

SENATE CS FOR CS FOR HOUSE BILL NO. 392(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-SECOND LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered: 5/9/22

Referred: Rules

Sponsor(s): REPRESENTATIVES SNYDER, Rauscher, Kurka, Tarr, Tilton, Rasmussen

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

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

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

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

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

(d) In a health care facility in which a physician, an advanced practice registered nurse, or a physician assistant chooses to proceed under (a) of this section, written policies and procedures shall be adopted that provide for the determination and pronouncement of death by a registered nurse authorized by a physician, an advanced practice registered nurse, or a physician assistant under this section. A registered nurse employed by a health care facility and authorized by a physician, an advanced practice registered nurse, or a physician assistant to make a determination and pronouncement of death under this section may not make the [A] determination or pronouncement [OF DEATH UNDER THIS SECTION] unless the facility has written policies and procedures implementing and

ensuring compliance with this section.

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

(a) A physician, an advanced practice registered nurse, or a physician assistant may issue a do not resuscitate order for a patient of the physician, the advanced practice registered nurse, or the physician assistant with the consent of the patient or the parent or guardian of the patient if the patient is under 18 years of age. The physician, the advanced practice registered nurse, or the physician assistant shall document the grounds for the order in the patient's medical file.

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

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

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

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

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

(f) A do not resuscitate order may not be made ineffective unless a physician, an advanced practice registered nurse, or a physician assistant revokes the do not resuscitate order, a patient for whom the order is written and who has capacity requests that the do not resuscitate order be revoked, or the patient for whom the order is written is under 18 years of age and the parent or guardian of the patient requests that the do not resuscitate order be revoked. Any physician, advanced practice

1 **registered nurse, or physician assistant** of a patient for whom a do not resuscitate
 2 order is written may revoke the do not resuscitate order if the person for whom the
 3 order is written requests that the physician, **the advanced practice registered nurse,**
 4 **or the physician assistant** revoke the do not resuscitate order.

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

6 (a) A health care provider or health care institution that acts in good faith and
 7 in accordance with generally accepted health care standards applicable to the health
 8 care provider or institution is not subject to civil or criminal liability or to discipline
 9 for unprofessional conduct for

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

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

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

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

20 (5) participating in the withholding or withdrawal of cardiopulmonary
 21 resuscitation under the direction or with the authorization of a physician, **an advanced**
 22 **practice registered nurse, or a physician assistant** or upon discovery of do not
 23 resuscitate identification upon an individual;

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

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

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

30 (C) because the patient is a woman of childbearing age and
 31 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. 10.** AS 13.52.100(c) is amended to read:

(c) An individual who is a qualified patient, including an individual for whom a physician, an advanced practice registered nurse, or a physician assistant has issued a do not resuscitate order, has the right to make a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures as long as the individual is able to make the decision. If an individual who is a qualified patient, including an individual for whom a physician, advanced practice registered nurse, or physician assistant has issued a do not resuscitate order, is not able to make the decision, the protocol adopted under AS 13.52.065 for do not resuscitate orders governs a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures.

* **Sec. 11.** 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

1 care. A "durable power of attorney for health care" means the
 2 designation of an agent to make health care decisions for you. Part 1
 3 lets you name another individual as an agent to make health care
 4 decisions for you if you do not have the capacity to make your own
 5 decisions or if you want someone else to make those decisions for you
 6 now even though you still have the capacity to make those decisions.
 7 You may name an alternate agent to act for you if your first choice is
 8 not willing, able, or reasonably available to make decisions for you.
 9 Unless related to you, your agent may not be an owner, operator, or
 10 employee of a health care institution where you are receiving care.

11 Unless the form you sign limits the authority of your agent,
 12 your agent may make all health care decisions for you that you could
 13 legally make for yourself. This form has a place for you to limit the
 14 authority of your agent. You do not have to limit the authority of your
 15 agent if you wish to rely on your agent for all health care decisions that
 16 may have to be made. If you choose not to limit the authority of your
 17 agent, your agent will have the right, to the extent allowed by law, to

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

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

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

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

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

28 Part 2 of this form lets you give specific instructions for any
 29 aspect of your health care to the extent allowed by law, except you may
 30 not authorize mercy killing, assisted suicide, or euthanasia. Choices are
 31 provided for you to express your wishes regarding the provision,

1 withholding, or withdrawal of treatment to keep you alive, including
 2 the provision of artificial nutrition and hydration, as well as the
 3 provision of pain relief medication. Space is provided for you to add to
 4 the choices you have made or for you to write out any additional
 5 wishes.

