HB

197

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: April 25, 2001 **FURTHER REFERRALS:**

Date of Committee Action: 4.10.02

The JUDICIARY Committee considered: **HB 197**

HOUSE BILL NO. 197 **HEALTH CARE SERVICES DIRECTIVES**

"An Act relating to directives for personal health care services and for medical treatment."

Recommends it be replaced with CS HB 197 (JUD) [ ] Same Title [✓] New Title

For Senate Bills with new title: [ ] *Technical Title* [ ] *New Title: HCR*_____

[ ] attach amendments

[ ] add new referral to _____ Committee

[ ] Letter of Intent _____ Committee

List of Abbrev. For Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LAA
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW FISCAL NOTES *For Chief Clerk's Office Use Only				
FN# *	List by Dept(s):	Fiscal	Indet.	Zero
	ALL			✓

PREVIOUS FISCAL NOTES				
List by Dept(s):	FN #	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	Berkowitz			✓	
	Meyer			✓	
	Coghill			✓	
	Davies			✓	
	Kookesh			✓	
Chair: Rokeberg	Rokeberg			✓	
Chair:					

Adopted as amended 4.10.02

22-LS0712\P.2
Bannister
4/9/02

AMENDMENT #1

OFFERED IN THE HOUSE

TO: CSHB 197(JUD), Draft Version "P"

Page 6, line 26, following "conscience":

Insert ", except for a do not resuscitate order"

Page 7, lines 18 - 22:

Delete all material and insert:

"**Sec. 13.52.060. Do not resuscitate protocol and identification requirements.** (a) An attending physician may issue a do not resuscitate order for a patient of the physician. The physician shall document the grounds for the order in the patient's medical file.

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

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

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

(e) Notwithstanding (d) of this section, if an individual has made a donation of a body part to occur at death and is in a hospital when a do not resuscitate order is to

be implemented for the individual, the do not resuscitate order may not be implemented until the donated body part can be evaluated to determine if it is suitable for donation.

(f) A physician may not revoke a do not resuscitate order at the request of a person, and a person may not make a do not resuscitate order ineffective, unless the person making the request or proposing to make the order ineffective is the person for whom the order has been issued. However, if the person for whom the order has been issued is not capable of expressing an opinion on the subject, the request or proposal may be made by

(1) the parent or guardian of the person for whom the order has been issued if the person for whom the order has been issued is under 18 years of age; or

(2) an agent, guardian, or surrogate of the person for whom the order has been issued to whom the person for whom the order has been issued has communicated the decision to make the order ineffective."

Page 8, line 4:

Delete "or"

Page 8, line 6, following "terminated":

Insert ";

(4) participating in the withholding or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures under the direction or with the authorization of a physician or upon discovery of do not resuscitate identification upon an individual; or

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

(A) under AS 13.52.060(e) when an individual has made a donation of a body part; or

(B) because an individual has made a do not resuscitate order ineffective under AS 13.52.060(f) or another provision of this chapter."

Page 8, following line 25:

Amendment to Amend #1

Insert a new subsection to read: who is a qualified patient

"(c) An individual, including an individual for whom a physician has issued a do not resuscitate order, has the right to make a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures as long as the individual is able to make the decision. If an individual, including an individual for whom a physician has issued a do not resuscitate order, is not able to make the decision, the protocol adopted under AS 13.52.060 for do not resuscitate orders governs a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures."

Page 9, lines 1 - 4:

Delete all material and insert:

"(b) Notwithstanding any other provision of law, if the withholding or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures is consistent with this chapter, death resulting from the withholding or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures under a do not resuscitate order, under the protocol for do not resuscitate orders established under AS 13.52.060, or under a do not resuscitate identification found on an individual does not, for any purpose, constitute a suicide or homicide.

(c) The issuance of a do not resuscitate order under this chapter, the possession of do not resuscitate identification under this chapter, or the making of a health care directive under this chapter does not affect in any manner the sale, procurement, or issuance of a policy of life insurance, and does not 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 individual or the withholding or withdrawal of cardiopulmonary resuscitation from an individual who possesses do not resuscitate identification or for whom a do not resuscitate order has been issued, notwithstanding any term of the policy to the contrary.

(d) This chapter does not create a presumption concerning the intention or

intended treatment of an individual who does not have do not resuscitate identification, has not executed a health care directive, or for whom a do not resuscitate order has not been issued with respect to the use, withholding, or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures.

(e) This chapter does not increase or decrease the right of an individual to make decisions regarding the use of cardiopulmonary resuscitation or other life-sustaining procedures as long as the individual is able to do so, and does not impair or supersede any right or responsibility that a person has to effect the withholding or withdrawal of medical care in a lawful manner."

Reletter the following subsections accordingly.

Page 9, following line 17:

Insert a new section to read:

"**Sec. 13.52.125. Prohibited requirements.** As a condition of receiving or being insured for health care services, a health care provider, a health care institution, a health care service plan, an insurer issuing health insurance, a self-insured employee welfare benefit plan, or a nonprofit hospital plan may not require an individual to execute a health care directive, obtain a do not resuscitate order from a physician, or possess do not resuscitate identification."

Page 9, following line 25:

Insert a new section to read:

"**Sec. 13.52.145. Do not resuscitate orders and identification of other jurisdictions.** A do not resuscitate order or a do not resuscitate identification executed, issued, or authorized in another state or a territory or possession of the United States in compliance with the law of that jurisdiction is effective for the purposes of this chapter."

Page 9, line 31, following "form":

Insert "or otherwise complies with this chapter"

Page 10, line 9, following "form":

Insert "or otherwise complies with the requirements of AS 13.52"

Page 13, line 23, following "want.":

Insert "There is a state protocol that governs the use of do not resuscitate orders by physicians and other health care providers. You may obtain a copy of the protocol from the state Department of Health and Social Services."

Page 18, following line 31:

Insert new paragraphs to read:

"(6) "department" means the Department of Health and Social Services;

(7) "do not resuscitate identification" means an identification card, form, necklace, or bracelet that carries the standardized design or symbol developed by the department under AS 13.52.060 to signify, when carried or worn, that the carrier or wearer is an individual for whom a physician has issued a do not resuscitate order;"

Renumber the following paragraphs accordingly.

Page 27, line 13:

Delete "AS 13.52.120(b)"

Insert "AS 13.52.120(c)"

Page 27, following line 20:

Insert a new bill section to read:

"* **Sec. 18.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONTINUING EFFECT OF CURRENT REGULATIONS. (a) The regulations found at 7 AAC 16, as modified by (b) of this section, continue in effect on and after

January 1, 2003, until the Department of Health and Social Services adopts the regulations authorized under sec. 17 of this Act.

(b) The regulations attorney in the Department of Law shall

(1) in 7 AAC 16.010(a), replace the reference to "AS 18.12.035(b)" with "AS 13.52.060(b)";

(2) in 7 AAC 16.010(d)(4), replace the reference to "AS 18.12.090" with "AS 13.52.145";

(3) in 7 AAC 16.010(f), replace the reference to "AS 18.12" with "AS 13.52";

(4) in 7 AAC 16.090(1), replace the reference to "AS 18.12.100" with "AS 13.52.190";

(5) in 7 AAC 16.090(3), replace ""do-not-resuscitate order" in AS 18.12.100" with ""do not resuscitate order" in AS 18.12.190."

Renumber the following bill sections accordingly.

Page 27, line 22:

Delete "Sec. 18"

Insert "Sec. 19"

STATE OF ALASKA

Department of Health & Social Services
Division of Public Health
Section of Community Health and Emergency Medical Services

TONY KNOWLES, GOVERNOR

P.O. Box 110616
Juneau, Alaska 99811-0616

Telephone: (907) 465-3027
Telefax: (907) 465-4101

April 10, 2002

Representative Norman Rokeberg
Room 118 State Capitol
Juneau, AK 99801-1182

RE: CSHB 197(JUD), Draft Version "P": 22-LS0712\P (3/20/02) and
Amendment P.2: 22-LS0712\P.2 (4/9/02)

Dear Representative Rokeberg;

On behalf of the Section of Community Health and Emergency Medical Services, Division of Public Health, Alaska Dept. of Health and Social Services, I would like to express support for CS HB 197(p) and Amendment P.2. The intention of the bill is to provide a mechanism for advance planning for end-of-life care and to carry out a patient's wishes when the patient is no longer able to speak for himself or herself. Emergency Medical Services providers seek to save lives but not to prolong the suffering of terminally-ill patients, and we support the goal of this bill to provide as much autonomy as possible for patients and families in arranging for humane and compassionate end-of-life care.

We have worked closely with the sponsor to evaluate the effects of the bill on the existing Comfort One Do Not Resuscitate Program which we feel is working and would like to continue. There is one change we would like to see made to the bill which I believe is supported by the Sponsor. Amendment P.2 (4/9/02) on page 3, starting at line 3 states:
"(c) An individual, including an individual for whom a physician has issued a do not resuscitate order, has the right to make a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures as long as the individual is able to make the decision."

The problem with the first use of the word "individual" in section (c) is that it would allow a person who is not otherwise terminally ill to refuse life-saving treatment, such as a young person who has attempted suicide and wishes to refuse life-saving treatment. We don't believe this is consistent with the goal of the bill to provide for autonomy in end-of life decisions. Existing law reads "A **qualified patient** or a patient for whom a physician has issued a do not resuscitate order...." The term "qualified patient" is defined in AS 18.12.100(11) and is retained in CSHB 197 in proposed section 13.52.190(6)(A) as "a terminal condition," which is further defined in 13.52.190(6)(B). A suggestion for amending the provision would be to state, "An individual who is a qualified patient, including an individual for whom a physician has issued a do not

resuscitate order, has the right to make a decision regarding the use of cardiopulmonary resuscitation...."

Thank you for the opportunity to comment on this important legislation.

Sincerely,

Shelley K. Owens
Health Program Manager

22-LS0712\P
Bannister
3/20/02

Adopted 4-10-02

CS FOR HOUSE BILL NO. 197(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES HUDSON, Kerttula, Crawford, Lancaster

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care decisions, including do not resuscitate orders and the donation of body parts, and to powers of attorney relating to health care, including the donation of body parts; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

PURPOSE. A principal purpose of this Act is to provide a comprehensive coordinated approach to the making of health care decisions, including the donation of body parts. To achieve this purpose, this Act repeals the current statutory devices that cover health care decisions and consolidates the subject into one chapter.

*** Sec. 2.** AS 12.65.100 is amended to read:

Sec. 12.65.100. Unclaimed bodies. When a person dies and no person appears to claim the body for burial, and no provision is made for the body under **AS 13.52** [AS 13.50], the Department of Health and Social Services, upon

notification, shall request a court order authorizing the body to be plainly and decently buried or cremated and the remains decently interred. A judicial officer shall issue the requested order upon the sworn testimony or statement of a representative of the Department of Health and Social Services that a person has not appeared to claim the body for burial and provision is not made for the body under **AS 13.52** [AS 13.50].

*** Sec. 3.** AS 13 is amended by adding a new chapter to read:

Chapter 52. Health Care Decisions Act.

Sec. 13.52.010. Advance health care directives. (a) An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(b) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health care decision the principal could have made while having capacity. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. The power must be in writing, contain the date of its execution, be signed by the principal, and be witnessed by one of the following methods:

(1) signed by at least two individuals, each of whom witnessed either the signing of the instrument by the principal or the principal's acknowledgment of the signature of the instrument; or

(2) acknowledged before a notary public at a place in this state.

(c) Unless related to the principal by blood, marriage, or adoption, an agent under a power of attorney for health care may not be an owner, operator, or employee of the health care institution at which the principal is receiving care.

(d) A witness for a power of attorney for health care may not be

(1) a health care provider;

(2) an employee of a health care provider or facility; or

(3) the agent.

(e) At least one of the individuals used as a witness for a power of attorney for health care shall be someone who is not

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

(2) entitled to a portion of the estate of the principal upon the principal's death under a will or codicil of the principal existing at the time of execution of the power of attorney for health care or by operation of law then existing.

(f) Unless otherwise specified in the power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity and ceases to be effective upon a determination that the principal has recovered capacity.

(g) Unless otherwise specified in a written advance health care directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, shall be made by the primary physician.

(h) An agent shall make a health care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

(i) A health care decision made by an agent for a principal is effective without judicial approval.

(j) A written advance health care directive may include the individual's nomination of a guardian of the person.

