HB
356

HOUSE COMMITTEE REPORT

(9)

Date Referred: January 10, 1994 FURTHER REFERRALS: Judiciary

Date of Committee Action: 3/14/94

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 356

HOUSE BILL NO. 356 LIVING WILLS AND DNR ORDERS

"An Act relating to living wills and do not resuscitate orders; and providing for an effective date."

RECOMMENDATIONS: [ ] the same title
be replaced with _____ [ ] a new title
[ ] have attached amendments(s)
[ ] do pass
[ ] do not pass
[X] no recommendations
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[X] fiscal impact H+SS [ ] fiscal note(s) _____

[X] zero fiscal note Commerce + Econ Devel [ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
	✓			✓	
	✓			–	
	✓			✓	
				i	
				✓	

Dan Bivens
CHAIRMAN'S SIGNATURE

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 3/14/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
CONFIRMATION HEARING: MARGARET LOWE
COMMISSIONER OF HEALTH & SOCIAL SERVICES
* HB 412: COMMUNITY CARE FACILITIES
- BILLS HELD OVER -
HB 356: LIVING WILLS & MEDICAL CARE ORDERS
* INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
[redacted]						Y	N	
Judy Engelman	Juneau Youth Service	PO Box 32839 Juneau	99803		789-7610	(Y)	N	HB 412
Pat Quigley	"	"	"		789-7610	Y	(N)	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

FISCAL NOTE

STATE OF ALASKA **BILL NO.** HB 356

1994 LEGISLATIVE SESSION

Revision Date: 3/2/94 Department: Commerce and Economic Dev.

Title: An Act relating to living wills and do not resuscitate orders;.... BRU: Occupational Licensing

Component: Operations

Sponsor: House HES

Requestor: House HES COMPONENT SERIAL NO. 1844

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 94) cost: $ None

POSITIONS

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: (Attach a separate page if necessary)

HB 356 mandates the Department of Health and Social Services to establish regulations to adopt a do not resuscitate protocol...for withholding of cardiopulmonary resuscitation by physicians and other health care providers; specifying that regulations may not be adopted unless approved by the State Medical Board. The board should be able to review draft regulations during their regularly scheduled meetings, without requiring additional meetings for this purpose. Therefore, new funds are not required.

Prepared by: Jennifer Strickler, Administrative Officer Phone: 465-2144

Division: Occupational Licensing Date: 3/2/94

Approved by Commissioner: Paul Fuhs Date: 3/3/94

Agency: Commerce and Economic Development

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FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. HB 356

Revision Date:
Title: "An Act relating to living wills and do not resuscitate orders..."
Sponsor: House HESS
Requestor:

Dept. Affected: Health and Social Services
BRU: State Health Services
Component: EMS Training and Licensing
COMPONENT SERIAL NO. 297

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES						
TRAVEL	5.0	2.0				
CONTRACTUAL	5.0	2.0				
SUPPLIES	2.0	3.0	3.0	3.0	3.0	3.0
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	12.0	7.0	3.0	3.0	3.0	3.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES	0	0	0	0	0	0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	12.0	7.0	3.0	3.0	3.0	3.0
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	12.0	7.0	3.0	3.0	3.0	3.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY94) cost $ 1.0

ANALYSIS: (Attach a separate page if necessary)
There will be some costs to the department for advertising, holding public hearings on proposed regulations, for developing, printing and distribution of protocols, identifications, training materials, and for travel to provide education and training to implement the system.

Prepared by: Peter M. Nakamura, MD, MPH
Division: Public Health
Phone: (907) 465-3090
Date: 1/19/94

Approved by Commissioner: Margaret R. Lowe, M.Ed., Ed.S.
Margaret R. Lowe
Date: 2/3/94
Agency: Department of Health & Social Services

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ANALYSIS (cont.):

Line 200 Travel

Travel will consist of:

Administrative travel for EMS Section staff to attend meetings of the Alaska State Medical Board and planning sessions;

Travel for the contractor to participate in planning meetings in Juneau;

Travel for a speaker at the Annual EMS Symposium to present a session on the Legislation; and

Travel for a speaker to attend the 1995 Southeast Symposium to address medicolegal and DNR issues.

Line 300 Contractual

A contractor will coordinate the protocol development, implementation, and evaluation processes. The contractor will be responsible for staffing planning meetings, developing and distributing working drafts of the protocols, compiling comments, and providing recommendations to the department. The contractor will also be responsible for coordinating the efforts of the department and the Alaska State Medical Board.

The department will attempt to contract with an individual as soon as the legislation is passed. As a result, some funds are requested for FY '94.

Line 400 Supplies

This line includes the printing of protocols, training materials, and brochures regarding the program. Also included in this line is the cost of identification materials, such as the "standardized designs for DNR identification cards, forms, necklaces, and bracelets," proposed in the bill.

These responsibilities are expected to remain throught the life of the project.

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 3/3/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
* HB 506: STUDENT LOAN PROGRAM
* HB 356: LIVING WILLS AND MEDICAL CARE DIRECTIVES
BILLS HELD OVER FROM PREVIOUS CALENDARS
* HB 333: DRUG FREE RECREATION AND YOUTH CENTERS
* HJR 52: INCREASE IN FEDERAL MEDICAID FUNDS

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
MARK JOHNSON	ANSS, EMS	P.O.BOX 110616 Juneau	99811-0616	463-5817	465-3027	(Y)	N	HB 356
Vona Hall	AHR Pres	23590 Glacier Highway	99801	780-4089	780-4089	(Y)	N	HB 356
Rupe Andrews	AARP	9416 Long Run, Juneau	9980?		789-7422	Y	(N)	HB 356
Kim Bunch	DHSS				465-3237	(Y)	N	HJR 52
~~Stevie Hon~~						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

LTN:100-R01 LEGISLATIVE TELECONFERENCE NETWORK PAGE 01
03/11/94 17:45:58
TCN: 40411 DATE & TIME: 03/03/94 15:00 TO 17:00 STATUS:7 STMTS. IN

**** ORDER SUMMARY ****
SPONSOR: HHES HOUSE HEALTH, EDUCATION AND SOCIAL SERVI CHAIRS: TOOHEY
PURPOSE: PUB PUBLIC HEARING LEGISLATIVE BUNDE
CONTACT: LYNNE SMITH TEL#: (907)465-6825
CHAIRING SITE: JUNEAU CAPITOL CAP106

SPONSOR REMARKS(PUB): TESTIMONY:Y ALLOWED 5 MINUTE LIMIT
HB 356 WILL NOT BE THE FIRST BILL ON THE CALENDAR.
TESTIMONY WILL BE TAKEN WITH A 5 MINUTE LIMIT.
TCN REQUESTED ON 03/03/94 AND HAS 7 UPDATES

**** AGENDA ****
1 HB 356 LIVING WILLS AND MEDICAL CARE ORDERS
2 HB 506 STUDENT LOAN PROGRAM

**** PARTICIPATING LIOS ****

	COR CORDOVA	705 2ND STREET		LOCATION STAFF
	FBX FAIRBANKS	119 N CUSHMAN ST		LOCATION STAFF
	HOM HOMER LTC	126 W PIONEER #4		LOCATION STAFF
*	JNU JUNEAU	CAPITOL	CAP106	LOCATION STAFF
	MAT MATSU	165 E PARKS HWY.		LOCATION STAFF
	PSG PETERSBURG	101 GJOA STREET		LOCATION STAFF
	SEW SEWARD	2901 SEWARD HWY		LOCATION STAFF
	SIT SITKA	210 LAKE STREET		LOCATION STAFF
	SOL KEN/SOL	34824 KALIFONSKY		LOCATION STAFF

**** VOLUNTEER & OFFNET SITES ****
ZZZ OF1 OFFNET 1 FAIRBANKS CRAIG LEWIS (907)456-3970

PARTICIPANTS IN:FAIRBANKS FBX

1	MR.	BRIAN	BRUBAKER	COAL.STUD.LEADER	TSFY. HB 506	
		PO BOX 84791	FAIRBANKS	AK 99708	(907)474-9052	
2	MR.	NICHOLAS	ABRAMCZYK	ASUAF	TSFY. HB 506	
		PO BOX 99775	FAIRBANKS	AK 99775	(907)474-5156	

PARTICIPANTS IN:HOMER LTC HOM

1	MRS.	MILDRED	MARTIN		OBSV. HB 356	
		PO BOX 2652	HOMER	AK 99603	(907)235-6652	
2	MS.	BRENDA	STEENBLOCK	SENIOR CITIZENS	OBSV. HB 356	
		3935 SVEDLUND ST	HOMER	AK 99603	(907)235-7675	

PARTICIPANTS IN:JUNEAU JNU

1	TO	OBSERVE	OBSV. ALL ITEMS
2	TO	OBSERVE	OBSV. ALL ITEMS
3	TO	OBSERVE	OBSV. ALL ITEMS
4	TO	OBSERVE	OBSV. ALL ITEMS
5	TO	OBSERVE	OBSV. ALL ITEMS
6	TO	OBSERVE	OBSV. ALL ITEMS
7	TO	OBSERVE	OBSV. ALL ITEMS
8	TO	OBSERVE	OBSV. ALL ITEMS
9	TO	TESTIFY	TSFY. ALL ITEMS
10	TO	TESTIFY	TSFY. ALL ITEMS
11	TO	TESTIFY	TSFY. ALL ITEMS

ICN: 40411 DATE & TIME: 03/03/94 15:00 TO 17:00 STATUS:7 STATE: IN

PARTICIPANTS IN:JUNEAU JNU

13	TO	TESTIFY		TSFY. ALL ITEMS
14	TO	TESTIFY		TSFY. ALL ITEMS
15	TO	TESTIFY		TSFY. ALL ITEMS
16	TO	TESTIFY		TSFY. ALL ITEMS
17	TO	TESTIFY		TSFY. ALL ITEMS
18	TO	TESTIFY		TSFY. ALL ITEMS
19	TO	TESTIFY		TSFY. ALL ITEMS
20	TO	TESTIFY		TSFY. ALL ITEMS
21	TO	TESTIFY		TSFY. ALL ITEMS
22	TO	TESTIFY		TSFY. ALL ITEMS
23	TO	TESTIFY		TSFY. ALL ITEMS
24	TO	TESTIFY		TSFY. ALL ITEMS
25	TO	TESTIFY		TSFY. ALL ITEMS
26	TO	TESTIFY		TSFY. ALL ITEMS
27	TO	TESTIFY		TSFY. ALL ITEMS
28	TO	TESTIFY		TSFY. ALL ITEMS

PARTICIPANTS IN:MATSU MAT

1 MR	ERNEST	LINE		TSFY. HB 356
	2654 WHISPERING WOODS DR	WASILLA	AK 99645	(907)376-6709

PARTICIPANTS IN:PETERSBURG PSG

1 MS	SANDY	TACKETT	PSG GEN HOSPITAL	TSFY. HB 356
	P.O. BOX 589	PETERSBURG	AK 99833	(907)772-4291
2 MRS.	FLORENCE	LEROY		OBSV. HB 356
	P.O. BOX 313	PETERSBURG	AK 99833	(907)772-3200

PARTICIPANTS IN:SEWARD SEW

1 MS.	JULIE	RENWICK	WESLEY REHAB	TSFY. HB 356	
	PO BOX 1066	SEWARD	AK 99664	(907)224-5241	
2 MS.	BARBARA	BLACKWELL R.N.	WESLEY REHAB	OBSV. HB 356	
	PO BOX 1541	SEWARD	AK 99664	(907)224-8613	
3 MS.	JOAN	CLEMENS R.N.	WESLEY REHAB	OBSV. HB 356	
	PO BOX 1345	SEWARD	AK 99664	(907)224-3674	
4	MARJORIE	MCELDOWNEY R.N.	SEWARD HOSPITAL	OBSV. HB 356	
	PO BOX 365	SEWARD	AK 99664	(907)224-5205	
5	DOREEN	BOOTH	SEWARD HOSPITAL	OBSV. HB 356	
	PO BOX 365	SEWARD	AK 99664	(907)224-5205	
6	LINDA	SWENSON RN	SEWARD HOSPITAL	TSFY. HB 356	
	PO BOX 365	SEWARD	AK 99664	(907)224-5205	
7 MS.	ELLEN	O'BRIEN	SEWARD HOSPITAL	OBSV. HB 356	
	PO BOX 365	SEWARD	AK 99664	(907)224-5205	
8 MS.	DITA	DEBOER	RBHC	OBSV. HB 356	
	PO BOX 1526	SEWARD	AK 99664	(907)224-3181	
9 MR.	RICHARD	JONES (DIRECTOR)	SGH RBHC WR&CC	TSFY. HB 356	
	PO BOX 361	SEWARD	AK 99664	(907)224-5241	
10	DOROTHY	LOCKE	SPRING CREEK CC	OBSV. HB 356	
	BOX 2109	SEWARD	AK 99664	(907)224-8200	
11	ANN	WHITMORE-PAINTER	WRCC	OBSV. HB 356	
	PO BOX 516	MOOSE PASS	AK 99631	(907)288-3143	