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

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

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

12 After completing this form, sign and date the form at the end
 13 and have the form witnessed by one of the two alternative methods
 14 listed below. Give a copy of the signed and completed form to your
 15 physician, to any other health care providers you may have, to any
 16 health care institution at which you are receiving care, and to any health
 17 care agents you have named. You should talk to the person you have
 18 named as your agent to make sure that the person understands your
 19 wishes and is willing to take the responsibility.

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

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

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

30 PART 1

31 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

1 unable to make my own health care decisions unless I mark the
 2 following box. In the case of mental illness, unless I mark the
 3 following box, my agent's authority becomes effective when a court
 4 determines I am unable to make my own decisions, or, in an
 5 emergency, if my primary physician or another health care provider
 6 determines I am unable to make my own decisions. If I mark this box [
 7], my agent's authority to make health care decisions for me takes effect
 8 immediately.

9 (4) AGENT'S OBLIGATION. My agent shall make
 10 health care decisions for me in accordance with this durable power of
 11 attorney for health care, any instructions I give in Part 2 of this form,
 12 and my other wishes to the extent known to my agent. To the extent
 13 my wishes are unknown, my agent shall make health care decisions for
 14 me in accordance with what my agent determines to be in my best
 15 interest. In determining my best interest, my agent shall consider my
 16 personal values to the extent known to my agent.

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

22 PART 2

23 INSTRUCTIONS FOR HEALTH CARE

24 If you are satisfied to allow your agent to determine what is best
 25 for you in making health care decisions, you do not need to fill out this
 26 part of the form. If you do fill out this part of the form, you may strike
 27 any wording you do not want. There is a state protocol that governs the
 28 use of do not resuscitate orders by physicians, advanced practice
 29 registered nurses, physician assistants, and other health care
 30 providers. You may obtain a copy of the protocol from the Alaska
 31 Department of Health and Social Services. A "do not resuscitate order"

means a directive from a licensed physician, advanced practice registered nurse, or physician assistant 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) Should I become unconscious and I am pregnant, I direct that _____

1 _____
 2 _____
 3 (7) OTHER WISHES. (If you do not agree with any of
 4 the optional choices above and wish to write your own, or if you wish
 5 to add to the instructions you have given above, you may do so here.) I
 6 direct that

7 _____
 8 _____
 9 Conditions or limitations: _____
 10 _____.

11 (Add additional sheets if needed.)

12 PART 3

13 ANATOMICAL GIFT AT DEATH

14 (OPTIONAL)

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

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

19 ☐ (A) I give any needed organs, tissues, or
 20 other body parts, OR

21 ☐ (B) I give the following organs, tissues, or
 22 other body parts only _____
 23 _____

24 ☐ (C) My gift is for the following purposes
 25 (mark any of the following you want):

26 ☐ (i) transplant;

27 ☐ (ii) therapy;

28 ☐ (iii) research;

29 ☐ (iv) education.

30 ☐ (D) I refuse to make an anatomical gift.

31 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)

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

4 _____
 5 (name of physician)

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

8 _____
 9 (telephone)

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

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

13 _____
 14 (date) (sign your name)

15 _____
 16 (print your name)

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

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

21 (A) signed by two qualified adult witnesses who
 22 are personally known to you and who are present when you sign
 23 or acknowledge your signature; the witnesses may not be a
 24 health care provider employed at the health care institution or
 25 health care facility where you are receiving health care, an
 26 employee of the health care provider who is providing health
 27 care to you, an employee of the health care institution or health
 28 care facility where you are receiving health care, or the person
 29 appointed as your agent by this document; at least one of the
 30 two witnesses may not be related to you by blood, marriage, or
 31 adoption or entitled to a portion of your estate upon your death

1 under your will or codicil; or

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

4 ALTERNATIVE NO. 1

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

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

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

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

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

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

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

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

23 _____
24 (date) (signature of witness)

25 _____
26 (printed name of witness)

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

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

30 I swear under penalty of perjury under AS 11.56.200
31 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. 12.** AS 13.52.390(12) is amended to read:

(12) "do not resuscitate order" means a directive from a licensed physician, advanced practice registered nurse, or physician assistant 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, advanced practice registered nurse, or physician assistant, 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 permanent unconsciousness, may keep the patient alive but is not expected to restore consciousness; in this paragraph, "medical treatment, procedure, or intervention" includes assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, including antibiotics, or artificial nutrition and hydration;

* **Sec. 14.** AS 13.52.390 is amended by adding new paragraphs to read:

(38) "advanced practice registered nurse" has the meaning given in AS 08.68.850;

(39) "physician assistant" means an individual licensed under AS 08.64.107.

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

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