(k) An advance health care directive is valid for purposes of this chapter if it complies with this chapter or if it was executed in compliance with the laws of the state where it was executed.

Sec. 13.52.020. Revocation of advance health care directive. (a) An individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

(b) An individual may revoke all or part of an advance health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(c) A health care provider, agent, guardian, or surrogate who is informed of a

revocation shall promptly communicate the fact of the revocation to the supervising health care provider and to any health care institution at which the patient is receiving care.

(d) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care.

(e) An advance health care directive that conflicts with an earlier advance health care directive revokes the earlier directive to the extent of the conflict.

Sec. 13.52.030. Decisions by surrogate. (a) A surrogate may make a health care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and an agent or guardian has not been appointed or the agent or guardian is not reasonably available.

(b) An adult or emancipated minor may designate an individual to act as surrogate by personally informing the supervising health care provider. In the absence of a designation, or if the designee is not reasonably available, a member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

(1) the spouse, unless legally separated;

(2) an adult child;

(3) a parent; or

(4) an adult sibling.

(c) If none of the individuals eligible to act as surrogate under (b) of this section is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate.

(d) A surrogate shall communicate the surrogate's assumption of authority as promptly as practicable to the members of the patient's family specified in (b) of this section who can be readily contacted.

(e) If more than one member of a class under (b)(2) - (4) of this section assumes authority to act as surrogate, the members of that class do not agree on a health care decision, and the supervising health care provider is informed of the

disagreement, the supervising health care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the class is evenly divided concerning the health care decision and the supervising health care provider is informed of the even division, that class and all individuals having a lower priority under (b)(2) - (4) of this section are disqualified from making the decision.

(f) A surrogate shall make a health care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

(g) A health care decision made by a surrogate for a patient is effective without judicial approval.

(h) An individual may, at any time, disqualify another person, including a member of the individual's family, from acting as the individual's surrogate by a signed writing or by personally informing the supervising health care provider of the disqualification.

(i) Unless related to the patient by blood, marriage, or adoption, a surrogate may not be an owner, operator, or employee of a residential long-term health care institution at which the patient is receiving care.

(j) A supervising health care provider may require an individual claiming the right to act as a surrogate for a patient to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

Sec. 13.52.040. Decisions by guardian. (a) A guardian shall comply with the ward's individual instructions and may not revoke a ward's advance health care directive executed before the ward's incapacity unless expressly authorized by a court.

(b) Unless there is a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.

(c) Except as provided in (a) of this section, a health care decision made by a

guardian for the ward is effective without judicial approval.

Sec. 13.52.050. Obligations of health care provider. (a) Before implementing a health care decision made for a patient, a supervising health care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision.

(b) A supervising health care provider who knows of the existence of an advance health care directive, a revocation of an advance health care directive, or a designation or disqualification of a surrogate shall promptly record its existence in the patient's health care record, shall request a copy if it is in writing, and shall arrange for its maintenance in the health care record if a copy is furnished.

(c) A supervising health care provider who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, a guardian, or a surrogate, shall promptly record the determination in the patient's health care record and communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patient.

(d) Except as provided in (e) and (f) of this section, a health care provider or institution providing care to a patient shall comply with

(1) an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and

(2) a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

(e) A health care provider may decline to comply with an individual instruction or a health care decision for reasons of conscience. A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is contrary to a policy of the institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

(f) A health care provider or institution may decline to comply with an

individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

(g) A health care provider or institution that declines to comply with an individual instruction or a health care decision shall

(1) promptly inform the patient, if possible, and any person then authorized to make health care decisions for the patient that the provider or institution has declined to comply with the instruction or decision;

(2) provide continuing care to the patient until a transfer is effected; and

(3) unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.

(h) A health care provider or institution may not require or prohibit the execution or revocation of an advance health care directive as a condition for providing health care.

Sec. 13.52.060. Do not resuscitate protocol. The Department of Health and Social Services shall by regulation adopt a protocol for do not resuscitate orders that sets out a standardized method of procedure for the withholding of cardiopulmonary resuscitation by health care providers and health care institutions. The regulations may not be adopted unless they have been approved by the State Medical Board.

Sec. 13.52.070. Health care information. Unless otherwise specified in an advance health care directive, a person then authorized to make health care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or other health care information.

Sec. 13.52.080. Immunities. (a) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for

(1) complying with a health care decision of a person apparently

having authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;

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

(3) complying with an advance health care directive and assuming that the directive was valid when made and has not been revoked or terminated.

(b) An individual acting as an agent, a guardian, or a surrogate under this chapter is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.

Sec. 13.52.090. Statutory damages. (a) A health care provider or institution that intentionally violates this chapter is liable to the aggrieved individual or the individual's estate for damages of $500 or actual damages resulting from the violation, whichever is greater, plus attorney fees as provided by court rule.

(b) A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health care directive or a revocation of an advance health care directive without the individual's consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health care directive, is liable to that individual for damages of $2,500 or actual damages resulting from the action, whichever is greater, plus attorney fees as provided by court rule.

Sec. 13.52.100. Capacity. (a) This chapter does not affect the right of an individual to make health care decisions while having capacity to make health care decisions.

(b) An individual is rebuttably presumed to have capacity to make a health care decision, to give or revoke an advance health care directive, and to designate or disqualify a surrogate.

Sec. 13.52.110. Status of copy. A copy of a written advance health care directive, revocation of an advance health care directive, or designation or disqualification of a surrogate has the same effect as the original.

Sec. 13.52.120. Effect of this chapter. (a) This chapter does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance health care directive.

(b) Death resulting from the withholding or withdrawal of health care under this chapter does not, for any purpose, constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity to the contrary.

(c) This chapter does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this state.

(d) This chapter does not authorize or require a health care provider or institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or institution.

(e) This chapter does not authorize an agent or a surrogate to consent to the admission of an individual to a mental health facility unless the individual's written advance health care directive expressly so provides.

(f) This chapter does not affect other statutes of this state governing treatment for mental illness of an individual involuntarily committed to a mental health facility.

(g) In this section, "mental health facility" has the meaning given to "designated treatment facility" in AS 47.30.915.

Sec. 13.52.130. Judicial relief. On petition of a patient, the patient's agent, guardian, or surrogate, or a health care provider or institution involved with the patient's care, the superior court may enjoin or direct a health care decision or order other equitable relief. A proceeding under this section is governed by AS 13.26.165 - 13.26.320.

Sec. 13.52.140. Uniformity of application and construction. This chapter shall be applied and construed to carry out its general purpose to make uniform the law with respect to the subject of this chapter among states enacting it.

Sec. 13.52.150. Optional form. The following sample form may be used to create an advance health care directive. The other sections of this chapter govern the effect of this or any other writing used to create an advance health care directive. This form may be duplicated. This form may be modified to suit the needs of the person, or a completely different form may be used that contains the substance of the following form:

ADVANCE HEALTH CARE DIRECTIVE

Explanation

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

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as an agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You do not have to limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to

(a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;

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

(c) approve or disapprove diagnostic tests, surgical procedures, programs of medication, and do not resuscitate orders; and

(d) direct the provision, withholding, or withdrawal of artificial

nutrition and hydration and all other forms of health care; and

(e) donate your body parts at your death.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your body parts following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

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

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

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

_____

(name of individual you choose as agent)

_____

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

_____ _____

(home phone) (work phone)

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

_____

(name of individual you choose as first alternate agent)

_____

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

_____

(home phone) (work phone)

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

_____

(name of individual you choose as second alternate agent)

_____ _____

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

_____

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my

primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

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

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

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you do not need to fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Check only one box.)

[ ] (A) Choice To Prolong Life

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

[ ] (B) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time; (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or (iii) the likely risks and burdens of treatment would outweigh the expected benefits.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: If I mark this box [ ], I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that

_____

_____

(Add additional sheets if needed.)

PART 3

DONATION OF BODY PARTS AT DEATH

(OPTIONAL)

If you are satisfied to allow your agent to determine whether to donate your body parts at your death, you do not need to fill out this part of the form.

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

[ ] (A) I give any needed organs, tissues, or

other body parts, OR

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

_____

[ ] (C) My gift is for the following purposes (strike any of the following you do not want):

(i) transplant;

(ii) therapy;

(iii) research;

(iv) education;

PART 4

PRIMARY PHYSICIAN

(OPTIONAL)

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

_____

(name of physician)

_____

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

_____

(phone)

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

_____

(name of physician)

_____

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

_____

(phone)

(12) EFFECT OF COPY: A copy of this form has the

same effect as the original.

(13) SIGNATURES: Sign and date the form here:

_____ _____

(date) (sign your name)

_____ _____

(address) (print your name)

_____

(city) (state)

(14) WITNESSES: This power of attorney will not be valid for making health care decisions unless it is

(A) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or

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

ALTERNATIVE NO. 1

Witness

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health care provider or an employee of a health care provider or facility. 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.

_____ _____

(date) (signature of witness)

_____ _____

(address) (printed name of witness)

_____

(city) (state)

Witness

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health care provider, or an employee of a health care provider or facility. 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.

_____ _____

(date) (signature of witness)

_____ _____

(address) (printed name of witness)

_____

(city) (state)

ALTERNATIVE NO. 2

State of Alaska

_____ Judicial District

On this ____ day of _____, in the year _____, before me, _____ (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that the person executed it.

Notary Seal

_____

(Signature of Notary Public)

Sec. 13.52.190. Definitions. In this chapter, unless the context otherwise requires,

(1) "advance health care directive" means an individual instruction or a power of attorney for health care;

(2) "agent" means an individual designated in a power of attorney for health care to make a health care decision for the individual granting the power;

(3) "best interest" means that the benefits to the individual resulting from a treatment outweigh the burdens to the individual resulting from that treatment and includes

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

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

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

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

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

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

(G) the religious beliefs and basic values of the individual receiving treatment, to the extent that these may assist in determining benefits and burdens;

(4) "capacity" means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision;

(5) "cardiopulmonary resuscitation" means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation;

(6) "do not resuscitate order" means a directive from a licensed physician that emergency cardiopulmonary resuscitation should not be administered to a qualified patient; in this paragraph,

(A) "qualified patient" means a patient who has been determined by the attending physician to be in a terminal condition;

(B) "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; in this subparagraph, "life-sustaining procedures" means medical procedures or interventions that, when administered to a qualified patient, will serve only to prolong the dying process;

(7) "emancipated minor" means a minor whose disabilities have been removed under AS 09.55.590 or who has arrived at the age of majority as determined under AS 25.20.020;

(8) "generally accepted health care standards" includes the protocol for do not resuscitate orders that is adopted under AS 13.52.060;

(9) "guardian" means a judicially appointed guardian or conservator having authority to make a health care decision for an individual;

(10) "health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition, including

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

(B) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and do not resuscitate orders;

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

(D) donation of body parts at death.

(11) "health care decision" means a decision made by an individual or the individual's agent, guardian, or surrogate regarding the individual's health care;

(12) "health care institution" means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business;

(13) "health care provider" means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession;

(14) "individual instruction" means an individual's direction concerning a health care decision for the individual;

(15) "person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, instrumentality, or another legal or commercial entity;

(16) "physician" means an individual authorized to practice medicine or osteopathy under AS 08.64;

(17) "power of attorney for health care" means the designation of an agent to make health care decisions for the individual granting the power;

(18) "primary physician" means a physician designated by an individual, or by the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility;

(19) "reasonably available" means able to be contacted with a level of diligence appropriate to the seriousness and urgency of a patient's health care needs, and willing and able to act in a timely manner considering the urgency of the patient's health care needs;

(20) "state" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States;

(21) "supervising health care provider" means the primary physician or

the physician's designee, or the health care provider or the provider's designee who has undertaken primary responsibility for an individual's health care;

(22) "surrogate" means an individual, other than a patient's agent or guardian, authorized under this chapter to make a health care decision for the patient.

Sec. 13.52.195. Short title. This chapter may be cited as the Health Care Decisions Act.