PARTICIPANTS IN:SITKA SIT

1	NANCY H.	MEIER	SEARHC	TSFY. HB 356

TCN: 40411 DATE & TIME: 03/03/94 15:00 TO 17:00 STATUS:7 STATS. IN

PARTICIPANTS IN:SITKA SIT

	222 TONGASS	SITKA	AK 99835	(907)966-2413
2	ANDREA PAIGE ADAMS	UAS/SITKA		TSFY. HB 356
	4-B LIFESAVER DRIVE	SITKA	AK 99835	(907)966-2244

PARTICIPANTS IN:KEN/SOL SOL

1 MS.	LINDA	KRISTENSEN	CPC-FORGETMENOT	OSCV. HB 356	
	905 COOK AVE. STE. B	KENAI	AK 99611	(907)283-7294	

PARTICIPANTS IN:OFFNET 1 ZZZ OFF

1	CRAIG	LEWIS		TSFY. HB 356	
		FAIRBANKS	AK	(907)456-3470	

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

STATE CAPITOL, JUNEAU 99801
(907) 465-3759

HB 356

An Act relating to living wills and do not resuscitate orders; and providing for an effective date.

HB 356 complements current statutes on the rights of the terminally ill by adding specific recognition of do not resuscitate (DNR) orders to the existing legislation on the rights of the terminally ill to make a declaration relating to the use of life-sustaining procedures.

A new section (18.12.035) allows attending physicians to issue do not resuscitate orders, requires the Department of Health and Social Services, with the approval of the State Medical Board, to issue regulations adopting a standardized protocol governing the withholding of CPR by physicians and other health care providers, and establishes the requirements under which health care providers other than physicians must comply with do not resuscitate orders.

Section 18.12.037 requires the Department of Health and Social Services to develop standardized designs for DNR identification cards, forms, necklaces, and bracelets to indicate that the possessor has executed a living will or that a DNR order has been issued by a physician. Other provisions of the bill amend existing statutory provisions by including DNRs along with living wills in areas such as immunities for health care providers acting under the provisions of living wills and DNR orders, penalties, etc.

Do not resuscitate orders are issued only in the case of terminal illness. Under existing practice, emergency response providers (EMTs and paramedics) are required to institute CPR on site even if the sick person has a living will. A properly executed DNR order and procedural protocol recognized by all concerned parties would help to avoid futile and unwanted interventions. Similarly, within health care institutions, DNR orders are necessary in the absence of a living will when attempts at resuscitation serve only to prolong the process of dying.

I urge your favorable considerable of this important legislation.

SPONSOR STATEMENT

National Association of State Emergency Medical Services Directors

(NASEMSD) POSITION STATEMENT

ON

EMS DO NOT RESUSCITATE ORDERS
(Approved October 27, 1993)

GUIDELINES FOR STATEWIDE IMPLEMENTATION OF EMS "DO NOT RESUSCITATE" (DNR) PROGRAMS

PURPOSE

With the growth of hospice and home health care, more patients with terminal illness are electing to avoid hospitalization until perhaps the final stages of illness. Many of these patients, as well as others with advanced chronic illnesses, have decided, with the help and support of their attending physicians, that they do not wish to be resuscitated in the event of cardiac or respiratory arrest. However, as death draws near, well-meaning family or friends, or perhaps the patient, may call emergency medical services personnel to transport the dying patient to the hospital; the prehospital providers who respond to these calls may be the last medical persons to attend terminal patients at home or in nursing homes. In many cases these calls to EMS personnel are intended only to obtain transportation or comfort measures for the loved one. However, unless the state provides statutory authority for EMS personnel to honor a "do not resuscitate" order, there may be a requirement for such personnel to attempt resuscitation, regardless of the patient's wishes and the physician's directive.

Over the last ten or so years, there has been increasing attention paid to issues such as "living wills", "advance directives", durable powers of attorney, and "do not resuscitate" Orders, with most of the focus being on care provided or withheld in an inpatient setting. The federal Patient Self-Determination Act[1], effective December, 1, 1991, has been the most comprehensive directive on this issue to date.

More recently, the EMS community has focused on the appropriateness and applicability of "do not resuscitate" orders in the prehospital or inter-facility setting. "Guidelines For "Do Not Resuscitate" Orders in the Prehospital Setting" were published by the American College of Emergency Physicians in October, 1988.[2] This was the first comprehensive discussion of important provisions for EMS DNR legislation and related EMS DNR order Forms. These guidelines were most helpful to states as they began to formally address this issue.

Another important step was taken in addressing the sensitive issues related to "do not resuscitate" orders in the field when the Emergency Cardiac Care Committee of the American Heart Association published the current "Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care", Part VIII Ethical Considerations for Resuscitation.[3] These guidelines include a provision for discontinuing CPR when a valid no-CPR order is presented to the rescuers.

Over the last five years there has been significant activity among the states to develop and implement EMS DNR programs, including legislative changes, where necessary. The most recent review of current status of state policies in this regard can be found in original research by James G. Adams, M.D., "Prehospital Do-Not-Resuscitate Orders: A Survey of State Policies in the United States", published in Prehospital and Disaster Medicine.[4] As reported by Dr. Adams, as of 1992, eleven states had specific legislation authorizing the implementation of EMS DNR orders, six had legal opinions or policies allowing implementation of EMS DNR orders, and fourteen states had working groups and/or legislation pending to address the issue.

NASEMSD Position Paper

It is the intent of this document to collect some of the best features of the statewide EMS DNR legislation and programs that have been implemented across the country to date and to suggest key points that should be considered in designing state legislation and developing and implementing EMS DNR programs and protocols. It is further hoped that these guidelines might encourage more standardization of certain features of the various statewide programs, such as the information on DNR orders and bracelets, to foster reciprocal recognition and honoring of such orders across state lines. It is recognized that this may not be immediately possible, but it was felt that a proper foundation could be established to build on in the future.

GUIDELINES FOR STATEWIDE IMPLEMENTATION OF EMS-DNR PROGRAMS

A comprehensive EMS "do not resuscitate" policy should be supported by both the state medical society and the state EMS lead agency. Wherever possible, it should have statewide applicability to reduce confusion for the public and to facilitate appropriate response, regardless of local jurisdictional boundaries. In most states it will be necessary, or at least desirable, to provide for legislative authority for such programs. Following is a review of recommended elements for consideration in developing EMS DNR legislation.

EMS-DNR Legislation should:

1. Define the conditions under which an EMS DNR order can be considered;

2. Define what patients are eligible to be considered for an EMS DNR order; It is recommended that eligibility be limited to patients with terminal conditions and other patients for whom a physician has issued a DNR order. This assures a <u>medical</u> determination of the appropriateness of such orders.

3. Define which patient is competent to agree to such an order and define a mechanism for determining a surrogate decision-maker in the event the patient is not competent to do so;

4. Provide for this to be an informed decision made by the patient's physician, in consultation with the patient or surrogate.

5. Establish clear authorization for physicians to issue DNR orders;

6. Authorize EMS personnel to follow EMS DNR orders, on scene and inter-facility;

7. Provide a clear definition of procedures to be withheld or withdrawn or define the authority to develop such procedures.

8. Define the information that should be included in an EMS "do not resuscitate" order and other EMS DNR identification items (if applicable) and the authority for designing such forms, etc. These items should be standardized on a statewide basis.

9. Establish periodic review of EMS DNR orders by a physician to assure ongoing medical accountability. It is recommended that review be done annually.

10. Define revocation process for EMS DNR orders at the scene of a medical emergency.

11. Provide immunity from liability for those who do or do not carry out an EMS DNR order, in good faith.

12. Provide that neither an EMS DNR order nor the failure of a person to have one executed shall affect, impair or modify any contract of life or health insurance or annuity or be the basis for any delay in issuing or refusing to issue an annuity or policy of life or health insurance or any increase of premium therefore.

Legislation to allow for prehospital application of "do not resuscitate" orders should be incorporated with related legislation, such as a health care decisions act or similarly titled sections that deal with advanced directives, etc. In some cases, there are more general provisions for "do not resuscitate" orders that may be honored by a full range of health care providers, including EMS personnel. A good example of this is the Montana "Comfort One" Program.

A coalition to assist in the legislative initiative might include the state medical society, hospital association, bar association, hospice association, nursing home association, ACEP chapter, ACS chapter, ENA chapter, Fire & EMS organizations, specialty medical societies, and the state AARP.

EMS "Do Not Resuscitate" Order - Authorization Forms

A single standardized statewide EMS DNR Order form that is easily identifiable should be available for review by EMS personnel when they are called to the scene of a "do not resuscitate" patient. At a minimum, such form should include the following information:

- A statement by the patient's attending physician acknowledging that the patient is in a terminal condition or is suffering from another medical condition, such as an advanced chronic condition, from which recovery is not expected;

- A certification by the attending physician that (1) the patient is capable of making an informed decision about providing, withholding or withdrawing a specific medical treatment, or (2) the patient has a written advance directive which directs life-prolonging procedures to be withheld under such circumstances, or (3) the patient has executed an advance directive appointing an agent to make health care decisions on his behalf, or (4) the patient has not appointed such an agent by advance directive, but there is an authorized decision-maker;

- An expression of the patient's wish that in the event of cardiac or respiratory arrest that no resuscitation efforts be undertaken;

- Signature and emergency telephone number of the responsible physician;

- Signature of the patient or the patient's authorized decision-maker;

- An issuance date and an expiration date. It is recommended that renewal be required at least annually to allow for review of the patient's medical prognosis and the decision to withhold resuscitation.

Distribution of EMS DNR forms should be limited to health care providers and the execution of such forms should be limited to the patient's attending physician. It is recommended that the original of the form be distinguishable from copies and that only the original be honored for purposes of withholding resuscitation.

Other EMS-DNR Identification Items

Some other unique forms of identification of DNR status, such as wallet cards, bracelets or necklaces, may be used in addition to the official EMS DNR Order to facilitate recognition of a DNR candidate. This is especially helpful when there is no one at the scene who knows the location of the EMS DNR form.

There are several types of bracelets or wrist bands in use across the country for this purpose. For example, Montana uses a "Comfort One" bracelet, which is actual jewelry with the unique "Comfort One" symbol. California has adopted the "Medic Alert" bracelet, with special DNR instructions. Virginia and several other states use a white hospital-type wrist band with the "Star of Life" and "EMS-DNR" printed in blue. As of this writing, the use of the Star of Life for this purpose is still under consideration by the National Highway Traffic Safety Administration (NHTSA).

It is recommended that any such bracelet or similar identification item include (1) information which identifies the patient, (2) the physician's name and phone number, if possible, and (3) the expiration date of the order. There should be a long-range goal of achieving as much standardization of EMS DNR forms and bracelets as possible among the states to facilitate movement of patients across state lines.

Statewide EMS "Do Not Resuscitate" Protocols

Standardized statewide protocols should be developed to guide EMS response to this special category of patients. Such protocols should, at a minimum, address the following aspects of response:

- Initial Assessment and Intervention
- Verification of Patient ID for DNR
- Resuscitative Measures to be Withheld or Withdrawn
- Comfort Care or Palliative Care Measures
- Documentation
- Special Considerations

The medical treatments to be withheld or withdrawn should be clearly articulated. A "do not resuscitate" order should indicate that in the event of cardiac or respiratory arrest cardiac resuscitation measures should not be initiated, or, if they have been initiated by another person, such measures should be withdrawn. Measures to be withheld might include cardiac compression, endotracheal intubation or other advanced airway maneuvers, defibrillation, cardiac resuscitation medications, and artificial ventilation.

