

HOUSE BILL NO. 392

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-SECOND LEGISLATURE - SECOND SESSION

BY REPRESENTATIVES SNYDER, Rauscher, Kurka, Tarr, Tilton, Rasmussen

Introduced: 2/22/22

Referred: Health and Social Services, Labor and Commerce

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to advanced practice registered nurses; and relating to death
2 certificates, do not resuscitate orders, and life sustaining treatment."

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

4 * **Section 1.** AS 08.68.700(a) is amended to read:

5 (a) A registered nurse licensed under this chapter may make a determination
6 and pronouncement of death of a person under the following circumstances:

7 (1) an attending physician or an attending advanced practice
8 registered nurse has documented in the person's medical or clinical record that the
9 person's death is anticipated due to illness, infirmity, or disease; this prognosis is valid
10 for purposes of this section for **not** [NO] more than 120 days from the date of the
11 documentation;

12 (2) at the time of documentation under (1) of this subsection, the
13 physician or the advanced practice registered nurse authorized in writing a specific
14 registered nurse or nurses to make a determination and pronouncement of the person's

1 death; however, if the person is in a health care facility and the health care facility has
 2 complied with (d) of this section, the physician **or the advanced practice registered**
 3 **nurse** may authorize all nurses employed by the facility to make a determination and
 4 pronouncement of the person's death.

5 * **Sec. 2.** AS 08.68.700(b) is amended to read:

6 (b) A registered nurse who has determined and pronounced death under this
 7 section shall document the clinical criteria for the determination and pronouncement in
 8 the person's medical or clinical record and notify the physician **or the advanced**
 9 **practice registered nurse** who determined that the prognosis for the patient was for
 10 an anticipated death. The registered nurse shall sign the death certificate, which must
 11 include the

- 12 (1) name of the deceased;
- 13 (2) presence of a contagious disease, if known; and
- 14 (3) date and time of death.

15 * **Sec. 3.** AS 08.68.700(c) is amended to read:

16 (c) Except as otherwise provided under AS 18.50.230, a physician licensed
 17 under AS 08.64 **or an advanced practice registered nurse licensed under this**
 18 **chapter** shall certify a death determined under (b) of this section within 24 hours after
 19 the pronouncement by the registered nurse.

20 * **Sec. 4.** AS 08.68.700(d) is amended to read:

21 (d) In a health care facility in which a physician **or an advanced practice**
 22 **registered nurse** chooses to proceed under (a) of this section, written policies and
 23 procedures shall be adopted that provide for the determination and pronouncement of
 24 death by a registered nurse **authorized by a physician or advanced practice**
 25 **registered nurse** under this section. A registered nurse employed by a health care
 26 facility **and authorized by a physician or advanced practice registered nurse to**
 27 **make a determination and pronouncement of death under this section** may not
 28 make **the** [A] determination or pronouncement [OF DEATH UNDER THIS
 29 SECTION] unless the facility has written policies and procedures implementing and
 30 ensuring compliance with this section.

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

1 (a) A physician **or an advanced practice registered nurse** may issue a do not
2 resuscitate order for a patient of the physician **or the advanced practice registered**
3 **nurse**. The physician **or the advanced practice registered nurse** shall document the
4 grounds for the order in the patient's medical file.

5 * **Sec. 6.** AS 13.52.065(c) is amended to read:

6 (c) The department shall develop standardized designs and symbols for do not
7 resuscitate identification cards, forms, necklaces, and bracelets that signify, when
8 carried or worn, that the carrier or wearer is an individual for whom a physician **or an**
9 **advanced practice registered nurse** has issued a do not resuscitate order.

10 * **Sec. 7.** AS 13.52.065(d) is amended to read:

11 (d) A health care provider other than a physician **or an advanced practice**
12 **registered nurse** shall comply with the protocol adopted under (b) of this section for
13 do not resuscitate orders when the health care provider is presented with a do not
14 resuscitate identification, an oral do not resuscitate order issued directly by a physician
15 **or an advanced practice registered nurse** if the applicable hospital allows oral do
16 not resuscitate orders, or a written do not resuscitate order entered on and as required
17 by a form prescribed by the department.