* **Sec. 4.** AS 18.65.311 is amended to read:

Sec. 18.65.311. Donation of body parts [ANATOMICAL GIFT OR LIVING WILL DOCUMENT]. (a) The department shall provide, at the time that an identification card is issued, a form for a document by which the card holder may make **a donation of body parts** [AN ANATOMICAL GIFT] under **AS 13.52** [AS 13.50 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER AS 18.12 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)]. The document (1) may not be larger than an identification card, (2) must contain sufficient space for the signature of two witnesses [OR A PERSON WHO IS QUALIFIED TO TAKE ACKNOWLEDGMENTS UNDER AS 09.63.010], **and** (3) [MUST USE THE FORMS AND DESIGNS DEVELOPED UNDER AS 18.12.037, AND (4)] must provide a means by which the card holder may cancel the gift [OR THE LIVING WILL]. If the document is executed by the applicant, it shall be sealed in plastic and attached to the identification card. [A SYMBOL DEVELOPED UNDER AS 18.12.037 INDICATING THE EXISTENCE OF THE ANATOMICAL GIFT OR LIVING WILL DOCUMENT MUST BE DISPLAYED IN THE LOWER RIGHT-HAND CORNER ON THE FACE OF THE IDENTIFICATION CARD.]

(b) An employee of the department who processes an identification card application, other than an application received by mail, shall ask the applicant orally whether the applicant wishes to execute **a donation of body parts** [AN ANATOMICAL GIFT OR A LIVING WILL]. The department shall, by placement of posters and brochures in the office where the application is taken, and by oral advice, if requested, make known to the applicant the procedure necessary to execute a **donation of body parts** [GIFT] under **AS 13.52** [AS 13.50 OR A LIVING WILL UNDER AS 18.12].

* **Sec. 5.** AS 28.10.021(c) is amended to read:

(c) An employee of the department who processes an application for registration or renewal of registration, other than an application received by mail or an application for registration under AS 28.10.152, shall ask the applicant orally whether the applicant wishes to execute **a donation of body parts** [AN ANATOMICAL GIFT OR A LIVING WILL]. The department shall make known to all applicants the procedure for executing a **donation of body parts** [GIFT] under **AS 13.52 (Health Care Decisions Act)** [AS 13.50 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER AS 18.12 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)] by displaying posters in the offices in which applications are taken, by providing a brochure or other written information to each person who applies in person or by mail, and, if requested, by providing oral advice.

* **Sec. 6.** AS 28.15.061(d) is amended to read:

(d) An employee of the department who processes a driver's license application, other than an application received by mail, shall ask the applicant orally whether the applicant wishes to execute **a donation of body parts** [AN ANATOMICAL GIFT OR A LIVING WILL]. The department shall make known to all applicants the procedure for executing a **donation of body parts** [GIFT] under **AS 13.52 (Health Care Decisions Act)** [AS 13.50 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER AS 18.12 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)] by displaying posters in the offices in which applications are taken, by providing a brochure or other written information to each person who applies in person or by mail, and, if requested, by providing oral advice.

* **Sec. 7.** AS 28.15.111(b) is amended to read:

(b) The department shall provide, at the time that an operator's license is issued, a form for a document by which the owner of a license may make **a donation of body parts** [AN ANATOMICAL GIFT] under **AS 13.52** [AS 13.50 OR A LIVING WILL UNDER AS 18.12]. The document (1) may not be larger than an operator's license, (2) must contain sufficient space for the signature of two witnesses [OR A PERSON WHO IS QUALIFIED TO TAKE ACKNOWLEDGMENTS UNDER AS 09.63.010], **and** (3) [MUST USE THE FORMS AND DESIGNS DEVELOPED

UNDER AS 18.12.037, AND (4)] must provide a means by which the owner may cancel the **donation** [GIFT OR THE LIVING WILL]. If the document is executed by the applicant, it shall be sealed in plastic and attached to the license. [A SYMBOL DEVELOPED UNDER AS 18.12.037 INDICATING THE EXISTENCE OF THE ANATOMICAL GIFT OR LIVING WILL DOCUMENT MUST BE DISPLAYED IN THE LOWER RIGHT-HAND CORNER ON THE FACE OF THE DRIVER'S LICENSE.]

* **Sec. 8.** AS 47.30.825(b) is amended to read:

(b) The patient and the following persons, at the request of the patient, are entitled to participate in formulating the patient's individualized treatment plan and to participate in the evaluation process as much as possible, at minimum to the extent of requesting specific forms of therapy, inquiring why specific therapies are or are not included in the treatment program, and being informed as to the patient's present medical and psychological condition and prognosis: (1) the patient's counsel, (2) the patient's guardian, (3) a mental health professional previously engaged in the patient's care outside of the evaluation facility or designated treatment facility, (4) a representative of the patient's choice, (5) a person designated as the patient's **agent or surrogate** [ATTORNEY-IN-FACT] with regard to mental health treatment decisions under **AS 13.52** [AS 13.26.332 - 13.26.358, AS 47.30.950 - 47.30.980, OR OTHER POWER-OF-ATTORNEY], and (6) the adult designated under AS 47.30.725. The mental health care professionals may not withhold any of the information described in this subsection from the patient or from others if the patient has signed a waiver of confidentiality or has designated the person who would receive the information as an **agent or surrogate under AS 13.52** [ATTORNEY-IN-FACT] with regard to mental health treatment.

* **Sec. 9.** AS 47.30.825(f) is amended to read:

(f) A patient capable of giving informed consent has the absolute right to accept or refuse electroconvulsive therapy or aversive conditioning. A patient who lacks substantial capacity to make this decision may not be given this therapy or conditioning without a court order unless the patient expressly authorized that particular form of treatment in **an advance health care directive** [A

DECLARATION] properly executed under **AS 13.52** [AS 47.30.950 - 47.30.980] or has authorized an **agent or surrogate under AS 13.52** [ATTORNEY-IN-FACT] to make this decision and the **agent or surrogate** [ATTORNEY-IN-FACT] consents to the treatment on behalf of the patient.

*** Sec. 10.** AS 47.30.836 is amended to read:

Sec. 47.30.836. Psychotropic medication in nonemergencies. An evaluation facility or designated treatment facility may not administer psychotropic medication to a patient in a situation that does not involve a crisis under AS 47.30.838(a)(1) unless the patient

(1) has the capacity to give informed consent to the medication, as described in AS 47.30.837, and gives that consent; the facility shall document the consent in the patient's medical chart;

(2) authorized the use of psychotropic medication in **an advance health care directive** [A DECLARATION] properly executed under **AS 13.52** [AS 47.30.950 - 47.30.980] or authorized an **agent or surrogate under AS 13.52** [ATTORNEY-IN-FACT] to consent to the use of psychotropic medication for the patient and the **agent or surrogate** [ATTORNEY-IN-FACT] does consent; or

(3) is determined by a court to lack the capacity to give informed consent to the medication and the court approves use of the medication under AS 47.30.839.

*** Sec. 11.** AS 47.30.838(d) is amended to read:

(d) An evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent if the patient is unable to give informed consent but has authorized the use of psychotropic medication in **an advance health care directive** [A DECLARATION] properly executed under **AS 13.52** [AS 47.30.950 - 47.30.980] or has authorized an **agent or surrogate under AS 13.52** [ATTORNEY-IN-FACT] to consent to this form of treatment for the patient and the **agent or surrogate** [ATTORNEY-IN-FACT] does consent.

*** Sec. 12.** AS 47.30.839(d) is amended to read:

(d) Upon the filing of a petition under (b) of this section, the court shall direct

the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

(1) the patient's responses to a capacity assessment instrument administered at the request of the visitor;

(2) any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, **an advance health care directive under AS 13.52,** or oral statements of the patient, including conversations with relatives and friends that are significant persons in the patient's life as those conversations are remembered by the relatives and friends; oral statements of the patient should be accompanied by a description of the circumstances under which the patient made the statements, when possible.

* **Sec. 13.** AS 47.33.070(a) is amended to read:

(a) An assisted living home shall maintain, for each resident of the home, a file that includes

(1) the name and birth date, and, if provided by the resident, the social security number of the resident;

(2) the name, address, and telephone number of the resident's closest relative, service coordinator, if any, and representative, if any;

(3) a statement of what actions, if any, the resident's representative is authorized to take on the resident's behalf;

(4) a copy of the resident's assisted living plan;

(5) a copy of the residential services contract between the home and the resident;

(6) a notice, as required under AS 47.33.030, regarding the depository in which the resident's advance payment money is being held;

(7) written **acknowledgment** [ACKNOWLEDGEMENT] by the resident or the resident's representative that the resident has received a copy of and has read, or has been read the

(A) resident's rights under AS 47.33.300;

(B) resident's right to pursue a grievance under AS 47.33.340;

(C) resident's right to protection from retaliation under AS 47.33.350;

(D) provisions of AS 47.33.510, regarding immunity; and

(E) home's house rules;

(8) an **acknowledgment** [ACKNOWLEDGEMENT] and agreement relating to home safekeeping and management of the resident's money, as required by AS 47.33.040;

(9) a copy of the resident's living will, if any**, or an advance health care directive made under AS 13.52, if any**; and

(10) a copy of a power of attorney or other written designation**, including an advance health care directive made under AS 13.52,** of an agent, representative, or surrogate by the resident.

*** Sec. 14.** AS 13.26.332(L), 13.26.335(1), 13.26.344(l); AS 13.50.010, 13.50.014, 13.50.016, 13.50.020, 13.50.030, 13.50.040, 13.50.050, 13.50.060, 13.50.065, 13.50.068, 13.50.070, 13.50.080, 13.50.090; AS 18.12.010, 18.12.020, 18.12.030, 18.12.035, 18.12.037, 18.12.040, 18.12.050, 18.12.060, 18.12.070, 18.12.080, 18.12.090, 18.12.100; AS 47.30.950, 47.30.952, 47.30.954, 47.30.956, 47.30.958, 47.30.960, 47.30.962, 47.30.964, 47.30.966, 47.30.968, 47.30.970, 47.30.972, and 47.30.980 are repealed.

*** Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONTINUING EFFECT OF EXISTING DOCUMENTS. (a) A donation of body parts made under AS 13.50 or AS 18.12, repealed by sec. 14 of this Act, before the effective date of secs. 1 - 14 of this Act continues in effect under AS 13.50 or AS 18.12, as those chapters exist before the effective date of secs. 1 - 14 of this Act, until the donation is revoked.

(b) A power of attorney that is made under AS 13.26.332(L), 13.26.335(1), or 13.26.344(l), repealed by sec. 14 of this Act, before the effective date of secs. 1 - 14 of this Act and that contains authority for health care services under AS 13.26.332(L), AS 13.26.335(1), or 13.26.344(l), repealed by sec. 14 of this Act, continues in effect under

AS 13.26.332(L), 13.26.335(1), and 13.26.344(l), as those provisions exist before the effective date of secs. 1 - 14 of this Act, until the power of attorney is revoked.

(c) A declaration made under AS 18.12, repealed by sec. 14 of this Act, before the effective date of secs. 1 - 14 of this Act continues in effect under AS 18.12, as that chapter exists before the effective date of secs. 1 - 14 of this Act, until the declaration is revoked.

(d) A declaration made under AS 47.30.950 - 47.30.980, repealed by sec. 14 of this Act, before the effective date of secs. 1 - 14 of this Act continues in effect under AS 47.30.950 - 47.30.980, as those sections exist before the effective date of secs. 1 - 14 of this Act, until the declaration is revoked.

* **Sec. 16.** The uncodified law of the State of Alaska is amended by adding a new section to read:

EFFECT ON EXISTING INSURANCE POLICIES AND ANNUITIES. AS 13.52.120(b), added by sec. 3 of this Act, does not apply to a policy of insurance or an annuity that was entered into before the effective date of secs. 1 - 14 of this Act.

* **Sec. 17.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by secs. 1 - 14 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before January 1, 2003.

* **Sec. 18.** Section 17 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 19.** Except as provided in sec. 18 of this Act, this Act takes effect January 1, 2003.

Moved by Rep. Coghill
Adopted — 3.20.02

22-LS0712\O.1
Bannister
3/20/02

AMENDMENT #1

OFFERED IN THE HOUSE

TO: CSHB 197( ), Draft Version "O"

Page 7, line 19:

Delete "do not resuscitate protocol"

Insert "protocol for do not resuscitate orders"

Page 10, line 30:

Delete "orders not to resuscitate"

Insert "do not resuscitate orders"

Page 18, following line 29:

Insert new paragraphs to read:

"(4) "cardiopulmonary resuscitation" means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation;

(5) "do not resuscitate order" means a directive from a licensed physician that emergency cardiopulmonary resuscitation should not be administered to a qualified patient; in this paragraph,

(A) "qualified patient" means a patient who has been determined by the attending physician to be in a terminal condition;

(B) "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; in this subparagraph, "life-sustaining procedures" means medical procedures or interventions that, when

administered to a qualified patient, will serve only to prolong the dying process; "

Renumber the following paragraphs accordingly.