Other medical therapies that might be medically indicated should not be withheld. Likewise, comfort care measures that might be undertaken to ease the patient's suffering should be addressed. These comfort care measures might include oxygen, suction, positioning for comfort, pain medications, and control of bleeding. It should be emphasized that an authorized EMS DNR order does not mean do not treat the patient or do not care. It indicates that there is a more appropriate and compassionate way to aid this patient than the traditional approach.

Special considerations should include discussion of under what conditions an EMS provider should not execute a "do not resuscitate" order. If there is a major confrontation with family members or others present, it may be best to perform normal resuscitative measures. Any difficult or confusing situations could be aided by contacting the EMS Medical Director. It should be clear that if there is any doubt about the identity of the patient or the validity of the DNR order, providers should always err on the side of attempting resuscitation.

NASEMSD Position Paper

Comprehensive Education Program

Any new program of this consequence certainly needs to be thoroughly explained to all concerned. Initial planning should include provisions for a comprehensive education program for at least the following people and organizations:

- All EMS providers, EMS instructors, and EMS medical directors
- Physicians, including component and specialty medical societies
- Other health care providers and institutions, including hospitals, nursing homes, hospices, home health care agencies
- Attorneys (especially those involved in elder law) and clergy
- General public

A clear and concise video tape presentation can be very helpful for EMS agencies and their personnel. Your state medical society probably has a periodic journal or newsletter that could be used to communicate with physicians. A press conference and corresponding video news release is an excellent way to introduce such a program to the general public. In addition to the above, individual physicians should thoroughly discuss with any patients for whom a DNR order is being considered, or their family members, the implications of the order and how the EMS system could be expected to respond.

References

1.Amendments to 42 U.S.C.1395 and 42 U.S.C.1396, December 1, 1991.

2. American College of Emergency Physicians: Guidelines for do not resuscitate orders in the prehospital setting. Annals of Emergency Medicine 1988;17:1106-1108.

3.Emergency Cardiac Care Committees and Subcommittees, American Heart Association. Guidelines for cardiopulmonary resuscitation and emergency cardiac care,VIII: ethical considerations in resuscitation. JAMA. 1992;268:2282-2288.

4. Adams, James G.: Prehospital do-not-resuscitate orders: A survey of state policies in the united states. Prehospital and Disaster Medicine 1993;8(4):317-322.

Cross references. — For transitional measures as to local governments, see Alaska Const., art. XV, § 3.

Sec. 18.10.050. Commissioner of department to supervise local health boards. Each local board of health whether inside or outside incorporated cities, and each representative of the Alaska Native Service acting in the capacity of health officer is responsible to and under the supervision of the commissioner. (§ 3 ch 118 SLA 1949)

Secs. 18.10.060 — 18.10.250. Consolidated Health Districts. [Repealed, § 39 ch 69 SLA 1970.]

Sec. 18.10.260. Definitions. In this chapter,

(1) "commissioner" means the commissioner of health and social services;

(2) "department" means the Department of Health and Social Services. (§ 1 ch 163 SLA 1955; am § 39 ch 69 SLA 1970; am § 6 ch 104 SLA 1971; am § 18 ch 21 SLA 1991)

Effect of amendments. — The 1991 amendment, effective June 11, 1991, rewrote the section.

Chapter 12. Rights of Terminally Ill.

Sec. 18.12.010. Declaration relating to use of life-sustaining procedures. (a) A competent person who is at least 18 years old may execute a declaration at any time directing that life-sustaining procedures be withheld or withdrawn from that person; but the declaration is given operative effect only if the declarant's condition is determined to be terminal and the declarant is not able to make treatment decisions. The declaration shall be signed by the declarant, or another at the declarant's direction, and in either case shall be witnessed by two persons or a person qualified to take acknowledgements under AS 09.63.010. The witnesses must be at least 18 years old and may not be related to the declarant by blood or marriage. A person may not charge a fee for preparing a declaration.

(b) It is the responsibility of the declarant to provide a copy of the declaration to the declarant's physician. A physician or other health

care provider who is provided a copy of the declaration shall make it a part of the declarant's medical records.

(c) A declaration may, but need not, be in the following form:

DECLARATION

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, it is my desire that my life not be prolonged by administration of life-sustaining procedures.

If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain.

I [ ] do [ ] do not desire that nutrition or hydration (food and water) be provided by gastric tube or intravenously if necessary.

Signed this _____ day of _____, _____.

Signature _____

Place _____

The declarant is known to me and voluntarily signed or voluntarily directed another to sign this document in my presence.

Witness _____

Address _____

Witness _____

Address _____

State of _____

_____ Judicial District

The foregoing instrument was acknowledged before me this (date) by (name of person who acknowledged).

_____

Signature of Person Taking Acknowledgement

_____

Title or Rank

_____

Serial Number, if any

THIS DECLARATION MUST BE EITHER WITNESSED BY TWO PERSONS OR ACKNOWLEDGED BY A PERSON QUALIFIED TO TAKE ACKNOWLEDGEMENTS UNDER AS 09.63.010.

(d) A physician or health care provider may presume, in the absence of actual notice to the contrary, that the declaration complies with this chapter and is valid. (§ 1 ch 144 SLA 1986)

Sec. 18.12.020. Revocation of declaration. (a) A declaration may be revoked at any time and in any manner by which the declarant is able to communicate an intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending physician or any health care provider acting under the guidance of that physician upon communication to the physician or health care provider by the declarant or by another to whom the revocation was communicated.

(b) The attending physician or health care provider shall make the revocation a part of the declarant's medical record. (§ 1 ch 144 SLA 1986)

Sec. 18.12.030. Recording determination of terminal condition and contents of declaration. When an attending physician who has been provided a copy of a declaration determines that the declarant is in a terminal condition, the physician shall record that determination and the contents of the declaration in the declarant's medical record. (§ 1 ch 144 SLA 1986)

Sec. 18.12.040. Treatment of qualified patients. (a) A qualified patient has the right to make decisions regarding use of life-sustaining procedures as long as the patient is able to do so. If a qualified patient is not able to make these decisions, the declaration governs decisions regarding use of life-sustaining procedures.

(b) This chapter does not prohibit the application of any medical procedure or intervention, including the provision of nutrition and hydration, considered necessary to provide comfort care or alleviation of pain. The declaration may provide that the declarant does not want nutrition or hydration administered intravenously or by gastric tube.

(c) The declaration of a qualified patient known to the attending physician to be pregnant is given no effect as long as it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining procedures. (§ 1 ch 144 SLA 1986)

Opinions of attorney general. — Subsection (c) is constitutionally problematic. Under settled case law, a woman has a constitutional right to make a determination regarding her pregnancy during the first two trimesters of her pregnancy. Subsection (c), in essence, would take this constitutionally recognized right from a woman who has expressed her wishes, and perhaps even alter the form declaration to state her specific wishes, regarding life-sustaining measures during her first two trimesters of pregnancy. The ineffectiveness of the declaration does not, however, deprive the pregnant and terminally ill woman of any other lawful means to effect the withholding or withdrawal of medicare. When an incompetent person's life cannot be saved in any meaningful sense by modern medicine, and the patient's family and the attending physician are in agreement that life-sustaining procedures would only prolong the process of death, it appears reasonable that life-sustaining procedures would be withheld or withdrawn. June 6, 1986, Op. Att'y Gen.

Sec. 18.12.050. Transfer of patients. (a) An attending physician who is unwilling to comply with the requirements of AS 18.12.030 or who is unwilling to comply with the declaration of a qualified patient under AS 18.12.040 shall withdraw as attending physician but the withdrawal is effective only when the services of another attending physician have been obtained.

(b) If the policies of a health care facility preclude compliance with the declaration of a qualified patient under this chapter, that facility shall take all reasonable steps to notify the patient or, if the patient is not able to make treatment decisions, the patient's guardian, of the facility's policy and shall take all reasonable steps to effect the transfer of the patient to the patient's home or to a facility where the provisions of this chapter can be carried out. (§ 1 ch 144 SLA 1986)

Sec. 18.12.060. Immunities. (a) In the absence of actual notice of the revocation of a declaration, the following, while acting in accordance with the requirements of this chapter, are not subject to civil or criminal liability or guilty of unprofessional conduct:

(1) a physician who causes the withholding or withdrawal of life-sustaining procedures from a qualified patient;

(2) a person who participates in the withholding or withdrawal of life-sustaining procedures under the direction or with the authorization of a physician;

(3) the health care facility in which the withholding or withdrawal occurs.

(b) A physician, a health care professional, or a health care facility is not subject to civil or criminal liability for actions under this chapter that are in accord with reasonable medical standards. (§ 1 ch 144 SLA 1986)

Sec. 18.12.070. Penalties. (a) An attending physician who fails to comply with the declaration of a qualified patient or to make the necessary arrangements to effect a transfer under AS 18.12.050 has no right to compensation for medical services provided to a qualified patient after withdrawal should have been effective or after transfer should have occurred and may be liable to the qualified patient and to the heirs of the qualified patient for a civil penalty not to exceed $1000.00 plus the actual costs associated with the failure to comply with the declaration, and this shall be the exclusive remedy at law for damages.

(b) A person who wilfully conceals, cancels, defaces, obliterates, or damages the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another may be civilly liable to the qualified patient and to the heirs of the qualified patient. (§ 1 ch 144 SLA 1986)

Sec. 18.12.080. General provisions. (a) Death resulting from the withholding or withdrawal of life-sustaining procedures under a declaration and in accordance with this chapter does not, for any purpose, constitute a suicide or homicide.

(b) The making of a declaration under AS 18.12.010 does not affect in any manner the sale, procurement, or issuance of a policy of life insurance, nor does it modify the terms of an existing policy of life insurance. A policy of life insurance is not legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) A physician, health care facility, or other health care provider, and a health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plant, or nonprofit hospital plan, may not require a person to execute a declaration as a condition for being insured for, or receiving, health care services.

(d) This chapter creates no presumption concerning the intention of an individual who has not executed a declaration with respect to the use, withholding, or withdrawal of life-sustaining procedures in the event of a terminal condition.

(e) Nothing in this chapter increases or decreases the right of a patient to make decisions regarding use of life-sustaining procedures as long as the patient is able to do so, or impairs or supersedes any right or responsibility that a person has to effect the withholding or withdrawal of medical care in a lawful manner. In that respect, the provisions of this chapter are cumulative.

(f) This chapter does not condone, authorize, or approve mercy killing or euthanasia. (§ 1 ch 144 SLA 1986)

Sec. 18.12.090. Recognition of declarations executed in other states. A declaration executed in another state or a territory or possession of the United States in compliance with the law of that jurisdiction is effective for purposes of this chapter. (§ 1 ch 144 SLA 1986)

Sec. 18.12.100. Definitions. In this chapter

(1) "attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient;

(2) "declaration" means a document executed in accordance with the requirements of AS 18.12.010;

(3) "health care provider" means a person who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession;

(4) "life-sustaining procedure" means a medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process;

(5) "physician" means a person licensed to practice medicine in this state or an officer in the regular medical service of the armed services of the United States or the United States Public Health Service while in the discharge of their official duties, or while volunteering services without pay or other remuneration to a hospital, clinic, medical office, or other medical facility in the state;

(6) "qualified patient" means a patient who has executed a declaration in accordance with this chapter and who has been determined by the attending physician to be in a terminal condition;

(7) "terminal condition" means a progressive incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of two physicians, when available, who have personally examined the patient, one of whom must be the attending physician, result in death within a relatively short time. (§ 1 ch 144 SLA 1986)

Chapter 15. Disease Control.

Article
1. Tuberculosis (§§ 18.15.120 — 18.15.145)
2. Prenatal Blood Tests (§§ 18.15.150 — 18.15.180)
3. Phenylketonuria (PKU) (§ 18.15.200)
4. Hepatitis B (§ 18.15.250)
5. General Provisions (§ 18.15.900)

Secs. 18.15.010 — 18.15.050. Infectious and contagious diseases. [Repealed, § 2 ch 63 SLA 1972.]

Secs. 18.15.060 — 18.15.110. Physical examination of nonresident employees. [Repealed, § 1 ch 130 SLA 1976.]

Article 1. Tuberculosis.

Section
120. Tuberculosis control program authorized
130. Department to cooperate with other agencies
135. Tuberculosis examinations
136. Quarantines
137. Reporting of violations
138. Penalty
140. Title to and inventory of equipment allotted to private institutions
145. Screening of school employees

Collateral references. — 39 Am. Jur. 2d, Health, §§ 22, 23, 27-30.