18 * **Sec. 8.** AS 13.52.065(f) is amended to read:

19 (f) A do not resuscitate order may not be made ineffective unless a physician
20 **or an advanced practice registered nurse** revokes the do not resuscitate order, a
21 patient for whom the order is written and who has capacity requests that the do not
22 resuscitate order be revoked, or the patient for whom the order is written is under 18
23 years of age and the parent or guardian of the patient requests that the do not
24 resuscitate order be revoked. Any physician **or advanced practice registered nurse**
25 of a patient for whom a do not resuscitate order is written may revoke the do not
26 resuscitate order if the person for whom the order is written requests that the physician
27 **or the advanced practice registered nurse** revoke the do not resuscitate order.

28 * **Sec. 9.** AS 13.52.080(a) is amended to read:

29 (a) A health care provider or health care institution that acts in good faith and
30 in accordance with generally accepted health care standards applicable to the health
31 care provider or institution is not subject to civil or criminal liability or to discipline

1 for unprofessional conduct for

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

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

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

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

12 (5) participating in the withholding or withdrawal of cardiopulmonary
13 resuscitation under the direction or with the authorization of a physician **or an**
14 **advanced practice registered nurse** or upon discovery of do not resuscitate
15 identification upon an individual;

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

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

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

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

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

26 * **Sec. 10.** AS 13.52.100(c) is amended to read:

27 (c) An individual who is a qualified patient, including an individual for whom
28 a physician **or an advanced practice registered nurse** has issued a do not resuscitate
29 order, has the right to make a decision regarding the use of cardiopulmonary
30 resuscitation and other life-sustaining procedures as long as the individual is able to
31 make the decision. If an individual who is a qualified patient, including an individual

1 for whom a physician or advanced practice registered nurse has issued a do not
 2 resuscitate order, is not able to make the decision, the protocol adopted under
 3 AS 13.52.065 for do not resuscitate orders governs a decision regarding the use of
 4 cardiopulmonary resuscitation and other life-sustaining procedures.

5 * **Sec. 11.** AS 13.52.300 is amended to read:

6 **Sec. 13.52.300. Optional form.** The following sample form may be used to
 7 create an advance health care directive. The other sections of this chapter govern the
 8 effect of this or any other writing used to create an advance health care directive. This
 9 form may be duplicated. This form may be modified to suit the needs of the person, or
 10 a different form that complies with this chapter may be used, including the mandatory
 11 witnessing requirements:

12 ADVANCE HEALTH CARE DIRECTIVE

13 Explanation

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

22 Part 1 of this form is a durable power of attorney for health
 23 care. A "durable power of attorney for health care" means the
 24 designation of an agent to make health care decisions for you. Part 1
 25 lets you name another individual as an agent to make health care
 26 decisions for you if you do not have the capacity to make your own
 27 decisions or if you want someone else to make those decisions for you
 28 now even though you still have the capacity to make those decisions.
 29 You may name an alternate agent to act for you if your first choice is
 30 not willing, able, or reasonably available to make decisions for you.
 31 Unless related to you, your agent may not be an owner, operator, or

1 employee of a health care institution where you are receiving care.

2 Unless the form you sign limits the authority of your agent,
3 your agent may make all health care decisions for you that you could
4 legally make for yourself. This form has a place for you to limit the
5 authority of your agent. You do not have to limit the authority of your
6 agent if you wish to rely on your agent for all health care decisions that
7 may have to be made. If you choose not to limit the authority of your
8 agent, your agent will have the right, to the extent allowed by law, to

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

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

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

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

18 (e) make an anatomical gift following your death.

19 Part 2 of this form lets you give specific instructions for any
20 aspect of your health care to the extent allowed by law, except you may
21 not authorize mercy killing, assisted suicide, or euthanasia. Choices are
22 provided for you to express your wishes regarding the provision,
23 withholding, or withdrawal of treatment to keep you alive, including
24 the provision of artificial nutrition and hydration, as well as the
25 provision of pain relief medication. Space is provided for you to add to
26 the choices you have made or for you to write out any additional
27 wishes.