Page 19, lines 2 - 3:

Delete "do not resuscitate protocol"

Insert "protocol for do not resuscitate orders that is"

Page 19, line 12:

Delete "orders not to resuscitate"

Insert "do not resuscitate orders"

STATE OF ALASKA

Department of Health & Social Services
Division of Public Health
Section of Community Health and Emergency Medical Services

TONY KNOWLES, GOVERNOR

P.O. Box 110616
Juneau, Alaska 99811-0616

Telephone: (907) 465-3027
Telefax: (907) 465-4101

March 19, 2002

Melanie Lesh
Office of Rep. Bill Hudson
Room 502 State Capitol
Juneau, AK 99801-1182

RE: CS HB 197

Dear Melanie,

Thank you for meeting with Matt Anderson and me on March 13th to discuss how HB 197 interacts with the Comfort One Do-Not-Resuscitate (DNR) program. We found the meeting to be both enjoyable and helpful. During the meeting, you requested that we provide you with a written summary of our recommendations and concerns. They are found below.

1. Restoration of DNR statutory sections.

With the exception of AS 18.12.035(b), the DNR statutory provisions would be repealed, including the provision for entry of a DNR order by the attending physician, the requirement that a health care provider comply with a DNR order, and penalties for refusing to comply with a DNR order. We would like the language in the current DNR law to remain in place, to the greatest extent possible for reasons explained below in the Discussion section.

2. Restoration of definitions pertaining to DNR order (AS 18.12.100)

We would like the definitions contained in AS 18.12.100 to be retained in the bill, particularly the definitions of 'cardiopulmonary resuscitation,' 'qualified patient' and 'terminal condition.'

3. Deletion of the provisions which would seem to allow a health care provider to decline to comply with a do-not resuscitate order. (Sec. 13.52.050(e)-(g))

Discussion

Removal of the DNR sections from the bill would eliminate the requirement that a DNR order be the directive of a licensed physician. AS 18.12.100(6). This change in the statute would appear to allow a health care decision which includes a DNR order to be made by a competent patient, an agent, a guardian or a surrogate. This does not seem to be the intent of the Uniform Health-Care Decisions Act or CS HB 197. The definitions section defines "health care" to include the "approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and

orders not to resuscitate" (emphasis added). A lay advocate cannot order diagnostic tests, surgical procedures, or medication, and similarly, a DNR order is a power which should remain the authority of a physician.

Another and related concern is the elimination of the requirement that a DNR order be issued only for a terminally-ill ("qualified") patient. AS 18.12.100. If a physician is not involved in a decision to allow a life to extinguish without cardio-pulmonary resuscitation, the result could be that an ill or injured person who is under the influence of alcohol or drugs, mentally impaired due to a head injury or diabetic hypoglycemia, or suffering from suicidal depression, could refuse life-saving treatment for a treatable condition. In an extreme example, it is conceivable that an abusive spouse could refuse treatment on behalf of an incapacitated partner. Even terminally-ill patients change their minds about DNR orders and it is essential that a physician be involved to ensure that the decision to withhold resuscitation is medically-informed. We may be willing to support an expanded definition of a 'qualified patient' which lists certain medical conditions which are not necessarily classified as terminal illnesses, such as advanced Alzheimer's Disease, if diagnosed and approved by a physician.

The existing DNR law has protections for implementing the patient's wishes which may be lost by repealing the DNR sections of law, as provided for in the current draft of CS HB 197. AS 18.12.040 provides that a patient for whom a DNR order has issued has the right to make decisions regarding CPR as long as the patient is able to do so, and if the patient is not competent, the declaration (living will) or DNR protocol governs. This statutory provision is enhanced by Section 13.52.190(9)(B) in CS HB 197 which defines "health care" to include the right of a patient or proxy to approve or disapprove DNRs. Unfortunately, the provision in Section 13.52.050(e)-(g) authorizing a health care provider to decline to comply with a health care directive for reasons of conscience, when applied to a DNR could result in a medic arriving on scene and performing CPR on a patient who, through a DNR order has expressed the desire not to be resuscitated. This result would be contrary to the intent of the bill and it is important to recognize the unique demands of the pre-hospital environment in which the DNR program is applied. Instantaneous life and death decisions are made without the opportunity to transfer the patient to another care provider or seek a court order regarding health care directives, all good protections otherwise provided for in the bill but inapplicable to the pre-hospital emergency medical environment.

We support the goals of the bill to allow maximum autonomy for patients and families in expressing and implementing humane and compassionate end-of-life care. We are concerned, however, that by removing the role of the physician in establishing a do-not-resuscitate order, removing the requirement that a patient be terminally ill before a DNR can be entered, and allowing health care providers to decline to honor a health care directive that the Comfort One Do-Not-Resuscitate program would become ineffective.

Thank you for the opportunity to provide comments on this important bill.

Sincerely,

Shelley K. Owens
Health Program Manager

cc: Matt Anderson, EMS Unit Manager
Mark Johnson, MPA, Chief, Section of Community Health & EMS
Karen E. Pearson, MS, Director, Division of Public Health
Elmer Lindstrom, Deputy Commissioner, Dept. of Health & Social Services

BETHANN BOUDAH CHAPMAN
One Sealaska Plaza, Suite 202
Juneau, Alaska 99801
Bchapman@faulknerbanfield.com

March 20, 2002

Via Fax Only 465-2040

Norman Rokeberg, Chairman
House Judiciary Committee
Alaska State Legislature
M/S 3100, Room 118
Juneau, AK 99811

Re: HB 197

Dear Chairman Rokeberg:

I am writing in support of HB 197 regarding health care decisions. I am an attorney who practices extensively in the area of estate planning, including the drafting powers of attorney for health care. In my practice, more than 90% of my clients sign durable powers of attorney and living wills. While these documents are provided for under current law, I believe HB 197 will clarify the agent's power under a health care power of attorney, will allow an individual more freedom to set forth his or her wishes for health care treatment, and will minimize conflicts regarding an individual's medical treatment.

Under current law, an individual needs to sign a durable power of attorney, which includes the power to make health care decisions. In addition, an individual who wishes to express his or her wishes regarding life-sustaining measures must sign a living will. The failure to sign one document and not the other could lead to confusion. For example, an agent under a durable power of attorney cannot make decisions regarding life-sustaining measures unless the incapacitated person also signed a living will. Conversely, if an individual signs a living will, but not a durable power of attorney, then that person has not appointed any person to represent his or her interests to assure that the living will is, in fact, implemented, or to make other health care decisions. Incorporating these documents into one document will assure that individuals consider all issues involved with medical treatment and end-of-life decisions.

Furthermore, proposed Section 13.52.030, regarding decisions by a surrogate, is a vast improvement over current law and will allow family members to participate in health care decisions without the need for a guardianship.

I commend the Legislature for considering changes to Alaska law that will provide Alaskans more freedom in making known their wishes for health care, and that will allow family members to participate in health care decisions without the need for a guardianship. By adopting this law, Alaska will be taking a positive step, which will benefit all Alaskans.

Thank you for your consideration of my comments.

Sincerely,

BethAnn Boudah Chapman

c: Representative Bill Hudson
Representative Beth Kerttula
Representative Harry Crawford
Representative Ken Lancaster

BBC\pab

22-LS0712\O
Bannister
2/26/02

Adopted
3.20.02

CS FOR HOUSE BILL NO. 197( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES HUDSON, Kerttula, Crawford, Lancaster

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care decisions, including do not resuscitate orders and the donation of body parts, and to powers of attorney relating to health care, including the donation of body parts; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

PURPOSE. A principal purpose of this Act is to provide a comprehensive coordinated approach to the making of health care decisions, including the donation of body parts. To achieve this purpose, this Act repeals the current statutory devices that cover health care decisions and consolidates the subject into one chapter.

*** Sec. 2.** AS 12.65.100 is amended to read:

Sec. 12.65.100. Unclaimed bodies. When a person dies and no person appears to claim the body for burial, and no provision is made for the body under AS 13.52 [AS 13.50], the Department of Health and Social Services, upon

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

notification, shall request a court order authorizing the body to be plainly and decently buried or cremated and the remains decently interred. A judicial officer shall issue the requested order upon the sworn testimony or statement of a representative of the Department of Health and Social Services that a person has not appeared to claim the body for burial and provision is not made for the body under **AS 13.52** [AS 13.50].

*** Sec. 3.** AS 13 is amended by adding a new chapter to read:

Chapter 52. Health Care Decisions Act.

Sec. 13.52.010. Advance health care directives. (a) An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(b) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health care decision the principal could have made while having capacity. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. The power must be in writing, contain the date of its execution, be signed by the principal, and be witnessed by one of the following methods:

(1) signed by at least two individuals, each of whom witnessed either the signing of the instrument by the principal or the principal's acknowledgment of the signature of the instrument; or

(2) acknowledged before a notary public at a place in this state.

(c) Unless related to the principal by blood, marriage, or adoption, an agent under a power of attorney for health care may not be an owner, operator, or employee of the health care institution at which the principal is receiving care.

(d) A witness for a power of attorney for health care may not be

(1) a health care provider;

(2) an employee of a health care provider or facility; or

(3) the agent.

(e) At least one of the individuals used as a witness for a power of attorney for health care shall be someone who is not

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

(2) entitled to a portion of the estate of the principal upon the principal's death under a will or codicil of the principal existing at the time of execution of the power of attorney for health care or by operation of law then existing.

(f) Unless otherwise specified in the power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity and ceases to be effective upon a determination that the principal has recovered capacity.

(g) Unless otherwise specified in a written advance health care directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, shall be made by the primary physician.

(h) An agent shall make a health care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

(i) A health care decision made by an agent for a principal is effective without judicial approval.

(j) A written advance health care directive may include the individual's nomination of a guardian of the person.

(k) An advance health care directive is valid for purposes of this chapter if it complies with this chapter or if it was executed in compliance with the laws of the state where it was executed.

Sec. 13.52.020. Revocation of advance health care directive. (a) An individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

(b) An individual may revoke all or part of an advance health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(c) A health care provider, agent, guardian, or surrogate who is informed of a

revocation shall promptly communicate the fact of the revocation to the supervising health care provider and to any health care institution at which the patient is receiving care.

(d) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care.

(e) An advance health care directive that conflicts with an earlier advance health care directive revokes the earlier directive to the extent of the conflict.

Sec. 13.52.030. Decisions by surrogate. (a) A surrogate may make a health care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and an agent or guardian has not been appointed or the agent or guardian is not reasonably available.

(b) An adult or emancipated minor may designate an individual to act as surrogate by personally informing the supervising health care provider. In the absence of a designation, or if the designee is not reasonably available, a member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

(1) the spouse, unless legally separated;

(2) an adult child;

(3) a parent; or

(4) an adult sibling.

(c) If none of the individuals eligible to act as surrogate under (b) of this section is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate.

(d) A surrogate shall communicate the surrogate's assumption of authority as promptly as practicable to the members of the patient's family specified in (b) of this section who can be readily contacted.

(e) If more than one member of a class under (b)(2) - (4) of this section assumes authority to act as surrogate, the members of that class do not agree on a health care decision, and the supervising health care provider is informed of the

disagreement, the supervising health care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the class is evenly divided concerning the health care decision and the supervising health care provider is informed of the even division, that class and all individuals having a lower priority under (b)(2) - (4) of this section are disqualified from making the decision.

(f) A surrogate shall make a health care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

(g) A health care decision made by a surrogate for a patient is effective without judicial approval.

(h) An individual may, at any time, disqualify another person, including a member of the individual's family, from acting as the individual's surrogate by a signed writing or by personally informing the supervising health care provider of the disqualification.

(i) Unless related to the patient by blood, marriage, or adoption, a surrogate may not be an owner, operator, or employee of a residential long-term health care institution at which the patient is receiving care.

(j) A supervising health care provider may require an individual claiming the right to act as a surrogate for a patient to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

Sec. 13.52.040. Decisions by guardian. (a) A guardian shall comply with the ward's individual instructions and may not revoke a ward's advance health care directive executed before the ward's incapacity unless expressly authorized by a court.

(b) Unless there is a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.

(c) Except as provided in (a) of this section, a health care decision made by a

guardian for the ward is effective without judicial approval.

Sec. 13.52.050. Obligations of health care provider. (a) Before implementing a health care decision made for a patient, a supervising health care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision.