39A C.J.S., Health and Environment, §§ 7-13, 18-22, 26, 27.

Right of one detained pursuant to quarantine to habeas corpus. 2 ALR 1542.

Pesthouse or contagious disease hospital as nuisance. 4 ALR 995; 18 ALR 122; 48 ALR 518.

General delegation of power to guard against spread of contagious disease. 8 ALR 836.

Liability for committing, or aiding commitment, to contagious disease hospital of one not suffering from contagious disease. 54 ALR 656.

Power of municipal or school authorities to prescribe vaccination or other health measure as a condition of school attendance. 93 ALR 1413.

Homer
Volunteer
Fire
Department

604 east pioneer avenue
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907/235-3155
fax 907/235-3157

Date: November 18, 1993

To: Representative Gail Phillips
Attention: Judy Jordan

From: Bob Painter, EMS Asst. Chief

Re: "Do Not Resuscitate"

Thank you for your interest in this important matter. Enclosed is all the information I have available regarding this issue of patient rights. As a pre-hospital care provider, I often encounter patients, and family members of patients with terminal illnesses who have no desire to see heroic efforts attempted in order to prolong inevitable death. As the Assistant Chief responsible for emergency medical services in Homer, I felt a strong need to develop and implement a policy to protect those last wishes of the terminally ill.

Based on available information from other states, and communities, I, in cooperation with the fire department Physician Sponsor, Dr. William Bell, developed a simple, and effective means to allow the responding firefighter, EMT, or police officer to readily know that the patient was suffering from a terminal disease, and that they, with the consent of their personal physician had made the conscious decision not to be resuscitated in the event of a cardiac or respiratory arrest. Since the policy was implemented, there has not been a single case of a patient with a Do Not Resuscitate, ("DNR") bracelet having to undergo the expense of a resuscitative effort.

My desires for a State law are simple. First, the policy and procedures must be simple to understand for the patient, physician, and public safety personnel. Secondly, the law should be flexible in that identification of "DNR" patients be made simple and quick. And finally, the law should offer some level of immunity from prosecution for a responders "good faith" attempt at resuscitation, even if the patient is identified as a "DNR".

Prior to the implementation of our local DNR policy, another system was in place that was non-functional. In fact, a man was resuscitated that was a DNR patient. Although this patient latter died without regaining consciousness, his family suffered the emotional and financial trauma of something that could have been prevented so easily. Even though I see this problem as a health care issue and not a legal one, I hope that the state will recognize the situation we are being placed in, and adequately

address the issue with input from the people it will most effect, the volunteers of local fire departments, rescue squads, ambulance services, and the health care agencies and providers that deal with the terminally ill on a regular basis. Again, thank you for your concern, and if there is anything I can assist you with, do not hesitate to contact me.

Hal Phillips

Homer
Volunteer
Fire
Department

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HOMER VOLUNTEER FIRE DEPARTMENT
"DO NOT RESUSCITATE" POLICY

It will be the policy of the Homer Volunteer Fire Department to honor each individuals request for non-intervention in cases of respiratory or cardiac arrest. In order for emergency responders to know that a person has a pre-existing terminal illness and does not desire resuscitation, those persons must be identified with a department approved and issued "DNR" bracelet. This bracelet must be worn on either arm, be unaltered in any way, and bear the patient's name, address, phone number, and physician's name.

If the bracelet must be removed for any reason, replacements may be requested from the fire department. The department emphasizes that if the bracelet is not on the patient, or has been altered in any way, full resuscitative measures must be undertaken by emergency responders.

this is only in Homer = ruled by the Homer judge =

We need a Statewide Policy

If the patient changes their mind about resuscitation prior to a fatal attack, the following should be done:

1. Remove the bracelet.
2. Notify the Fire Department about the change.
3. Return the bracelet to the Fire Department for proper disposal. (a representative of the Fire Department will pick up the bracelet if necessary)

If during, or after a fatal attack a family member changes their mind about resuscitation of the patient, the following should be done prior to the arrival of emergency personnel:

1. Remove the bracelet.
2. Notify the 911 operator that the patient's "DNR" status has been revoked.
3. Request that emergency responders attempt resuscitation once they arrive.

If emergency responders arrive on scene and the bracelet is properly displayed on the patient, CPR will not be started even if ordered to do so by a family member. The desire of the patient not to be resuscitated supersedes any family member request to the contrary.

Although Homer Volunteer Fire Department personnel and Homer Police Department officers are familiar with this "DNR" Policy, neither department makes, nor implies any guarantee that resuscitative efforts will be not be attempted, especially by lay persons trained in CPR.

The presence of a "DNR" bracelet does not preclude emergency responders from providing other emergency medical care or patients

Fahrenkamp's legislation
Ctc Dr. Raymond Paulin 235-7000
Ctc Judy Calhoun - 235-3290
Ctc Chief Haintz @ Fire Hall 235-3155

from requesting specific interventions such as oxygen administration by mask or nasal prongs, or other non-invasive procedures to ease a patients distress. A "DNR" order only means that cardiopulmonary resuscitation, endotracheal intubation, drug therapy, or electrical defibrillation will not be performed.

Homer
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STANDING ORDER FOR DO NOT RESUSCITATE

I, THE UNDERSIGNED PHYSICIAN, CERTIFY THAT THE BELOW LISTED PERSON IS A PATIENT UNDER MY CARE AND THAT THIS PERSON HAS A TERMINAL MEDICAL CONDITION.

PATIENTS NAME: _____

PATIENTS DATE OF BIRTH: _____

PATIENTS ADDRESS OR PHYSICAL LOCATION: _____

_____

PATIENTS HEALTH STATUS/DIAGNOSIS: _____

PATIENT OR RESPONSIBLE PARTY'S PHONE: _____

I, THE UNDERSIGNED, HAVE READ AND UNDERSTAND THE POLICY OF THE HOMER VOLUNTEER FIRE DEPARTMENT AND AGREE TO ITS CONDITIONS. I UNDERSTAND THAT IF THE "DNR" BRACELET IS REMOVED, OR ALTERED IN ANY WAY, FULL RESUSCITATIVE MEASURES WILL BE TAKEN BY EMERGENCY RESPONDERS.

_____ _____
PATIENT OR RESPONSIBLE PARTY DATE

_____ _____
PHYSICIAN'S SIGNATURE DATE

JUNEAU EMPIRE 1/19/94

'Do-not-resuscitate' bill debated

By JEANINE POHL 1/19/94
THE JUNEAU EMPIRE

A person suffering from a terminal illness whose heart has stopped would have the right – if they plan in advance – to refuse resuscitation under a bill introduced by a House committee.

If approved by lawmakers, terminally ill people could request that health-care professionals – doctors, nurses and paramedics – not resuscitate them.

Rep. Cynthia Toohey, R-Anchorage, said the Anchorage Fire Department already has a procedure accepting such "do-not-resuscitate orders," and she wants to make similar orders available statewide.

Toohey, who has worked as an emergency room nurse, is co-chairwoman of the House Health, Education and Social Services Committee, which offered the legislation last week.

"Usually in hospital settings it's not a problem," she said today. "(But) if people dial 911 because they see someone fall on the street, there's no conduit or follow-through on it."

If passed, House Bill 356 would require the state Department of Health and Social Services to develop standardized designs for identification cards, forms, necklaces and bracelets to identify that a person has a do-not-resuscitate order. The law would clarify existing state law on the rights of the terminally ill.

The Juneau fire department also has a program in place, said Capital City Fire/Rescue emergency services Capt. Steve Iha.

"Essentially it targets a patient who has already been diagnosed with a terminal illness that when it's their time to pass away that they not be resuscitated," Iha said.

In Juneau, the fire department created a form that is kept on file at the fire hall when a terminally ill patient has agreed with their doctor that they do not want to be resuscitated in case their heart has stopped.

The patient usually has a copy of the form with them at home or in the hospital or nursing home.

Iha said most of the time, the fire department gets a call after a patient has died, but having a do-not-resuscitate order "takes the pressure off the medics about having to make a decision."

The state coordinator of emergency medical services, Mark Johnson, said interest in do-not-re-

Please see Don't, back page

Don't...

Continued from Page 1

suscitate orders has grown in recent years. Emergency medical personnel – paramedics and fire departments – generally agree that such orders are a good idea, "assuming that they're handled appropriately."

Information from the National Association of State Emergency Medical Services Directors indicates that 11 states have do-not-resuscitate laws, six have policies or legal opinions allowing such orders and 14 states are considering legislation.

However, Sid Heidersdorf of Juneau, vice president of Alaskans for Life, has concerns over do-not-resuscitate orders, although his group doesn't have an official opinion on the bill.

"It's something that we need to look at carefully to see that we don't open the door to make these other things easier to accomplish," he said, referring to the increase in assisted suicides and the expanding scope of living wills.

Living wills are written instructions prepared in advance by people to guide their medical care if they are incapacitated.

Toohey's bill is generally supported by the Alaska State Medical Association, although Dr. Don Lehmann of Sitka said the group has yet to consider the bill specifically.

"We're looking at ways to make it easier to comply with patient's wishes," Lehmann said. "This is not euthanasia, this is not killing people, this is just not intervening futilely in life's processes."

Provisions in the bill would protect health-care professionals from liability when they do not try to resuscitate a patient who has a do-not-resuscitate order. The measure would hold them liable for failing to comply with a do-not-resuscitate order.

ORIGINAL RESEARCH

Prehospital Do-Not-Resuscitate Orders: A Survey of State Policies in the United States

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The opinions expressed in this paper are solely those of the author and do not necessarily represent the opinions of the Department of Defense or the United States Air Force.

Key Words: emergency medical services (EMS); EMS directors; do-not-resuscitate (DNR); legislation; medical control; medical direction; policies; prehospital; protocols; resuscitation; terminally ill

Abbreviations: ACEP = American College of Emergency Physicians; DNR = do-not-resuscitate; EMS = emergency medical services

Abstract

Introduction: Many states in the United States have developed policies that enable prehospital emergency medical services (EMS) providers to withhold cardiopulmonary resuscitation (CPR) in the terminally ill. Several states also have policies that enable the implementation of do-not-resuscitate (DNR) orders.

Objectives: 1) assess which states have statutes governing DNR orders for the prehospital setting; 2) determine which states authorize DNR orders in ways other than by specific state statue; and 3) define those states that had regional protocols which address prehospital DNR orders.

Methods: Survey of the state EMS directors in each of the 50 U.S. states, the District of Columbia, and Puerto Rico.

Results: As of 1992, specific legislation authorizing the implementation of DNR orders was in place in 11 states. In addition, six others have a legal opinion or policy allowing the implementation of DNR orders. Fourteen additional states have either working groups or legislation pending that address prehospital DNR orders. In only five were there no existing regional protocol for implementation of DNR orders in the prehospital setting.

Conclusions: There exists great variation in legal authorization by states for implementation of DNR orders in the prehospital setting. Despite the existence of enabling legislation, many state, regional, or local EMS systems have implemented policies dealing with DNR orders. **Prehospital and Disaster Medicine, 1993;8(4):317–322.**

Introduction

Over the past eight years, some states in the United States have developed policies that allow prehospital providers to honor requests to withhold resuscitation in terminally ill patients (i.e., do not resuscitate [DNR] orders). Such orders allow terminally ill patients to express their wishes regarding cardiopulmonary resuscitation at the time of their death. By 1991, eight states had policies which enabled prehospital DNR orders and 23 states were addressing the issue.[1–3] To assist in the development of prehospital DNR orders, the American College of Emergency Physicians (ACEP) developed guidelines for DNR orders in the prehospital setting,[1] and the issue has been discussed in the prehospital literature.[5–7] Similarly, the issue has been addressed in the medical ethics literature[4] and in the medical news.[9,10] During this period, it appeared that there was an ongoing expansion in the number of states that authorize prehospital DNR orders on a statewide basis.[10,11] The objective of this study was to assess which of the states (and District of Columbia and Puerto Rico) have statutes that govern prehospital DNR orders. In addition, this study attempted to determine which states authorize DNR orders in ways other than by state statute. Further, emergency medical services (EMS) that had protocols that address prehospital DNR orders were noted, whether the protocols conformed to state law or not.