28 Part 3 of this form lets you express an intention to make an
29 anatomical gift following your death.

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

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

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

11 You have the right to revoke this advance health care directive
12 or replace this form at any time, except that you may not revoke this
13 declaration when you are determined not to be competent by a court, by
14 two physicians, at least one of whom shall be a psychiatrist, or by both
15 a physician and a professional mental health clinician. In this advance
16 health care directive, "competent" means that you have the capacity

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

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

21 PART 1

22 DURABLE POWER OF ATTORNEY FOR 23 HEALTH CARE DECISIONS

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

26 _____
27 (name of individual you choose as agent)

28 _____
29 (address) (city) (state) (zip code)

30 _____
31 (home telephone) (work telephone)

1 OPTIONAL: If I revoke my agent's authority or if my agent is
2 not willing, able, or reasonably available to make a health care decision
3 for me, I designate as my first alternate agent

4 _____
5 (name of individual you choose as first alternate agent)

6 _____
7 (address) (city) (state) (zip code)

8 _____
9 (home telephone) (work telephone)

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

14 _____
15 (name of individual you choose as second alternate agent)

16 _____
17 (address) (city) (state) (zip code)

18 _____
19 (home telephone) (work telephone)

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

27 _____
28 _____
29 _____

30 (Add additional sheets if needed.)

31 Under this authority, "best interest" means that the benefits to you

1 resulting from a treatment outweigh the burdens to you resulting from
2 that treatment after assessing

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

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

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

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

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

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

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

20 (3) WHEN AGENT'S AUTHORITY BECOMES
21 EFFECTIVE. Except in the case of mental illness, my agent's authority
22 becomes effective when my primary physician determines that I am
23 unable to make my own health care decisions unless I mark the
24 following box. In the case of mental illness, unless I mark the
25 following box, my agent's authority becomes effective when a court
26 determines I am unable to make my own decisions, or, in an
27 emergency, if my primary physician or another health care provider
28 determines I am unable to make my own decisions. If I mark this box [
29], my agent's authority to make health care decisions for me takes effect
30 immediately.

31 (4) AGENT'S OBLIGATION. My agent shall make

1 health care decisions for me in accordance with this durable power of
 2 attorney for health care, any instructions I give in Part 2 of this form,
 3 and my other wishes to the extent known to my agent. To the extent
 4 my wishes are unknown, my agent shall make health care decisions for
 5 me in accordance with what my agent determines to be in my best
 6 interest. In determining my best interest, my agent shall consider my
 7 personal values to the extent known to my agent.

8 (5) NOMINATION OF GUARDIAN. If a guardian of
 9 my person needs to be appointed for me by a court, I nominate the
 10 agent designated in this form. If that agent is not willing, able, or
 11 reasonably available to act as guardian, I nominate the alternate agents
 12 whom I have named under (1) above, in the order designated.

13 PART 2

14 INSTRUCTIONS FOR HEALTH CARE

15 If you are satisfied to allow your agent to determine what is best
 16 for you in making health care decisions, you do not need to fill out this
 17 part of the form. If you do fill out this part of the form, you may strike
 18 any wording you do not want. There is a state protocol that governs the
 19 use of do not resuscitate orders by physicians, **advanced practice**
 20 **registered nurses**, and other health care providers. You may obtain a
 21 copy of the protocol from the Alaska Department of Health and Social
 22 Services. A "do not resuscitate order" means a directive from a
 23 licensed physician **or advanced practice registered nurse** that
 24 emergency cardiopulmonary resuscitation should not be administered
 25 to you.

26 (6) END-OF-LIFE DECISIONS. Except to the extent
 27 prohibited by law, I direct that my health care providers and others
 28 involved in my care provide, withhold, or withdraw treatment in
 29 accordance with the choice I have marked below: (Check only one
 30 box.)

31 [] (A) Choice To Prolong Life

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

4 [] (B) Choice Not To Prolong Life

5 I want comfort care only and I do not want my
 6 life to be prolonged with medical treatment if, in the judgment
 7 of my physician, I have (check all choices that represent your
 8 wishes)

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

20 [] (ii) a terminal condition: an
 21 incurable or irreversible illness or injury that without the
 22 administration of life-sustaining procedures will result in
 23 my death in a short period of time, for which there is no
 24 reasonable prospect of cure or recovery, that imposes
 25 severe pain or otherwise imposes an inhumane burden
 26 on me, and for which, in light of my medical condition,
 27 initiating or continuing life-sustaining procedures will
 28 provide only minimal medical benefit;

29 [] Additional instructions: _____
 30 _____

31 (C) Artificial Nutrition and Hydration. If I am

1 _____
 2 (Add additional sheets if needed.)