(b) A supervising health care provider who knows of the existence of an advance health care directive, a revocation of an advance health care directive, or a designation or disqualification of a surrogate shall promptly record its existence in the patient's health care record, shall request a copy if it is in writing, and shall arrange for its maintenance in the health care record if a copy is furnished.

(c) A supervising health care provider who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, a guardian, or a surrogate, shall promptly record the determination in the patient's health care record and communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patient.

(d) Except as provided in (e) and (f) of this section, a health care provider or institution providing care to a patient shall comply with

(1) an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and

(2) a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

(e) A health care provider may decline to comply with an individual instruction or a health care decision for reasons of conscience. A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is contrary to a policy of the institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

(f) A health care provider or institution may decline to comply with an

individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

(g) A health care provider or institution that declines to comply with an individual instruction or a health care decision shall

(1) promptly inform the patient, if possible, and any person then authorized to make health care decisions for the patient that the provider or institution has declined to comply with the instruction or decision;

(2) provide continuing care to the patient until a transfer is effected; and

(3) unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.

(h) A health care provider or institution may not require or prohibit the execution or revocation of an advance health care directive as a condition for providing health care.

Sec. 13.52.060. Do not resuscitate protocol. The Department of Health and Social Services shall by regulation adopt a do not resuscitate protocol that sets out a standardized method of procedure for the withholding of cardiopulmonary resuscitation by health care providers and health care institutions. The regulations may not be adopted unless they have been approved by the State Medical Board.

Sec. 13.52.070. Health care information. Unless otherwise specified in an advance health care directive, a person then authorized to make health care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or other health care information.

Sec. 13.52.080. Immunities. (a) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for

(1) complying with a health care decision of a person apparently

having authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;

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

(3) complying with an advance health care directive and assuming that the directive was valid when made and has not been revoked or terminated.

(b) An individual acting as an agent, a guardian, or a surrogate under this chapter is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.

Sec. 13.52.090. Statutory damages. (a) A health care provider or institution that intentionally violates this chapter is liable to the aggrieved individual or the individual's estate for damages of $500 or actual damages resulting from the violation, whichever is greater, plus attorney fees as provided by court rule.

(b) A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health care directive or a revocation of an advance health care directive without the individual's consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health care directive, is liable to that individual for damages of $2,500 or actual damages resulting from the action, whichever is greater, plus attorney fees as provided by court rule.

Sec. 13.52.100. Capacity. (a) This chapter does not affect the right of an individual to make health care decisions while having capacity to make health care decisions.

(b) An individual is rebuttably presumed to have capacity to make a health care decision, to give or revoke an advance health care directive, and to designate or disqualify a surrogate.

Sec. 13.52.110. Status of copy. A copy of a written advance health care directive, revocation of an advance health care directive, or designation or disqualification of a surrogate has the same effect as the original.

Sec. 13.52.120. Effect of this chapter. (a) This chapter does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance health care directive.

(b) Death resulting from the withholding or withdrawal of health care under this chapter does not, for any purpose, constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity to the contrary.

(c) This chapter does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this state.

(d) This chapter does not authorize or require a health care provider or institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or institution.

(e) This chapter does not authorize an agent or a surrogate to consent to the admission of an individual to a mental health facility unless the individual's written advance health care directive expressly so provides.

(f) This chapter does not affect other statutes of this state governing treatment for mental illness of an individual involuntarily committed to a mental health facility.

(g) In this section, "mental health facility" has the meaning given to "designated treatment facility" in AS 47.30.915.

Sec. 13.52.130. Judicial relief. On petition of a patient, the patient's agent, guardian, or surrogate, or a health care provider or institution involved with the patient's care, the superior court may enjoin or direct a health care decision or order other equitable relief. A proceeding under this section is governed by AS 13.26.165 - 13.26.320.

Sec. 13.52.140. Uniformity of application and construction. This chapter shall be applied and construed to carry out its general purpose to make uniform the law with respect to the subject of this chapter among states enacting it.

Sec. 13.52.150. Optional form. The following sample form may be used to create an advance health care directive. The other sections of this chapter govern the effect of this or any other writing used to create an advance health care directive. This form may be duplicated. This form may be modified to suit the needs of the person, or a completely different form may be used that contains the substance of the following form:

ADVANCE HEALTH CARE DIRECTIVE

Explanation

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

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as an agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You do not have to limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to

(a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;

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

(c) approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and

(d) direct the provision, withholding, or withdrawal of artificial

nutrition and hydration and all other forms of health care; and

(e) donate your body parts at your death.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your body parts following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

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

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

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

_____

(name of individual you choose as agent)

_____

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

_____

(home phone) (work phone)

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

_____

(name of individual you choose as first alternate agent)

_____

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

_____

(home phone) (work phone)

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

_____

(name of individual you choose as second alternate agent)

_____

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

_____

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my

primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

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

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

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you do not need to fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Check only one box.)

[ ] (A) Choice To Prolong Life

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

[ ] (B) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time; (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or (iii) the likely risks and burdens of treatment would outweigh the expected benefits.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: If I mark this box [ ], I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that

_____

_____

(Add additional sheets if needed.)

PART 3

DONATION OF BODY PARTS AT DEATH

(OPTIONAL)

If you are satisfied to allow your agent to determine whether to donate your body parts at your death, you do not need to fill out this part of the form.

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

[ ] (A) I give any needed organs, tissues, or

other body parts, OR

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

_____

[ ] (C) My gift is for the following purposes (strike any of the following you do not want):

(i) transplant;

(ii) therapy;

(iii) research;

(iv) education;

PART 4

PRIMARY PHYSICIAN

(OPTIONAL)

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

_____

(name of physician)

_____

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

_____

(phone)

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

_____

(name of physician)

_____

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

_____

(phone)

(12) EFFECT OF COPY: A copy of this form has the

same effect as the original.

(13) SIGNATURES: Sign and date the form here:

_____ _____

(date) (sign your name)

_____ _____

(address) (print your name)

_____ _____

(city) (state)

(14) WITNESSES: This power of attorney will not be valid for making health care decisions unless it is

(A) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or

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

ALTERNATIVE NO. 1

Witness

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health care provider or an employee of a health care provider or facility. 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.

_____ _____

(date) (signature of witness)

_____ _____

(address) (printed name of witness)

_____

(city) (state)

Witness

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health care provider, or an employee of a health care provider or facility. 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.

_____ _____

(date) (signature of witness)

_____ _____

(address) (printed name of witness)

_____

(city) (state)

ALTERNATIVE NO. 2

State of Alaska

_____ Judicial District

On this ____ day of _____, in the year _____, before me, _____ (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that the person executed it.

Notary Seal

_____

(Signature of Notary Public)

Sec. 13.52.190. Definitions. In this chapter, unless the context otherwise requires,

(1) "advance health care directive" means an individual instruction or a power of attorney for health care;

(2) "agent" means an individual designated in a power of attorney for health care to make a health care decision for the individual granting the power;

(3) "best interest" means that the benefits to the individual resulting from a treatment outweigh the burdens to the individual resulting from that treatment and includes

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

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

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

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

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

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

(G) the religious beliefs and basic values of the individual receiving treatment, to the extent that these may assist in determining benefits and burdens;

(4) "capacity" means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision;

(5) "emancipated minor" means a minor whose disabilities have been removed under AS 09.55.590 or who has arrived at the age of majority as determined

under AS 25.20.020;

(6) "generally accepted health care standards" includes the do not resuscitate protocol adopted under AS 13.52.060;

(7) "guardian" means a judicially appointed guardian or conservator having authority to make a health care decision for an individual;

(8) "health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition, including

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

(B) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate;

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

(D) donation of body parts at death.

(9) "health care decision" means a decision made by an individual or the individual's agent, guardian, or surrogate regarding the individual's health care;

(10) "health care institution" means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business;

(11) "health care provider" means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession;

(12) "individual instruction" means an individual's direction concerning a health care decision for the individual;

(13) "person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, instrumentality, or another legal or commercial entity;

(14) "physician" means an individual authorized to practice medicine

or osteopathy under AS 08.64;

(15) "power of attorney for health care" means the designation of an agent to make health care decisions for the individual granting the power;

(16) "primary physician" means a physician designated by an individual, or by the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility;

(17) "reasonably available" means able to be contacted with a level of diligence appropriate to the seriousness and urgency of a patient's health care needs, and willing and able to act in a timely manner considering the urgency of the patient's health care needs;

(18) "state" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States;

(19) "supervising health care provider" means the primary physician or the physician's designee, or the health care provider or the provider's designee who has undertaken primary responsibility for an individual's health care;

(20) "surrogate" means an individual, other than a patient's agent or guardian, authorized under this chapter to make a health care decision for the patient.

Sec. 13.52.195. Short title. This chapter may be cited as the Health Care Decisions Act.

* **Sec. 4.** AS 18.65.311 is amended to read:

Sec. 18.65.311. Donation of body parts [ANATOMICAL GIFT OR LIVING WILL DOCUMENT]. (a) The department shall provide, at the time that an identification card is issued, a form for a document by which the card holder may make **a donation of body parts** [AN ANATOMICAL GIFT] under **AS 13.52** [AS 13.50 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER AS 18.12 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)]. The document (1) may not be larger than an identification card, (2) must contain sufficient space for the signature of two witnesses [OR A PERSON WHO IS QUALIFIED TO

TAKE ACKNOWLEDGMENTS UNDER AS 09.63.010], **and** (3) [MUST USE THE FORMS AND DESIGNS DEVELOPED UNDER AS 18.12.037, AND (4)] must provide a means by which the card holder may cancel the gift [OR THE LIVING WILL]. If the document is executed by the applicant, it shall be sealed in plastic and attached to the identification card. [A SYMBOL DEVELOPED UNDER AS 18.12.037 INDICATING THE EXISTENCE OF THE ANATOMICAL GIFT OR LIVING WILL DOCUMENT MUST BE DISPLAYED IN THE LOWER RIGHT-HAND CORNER ON THE FACE OF THE IDENTIFICATION CARD.]

(b) An employee of the department who processes an identification card application, other than an application received by mail, shall ask the applicant orally whether the applicant wishes to execute **a donation of body parts** [AN ANATOMICAL GIFT OR A LIVING WILL]. The department shall, by placement of posters and brochures in the office where the application is taken, and by oral advice, if requested, make known to the applicant the procedure necessary to execute a **donation of body parts** [GIFT] under **AS 13.52** [AS 13.50 OR A LIVING WILL UNDER AS 18.12].

* **Sec. 5.** AS 28.10.021(c) is amended to read:

(c) An employee of the department who processes an application for registration or renewal of registration, other than an application received by mail or an application for registration under AS 28.10.152, shall ask the applicant orally whether the applicant wishes to execute **a donation of body parts** [AN ANATOMICAL GIFT OR A LIVING WILL]. The department shall make known to all applicants the procedure for executing a **donation of body parts** [GIFT] under **AS 13.52 (Health Care Decisions Act)** [AS 13.50 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER AS 18.12 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)] by displaying posters in the offices in which applications are taken, by providing a brochure or other written information to each person who applies in person or by mail, and, if requested, by providing oral advice.

* **Sec. 6.** AS 28.15.061(d) is amended to read:

(d) An employee of the department who processes a driver's license application, other than an application received by mail, shall ask the applicant orally

whether the applicant wishes to execute **a donation of body parts** [AN ANATOMICAL GIFT OR A LIVING WILL]. The department shall make known to all applicants the procedure for executing a **donation of body parts** [GIFT] under **AS 13.52 (Health Care Decisions Act)** [AS 13.50 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER AS 18.12 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)] by displaying posters in the offices in which applications are taken, by providing a brochure or other written information to each person who applies in person or by mail, and, if requested, by providing oral advice.

*** Sec. 7.** AS 23.15.111(b) is amended to read:

(b) The department shall provide, at the time that an operator's license is issued, a form for a document by which the owner of a license may make **a donation of body parts** [AN ANATOMICAL GIFT] under **AS 13.52** [AS 13.50 OR A LIVING WILL UNDER AS 18.12]. The document (1) may not be larger than an operator's license, (2) must contain sufficient space for the signature of two witnesses [OR A PERSON WHO IS QUALIFIED TO TAKE ACKNOWLEDGMENTS UNDER AS 09.63.010], **and** (3) [MUST USE THE FORMS AND DESIGNS DEVELOPED UNDER AS 18.12.037, AND (4)] must provide a means by which the owner may cancel the **donation** [GIFT OR THE LIVING WILL]. If the document is executed by the applicant, it shall be sealed in plastic and attached to the license. [A SYMBOL DEVELOPED UNDER AS 18.12.037 INDICATING THE EXISTENCE OF THE ANATOMICAL GIFT OR LIVING WILL DOCUMENT MUST BE DISPLAYED IN THE LOWER RIGHT-HAND CORNER ON THE FACE OF THE DRIVER'S LICENSE.]

