if the physician has a physician-patient relationship with the patient.

*** Sec. 7.** AS 13.52.080(a) is amended to read:

(a) A health care provider or health care institution that acts in good faith and

in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for

(1) providing health care information in good faith under AS 13.52.070;

(2) complying with a health care decision of a person based on a good faith belief that the person has authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;

(3) declining to comply with a health care decision of a person based on a good faith belief that the person then lacked authority;

(4) complying with an advance health care directive and assuming in good faith that the directive was valid when made and has not been revoked or terminated;

(5) participating in the withholding or withdrawal of cardiopulmonary resuscitation under the direction or with the authorization of a physician or upon discovery of do not resuscitate identification upon an individual;

(6) causing or participating in providing cardiopulmonary resuscitation or other life-sustaining procedures

(A) under AS 13.52.065(e) when an individual has made an anatomical gift;

(B) because an individual has made a do not resuscitate order ineffective under **AS 13.52.065** [AS 13.52.065(f)] or another provision of this chapter; or

(C) because the patient is a woman of childbearing age and AS 13.52.055 applies; or

(7) acting in good faith under the terms of this chapter or the law of another state relating to anatomical gifts.

*** Sec. 8.** AS 13.52.300 is amended to read:

Sec. 13.52.300. Optional form. The following sample form may be used to create an advance health care directive. The other sections of this chapter govern the effect of this or any other writing used to create an advance health care directive. This

form may be duplicated. This form may be modified to suit the needs of the person, or a different form that complies with this chapter may be used, including the mandatory witnessing requirements:

ADVANCE HEALTH CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care to the extent allowed by law. You also have the right to name someone else to make health care decisions for you to the extent allowed by law. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form if the form complies with the requirements of AS 13.52.

Part 1 of this form is a durable power of attorney for health care. A "durable power of attorney for health care" means the designation of an agent to make health care decisions for you. Part 1 lets you name another individual as an agent to make health care decisions for you if you do not have the capacity to make your own decisions or if you want someone else to make those decisions for you now even though you still have the capacity to make those decisions. 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 health care institution where 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 that you could legally make for yourself. This form has a place for you to limit the authority of your agent. You do not have to 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 the extent allowed by law, to

(a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including the administration or discontinuation of psychotropic medication;

(b) select or discharge health care providers and institutions;

(c) approve or disapprove proposed diagnostic tests, surgical procedures, and programs of medication;

(d) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care; and

(e) make an anatomical gift following your death.

Part 2 of this form lets you give specific instructions for any aspect of your health care to the extent allowed by law, except you may not authorize mercy killing, assisted suicide, or euthanasia. 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 medication. 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 express an intention to make an anatomical gift following your death.

Part 4 of this form lets you make decisions in advance about certain types of mental health treatment.

Part 5 of this form lets you designate a physician to have primary responsibility for your health care.

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 your agent to make sure that the person 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, except that you may not revoke this declaration when you are determined not to be competent by a court, by two physicians, at least one of whom shall be a psychiatrist, or by both a physician and a professional mental health clinician. In this advance health care directive, "competent" means that you have the capacity

(1) to assimilate relevant facts and to appreciate and understand your situation with regard to those facts; and

(2) to participate in treatment decisions by means of a rational thought process.

PART 1

DURABLE POWER OF ATTORNEY FOR
HEALTH CARE DECISIONS

(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 telephone) (work telephone)

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 telephone) (work telephone)

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 telephone) (work telephone)

(2) AGENT'S AUTHORITY. My agent is authorized and directed to follow my individual instructions and my other wishes to the extent known to the agent in making all health care decisions for me. If these are not known, my agent is authorized to make these decisions in accordance with my best interest, including decisions to provide, withhold, or withdraw artificial hydration and nutrition and other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

Under this authority, "best interest" means that the benefits to you resulting from a treatment outweigh the burdens to you resulting from that treatment after assessing

(A) the effect of the treatment on your physical, emotional, and cognitive functions;

(B) the degree of physical pain or discomfort caused to you by the treatment or the withholding or withdrawal of the treatment;

(C) the degree to which your medical condition, the treatment, or the withholding or withdrawal of treatment, results in a severe and continuing impairment;

(D) the effect of the treatment on your life expectancy;