Methods

A survey was mailed to the state EMS directors of the 50 states, the District of Columbia, and Fuerto Rico. The survey asked if the state legislature had passed a bill to allow DNR orders in the prehospital setting, and if so, what was the consideration and date of the bill was requested. Further, the mechanisms by which prehospital providers could recognize DNR requests were assessed. The survey also asked whether there was legal immunity for prehospital providers who honor a DNR order in good faith. Finally, copies of the rules, regulations, and protocols were requested.

Information regarding local EMS policies for DNR orders was also col-

lected through this survey as well as through direct contact with state EMS directors and local EMS medical directors.

Results

Mechanisms for DNR Orders

Thirty responses were received from the initial mailing and an additional 19 responses were obtained from a second mailing. The three remaining regions were contacted by telephone. If the state EMS director was not available, information was obtained from an administrator or EMS physician knowledgeable in the area.

Eleven states have specific legislation which authorizes the implementation of prehospital DNR orders. Six additional states have a legal opinion or policy which allows implementation of prehospital DNR orders. Fifteen states have working groups or legislation pending to address the issue. In all but five of the 52 regions surveyed, some local protocol was identified that allows the use of prehospital DNR orders.

Table 1 provides a summary of the data. In the table, "CONSIDERED" means that some action has been taken: a working group has formed or legislation has been introduced. "State Law" means that the law is explicit in regards to the prehospital setting. Other states, such as Texas and Oregon, interpret existing laws as applicable to the prehospital setting. Such cases are categorized as "permitting regional protocols." "Regional" means that there are local systems in the state which have policies that authorize prehospital DNR orders. Such policies may be present with explicitly stated permission or without explicit guidance.

Table 2 lists those states which have written into law that immunity is granted to the prehospital provider who honors a DNR request in good faith and according to the EMS protocol.

Examples of DNR Policies

The states which have developed standardized prehospital DNR protocols (Connecticut, Montana, Virginia) or are in the process of developing a standardized approach (Colorado, Hawaii, Massachusetts, New Hampshire, Rhode Island, Tennessee) have implemented or are considering implementation of a wristband to identify the patient and a written, signed form to note the DNR order.

Other states rely on regional protocols (Alabama, California, District of Columbia, Florida, Idaho, Kentucky, Maine, Maryland, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York,

	State Law	Local Protocols Exist		State Law	Local Protocols Exist
ALABAMA	N	Y	MONTANA	Y	Y
ALASKA	N	Y	NEBRASKA	N	Y
ARIZONA	Y	Y	NEVADA	N	Y
ARKANSAS	CONSIDERED	Y	NEW HAMPSHIRE	Y	Y
CALIFORNIA	CONSIDERED	Y	NEW JERSEY	CONSIDERED	Y
COLORADO	Y	Y	NEW MEXICO	CONSIDERED	Y
CONNECTICUT	Y	Y	NEW YORK	Y	Y
DELAWARE	N	Y	NORTH CAROLINA	Y	Y
DC	CONSIDERED	Y	NORTH DAKOTA	N	Y
FLORIDA	Y	Y	OHIO	N	Y
GEORGIA	CONSIDERED	Y	OKLAHOMA	N	Y
HAWAII	CONSIDERED		OREGON	N	Y
IDAHO	N	Y	PENNSYLVANIA	N	Y
ILLINOIS	Y	Y	PUERTO RICO	CONSIDERED	
INDIANA	N	Y	RHODE ISLAND	Y	Y
IOWA	N		SOUTH CAROLINA	N	
KANSAS	CONSIDERED	Y	SOUTH DAKOTA	N	Y
KENTUCKY	N	Y	TENNESSEE	CONSIDERED	
LOUISIANA	N		TEXAS	N	Y
MAINE	CONSIDERED	Y	UTAH	CONSIDERED	Y
MARYLAND	N	Y	VERMONT	N	Y
MASSACHUSETTS	N	Y	VIRGINIA	Y	Y
MICHIGAN	CONSIDERED	Y	WASHINGTON	Y	Y
MINNESOTA	N	Y	WEST VIRGINIA	CONSIDERED	Y
MISSISSIPPI	N	Y	WISCONSIN	N	Y
MISSOURI	N	Y	WYOMING	CONSIDERED	Y

Table 1— Status of Do-Not-Resuscitate (DNR) Legislation and Existence of DNR Protocols in the U.S. by States (1992). State Law Means some Action has been taken Specific to the Prehospital Setting. "Considered" Means some Action has been taken.

Colorado	New York
Connecticut	North Carolina
Florida	Rhode Island
Illinois	Virginia
Montana	Washington
New Hampshire	

Oregon and Texas apply existing laws to the prehospital setting and may offer immunity through this legislation, although it is not specific to the prehospital setting.

Table 2—States [U.S.] with Laws Providing Specific Immunity for EMS Providers Who Honor DNR Requests in Good Faith in Accordance with Explicit Prehospital EMS Protocols

North Carolina, Oklahoma, West Virginia). These protocols authorize nursing home or hospice orders, written physician orders, DNR requests signed by the patient, and in some cases, verbal requests by family.

The District of Columbia, Maryland, Maine, Massachusetts, and Wyoming have state EMS or Department of Health protocols that authorize DNR orders in the prehospital setting. Missouri enables prehospital DNR orders based upon the opinion of legal counsel. North Carolina allows prehospital DNR orders on the basis of the Attorney General's official authorization.

A brief statement regarding the approach by each state follows:

Alabama: No statute authorizes prehospital DNR orders. No bill is under consideration. Do not resuscitate orders which are signed by a physician can be accepted by prehospital providers and is governed by local or regional authority.

Alaska: No statute governs prehospital DNR orders, although individual EMS systems have developed regional protocols. There is some interest in developing a statewide approach and other states are being looked to as models.

Arizona: The state legislature passed a bill which became effective on 30 September 1992 which authorizes prehospital DNR orders. A statewide approach is planned using standardized forms, wallet card, and optional wristband. Immunity is granted for prehospital personnel who honor the order as well as for those who initiate resuscitation because of an unclear directive.

Arkansas: No specific prehospital DNR law exists. Arkansas does have Living Will legislation. Additional legislation is under development specifically to authorize DNR orders in the prehospital setting. There is no specific legislation which provides immunity to the prehospital provider who honors a DNR request. Currently, prehospital DNR orders are not accepted, although system-specific protocols may exist to address the issue.

California: Legislation regarding a DNR statute is currently under consideration. Specific emergency medical services have individual protocols to deal with DNR requests. In some systems, a signed DNR order in a patient's medical record or a completed, standardized DNR form can be honored.

Colorado: A state bill was passed in 1992 that specifically authorizes DNR orders in the prehospital setting. Specific mechanisms are under development to implement a statewide DNR mechanism. There is immunity for prehospital providers who honor such an order in good faith.

Connecticut: The 1991 Living Will Act authorizes DNR orders for terminally ill patients. The Connecticut Chapter of the American College of Emergency Physicians convened a multidisciplinary group to devise a mechanism for prehospital use. A written form in conjunction with a wristband has been developed to communicate the DNR order. There is general immunity for physicians in the state Living Will statute.

Delaware: No state legislation governs prehospital DNR orders. Currently, individual systems may have protocols which address the issue. Legislation is under development which addresses the issue.

District of Columbia: There is no bill that authorizes prehospital DNR orders, although such a bill is under consideration. Currently, hospice and nursing home orders can be accepted by prehospital personnel and immunity is recognized for those who honor such orders in good faith.

Florida: "Health Care Advance Directives" and the "EMS Medical Transportation Act" were passed by the legislature in 1992. These provide authority to honor prehospital DNR orders and provide EMS immunity. A standard, written form, signed by the personal physician and the patient or surrogate, is used to communicate the order.

Georgia: Current DNR legislation does not address the prehospital setting, so the applicability of the current legislation is not entirely clear. Additional legislation is under development with a group of interested parties, including the Medical Society of Georgia.

Hawaii: Draft legislation is expected to be submitted to the 1993 Hawaii legislature to expand authorization for DNR orders to the prehospital setting. Wristbands and standardized forms are being proposed to communicate the directive. A legal review is being conducted to determine whether immunity exists for prehospital personnel who honor a DNR order in

Idaho: Do-not-resuscitate mecha[illegible] cussed in conjunction with the state medical association. Currently, there is no state legislation which deals with prehospital DNR mechanisms. Likewise, there is no specific immunity for the prehospital provider who honors a DNR request. Currently, nursing home orders, family wishes, physician orders, and Living Wills are all used to guide care. A standardized DNR form is under development.

Illinois: The state administrative code authorizes systems to develop policies for DNR orders in the prehospital setting. No single approach is required, although

detailed guidelines are set forth in the code. Immunity is granted to prehospital personnel under the state EMS Act.

Indiana: While no legislation has been introduced regarding DNR orders, preliminary discussions have taken place. While there is Living Will legislation, no specific prehospital DNR provisions are included.

Iowa: No mechanism officially exists to honor prehospital DNR orders, the legislature has passed no bill authorizing them, and no immunity is specified for prehospital providers regarding DNR orders.

Kansas: No state legislation has been passed which authorizes prehospital DNR orders, although such legislation is under consideration. The legal authority for prehospital DNR orders is therefore uncertain. No specific immunity for EMS providers exists.

Kentucky: Currently there is no specific legal authority for DNR orders in the prehospital setting. At the present time, there is no bill under consideration. Some services recognize written or verbal DNR orders based on local protocols. There is no specific good-faith immunity.

Louisiana: No state legislation or direction guides prehospital DNR orders. Therefore, no legal immunity exists for the prehospital provider who honors a DNR order. No bill is under legislative consideration at this time.

Maine: No legislation or statewide protocol governs prehospital DNR orders, but the matter is of significant interest and a working group addressing the issue is in process. Currently, regional EMS systems may have protocols to address prehospital DNR orders.

Maryland: While there are no statutes that specifically address the prehospital setting, and there is no specific immunity for prehospital personnel who honor DNR requests, there is a palliative care/hospice program in place with general immunity for health care workers who honor the DNR request of terminally ill patients.

Massachusetts: No legislation has been passed which authorizes prehospital DNR orders. No immunity is specified for prehospital providers regarding DNR orders. A policy is being developed to honor advance directives using a standardized form and wristband, similar to Connecticut's.

Michigan: House Bill 5453 presently is under consideration to authorize prehospital DNR orders. There currently is no other specified authorization or immunity for prehospital DNR orders.

Minnesota: No legislation specifically authorizes prehospital DNR orders. Living Will legislation exists which is related to the issue. Mechanisms have been developed on a regional basis to honor DNR orders with physician signatures in the nursing home or personal residence. There is no specific legal immunity for prehospital providers who honor DNR orders.

Mississippi: No statute authorizes prehospital DNR orders. Standardized written orders that are signed by the patient or surrogate and attending physician can be honored. No specific immunity is granted to prehospital providers who honor the order and withhold resuscitation attempts.

Missouri: No statute specifically authorizes prehospital DNR orders. Hospice orders can be accepted, but only with concurrence of on-line medical control. Although no immunity is granted specifically to prehospital providers who, in good faith, honor a DNR request, the Missouri Public Duty Doctrine does provide some protection for providers who are employed by the government.

Montana: The Living Will Act was revised in 1989 to authorize prehospital DNR orders and to grant immunity to prehospital providers who honor them. "Comfort One" is a statewide program to standardize prehospital DNR rules and protocols. A standardized form and bracelet will be used to communicate DNR orders. An educational video is used in both initial training and recertification of basic and advanced prehospital providers. The Montana Hospital Association primarily is responsible for administration of the system.

Nebraska: In February 1992, the "Rights of the Terminally Ill" Act was passed which authorized withholding life-sustaining treatment based on a terminally ill patient's directive. Implicitly included are prehospital providers, although no specific mention is made. There is immunity for health care providers who act in accordance with the Act. The exact implications for the prehospital setting is unclear, and no standardized mechanism is present for DNR orders in the prehospital setting.

Nevada: While there is no specific state legislation which authorizes DNR orders in the prehospital setting, DNR policies are authorized at a local level. Standardized written forms are used. Updated review and a physician signature is required. There is no specific statutory good-faith immunity for prehospital providers.

New Hampshire: A statute that took effect 1 January 1993 authorizes consideration of durable powers of attorney and Living Wills in the prehospital setting. No formal statewide mechanism is in place, although consideration is being given to a standardized form/bracelet system similar to Connecticut's.