*** Sec. 8.** AS 47.30.825(b) is amended to read:

(b) The patient and the following persons, at the request of the patient, are entitled to participate in formulating the patient's individualized treatment plan and to participate in the evaluation process as much as possible, at minimum to the extent of requesting specific forms of therapy, inquiring why specific therapies are or are not included in the treatment program, and being informed as to the patient's present medical and psychological condition and prognosis: (1) the patient's counsel, (2) the patient's guardian, (3) a mental health professional previously engaged in the patient's

care outside of the evaluation facility or designated treatment facility, (4) a representative of the patient's choice, (5) a person designated as the patient's **agent or surrogate** [ATTORNEY-IN-FACT] with regard to mental health treatment decisions under **AS 13.52** [AS 13.26.332 - 13.26.358, AS 47.30.950 - 47.30.980, OR OTHER POWER-OF-ATTORNEY], and (6) the adult designated under AS 47.30.725. The mental health care professionals may not withhold any of the information described in this subsection from the patient or from others if the patient has signed a waiver of confidentiality or has designated the person who would receive the information as an **agent or surrogate under AS 13.52** [ATTORNEY-IN-FACT] with regard to mental health treatment.

*** Sec. 9.** AS 47.30.825(f) is amended to read:

(f) A patient capable of giving informed consent has the absolute right to accept or refuse electroconvulsive therapy or aversive conditioning. A patient who lacks substantial capacity to make this decision may not be given this therapy or conditioning without a court order unless the patient expressly authorized that particular form of treatment in **an advance health care directive** [A DECLARATION] properly executed under **AS 13.52** [AS 47.30.950 - 47.30.980] or has authorized an **agent or surrogate under AS 13.52** [ATTORNEY-IN-FACT] to make this decision and the **agent or surrogate** [ATTORNEY-IN-FACT] consents to the treatment on behalf of the patient.

*** Sec. 10.** AS 47.30.836 is amended to read:

Sec. 47.30.836. Psychotropic medication in nonemergencies. An evaluation facility or designated treatment facility may not administer psychotropic medication to a patient in a situation that does not involve a crisis under AS 47.30.838(a)(1) unless the patient

(1) has the capacity to give informed consent to the medication, as described in AS 47.30.837, and gives that consent; the facility shall document the consent in the patient's medical chart;

(2) authorized the use of psychotropic medication in **an advance health care directive** [A DECLARATION] properly executed under **AS 13.52** [AS 47.30.950 - 47.30.980] or authorized an **agent or surrogate under AS 13.52**

[ATTORNEY-IN-FACT] to consent to the use of psychotropic medication for the patient and the **agent or surrogate** [ATTORNEY-IN-FACT] does consent; or

(3) is determined by a court to lack the capacity to give informed consent to the medication and the court approves use of the medication under AS 47.30.839.

* **Sec. 11.** AS 47.30.838(d) is amended to read:

(d) An evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent if the patient is unable to give informed consent but has authorized the use of psychotropic medication in **an advance health care directive** [A DECLARATION] properly executed under **AS 13.52** [AS 47.30.950 - 47.30.980] or has authorized an **agent or surrogate under AS 13.52** [ATTORNEY-IN-FACT] to consent to this form of treatment for the patient and the **agent or surrogate** [ATTORNEY-IN-FACT] does consent.

* **Sec. 12.** AS 47.30.839(d) is amended to read:

(d) Upon the filing of a petition under (b) of this section, the court shall direct the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

(1) the patient's responses to a capacity assessment instrument administered at the request of the visitor;

(2) any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, **an advance health care directive under AS 13.52,** or oral statements of the patient, including conversations with relatives and friends that are significant persons in the patient's life as those conversations are remembered by the relatives and friends; oral statements of the patient should be accompanied by a description of the circumstances under which the patient made the statements, when possible.

* **Sec. 13.** AS 47.33.070(a) is amended to read:

(a) An assisted living home shall maintain, for each resident of the home, a file that includes

(1) the name and birth date, and, if provided by the resident, the social security number of the resident;

(2) the name, address, and telephone number of the resident's closest relative, service coordinator, if any, and representative, if any;

(3) a statement of what actions, if any, the resident's representative is authorized to take on the resident's behalf;

(4) a copy of the resident's assisted living plan;

(5) a copy of the residential services contract between the home and the resident;

(6) a notice, as required under AS 47.33.030, regarding the depository in which the resident's advance payment money is being held;

(7) written **acknowledgment** [ACKNOWLEDGEMENT] by the resident or the resident's representative that the resident has received a copy of and has read, or has been read the

(A) resident's rights under AS 47.33.300;

(B) resident's right to pursue a grievance under AS 47.33.340;

(C) resident's right to protection from retaliation under AS 47.33.350;

(D) provisions of AS 47.33.510, regarding immunity; and

(E) home's house rules;

(8) an **acknowledgment** [ACKNOWLEDGEMENT] and agreement relating to home safekeeping and management of the resident's money, as required by AS 47.33.040;

(9) a copy of the resident's living will, if any**, or an advance health care directive made under AS 13.52, if any**; and

(10) a copy of a power of attorney or other written designation**, including an advance health care directive made under AS 13.52,** of an agent, representative, or surrogate by the resident.

* **Sec. 14.** AS 13.26.332(L), 13.26.335(l), 13.26.344(l); AS 13.50.010, 13.50.014,

13.50.016, 13.50.020, 13.50.030, 13.50.040, 13.50.050, 13.50.060, 13.50.065, 13.50.068, 13.50.070, 13.50.080, 13.50.090; AS 18.12.010, 18.12.020, 18.12.030, 18.12.035, 18.12.037, 18.12.040, 18.12.050, 18.12.060, 18.12.070, 18.12.080, 18.12.090, 18.12.100; AS 47.30.950, 47.30.952, 47.30.954, 47.30.956, 47.30.958, 47.30.960, 47.30.962, 47.30.964, 47.30.966, 47.30.968, 47.30.970, 47.30.972, and 47.30.980 are repealed.

* **Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONTINUING EFFECT OF EXISTING DOCUMENTS. (a) A donation of body parts made under AS 13.50 or AS 18.12, repealed by sec. 14 of this Act, before the effective date of secs. 1 - 14 of this Act continues in effect under AS 13.50 or AS 18.12, as those chapters exist before the effective date of secs. 1 - 14 of this Act, until the donation is revoked.

(b) A power of attorney that is made under AS 13.26.332(L), 13.26.335(1), or 13.26.344(l), repealed by sec. 14 of this Act, before the effective date of secs. 1 - 14 of this Act and that contains authority for health care services under AS 13.26.332(L), AS 13.26.335(1), or 13.26.344(l), repealed by sec. 14 of this Act, continues in effect under AS 13.26.332(L), 13.26.335(1), and 13.26.344(l), as those provisions exist before the effective date of secs. 1 - 14 of this Act, until the power of attorney is revoked.

(c) A declaration made under AS 18.12, repealed by sec. 14 of this Act, before the effective date of secs. 1 - 14 of this Act continues in effect under AS 18.12, as that chapter exists before the effective date of secs. 1 - 14 of this Act, until the declaration is revoked.

(d) A declaration made under AS 47.30.950 - 47.30.980, repealed by sec. 14 of this Act, before the effective date of secs. 1 - 14 of this Act continues in effect under AS 47.30.950 - 47.30.980, as those sections exist before the effective date of secs. 1 - 14 of this Act, until the declaration is revoked.

* **Sec. 16.** The uncodified law of the State of Alaska is amended by adding a new section to read:

EFFECT ON EXISTING INSURANCE POLICIES AND ANNUITIES. AS 13.52.120(b), added by sec. 3 of this Act, does not apply to a policy of insurance or an annuity that was entered into before the effective date of secs. 1 - 14 of this Act.

* **Sec. 17.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by secs. 1 - 14 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before January 1, 2003.

*** Sec. 18.** Section 17 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 19.** Except as provided in sec. 18 of this Act, this Act takes effect January 1, 2003.

REPRESENTATIVE BILL HUDSON Alaska State Legislature

Room 502 • State Capitol, Juneau, Alaska 99801 (907)465-3744 Fax: 465-2273

Sponsor Statement
Draft CS HB 197 ( )

Relating to directives for personal health care services and for medical treatment

I introduced this legislation at the request of several dear friends and many local and state organizations that have brought the "Five Wishes" document to my attention.

Currently Alaska's statutes don't go far enough to allow use of this form, much less encourage its broad dissemination to help provide assistance to individuals and their loved ones during the process of creating a personalized set of instructions for the end of life. Statute's that effect the various aspects of living wills, organ donations, do- not-resuscitate orders and other personal decisions that can be made on behalf of the person, do not fully facilitate the process, create some confusions and occur in various unrelated Chapters of statutes.

This new draft committee substitute represents the effort over the interim to work with interested supporters of the "Five Wishes" form for end-of-life health care decisions. The resulting draft CS will incorporate the Uniform Health Care Decisions Act into HB 197 to align existing state statutes concerning living wills, do not resuscitate orders with a new durable power of attorney for health care decisions, into a new Chapter designed to allow the patient to specify their "Wishes" relating to end of life decisions. To date I have received only positive public opinion on the concept. Alaska would be following suit from several other state's that have also helped facilitate use of the Five Wishes form, by adopting this model legislation developed by the National Conference of Commissioner's of Uniform State Laws.

The legislation is comprehensive because it speaks to the details and instructions that patients put in place regarding their care should they become incapacitated. It is simple in that the directives speak simply to the patient's wishes (the legislation is known nationally as the Five-Wishes) as follows:

My Wish for:

1. The person I want to make care decisions for me when I can't
2. The kind of medical treatment I want or don't want
3. How comfortable I want to be
4. How I want other people to treat me
5. What I want my loved ones to know

The object of this bill is to facilitate the process whereby a person can let these wishes be known. The end result will be the production of a document or several that helps you express how you want to be treated if you are seriously ill and unable to speak for yourself. It is unique among all other living will and health agent forms because it looks to

all of a person's needs: medical, personal, emotional and spiritual. Five Wishes also encourages discussing your wishes with your family and physician.

Five Wishes is changing the way America talks about and plans for care at the end of life. Nearly one million copies of the document are circulating throughout the nation, and more than 1,400 organizations are distributing this revolutionary document, including churches, synagogues, hospices, hospitals, doctor and law offices, and social service agencies. Many employers are providing the document to their employees, to help them plan for themselves as well as have those delicate discussions with their aging parents.

Five Wishes speaks to people in their own language, helping families talk with their physician about a subject that is often avoided as being too hard to face.

The 15 states that Five Wishes is not legally valid in, either require a specific state form or that the person completing an advance directive be read a mandatory notice or "warning." Residents of these states can still use Five Wishes to put their wishes in writing and communicate their wishes with their family and physician. Most health care professionals understand they have a duty to listen to the wishes of their patients no matter how they are expressed.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 27, 2002

SUBJECT: Sectional summary of CSHB '07( ) relating to health care decisions (Work Order No. 22-LS0712\O)

TO: Representative Bill Hudson
Attn: Mel

FROM: Theresa L. Bannister
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. States a principal purpose of the bill.

Section 2. Makes technical changes to conform this section to other changes in the bill.

Section 3. Establishes a new chapter called the Health Care Decisions Act.

Sec. 13.52.010(a). Allows a person to give an oral or written individual instruction. The instruction may be limited.

Sec. 13.52.010(b). Allows a person to make a written power of attorney for health care. Power of attorney remains effective notwithstanding later incapacity of maker. Power of attorney may include individual instructions. Establishes the technical requirements for the power of attorney.

Sec. 13.52.010(c). Prohibits certain health care institution persons from being agents under a power of attorney for health care, unless related to the principal.

Sec. 13.52.010(d). Prohibits certain persons from acting as witnesses for a power of attorney for health care.

Sec. 13.52.010(e). Requires that at least one witness for a power of attorney for health care meet certain described criteria.

Sec. 13.52.010(f). Establishes the general rule as to when an agent's authority under a power of attorney for health care becomes effective and when the agent's authority ceases.