(E) your prognosis for recovery, with and without the treatment;

(F) the risks, side effects, and benefits of the treatment or the withholding of treatment; and

(G) your religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE. Except in the case of mental illness, 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. In the case of mental illness, unless I mark the following box, my agent's authority becomes effective when a court determines I am unable to make my own decisions, or, in an emergency, if my primary physician or another health care provider determines I am unable to make my own decisions. 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 durable 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 under (1) above, 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 health care decisions, you do not need to 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. There is a state protocol that governs the use of do not resuscitate orders by physicians and other health care providers. You may obtain a copy of the protocol from the Alaska Department of Health and Social Services. A "do not resuscitate order" means a directive from a licensed physician that emergency cardiopulmonary resuscitation should not be administered to you.

(6) END-OF-LIFE DECISIONS. Except to the extent prohibited by law, 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: (Check only one box.)

(A) [ ] Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards; OR

(B) [ ] Choice Not To Prolong Life

I want comfort care only and I do not want my life to be prolonged with medical treatment if, in the judgment of my physician,

I have (check all choices that represent your wishes)

[ ] (i) a condition of permanent unconsciousness: a condition that, to a high degree of medical certainty, will last permanently without improvement; in which, to a high degree of medical certainty, thought, sensation, purposeful action, social interaction, and awareness of myself and the environment are absent; and for which, to a high degree of medical certainty, initiating or continuing life-sustaining procedures for me, in light of my medical outcome, will provide only minimal medical benefit for me; or

[ ] (ii) a terminal condition: an incurable or irreversible illness or injury that without the administration of life-sustaining procedures will result in my death in a short period of time, for which there is no

reasonable prospect of cure or recovery, that imposes severe pain or otherwise imposes an inhumane burden on me, and for which, in light of my medical condition, initiating or continuing life-sustaining procedures will provide only minimal medical benefit;

[ ] Additional instructions:_____

_____

(C) Artificial Nutrition and Hydration. If I am unable to safely take nutrition, fluids, or nutrition and fluids (check your choices or write your instructions),

[ ] I wish to receive artificial nutrition and hydration indefinitely;

[ ] I wish to receive artificial nutrition and hydration indefinitely, unless it clearly increases my suffering and is no longer in my best interest;

[ ] I wish to receive artificial nutrition and hydration on a limited trial basis to see if I can improve;

[ ] In accordance with my choices in (6)(B) above, I do not wish to receive artificial nutrition and hydration.

[ ] Other instructions: _____

_____

(D) Relief from Pain.

[ ] I direct that adequate treatment be provided at all times for the sole purpose of the alleviation of pain or discomfort; or

[ ] I give these instructions:

_____

_____

(E) **Life-Sustaining Procedures. "Life-sustaining procedures" means any medical treatment, procedure, or intervention that may keep you alive but will not remove your terminal condition or remove permanent unconsciousness; "life-sustaining procedures" includes assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, including**

antibiotics, or artificial nutrition and hydration.

[ ] I wish to receive all life-sustaining procedures.

[ ] I do not wish to receive any life-sustaining procedures.

[ ] I wish to receive the following life-sustaining procedures:

_____

_____

_____

_____

(F) Should I become unconscious and I am pregnant, I direct that

_____

_____

(7) 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

_____

_____

Conditions or limitations: _____

_____ .

(Add additional sheets if needed.)

PART 3

ANATOMICAL GIFT AT DEATH

(OPTIONAL)

If you are satisfied to allow your agent to determine whether to make an anatomical gift at your death, you do not need to fill out this part of the form.

(8) Upon my death: (mark applicable box)

(A) [ ] I give any needed organs, tissues, or other body parts, OR

(B) [ ] I give the following organs, tissues, or other body parts only

_____

_____

(C) [ ] My gift is for the following purposes (mark any of the

following you want):

[ ] (i) transplant;

[ ] (ii) therapy;

[ ] (iii) research;

[ ] (iv) education.

(D) [ ] I refuse to make an anatomical gift.

PART 4

MENTAL HEALTH TREATMENT

This part of the declaration allows you to make decisions in advance about mental health treatment. The instructions that you include in this declaration will be followed only if a court, two physicians that include a psychiatrist, or a physician and a professional mental health clinician believe that you are not competent and cannot make treatment decisions. Otherwise, you will be considered to be competent and to have the capacity to give or withhold consent for the treatments.