New Jersey: No state legislation specifically authorizes DNR orders in the prehospital setting. Local protocol allows services associated with certain hospice/nursing homes to honor DNR orders. There is no specific law which governs this practice. There is no specific immunity for prehospital providers who honor such requests.

New Mexico: Consideration is being given to amending the EMS Act to authorize DNR orders in the prehospital setting. No standardized, statewide DNR mechanism is in effect, but some local systems have protocols to honor DNR requests. No specific immunity is granted to prehospital personnel, but immunity is granted to physicians, which may extend to prehospital personnel.

New York: The state Public Health Law, Section 2960-2977 sets forth guidelines and requirements for DNR orders in the prehospital setting and defines acceptable actions in the event of surrogate decision-makers.

nonhospital orders, patient transfers and other special circumstances. Immunity is granted to the provider who honors acceptable orders in good faith.

North Carolina: A standardized form was developed by a multidisciplinary committee under the auspices of the North Carolina Medical Society. An opinion by the state Attorney General authorized use of the form and stated that EMS personnel would be free from liability if the form was used appropriately.

North Dakota: While Living Will legislation exists, there is no specific authorization for prehospital DNR orders. No uniform or official policy exists to honor DNR requests in the prehospital setting.

Ohio: No legislation or standardized DNR mechanism is in place. Legislation authorizes Living Wills, but prehospital concerns are not addressed.

Oklahoma: Living Will legislation has been passed, but no specific prehospital provisions have been defined. No standardized prehospital DNR system is in place, and there is no specific legal immunity for the prehospital provider. Do-not-resuscitate requests can be honored according to local or regional protocols. A standardized mechanism is being considered based on the example of other states, such as Virginia.

Oregon: Given the current Living Will legislation, the current opinion is that additional legislation is unnecessary to specifically authorize DNR requests in the prehospital setting.

Pennsylvania: There is no statutory authority for DNR orders in the prehospital setting. Recent legislation has been adopted to govern advance directives, but does not address the special circumstances of the prehospital setting. No immunity exists for prehospital personnel who honor a DNR order.

Puerto Rico: While there is no current legislation that specifically authorizes DNR orders in the prehospital setting, there is a Uniform Rights of the Terminally Ill Act and Uniform Determination of Death Act. Initial consideration of the applicability of these acts to the prehospital setting and the need for additional legislation began in August 1992.

Rhode Island: A bill was passed which authorizes acceptance of DNR orders in the prehospital setting. It became effective on 1 January 1993. Development of a system to implement DNR orders is under development. A system utilizing written physician orders and wristband identification is being considered. Good-faith immunity for prehospital providers is part of the legislation.

South Carolina: No state law specifically authorizes prehospital DNR orders, but the state Medical Control Committee is planning a multidisciplinary committee to address the issue and develop a plan or legislation.

South Dakota: There is no legislative authorization or consideration regarding prehospital DNR orders. No standardized mechanism is in place or under consideration.

Tennessee: The state EMS Board has established a subcommittee to resolve issue of prehospital DNR orders. An amendment to the Living Will Act will be required. Systems in place in Montana and Virginia are being considered as models for legislation, procedures, and materials. The amended legislation will provide immunity.

Texas: The Texas Natural Death Act authorizes Living Wills and advance directives. This has been interpreted to authorize prehospital DNR orders, although no specific mention is made of the prehospital setting. The Natural Death Act grants immunity to health care professionals who honor advance directives in good faith.

Utah: A bill is being planned for presentation to the 1993 legislative session. A committee currently is working on the bill.

Vermont: The Living Will and durable power of attorney statutes do not address the prehospital setting. Advance directives are accepted according to protocols developed by specific systems, or decisions are made to terminate resuscitative efforts in the emergency department.

Virginia: Effective 1 July 1992, legislation went into effect that authorizes prehospital DNR orders. A standardized EMS/DNR form and wristband are used to identify patients. An extensive educational campaign has been undertaken regarding the system.

Washington: In March 1992, state legislation was passed that authorizes DNR orders in the prehospital setting. There is specific legal immunity for the prehospital provider who honors a DNR order. Currently, no statewide DNR mechanism is in place. A work group has been formed to create a standardized system.

West Virginia: No state legislation currently authorizes prehospital DNR orders. A bill is under development. Currently, only hospice and nursing home orders can be considered. There is no specific legal immunity for prehospital providers who honor DNR requests.

Wisconsin: There is no state legislation which governs prehospital DNR orders. Similarly, there is no immunity for the prehospital personnel who might honor a DNR request.

Wyoming: No statute authorizes DNR orders in the prehospital setting. No bill is under consideration which would authorize prehospital DNR orders.

Discussion

Wide variation in the legal authorization of prehospital DNR requests are noted. Statewide systems commonly use wristbands and an authorized, written form. The success of having DNR patients acquire and wear wristbands has not been [illegible] these programs decrease ethical conflict. However, this system has been found to be acceptable both legally and operationally in a number of states. Ensuring that bracelets are distributed, obtained, and worn by DNR patients may present an administrative obstacle that is not faced when regional systems rely on a signed order and family, friend, or nurse identification. The benefit of assured identification by bracelet compared to identification by the person at the scene intuitively seems better and is an emerging trend. Wristbands are the most common mechanism in standardized state poli-

cies. Likewise, they are common, but not universal, in regional systems. Many local protocols allow a written DNR form alone to be honored.

Whether enabling legislation exists or not, whether there is a statute, legal opinion, or silence, many emergency medical services have developed mechanisms to honor DNR requests. The vast majority of states have emergency medical services that have developed DNR policies. Some specific state guidance must be offered to ensure that the mechanisms are sound legally. Further, the EMS medical director should seek experienced legal guidance. It is important that the medical director also assure that the system will be operationally effective and not so complicated that it is unwieldy. The medical director may have to work to publicize the system within the larger local medical community, and will be tasked to educate the EMTs regarding the DNR mechanism.

This survey did not analyze the relationship between Living Will legislation and prehospital DNR orders. Although legislation increasingly is addressing prehospital DNR orders, other advance directive legislation has been passed more rapidly. In 1991 alone, 24 states either passed new advance medical directive laws or amended existing statutes. In 1990, 18 states passed or amended advance directive laws. All 50 states now have some type of advance directive authorization in place.[11] The most common type is the Living Will. Living Wills allow patients to specify under what conditions they would want care withheld or withdrawn. Living Wills often are not applicable to the prehospital setting, since it generally is not possible to know if the directive is applicable or relevant. Such a directive does not guarantee that a terminal condition exists and might state only that "in the event of" a terminal illness, no life support should be instituted. Also, durable powers of attorney are being enacted by an increasing number of states. The applicability and operational effect of such directives were not explored in this survey.

It is apparent that emergency medical services (EMS) are challenged to develop legally acceptable, operationally useful, medically and ethically sound mechanisms to honor DNR requests in the prehospital setting. The success and difficulties of the current variety of mechanisms must continue to be explored. The most recent Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care discussed the issue of "No-CPR" orders (i.e., DNR orders) in the prehospital setting.[12] It clearly is stated that EMS should have provisions to identify adults and children who have No-CPR orders. No specific mechanism is endorsed. Formal orders sheets, identification cards, or bracelets might be appropriate.

Any mechanism must be sound operationally, legally, and ethically. This is balanced with the administrative and practical difficulties of implementation for widespread use. The development of a policy for DNR orders (or No-CPR orders) is not complete once the legal and medical communities accept it. The real test is successful implementation for the benefit of prehospital patients. Patients must be given the opportunity to take advantage of the prehospital DNR system. Prehospital providers must be comfortable accepting the orders, and be sophisticated enough to recognize when attempts at resuscitation are warranted. Further, prehospital personnel must interact compassionately and sensitively with family members. When these challenges are met, the community will have a successful prehospital DNR mechanism.

Acknowledgement

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FEB 10 1994

State of Alaska Legislature
House Health, Education and Social Services Comm.
Juneau, AK 99811

600E. HemlockSt.
Oxnard CA 93033
Feb. 6, 1944

Dear sirs: re: House Bill N0. 356 The Right To Die

I have been working for several years on the right of a person to make a Living Will specifying the kind of treatment he desires to receive or not to receive when a terminal condition exists. The United States Supreme Court recognized these rights to include food and water as well as cardiopulmonary resuscitation and other life-sustaining procedures.

Because food and water are specifically named in our newer forms the withholding of both is honored. Before their specific inclusion, the dying process was painfully extended on the premise they "were not life-sustaining procedures". Many forms still do not include them, including your proposed House Bill No.356.

Having closely followed the progress of our right to determine our terminal treatment because my mother was cruelly maintained for years, I have available updated forms that reflect recent U.S. Supreme Court decisions. A copy is enclosed for your consideration.

One more change awaits the California legislature: there should be no termination date. This is a subject of great concern which people do not wish to change but one which people do not wish to repeat. They are greatly relieved when these papers are signed. One couple said they (the two forms) are the most important papers they have signed after their marriage certificate.

This Californian is concerned about your action on this because my son and his family became loyal Alaskans years ago and I am a frequent visitor.

Yours truly,
(Mrs.) Lois L. Seaton

P.S. A recently added hospital regulation: if a patient has been out of the hospital for 30 days, the Right To Die forms must be resubmitted at the time of re-entry. This is difficult for the family because they have to beat the ambulance or find the tubes attached -- and just try to get them off! Hospitals try to refuse to put the forms into an inactive file; California has a law that they must do so but few know of the law.

RIGHT TO DIE FORMS

INFORMATION ONLY

The loose double-sided sheet "Guidelines for Signers", pages 1 and 2, is extra , for information to pass along. The two pages are re-printed and stapled with the forms as the last pages, as additional information to accompany the forms. Remove the staple for copying. It is suggested that the pages 1,2 and 3 then be stapled as the last pages of the document.

The Courts and doctors want to know INTENT! COMMUNICATE!! COMMUNICATE!!!

Do NOT neglect to make and DISTRIBUTE COPIES of either / both the "Durable Power --" and "The Right To Die--" so they are available to the people who will need them.

Do NOT feel relieved the job is done and tuck them away in your safe-deposit box!! Do make copies available to concerned persons.

Page 8 of "Durable Power---" is special for a person in a nursing home.
NOTE the last line -- copies are valid--- but they won't do you any good unless you get them made and distributed.

QUALIFICATIONS FOR WITNESSES:

Adults who personally know the signer or have convincing proof of identity, i.e. driver's license, I.D. card, passport, etc.
Observed that the signer appears to be of sound mind, under no duress, fraud or undue influence.
Cannot be the health care provider nor employee of the health care facility where the signer resides nor of the attending physician.
Cannot be related in any way to the signer or an heir to any part of the signer's estate under any now-existing will.

SUGGESTED ADDITIONAL STATEMENTS for both the DURABLE POWER– and MY RIGHT TO DIE:
In your handwriting, cp. type add the statement, initial and date it. Witness initial and date it.

To DURABLE POWER-- , page 5, paragraph 6: Should any member of my family or other person except as designated above consider he/she has any authority over my treatment, I instruct that in no way shall such person be permitted to countermand my rights or treatment as stated above. added to pages 5 + 6
Page 6, paragraph 8: It is my intent that this document remain in force and effect without termination unless I specifically terminate the document.

To MY RIGHT TO DIE: on reverse side of Statement, ~~write the two additional statements~~.
Do not initial or sign except before witnesses

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(California Civil Code Sections 2410-2444)

GUIDELINES FOR SIGNERS

I. WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

A "Durable Power of Attorney for Health Care" is a document that you can use to appoint another person, such as a family member or friend, who can make health care decisions for you if you become unable to make the decisions on your own. The person may make all decisions about your health care, subject only to limitations you specify on that person's authority and several restricts imposed by law.

II. WHY COMPLETE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

A Durable Power of Attorney for Health Care will be helpful even if you have executed a "Living Will" or a "Directive to Physicians" since it applies to all health care decisions and allows you to appoint a person who can carry out your wishes if you become incapable of making your own decisions. The other primary reasons for completing a Durable Power of Attorney for Health Care are to avoid court proceedings, possible delays in receiving needed medical care, and emotional and financial stress on family or friends. These benefits are available because a Durable Power of Attorney for Health Care can be executed by simply completing this form, without going to court. It may be advisable to execut a Durable Power of Attorney for Health Care before surgery or other medical care. Persons with chronic conditions that may "flare up" and leave them unable to make decisions might also consider executing a Durable Power of Attorney. Persons with no close relatives living nearby may want to identify a close friend to make medical decisions for them in the event they should become unable to make such decisions for themselves. As a practical matter, many people may want to keep a Durable Power of Attorney for Health Care in effect at all times, just as they maintain insurance to protect their interests in the event of unforseen occurrences.