Sec. 13.52.010(g). Requires that certain determinations be made by a person's primary physician, unless otherwise specified in a written advance health care directive.

Sec. 13.52.010(h). Requires an agent to make health care decisions in accordance with the principal's individual instructions and other wishes to the extent known. Otherwise, directs the agent to make the decision in accordance with the agent's determination of the principal's best interest.

Sec. 13.52.010(i). Establishes that an agent's health care decision does not need judicial approval to be effective.

Sec. 13.52.010(j). Allows a written advance health care directive to nominate a guardian.

Sec. 13.52.010(k). Establishes when an advance health care directive is valid under this chapter.

Sec. 13.52.020(a). Allows an individual to revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

Sec. 13.52.020(b). Allows an individual to revoke an advance health care directive, except for the agent designation, at any time and in any manner that communicates the intent to revoke.

Sec. 13.52.020(c). Requires health care providers, agents, guardians, and surrogates to promptly communicate a revocation to the supervising health care provider and the health care institution.

Sec. 13.52.020(d). Establishes that a decree of annulment, divorce, dissolution, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or power of attorney.

Sec. 13.52.020(e). Provides that a conflicting advance health care directive revokes an earlier directive to the extent of the conflict.

Sec. 13.52.030(a). Allows a surrogate to make a health care decision for a patient who has been determined to lack capacity if an agent or guardian has not been appointed or is not reasonably available.

Sec. 13.52.030(b). Allows an individual to designate an individual as a surrogate by personally informing the supervising health care provider. If there is no designation, or

the designee is not reasonably available, establishes the priority of persons who may act as surrogate.

Sec. 13.52.030(c). Allows an adult who meets certain described criteria to act as a surrogate if no individual who is eligible under (b) is reasonably available to act as a surrogate.

Sec. 13.52.030(d). Requires a surrogate to communicate the surrogate's assumption of authority as promptly as practicable to the patient's family listed in (b).

Sec. 13.52.030(e). Establishes how to handle certain disagreements about health care decisions.

Sec. 13.52.030(f). Establishes guidelines for surrogates when making health care decisions.

Sec. 13.52.030(g). Establishes that a health care decision by a surrogate is effective without judicial approval.

Sec. 13.52.030(h). Allows an individual to disqualify another person from acting as the individual's surrogate by using a signed writing or by personally informing the supervising health care provider.

Sec. 13.52.030(i). Prohibits, except when related to the patient, a surrogate from being an owner, operator, or employee of the patient's residential long-term health care institution.

Sec. 13.52.030(j). Allows a supervising health care provider to require from an individual claiming to be a surrogate a written declaration to establish the claimed authority.

Sec. 13.52.040(a). Requires a guardian to comply with the ward's individual instructions, and prohibits a guardian from revoking a ward's advance health care directive executed before incapacity, unless a court authorizes it.

Sec. 13.52.040(b). Establishes that a health care decision of an agent takes precedence over that of a guardian, unless a court orders otherwise.

Sec. 13.52.040(c). Provides that a health care decision made by a guardian for the ward is effective without judicial approval, except as provided in (a).

Sec. 13.52.050(a). Requires a supervising health care provider, if possible and before implementing the order, to promptly communicate a health care decision to the patient and identify the person making the decision.

Sec. 13.52.050(b). Requires a supervising health care provider who knows of an advance health care directive, the revocation of a directive, or a surrogate designation or disqualification, to promptly record the item in the patient's record, request a copy if written, and arrange to keep any furnished copy in the record.

Sec. 13.52.050(c). Requires a supervising health care provider who makes or is informed of a determination of a patient's condition that affects an individual instruction or an agent's, a guardian's, or a surrogate's authority, to promptly record the determination in the patient's record and communicate the determination to the patient, if possible, and to any person then authorized to make the health care decisions for the patient.

Sec. 13.52.050(d). Requires, with certain exceptions, that a health care provider or institution comply with qualifying individual instructions, reasonable instruction interpretations, and health care decisions.

Sec. 13.52.050(e). Permits a health care provider to decline, for reasons of conscience, to comply with individual instructions or health care decisions. Permits a health care institution to decline to comply with individual instructions or health care decisions if contrary to a policy of the institution's that is based on reasons of conscience.

Sec. 13.52.050(f). Permits a health care provider or institution to decline to comply with individual instructions or health care decisions that require medically ineffective health care or care contrary to generally accepted health care standards.

Sec. 13.52.050(g). Establishes the steps that a health care provider or institution must take if declining to comply with an individual instruction or a health care decision.

Sec. 13.52.050(h). Prohibits health care providers and institutions from requiring or prohibiting the execution or revocation of advance health care directives as a condition for providing care.

Sec. 13.52.060. Directs the Department of Health and Social Services to adopt a do not resuscitate protocol for health care providers and health care institutions.

Sec. 13.52.070. Provides that, unless otherwise provided in a directive, an authorized person has the same rights as the patient regarding access to and consent to the disclosure of health care information.

Sec. 13.52.080(a). States that a health care provider or institution acting in good faith and under generally accepted health care standards is not subject to civil or criminal liability or to disciplinary actions for complying with qualified health care decisions, declining to comply with what appears to be an unauthorized decision, and complying with a directive and assuming the directive was valid when made and has not been revoked or terminated.

Sec. 13.52.080(b). States that agents, guardians, and surrogates are not subject to civil or criminal liability or to discipline for health care decisions made in good faith.

Sec. 13.52.090(a). Makes a health care provider or institution liable to an aggrieved individual or the individual's estate for damages if the provider or institution intentionally violates this chapter.

Sec. 13.52.090(b). Holds a person engaging in certain described acts relating to an existing directive, to the making of a directive, or to the revocation of a directive liable to the individual concerned for damages.

Sec. 13.52.100(a). Establishes that this chapter does not affect the right of an individual to make health care decisions while having the capacity to make the decisions.

Sec. 13.52.100(b). Establishes a rebuttable presumption that an individual has the capacity to make health care decisions, to give or revoke a directive, and to designate or disqualify a surrogate.

Sec. 13.52.110. Provides that a copy of a directive, a revocation of a directive, or a designation or disqualification of a surrogate is as effective as the original.

Sec. 13.52.120(a). States that this chapter does not create a presumption about the intention of an individual who has not made or who has revoked a directive.

Sec. 13.52.120(b). Provides that death resulting from the withholding or withdrawal of health care under this chapter does not constitute a suicide or homicide or impair or invalidate an insurance policy or certain annuities.

Sec. 13.52.120(c). States that this chapter does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of the state.

Sec. 13.52.120(d). States that this chapter does not authorize or require a health care provider or institution to provide health care contrary to generally accepted health care standards applicable to the provider or institution.

Sec. 13.52.120(e). States that this chapter does not authorize an agent or a surrogate to consent to the admission of an individual to a mental health facility unless a written directive expressly allows it.

Sec. 13.52.120(f). States that this chapter does not affect other statutes governing treatment for mental illness of involuntarily committed individuals.

Sec. 13.52.120(g). Defines "mental health facility" for the section.

Sec. 13.52.130. Allows the superior court, on petition by certain listed persons, to enjoin or direct a health care decision or to order other equitable relief.

Sec. 13.52.140. Directs that this chapter is to be applied and construed to carry out the purpose of making the law uniform among states enacting this law.

Sec. 13.52.150. Provides a sample optional form for an advance health care directive. Provides that the form may be modified or a different form used that contains the substance of this sample form.

Sec. 13.52.190. Defines terms for the new chapter.

Sec. 13.52.195. Calls the chapter the Health Care Decisions Act.

Section 4. Makes changes to conform the section to other parts of the bill and removes the references to living wills and the former living will chapter.

Section 5. Makes changes to conform the subsection to other parts of the bill and removes the references to living wills.

Section 6. Makes changes to conform the subsection to other parts of the bill and removes the references to living wills.

Section 7. Makes changes to conform the subsection to other parts of the bill and removes references to living wills and to the former chapter on living wills.

Section 8. Makes changes to conform the subsection to other parts of the bill.

Section 9. Makes changes to conform the subsection to other parts of the bill.

Section 10. Makes changes to conform the section to other parts of the bill.

Section 11. Makes changes to conform the subsection to other parts of the bill.

Section 12. Adds advance health care directives to the list of items that must be documented when providing the court with information under the subsection.

Section 13. Adds advance health care directives to the list of items that an assisted living home is required to maintain in a patient's file.

Section 14. Repeals certain statutes.

Section 15. Provides that certain existing documents continue until they are revoked.

Section 16. Provides that AS 13.52.120(b) does not apply to certain existing insurance policies and annuities.

Section 17. Directs the Department of Health and Social services to adopt implementing regulations.

Section 18. Gives bill sec. 17 an immediate effective date.

Section 19. Gives the rest of the bill an effective date.

If I may be of further assistance, please advise.

TLB:med
02-218.med

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSHB 197(HES)
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: All
Title: Health Care Services Directives
BRU
Component
Sponsor: Rep. Bill Hudson
Requester: House Judiciary Committee
Component No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
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 ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill is not expected to have any fiscal impact.

Prepared by: Heather Nobrega, Counsel
Phone 907-465-4990
Division: House Judiciary Committee
Date/Time 3/19/02 2:22 PM
Approved by: Rep. Norman Rokeberg, Chairman
Date 3/19/2002
Agency: House Judiciary Committee

(Revised 9/2001 OMB)

CONTACT
Ann Secrest
Associate State Director
(907) 762-3302
asecrest@aarp.org

FOR IMMEDIATE RELEASE
February 25, 2002

AARP ALASKA SUPPORTS FIVE WISHES LEGISLATION

We plan our day, we plan weddings, and we plan our vacations. Increasingly, Americans – and Alaskans – want a say in planning how they want to be cared for as they age.

ANCHORAGE, ALASKA -- Health care and death are two subjects you're unlikely to entertain yourself with, but they are topics that are simply waiting for us to address. We can't hide behind the issues and the sooner we specify what we want, the better.

AARP Alaska supports legislation introduced by Representative Bill Hudson (R, Juneau), and co-sponsored by Representatives Beth Kerttula (D, Juneau), Harry Crawford (D, Anchorage), and Ken Lancaster (R, Soldotna) which may change how Alaskans spend their final hours.

The simple truth is Alaskans, like the majority of Americans, want to die at home surrounded by family and friends. Unfortunately, most end up dying in a nursing home or in a hospital. Patients end up in rooms that do not hold precious family memories, unable to take comfort in seeing familiar faces, familiar sounds, or familiar surroundings when they're placed in hospitals or nursing homes.

HB197 allows Alaskans to take control in designing how they want to be cared for and after death, what arrangements are to be carried out. The bill facilitates the creation of a document similar to "Five Wishes," which helps individuals spell out their medical, emotional, spiritual, and personal needs. The Five Wishes form is a copyrighted document by Aging with Dignity, November 2000 and is recognized by 35 states in the Lower 48. Alaska does not recognize the Five Wishes document as valid, although most health care professionals will listen to end-of-life concerns, no matter how they're articulated.

As prime sponsor of House Bill 197, Rep. Hudson said, "This bill will allow Five Wishes to be a tool to be used for end-of-life planning and health care decisions. It will reconstitute our state statutes to be user friendly for the Five Wishes model."

The patient, in designing their personal document would be able to identify another person who would act as an attorney-in-fact; identify a person to make health decisions on their behalf, direct particular

(more)

health treatments, make funeral arrangements, and direct what is to be done with the person's body or body parts after death. The use of euthanasia is not allowed under HB197.

Five Wishes lets your family and doctors know:

- Who you want to make health care decisions for you when you can't make them.
- The kind of medical treatment you want or don't want.
- The level of comfort you want.
- How you want people to treat you.
- What you want your loved ones to know.

Liz Lucas, AARP State President praised Representative Hudson and all co-sponsors of the bill. "I was pleased to learn how easy it is to complete the document. Individuals would not have to contact an attorney or even a notary. It certainly empowers individuals in making their own decisions," said Lucas. Two witnesses would be required to sign the completed document. "AARP Alaska is very supportive of HB197," said Lucas.

"Alaskans have always wanted a say in how their lives are run," said Rep. Hudson. "The Five Wishes model gives control to the individual and makes it easier for family members and loved ones."

For a complete version of HB197, call the AARP Alaska Information in Anchorage at 272-1444 or toll free within Alaska at (888) 805-1540, or go to **http://www.legis.state.ak.us/basis/start.asp** and enter HB197 at the "Bill Root" prompt.