If you are satisfied to allow your agent to determine what is best for you in making these mental health decisions, you do not need to 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.

(9) PSYCHOTROPIC MEDICATIONS. If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

_____ I consent to the administration of the following medications:

_____ I do not consent to the administration of the following medications:

Conditions or limitations: _____

_____ .

(10) ELECTROCONVULSIVE TREATMENT. If I do not have the capacity to give or withhold informed consent for mental health

treatment, my wishes regarding electroconvulsive treatment are as follows:

_____ I consent to the administration of electroconvulsive treatment.

_____ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: _____

_____ .

(11) ADMISSION TO AND RETENTION IN FACILITY. If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding admission to and retention in a mental health facility for mental health treatment are as follows:

_____ I consent to being admitted to a mental health facility for mental health treatment for up to _____ days. (The number of days not to exceed 17.)

_____ I do not consent to being admitted to a mental health facility for mental health treatment.

Conditions or limitations: _____

_____ .

OTHER WISHES OR INSTRUCTIONS

_____

_____

_____

Conditions or limitations: _____

_____ .

PART 5

PRIMARY PHYSICIAN

(OPTIONAL)

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

_____

(name of physician)

_____

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

_____

(telephone)

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)

_____

(telephone)

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

(14) SIGNATURES. Sign and date the form here:

_____

(date) (sign your name)

_____

(print your name)

_____

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

(15) WITNESSES. This advance care health directive will not be valid for making health care decisions unless it is

(A) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; the witnesses may not be a health care provider employed at the health care institution or health care facility where you are receiving health care, an employee of the health care provider who is providing health care to you, an employee of the health care institution or health

care facility where you are receiving health care, or the person appointed as your agent by this document; at least one of the two witnesses may not be related to you by blood, marriage, or adoption or entitled to a portion of your estate upon your death under your will or codicil; or

(B) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

Witness Who is Not Related to or a Devisee of the Principal

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider providing health care to the principal;

(3) an employee of the health care institution or health care facility where the principal is receiving health care;

(4) the person appointed as agent by this document;

(5) related to the principal by blood, marriage, or adoption; or

(6) entitled to a portion of the principal's estate upon the principal's death under a will or codicil.

_____

(date) (signature of witness)

_____

(printed name of witness)

_____

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

Witness Who May be Related to or a Devisee of the Principal

I swear under penalty of perjury under AS 11.56.200 that the

principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider who is providing health care to the principal;

(3) an employee of the health care institution or health care facility where the principal is receiving health care; or

(4) the person appointed as agent by this document.

_____

(date) (signature of witness)

_____

(printed name of witness)

_____

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

ALTERNATIVE NO. 2

State of Alaska

_____ Judicial District

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 the person executed it.

Notary Seal

_____

(signature of notary public)

*** Sec. 9.** AS 13.52.390(17) is amended to read:

(17) "health care decision" means a decision made by an individual or

the individual's agent, guardian, or surrogate regarding the individual's health care, including

(A) selection and discharge of health care providers and institutions;

(B) approval or disapproval of proposed diagnostic tests, surgical procedures, and programs of medication;

(C) direction to provide, withhold, or withdraw artificial nutrition and hydration if providing, withholding, or withdrawing artificial nutrition, artificial hydration, or artificial nutrition and hydration is in accord with generally accepted health care standards applicable to health care providers or institutions;

(D) the administration or withdrawal of psychotropic medications, the use of electroconvulsive treatment, and the admission to a mental health facility; [AND]

(E) making an anatomical gift at death; **and**

(F) a direction relating to the provision of cardiopulmonary resuscitation or other resuscitative measures;

*** Sec. 10.** AS 13.52.065(f) is repealed.

*** Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONTINUING EFFECT OF DO NOT RESUSCITATE ORDERS. A do not resuscitate order made under AS 13.52 before the effective date of this Act continues in effect under AS 13.52, unless the do not resuscitate order is revoked under AS 13.52.065(i) or (j), added by sec. 6 of this Act, or made ineffective under another provision of AS 13.52, as amended by this Act.