3 PART 3

4 ANATOMICAL GIFT AT DEATH

5 (OPTIONAL)

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

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

10 (A) I give any needed organs, tissues, or
 11 other body parts, OR

12 (B) I give the following organs, tissues, or
 13 other body parts only _____
 14 _____

15 (C) My gift is for the following purposes
 16 (mark any of the following you want):

17 (i) transplant;

18 (ii) therapy;

19 (iii) research;

20 (iv) education.

21 (D) I refuse to make an anatomical gift.

22 PART 4

23 MENTAL HEALTH TREATMENT

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

1 If you are satisfied to allow your agent to determine what is best
2 for you in making these mental health decisions, you do not need to fill
3 out this part of the form. If you do fill out this part of the form, you
4 may strike any wording you do not want.

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

9 _____ I consent to the administration of the following
10 medications: _____

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

13 Conditions or limitations: _____

14 _____.

15 (10) ELECTROCONVULSIVE TREATMENT. If I do
16 not have the capacity to give or withhold informed consent for mental
17 health treatment, my wishes regarding electroconvulsive treatment are
18 as follows:

19 _____ I consent to the administration of electroconvulsive
20 treatment.

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

23 Conditions or limitations: _____

24 _____.

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

30 _____ I consent to being admitted to a mental health facility
31 for mental health treatment for up to _____ days. (The number of

1 days not to exceed 17.)

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

4 Conditions or limitations: _____

5 _____

6 OTHER WISHES OR INSTRUCTIONS

7 _____

8 _____

9 _____

10 Conditions or limitations: _____

11 _____

12 PART 5

13 PRIMARY PHYSICIAN

14 (OPTIONAL)

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

17 _____

18 (name of physician)

19 _____

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

21 _____

22 (telephone)

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

26 _____

27 (name of physician)

28 _____

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

30 _____

31 (telephone)

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

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

4 _____
5 (date) (sign your name)

6 _____
7 (print your name)

8 _____
9 (address) (city) (state) (zip code)

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

12 (A) signed by two qualified adult witnesses who
13 are personally known to you and who are present when you sign
14 or acknowledge your signature; the witnesses may not be a
15 health care provider employed at the health care institution or
16 health care facility where you are receiving health care, an
17 employee of the health care provider who is providing health
18 care to you, an employee of the health care institution or health
19 care facility where you are receiving health care, or the person
20 appointed as your agent by this document; at least one of the
21 two witnesses may not be related to you by blood, marriage, or
22 adoption or entitled to a portion of your estate upon your death
23 under your will or codicil; or

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

26 ALTERNATIVE NO. 1

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

28 I swear under penalty of perjury under AS 11.56.200
29 that the principal is personally known to me, that the principal signed or
30 acknowledged this durable power of attorney for health care in my
31 presence, that the principal appears to be of sound mind and under no

1 duress, fraud, or undue influence, and that I am not

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

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

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

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

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

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

14 _____
15 (date) (signature of witness)

16 _____
17 (printed name of witness)

18 _____
19 (address) (city) (state) (zip code)

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

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

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

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

31 (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. 12.** AS 13.52.390(12) is amended to read:

(12) "do not resuscitate order" means a directive from a licensed
physician **or advanced practice registered nurse** that emergency cardiopulmonary
resuscitation should not be administered to a qualified patient;

* **Sec. 13.** AS 13.52.390(23) is amended to read:

(23) "life-sustaining procedures" means any medical treatment,
procedure, or intervention that, in the judgment of the primary physician **or advanced
practice registered nurse**, when applied to a patient with a qualifying condition,
would not be effective to remove the qualifying condition, would serve only to
prolong the dying process, or, when administered to a patient with a condition of

1 permanent unconsciousness, may keep the patient alive but is not expected to restore
2 consciousness; in this paragraph, "medical treatment, procedure, or intervention"
3 includes assisted ventilation, renal dialysis, surgical procedures, blood transfusions,
4 and the administration of drugs, including antibiotics, or artificial nutrition and
5 hydration;

6 * **Sec. 14.** AS 13.52.390 is amended by adding a new paragraph to read:

7 (38) "advanced practice registered nurse" has the meaning given in
8 AS 08.68.850.

9 * **Sec. 15.** AS 18.50.230(c) is amended to read:

10 (c) The medical certification shall be completed and signed within 24 hours
11 after death by the physician **or the advanced practice registered nurse** in charge of
12 the patient's care for the illness or condition that resulted in death except when an
13 official inquiry or inquest is required and except as provided by regulation in special
14 problem cases.