III. WHO CAN COMPLETE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

Any person who is a California resident, is at least 18 years old, is of sound mind, and is acting on his or her own free will may execute a Durable Power of Attorney for Health Care.

IV. CAN A PERSON APPOINTED IN A DURABLE POWER OF ATTORNEY FOR HEALTH CARE MANAGE MY FINANCIAL AFFAIRS?

A person appointed in a Durable Power of Attorney for Health Care is allowed only to make health care decisions, arrangements for medical services, and related decisions. If you want to appoint a person to handle your other financial or legal affairs, you should consult with an attorney about completing a Durable Power of Attorney for such matters or using alternative methods for taking care of these matter.

V. HOW DO I COMPLETE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

Simply fill out this form, which will name your health care agent and set forth the limits imposed by you and by law on his or her authority. READ THE FORM CAREFULLY BEFORE FILLING IT OUT.

VI. MUST THE APPOINTED PERSON BE AN ATTORNEY?

Although the Durable Power of Attorney for Health Care has the term "attorney" in the title, and the person appointed to make decisions is called an "attorney-in-fact", he or she does not need to be an attorney. There are only a few limits on who may be appointed. These are set forth in the attached form.

VII. WHO CAN I APPOINT TO MAKE HEALTH CARE DECISIONS FOR ME?

Your agent must be an adult (at least 18 year of age). None of the following can be appointed: 1) your treating health care provider; 2) an employee of your treating health care provider, unless the employee is related to you by blood, marriage or adoption; 3) an operator of a community care facility; or 4) an employee of an operator of a community care facility, unless the employee is related to you by blood, marriage or adoption.

VIII. WHAT CONTROL WILL I HAVE OVER THE DECISIONS MADE BY THE PERSON I APPOINT?

1) The person you appoint may not agree to:

   a) Commitment or placement in a mental health treatment facility.
   b) Convulsive treatment.
   c) Psychosurgery.
   d) Sterilization
   e) Abortion

2) You can, but are not required to, indicate your desires in writing on the form, these will generally be legally binding.

3) If your desires are unknown or not covered in written instructions, your agent has the duty to act in your best interest; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decisions that are in your best interests.

4) The person you chose may make health care decisions for you only if you are in a coma or mentally incapacitated or unable for any reason to make your own decisions.

5) Should you wish to terminate the Durable Power of Attorney for Health Care at any time, simply contact your doctor or the person you have chosen to make health care decisions for you.

6) If you have named your spouse as the person to make decisions for you and you divorce, your spouse is automatically revoked as your agent.

7) The Durable Power of Attorney for Health Care will exist for seven years from the date you execute the document unless you establish a shorter time. If you are unable to make health care decions for yourself when the date expires, the authority you have granted your agent will continue to exist until the time when you become able to make health care decisions for yourself.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(California Civil Code Section 2410-2444)

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT (ATTORNEY-IN-FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. YOUR AGENT MUST ACT CONSISTENTLY WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN.

EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE.

NOTHWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT AT THE TIME.

THIS DOCUMENT GIVES YOUR AGENT AUTHORITY TO CONSENT, TO REFUSE TO CONSENT, OR TO WITHDRAW CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. THIS POWER IS SUBJECT TO ANY STATEMENT OF YOUR DESIRES AND ANY LIMITATIONS THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT THAT YOU DO NOT DESIRE. IN ADDITION, A COURT CAN TAKE AWAY THE POWER OF YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOUR AGRNT (1) AUTHORIZES ANYTHING THAT IS ILLEGAL, (2) ACTS CONTRARY TO YOUR KNOWN DESIRES, OR (3) WHERE YOUR DESIRES ARE NOT KNOWN, DOES ANYTHING THAT IS CLEARLY CONTRARY TO YOUR BEST INTERESTS.

UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST FOR SEVEN YEARS FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AT THE TIME WHEN THIS SEVEN-YEAR PERIOD ENDS, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT BY NOTIFYING YOUR AGENT OR YOUR TREATING DOCTOR, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING OF THE REVOCATION.

YOUR AGENT HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

UNLESS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER AFTER YOU DIE TO (1) AUTHORIZE AN AUTOPSY, (2) DONATE YOUR BODY OR PARTS AND (3) DIRECT THE DISPOSITION OF YOUR REMAINS.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

7

* In 1990 -- State Law, ~~five~~ years

1. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a durable power of attorney by appointing the person designated below to make health care decisions for me as allowed by the California Civil Code. This power of attorney shall not be affected by my subsequent incapacity.

2. DESIGNATION OF HEALTH CARE AGENT

(Your attorney-in-fact, i.e., your agent, must be an adult (at least 18 years of age). Insert the name, address, and telephone number of the person you wish to designate as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider; (2) an employee of your treating health care provider, *unless* the employee is related to you by blood, marriage or adoption; (3) an operator of a community care facility; or (4) an employee of an operator of a community care facility, *unless* the employee is related to you by blood, marriage or adoption. For example, your agent may not be your physician; your nurse, *unless* the nurse is related to you by blood, marriage or adoption; an employee of your nursing home, *unless* the employee is related to you by blood, marriage or adoption; or an operator of a board and care home.)

I,_____ do hereby designate and appoint:
(Insert Your Name)

Name: _____

Address: _____

Telephone Number: (___) _____ as my agent to make health care decisions for me as authorized in this document.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

If I become incapable of giving informed consent with respect to health care decisions, I hereby grant to my agent full power and authority to make health care decisions for me including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, and to receive and to consent to the release of medical information, and, in the event of my death, to authorize an autopsy and arrange for the disposition of my remains, subject to the limitations and special provisions, set forth in Paragraph 6 below.

4. CONTRIBUTION OF ANATOMICAL GIFT

(You may choose to make a gift of all or part of your body to a hospital, physician, or medical school, for scientific, educational, therapeutic, or transplant purposes. Such a gift is allowed by California's Uniform Anatomical Gift Act. If you do not make such a gift, you may authorize your agent to do so, or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of all or a part of your body under the Uniform Anatomical Gift Act.)

If either statement reflects your desires, sign the box next to the statement. You do not have to sign either statement. If you do not sign either statement, your agent and your family will have the authority to make a gift of all or part of your body under the Uniform Anatomical Gift Act.

[_____] Pursuant to the Uniform Anatomical Gift Act, I hereby give, effective upon my death:

☐ Any needed organ or parts; or

☐ The parts or organs listed:

_____

_____

_____

[_____] I do not want to make a gift under the Uniform Anatomical Gift Act, nor do I want my agent or family to do so.

5. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life-sustaining treatment, your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your agent has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement that reflects your desires and/or write your own statements in the space below.)

MAXIMUM TREATMENT

I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long term survival, or the cost of the procedures.

If this statement reflects your desires, initial here: _____

LIMITED TREATMENT

I do *not* desire that my life be prolonged to the greatest extent possible, and I do *not* want life sustaining treatment to be provided or continued if the burdens of the treatment outweigh the expected benefits. In making decisions concerning life-sustaining treatment, my agent is to consider the relief of suffering, the prevention or restoration of functioning, and the quality as well as the extent of my life.

If this statement reflects your desires initial here: _____

Other or Additional Statements of Desires: (Initial any of the following you desire)

_____ 1. No artificial respiration or resuscitation

_____ 2. No intubation for food or water.

_____ 3. No Ensure or forced feeding (including baster).

_____ 4. No intravenous saline solution.

_____ 5. No antibiotics.

_____ 6. Generous intervention for pain control.

6. SPECIAL PROVISIONS AND LIMITATIONS

(By law, your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. In every other respect, your agent may make health care decisions for you to the same extent that you could make them for yourself if you were capable of doing so. If there are any special restrictions you wish to place on your agent's authority, you should list them in the space below. If you do not write in any limitations, your agent will have the broad powers to make health care decisions on your behalf which are set forth in Paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

_____

_ Should any member of my family or other person except as designated above ____
_ consider : ? has any authority over my treatment under the terms of this ____
_ agreement, I instruct that in no way shall such person be permitted to ____
countermand my rights or treatment as stated above.

_____

_____

_____

_____

7. DESIGNATION OF ALTERNATE AGENT

(You are not required to designate any alternative agents but you may do so. Any alternative agent must meet the requirements set forth in Paragraph 2 above. Any alternate agent you designate will be able to make the same health care decisions as the agent designated in Paragraph 2 above in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in Paragraph 2 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

If the person designated in Paragraph 2 as my agent is unable to make health care decisions for me or is disqualified by law from so doing, then I designate the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

a. First Alternative Agent

Name: _____

Address: _____

_____

Telephone Number: (___) _____

b. Second Alternative Agent

Name: _____

Address: _____

_____

Telephone Number: (___) _____

8. DURATION

I understand that this power of attorney will exist for seven years from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent will continue to exist until the time when I become able to make health care decisions for myself.

[*Optional*] I wish to have this power of attorney end before seven years on the following date: _____

It is my intent that this document remain in full force without termination unless I specifically terminate the document. _____

9. PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care on _____ (Date) at _____ (City).

_____ (State)

_____ (Signature)

THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY TWO QUALIFIED ADULT WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC IN CALIFORNIA.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of California)
) ss.
County of _____)

On this _____ day of _____, in the year _____

before me, _____
(Here Insert Name of Notary Public)

personally appeared _____
(Here Insert Name of Principal)

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 he or she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

_____
(Signature of Notary Public)

STATEMENT OF WITNESSES

If you elect to use witnesses instead of having this document notarized, you should carefully read and follow this witnessing procedure; otherwise this document will not be valid.

You must use two qualified adult witnesses who personally know you. None of the following may be used as a witness: (1) a person you designate as your agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility. For example, your witness may not be a physician, a nurse, a hospital employee, a nursing home employee, or an operator of a board and care home. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact (agent) by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury under the laws of California that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Optional Second Signature: _____

If Signer is a patient in a SKILLED NURSING FACILITY or a CONSERVATEE:

SPECIAL REQUIREMENTS

(Special additional requirements must be satisfied for this document to be valid if (1) you are a patient in a skilled nursing facility or (2) you are a conservatee under the Lanterman-Petris-Short Act and you are appointing the conservator as your agent to make health care decisions for you. If you are not sure whether you are in a skilled nursing facility, which is a special type of nursing home, ask the facility staff.)

1. If you are a patient in a skilled nursing facility (as defined in Health and Safety Code Section 1250(c)) at least one witness must be a patient advocate or ombudsman. The patient advocate or ombudsman must sign the witness statement *and* must also sign the following declaration.

   I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and am serving as a witness as required by subdivision (a) (3)A of Civil Code 2432.

   Signature: _____ Address: _____

   Print Name: _____ _____

   Date: _____ _____

2. If you are a conservatee under the Lanterman-Petris-Short Act (of Division 5 of the Welfare and Institutions Code) and you wish to designate your conservator as your agent to make health care decisions, you must be represented by legal counsel. Your lawyer must sign the following statement:

   I am a lawyer authorized to practice law in the state where this power of attorney was executed, and the principal was my client at the time this power of attorney was executed. I have advised my client _____ (Name) concerning his or her rights in connection with this power of attorney and the applicable law and the consequence of signing or not signing this power of attorney, and my client, after being so advised, has executed th. durable power of attorney.

   Name: _____ Address: _____

   Print Name: _____ _____

   Date: _____ _____

COPIES: Photocopies of this document can be relied upon as though they were originals. Copies should be given to your agent and alternate agents, your doctor, hospital file, and members of your family.

MY RIGHT TO DIE STATEMENT

1. To my family, my physician, my clergyman, my lawyer:
   To any medical facility in whose care I happen to be:
   To any individual who may be responsible for my health, welfare or affairs:

2. Death is as much a reality as birth, growth, maturity and old age -- it is the one certainty of life. If the time comes when I, _____, can no longer take part in decisions for my own future, let this statement stand as the expression of my wishes while I am of sound mind.

