

HB

356

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 5/5/94

FURTHER:

DATE TURNED INTO OFFICE: 5-7-94

The Finance Committee considered HOUSE BILL NO. 356

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

and recommends:

- replace with _____ CS _____ (FINANCE)
- or adopt previous _____ CS _____ (_____)
- attaches amendment(s)

- same title.
- new title
- technical title change (HB only)

adopts _____ Letter of Intent

further referral to the _____

do pass

do not pass

no recommendation

individual recommendations

NEW FISCAL NOTES

| Department | Date | Zero | Fiscal |
|------------|------|------|--------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PREVIOUS FISCAL NOTES

| Department | Date | Zero | Fiscal |
|------------|--------|-------------------------------------|--------|
| DC & ED | 3/3/94 | <input checked="" type="checkbox"/> | |
| DH & SS | 2/3/94 | | 12.0 |
| | | | |
| | | | |
| | | | |
| | | | |

Appropriation No Fiscal Note

DO PASS.

Tim Kelly
Steve Rios
Bob Murphy

OTHER RECOMMENDATIONS:

1. [Signature] DO PASS
 Co-Chair: Signature/Recommendation

2. [Signature] DO PASS
 Co-Chair: Signature/Recommendation

FISCAL NOTE

No. 1
 Bill Version: HB 356
 (H) Publish Date: 3/15/94

STATE OF ALASKA
 1994 LEGISLATIVE SESSION

BILL

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: "An Act relating to living wills and do not resuscitate orders..." BRU: State Health Services
 Sponsor: House HESS Component: EMS Training and Licensiug
 Requestor: _____ 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)

| FUND SOURCE | FY95 | FY96 | FY97 | FY98 | FY99 | FY00 |
|--------------------------|-------------|------------|------------|------------|------------|------------|
| 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:

| POSITIONS: | FY95 | FY96 | FY97 | FY98 | FY99 | FY00 |
|------------|------|------|------|------|------|------|
| 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
 Approved by Commissioner: Margaret R. Lowe, M.Ed., Ed.S.
 Agency: Department of Health & Social Services

Phone: (907) 465-3090
 Date: 1/19/94
 Date: 2/3/94

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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 throughout the life of the project.

FISCAL NOTE

No. 2
 Bill Version: HB 356
 (H) Publish Date: 3/15/94

**STATE OF ALASKA
 1994 LEGISLATIVE SESSION**

BILL

Revision Date: 3/2/94
 Title: An Act relating to living wills and do not resuscitate orders;...
 Sponsor: House HES
 Requestor: House HES

Department: Commerce and Economic Dev.
 BRU: Occupational Licensing
 Component: Operations

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 | FY 95 | FY 96 | FY 97 | FY 98 | FY 99 | FY 00 |
|-----------|-------|-------|-------|-------|-------|-------|
| 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
 Division: Occupational Licensing
 Approved by Commissioner: Paul Fuhs
 Agency: Commerce and Economic Development

Phone: 465-2144
 Date: 3/2/94
 Date: 3/3/94

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Back-up

HB 356

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

STATE CAPITOL, JUNEAU 99801
(907) 465-3750



MEMORANDUM

TO: Senator Drue Pearce
 Senator Steve Frank
 Senate Finance Committee Co-Chairs

FR: Representative Cynthia D. Toohy
 Representative ~~Con Bunde~~
 House HESS Committee Co-Chairs

DA: May 4, 1994

RE: Committee Schedule

We respectfully request that you schedule HB 356, relating to living wills and do not resuscitate orders, at your earliest convenience.

This bill 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.

Thank you for your consideration in getting this important piece of legislation scheduled.

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 consideration of this important legislation.

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 Act¹, 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 medical 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.

NASEMSD Position Paper

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.

NAEMSD Position Paper

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.

| Section | Section |
|---|--|
| 10. Declaration relating to use of life-sustaining procedures | 50. Transfer of patients |
| 20. Revocation of declaration | 60. Immunities |
| 30. Recording determination of terminal condition and contents of declaration | 70. Penalties |
| 40. Treatment of qualified patients | 80. General provisions |
| | 90. Recognition of declarations executed in other states |
| | 100. Definitions |

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 ineffective-

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

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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.

Neil Phillips

Homer
Volunteer
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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 =

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

We need a Statewide Policy

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 fata' 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, CFR 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
etc Dr. Raymond J Paul 235-7000
etc Judy Galhorn 2297-7200
etc. Cheryl Painter @ Fire Hall 235-2000*

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
Volunteer
Fire
Department

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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

'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-resuscitate orders is growing. **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 sup-

ported 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.

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 statute; 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 protocols 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,⁴ and the issue has been discussed in the prehospital literature.⁵⁻⁷ Similarly, the issue has been addressed in the medical ethics literature⁴ 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 Puerto Rico. The survey asked if the state legislature had passed a bill to allow DNR orders in the prehospital setting. If a bill had been considered, the 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 |

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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. | |

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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 cur-

rently 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 good faith.

Idaho: Do-not-resuscitate mechanisms are being discussed 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 req.

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 reported. 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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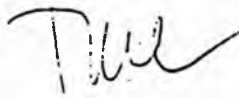
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MEMORANDUM

March 4, 1994

SUBJECT: Sectional Summary of HB 356. (An Act relating to living wills and do not resuscitate orders)

TO: Representative Cynthia Toohey, Co-Chair
Representative Con Bunde, Co-Chair
House Health, Education & Social Services Committee

FROM: Terri Lauterbach
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

Since you have not asked any specific questions about the legal effect of this bill, this summary is short. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1.

Authorizes physicians to issue do not resuscitate (DNR) orders for their patients. Directs the Department of Health and Social Services, with the approval of the State Medical Board, to adopt protocols for withholding of cardiopulmonary resuscitation (CPR) by physicians and other health care providers. Requires that health care providers comply with the DNR protocols when presented with DNR identification, an oral order of a physician, or a written DNR order. Requires DHSS to develop designs for cards, necklaces, and bracelets that can be worn by persons for whom a DNR order has been issued.

Secs. 2 - 12.

Adds appropriate references to DNR orders and DNR identification throughout AS 18.12 so that they are treated the same way living wills are now treated under AS 18.12.

Representative Cynthia Toohey
Representative Con Bunde
March 4, 1994
Page 2

Secs. 13 - 15.

Provides effective dates in a manner that authorizes the regulations process to start immediately and delays the effective date of the rest of the bill until the regulations take effect.

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