3. If the situation should arise from physical debilitation, disease, accident, or other circumstance in which there is no expectation of my recovery to life with quality and reasonable independence, I request that I be allowed to die and not be kept alive by "heroic measures" or artificial means -- this includes IV tubes, breathing machines, Ensure tubes, gaster-feeding and drugs.

4. I do not fear death itself but the indignities of deterioration, dependence, and/or hopeless pain. I therefore ask that medication mercifully be administered to me to alleviate suffering even though this may hasten the moment of death.

5. Modern medicine can maintain the body functioning as an organism rather than as a human being. Modern law recognizes my right not to be so maintained. ANTIBIOTICS can be a means of artificial extension of life. If my body has deteriorated as heretofore defined in this statement, and any other signed statements if any, in case of pneumonia I specifically state I do not want antibiotics administered. "Pneumonia is the Old One's friend" -- a friend to my exhausted body and Spirit. My Spirit is to be permitted to depart in peace and with grace.

6. This request is made after careful consideration. I hope you who care for me will feel morally bound to follow its mandate. I recognize that this places a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and of placing it upon myself in accordance with my strong convictions that this statement is made.

7. Signed _____ Date _____

   Address _____ 8. Copies to

   Witne _____ _____

   Address _____ _____

   Witness _____ _____

   Address _____ _____

9. I further state that should mental deterioration preceed the physical, after the time at which I require full custodial care, then any condition that requires hospitalization to maintain or preserve life shall be considered the Terminal Condition. Then there shall be no surgery, no antibiotics, no medical-office or home-administered medication to interfere with my departure. No method of artificial or forced-feeding shall be used -- the depletion of nourishment is the natural way to death.

10. Signed _____ Date _____

    Witnesses _____, _____

MY CHRISTIAN STATEMENT

11. I further state: I have lived my life as best I could. When the time comes for my death from natural cause or accident, my Spirit must be allowed to depart from its failing earthly temple in peace and dignity. Quality of life is more important than quantity. I am a Christian; I do not fear death. No man has the right to interfere with the departure of my Spirit when my time has come.

12. Signed _____, Date _____

    Witnesses _____, _____

ADDITIONAL STATEMENTS

1. Should any member of my family or other person except as designated by me consider he/she has any authority over my treatment, I instruct that in no way shall such person be permitted to countermand my rights or treatment as stated in "My Right To Die Statement".

_____
name date

2. It is my intent that this directive shall remain in force and effect without termination unless I have specifically terminated the directive.

_____
name date

Witness _____

Witness _____

Photocopies of this document can be relied upon as the originals.

ADDITIONAL STATEMENTS

1. Should any member of my family or other person except as designated by me consider he/she has any authority over my treatment, I instruct that in no way shall such person be permitted to countermand my rights or treatment as stated in "My Right To Die Statement".

   _____
   name date

2. It is my intent that this directive shall remain in force and effect without termination unless I have specifically terminated the directive.

   _____
   name date

Witness _____

Witness _____

Photocopies of this document can be relied upon as the originals.

P.2

Declaration of Witnesses to the
"MY RIGHT TO DIE STATEMENT" of

_____
name of signer

(Statement may be notarized instead.)

I declare under penalty of perjury under the laws of California (or _____) that this "My Right to Die Statement", dated _____, was signed in my presence, that I personally know the signer / have seen evidence of proof of identity, that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am in no way connected with provision of health care, nor related in any way to the signer, nor in any way an heir to the estate of the signer under any existing will or law.

Witness _____ _____
date

Address _____

_____

Witness _____ _____
date

Address _____

_____

GUIDELINES FOR "MY RIGHT TO DIE STATEMENT"

1. This is a personal statement incorporating your directives to those responsible for you if you are unable to speak for yourself. The DURABLE POWER OF ATTORNEY FOR HEALTH CARE assigns that responsibility to a person of your choice. If you have no person to whom you desire to assign this responsibility, this RIGHT TO DIE STATEMENT expresses your intentions regarding treatment. This Statement is recommended with or without the Durable Power. Courts and doctors want to know INTENT.

2. This statement is in no way connected with euthanasia. It is specifically designed for permitting natural death at the natural time.

3. This statement is revocable at any time if the signer is mentally competent. Such revocation can be done in writing or verbally at any time or by communicating the desire for life-sustaining treatment to the attending physician.

4. Any portion -- word, phrase or whole section -- may be deleted by crossing it out. The deletion should be initialed by signer and one witness and dated using the same pen.

5. Any additions within the statement should be made with the same pen and initialed by signer and one witness at time of signing.

6. Additional statements may be added on the reverse side, typed or handwritten by the signer, and signed and dated at time of witnessing, and signed by at least one witness.

7. Sections 9 and 11 are separate to accommodate individual preferences. They may be signed or not, left blank or crossed out.

8. Photocopies should be given to your doctor, lawyer if you have one, children, and at least one person closely involved with you (if available). Keep your own copy readily accessible, not in a safe or safety-deposit box. **This has nothing to do with your estate or will.** Your will has nothing to do with your right to natural death.

9. A "DURABLE POWER OF ATTORNEY FOR HEALTH CARE" is a top-priority document. It names a person to be your spokesman if you are not capable. It is viable for seven years (1991). It is recommended that the "Right to Die Statement" accompany the Durable Power. The "DURABLE POWER OF ATTORNEY FOR HEALTH CARE" has nothing to do with your finances; it may be obtained from a stationary store, a lawyer (check fee first), or the Oxnard First Baptist Church. The "MY RIGHT TO DIE STATEMENT" is available at the Oxnard First Baptist Church.

10. SUGGESTED ADDITIONAL STATEMENT to be typed or written on back of Statement: "Should any member of my family or other person except as designated by me consider he/she has any authority over my treatment, I instruct that in no way shall such person be permitted to countermand my rights or treatment as stated in the "My Right To Die Statement". Maker and witnesses sign and date.

11. SUGGESTED ADDITIONAL STATEMENT to be typed or written on back of statement: "It is my intent that this directive shall remain in force and effect without termination unless I have specifically terminated the directive." Maker and witnesses sign and date.

12. Qualifications for witnesses: defined in "Declaration of Witnesses".

EMS
An Alaskan tradition
Neighbor helping neighbor

INTERIOR REGION EMERGENCY MEDICAL SERVICES COUNCIL, INC.

1881 MARIKA ST • FAIRBANKS, ALASKA 99709
PHONE (907) 456 3979 • FAX 456 3970

MEMORANDUM

To: Representative Cynthia Toohey, Co-Chairman
Representative Con Bunde, Co Chairman

From: Craig Lewis, Executive Director, IREMSC

Subject: HB 356 "Do Not Resuscitate Orders and Protocols"

Date: January 30, 1994

I would like to commend your efforts to improve the "Do Not Resuscitate Orders" (DNR) portion of Alaska statutes. As a major training and EMS consultant agency we are very interested in improving and clarifying DNR issues.

I have recently reviewed HB 356 and offer the following comments as suggestions for your consideration.

As a general observation, it appears that HB 356 is specifically focused on terminally ill individuals or those who have medical conditions where physicians ORDER (as opposed to complying with a patients request for) withholding resuscitation. DNR prerogatives and methods to alert medical care practioners should also be available to persons who are not terminally ill, but who do not want extraordinary resuscitative efforts in certain circumstances. **RECOMMEND:** Add language that addresses individuals other than the terminally ill.

1. Line 5 - 8 Sec. 18.12.035 (a) provides that an attending physician may issue a DNR order for a patient of the physician. By using the words "attending physician" this section would allow any physician in the process of providing care to the patient the prerogative to issue a DNR order. **RECOMMEND DELETING THE WORD "ATTENDING".**

2. Line 7 requires the physician to document the grounds for the DNR in the patients file. **RECOMMEND** changing the language to clarify that this is applicable only when the situation is based on an illness currently treated by the physician issuing the order.

3. Line 11 deals with ".....withholding CPR resuscitation by physicians and other health care providers". Line 10 and 11 on page 5 define CPR resuscitation as CPR or a component of CPR. Together this effectively means that a person may not re-position the head of a patient who stopped breathing as a result of changing head positions or administer oxygen. **RECOMMEND** this section be changed to specify artificial exchange of air or physically breathing for the patient as well as physically compressing the chest. **RECOMMEND** the definition be changed to reflect definition used by the American Heart Association and that the words "or a component of cardiopulmonary resuscitation be deleted from line 11 page 5.

4. Line 11 on page 1 addresses withholding CPR - **RECOMMEND** adding the words "or cessation" immediately following the word "withholding". Given the fact that identification may not be immediately available and individuals may be in a rural setting, where telephonic confirmation of the existence of a DNR may be necessary. One does not wait for confirmation to initiate care. As such one would have to cease after the process started.

5. Line 2 on page 2 allows physicians to give oral DNR orders. However, the section is mute with regard to the setting where oral DNR orders may be issued. **RECOMMEND** this be limited to situations where the physician is "eye to eye" with those following the order or when confirmation of an already existing DNR is limited to speaking to the issuing physician. To issue a DNR orally in a rural setting, over the telephone, may cause uncertainty on the part of the provider in that the provider may not know who is really on the other end of the phone. It could also create a number of liability questions with regard to responsibility and accountability.

6. Lines 11 - 17 raise a number of questions. Using the words "qualified" when referring to a patient may cause a reader to conclude there is an "un-qualified" patient. The Statute is mute on these terms. Regarding line 14, although DNR decision making is the prerogative of the patient, there is a limitation to ".....only as long as the patient is able to do so." The next sentence gives a physician ultimate authority over a patient. What would happen should a spouse or relative be present, or an individual who has been vested with a medical or limited power of attorney on behalf of the patient or a previously appointed guardian or some other situation where patients not able to make decisions have someone else empowered to do it for them. Who decides when the patient is unable to make a decision and what are the circumstances? Would this decision take a court action of some kind?

7. Line 15 refers to ".... health care facilities ...." and the requirements should that facility not choose to recognize a DNR order. DNR orders will appear in clinics, ambulance services and so forth. Language needs to be present to provide guidance in dealing with DNR situations outside a fixed health care facility.

8. Lines 10 - 12 on page 3 are not realistic.

9. Lines 7 - 15 on page 4 address issuance of life insurance and/or modification of existing life insurance. Who decides? An agent of the State of Alaska - if so who is it? Or, is it the insurance company?

10. Lines 17 - 21 on page 4 address precluding employers from requiring persons to obtain a DNR or possess DNR identification. What about if the client or employee has a DNR order? Does this have an impact on employability?

11. Lines 4 - 8 on page 5 address recognition of DNR orders from other States or territory or possession of the United States as long as the declaration/DNR order is compliant with the law of that jurisdiction. How would a provider become aware (from a practical standpoint) if the DNR identification/declaration has been executed and is in compliance with other States or territories? It would seem better if the individuals were required to register in some manner such that the State of Alaska could verify/authenticate the DNR information.

Thank you for your patience in reading this document. DNR orders are a very complex, controversial and emotion filled issue. The impact of this legislation touches all levels of the health care field.

I hope that you will contact me if I can be of assistance in drafting additional language.

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Fax Transmittal Memo

To	L. I.O.	No. of Pages	
Company		Today's Date	
Location		Time	
Fax #	456 - 3346	Telephone #	
Comments	please forward to House HES Committee. thank you.		

From	Cheryl Keepers		
Company	FNSB		
Location		Dept. Charge	
Fax #	459 1280	Telephone #	459 1474
Original Disposition	☐ Destroy	☐ Return	☐ Call for pickup

Fairbanks North Star Borough

809 Pioneer Road P.O. Box 71267 Fairbanks, Alaska 99707-1267 907/459-1000

To: House Health, Education and Social Services Committee
Representatives Toohey, Bunde, Davis, Vezey, Kott, Olberg, Davis, Nicholia and Brice

VIA: Legislative Information Office, Fairbanks

From: Cheryl Keepers, Administrator
Child Care Assistance

Date: 3/14/94

Subject: HB 412, Community Care Licensing

I am sorry I was not able to participate in the teleconferenced hearing today, but I do want to convey to the Committee that I support this bill with the amendments proposed by the Department.

I have reviewed it with child care licensing in mind, as that is the portion of community care licensing I am familiar with. This bill as amended will permit some streamlining of administrative functions, which will help both licensing staff and the public. It will have no adverse impacts that I can see.

Please pass the bill.

Thank you for the opportunity to comment.