-30-

adn.com
Anchorage Daily News

Alaskans want more of a say over their final days

Legislation in House would change state's law to allow simpler approach

By Lisa Demer
Anchorage Daily News
(Published: January 25, 2002)

If you knew you were going to die soon, what would your last wishes be?

Maybe you'd like your old dog by your side. Or ice cream for lunch every day. Or your children to know you're sorry for a long-ago wrong.

If you're like most people, you want to die at home with family members and friends. But people usually end up in a hospital or nursing home cared for by strangers, according to Aging with Dignity, a national organization that advocates for the elderly.

Alaska is among 15 states where narrow laws crimp efforts by people to spell out their last wishes, said Jim Towey, the Washington, D.C., based-president and founder of Aging with Dignity.

That would change under a bill before the Legislature. House Bill 197, sponsored by Rep. Bill Hudson, R-Juneau, would retool Alaska law on health care decision-making and other matters that arise at the end of life.

The idea is to help people spell out their wishes now so that later, if they can't walk to the fridge or even speak, their family, friends and medical providers know what they want.

Alaska already has laws for setting up living wills and appointing someone to make health care decisions through a power of attorney. When the bill was aired last year, some legislators questioned whether Alaska needs a new law.

Advocates say it does. Existing laws include legal forms that people feel bound to use even when there are good alternatives, including an approach known as Five Wishes, which is gaining popularity.

"People are concerned if they go beyond the statutory form, it would cause problems if there was any dispute," said Beth Chapman, a Juneau attorney who works in estate planning. "They want to be more detailed about their wishes."

Under the legislation, people could more easily write their own tailored last wishes, advocates said. Their wishes would, in effect, get a state stamp of validity whether a lawyer wrote the document or the person scrawled something himself or herself on the back of a paper bag, Towey said.

In Alaska, hospice organizations, AARP, the Juneau End of Life Task Force, the state Commission on Aging, and the statewide Senior Advocacy Coalition have supported changing the law to allow the Five Wishes approach. That trademark system, designed by Aging with Dignity, uses simple language and covers emotional and spiritual needs as well as health care.

"People in America treat dying like a medical moment. The discussion is all about feeding tubes and respirators. It leaves family members guessing and feeling guilty," said Towey, who once worked in a Mother Teresa home for the dying and was her lawyer for a dozen years.

An American Bar Association analysis found that Five Wishes is valid in 35 states. But the rest, including Alaska, either direct people to use specific forms or require that someone preparing a health care directive

be read a warning first.

Besides living wills, people should delegate a trusted health care agent to make decisions, said Charles Sabatino of Washington, D.C., assistant director of the American Bar Association Commission on Legal Problems of the Elderly. There are too many medical scenarios to anticipate them all, he said.

But Alaska law governing how to do that through a health care power of attorney is rigid, he said.

The latest version of the Alaska bill doesn't mention Five Wishes specifically but would allow it under an "other wishes" section for people who write their own instructions from scratch or just want to add a few extra thoughts, said Melanie Lesh, a legislative aide to Hudson.

States that allow Five Wishes typically don't name it. Their laws let people choose what form to use or write their own if they want, Sabatino said.

"Five Wishes is a great form. It ought to be clearly valid in every state. It isn't the end all and be all for everybody," Sabatino said.

The Five Wishes approach includes:

Whom you want to make medical decisions for you.

The type of medical treatment you want, or don't want, through a living will.

How comfortable you want to be in terms of pain medicine, bathing and comfort measures like oil massages.

How you want people to treat you, including who should be around.

Your last thoughts for your family and friends.

Sabatino said he found Five Wishes valuable in unexpected ways when his mother died about six months ago. At her eulogy, he read aloud her fifth wish, in which she asked for forgiveness and said she forgave the hurts against her.

"It's kind of a closure wish and a blessing on her friends," he said.

The effort to change Alaska law began after a Bill Moyers public television series on dying that aired in fall 2000. Afterward, some Juneau residents formed an End of Life Task Force that decided to push for Five Wishes in Alaska, said Sioux Plummer, its chairwoman. She was a former aide to Hudson, and he agreed to carry the bill.

"They can be pretty much in control of their lives at the end," if the details are spelled out ahead of time, said Plummer, whose husband died of lung cancer three years ago.

Some Alaska advocates have been using Five Wishes for years, even though they are unsure whether it would hold up if tested.

Brenda Brown, a retired nurse who volunteers with families through an interfaith program, stumbled on the approach in Florida when her father-in-law became ill with a brain tumor in 1998. She used it to help him talk about whom he wanted to visit him at the end.

She takes a copy or two of Five Wishes when she gives workshops on living wills.

"The desire, I have heard from man after man after man, is I got to die at home because I've got a dog there, my big old dog,' " Brown said.

Others say they want "spiritual privacy." They may be religious but still not want their priest or pastor or rabbi to come by.

One woman wanted to die on her sofa, where she had a view of her hanging baskets, Brown said.

The conversations are so moving, she said, they should be taped to preserve as special treasures.

Reporter Lisa Demer can be reached at ldemer@adn.com and 907 257-4390.

Brenda Brown, A Retired Nurse, Helps People Address End-of-life Issues And Plan Living Wills. She Advocates For Legislation Allowing More Detailed Documents.

Close Window

Chapter Four

Advance Directives:

Living Wills, Durable Power of Attorney and Surrogate Consent

Irma Jones—an 88-year-old woman with lymphoma and diabetes—had undergone a difficult course of surgery and radiation that left her unable to swallow. Because she was still quite delirious, she could not communicate except for spontaneous moans in response to discomfort with her tubes. Ms. Jones had filled out a boilerplate advance directive form, but the form's vague language left her doctor wondering about her true wishes. Because the one-page form did not include naming a health care proxy, Ms. Jones also had authorized no one to make treatment decisions on her behalf. Given that and the poor prognosis for recovery, her doctor felt he should be the one to determine the course of her treatment. The scenario might have been different had advance care planning been an integral part of Ms. Jones' experience.

Introduction

As the powers of health care technology have advanced, so has the average age of death for Americans. More people are dying of slow, chronic illnesses, which often lead to a loss of competence and the ability to make decisions. Completing an *advance directive*—a statement, usually in writing, that delineates an individual's preferences and values for end-of-life care in advance of the time when he or she is no longer able to communicate such preferences—can help to ensure that end-of-life care wishes are followed, even when the individual can no longer directly participate in treatment decisions. (In theory, decisions about medical treatment generally should follow patient choice, as long as the patient remains competent and able to express preferences.)

The term advance directive also covers oral statements made to family or doctors regarding treatment decisions. Although all such communication is valuable, spoken statements usually will not carry the same legal force as written statements, and can be left open to interpretation.

Generally, advance directives take one of two forms. The first, called a *living will* or health care directive, is a written statement that typically includes a conditional statement about dying and expresses a person's general willingness to accept life-sustaining treatments or, conversely, to die without use of artificial intervention. The second, known as a *proxy designation,* involves delegation of decision-making authority to another individual. (Terminology can vary from state to state. For example, Florida uses the term, "surrogate," and Michigan uses "patient advocate.") Naming as one's health care agent a trusted family member or friend with whom one has discussed end-of-life issues and values is an important step in ensuring that treatment preferences will be followed. The designation is also referred to as a *durable power of attorney*—durable in that the authority of the agent continues, even after the principal becomes incompetent. Ideally, living will-style treatment instructions and designation of a proxy both are included in a written advance directive.

Even in the absence of advance directives, health care providers often involve families and friends in decisions affecting the treatment of a patient who is unable to make them independently. Some states have statutory provisions outlining a hierarchy of decision-makers, or *surrogates* (e.g., spouse, adult child, parent), in the event a patient becomes incapacitated and has not indicated a preference for a proxy.

Families and friends may disagree about the most appropriate course of treatment for the patient, or may be reluctant to speak up in defense of the patient's stated desire to avoid or continue heroic treatment, thereby leaving the decisions to physicians by

default. In other cases, a judge may appoint a guardian to authorize someone (who may or may not be a family member) to intervene in the process. Thus, the naming of a health care proxy helps to ensure that a patient's wishes are followed and helps to avoid disagreement and costly legal proceedings. Also, if an individual who completes a living will fails to share that information with his or her family and physician, or if the document is not readily accessible at the time important treatment decisions are being made, it may not have the opportunity to 'speak' on his or her behalf.

Question One

Are living wills enforceable without designation of a health care proxy?

Yes, although the appointment of a proxy usually is more effective than the exclusive reliance on a living will. The real question when discussing cessation of life-prolonging treatment is not *whether* but *when* treatment should stop. That question is not addressed adequately in most living wills, leaving family, friends and physicians to sort out what the dying person would have wanted.

The standard forms used by most states do not encompass the wide range of possible scenarios in which a patient can be involved; nor would it be realistic to try to do so. Appointment of a health care agent can help to address such deficiencies, especially when it is unclear who will act as the patient's proxy, should that become necessary. If, for example, a person is divorced with several adult children or, perhaps, has no family still living, appointment of a proxy can reduce confusion and arguments at a later date. It remains crucial, however, that the individual and the designated proxy discuss preferences and values as they relate to health care before a medical crisis arrives.

Question Two

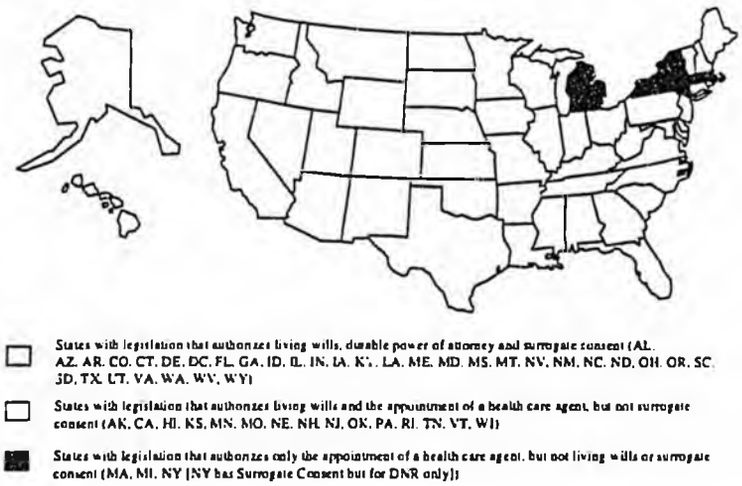
Does your state recognize advance directives?

Yes. All states recognize living wills and proxies, although the provisions of the various laws differ significantly. There are two accessible sources to obtain information about these state laws. First, state Medicaid offices have written descriptions of their own state's laws regarding advance directives as mandated by the federal Patient Self-Determination Act (Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, §§ 4206 and 4751). Second, the nonprofit organization, Choice in Dying, maintains a database on its web site of advance directives from each state.

More specifically, all but three states—Massachusetts, Michigan and New York—have laws authorizing living wills (see figure 12), although laws in those three jurisdictions allow for instructions to be included within the appointments of health care agents. As with living will instructions, all states have durable power of attorney statutes, although Alaska does not allow the agent to authorize termination of life-sustaining procedures.

In addition, most states have family consent or surrogate consent laws to address who makes health care decisions in the absence of an advance directive. Thirty-four states have statutes governing family consent or surrogate consent. In New York, the law pertains only to do-not-resuscitate orders.

Figure 12.
States with Living Wills, Appointment of Health Care Agents and Surrogate Consent Laws



Source: ABA Commission on Legal Problems of the Elderly, 1997.

Question Three

Are the existing advance directive laws effective?

An advance directive is most helpful to assist individuals to begin thinking about alternatives for treatment at the end of life. It makes them consider important religious, familial and financial considerations that inevitably will affect treatment and care decisions. And, given that all states recognize the documents, completing one is an important step in ensuring that a patient's preferences for treatment are followed.

However, there are several deficiencies surrounding advance directives. First, only one of five adults has completed a living will at the time of death. Second, many states use living will forms that contain vague language—"heroic measures," for example, and "terminally ill," neither of which can be defined with any precision and both of which require a subjective determination. Third, most states have separate laws for living wills, durable power of attorney and surrogate consent. That piecemeal process has led to different definitions of witnessing requirements and terminal illness, as well as different reciprocity requirements between states. Such disparities have caused confusion among the public. Fourth, controversy persists about whether special conditions should be required for the discontinuation of artificially supplied nutrition and hydration. Finally, some states do not address reciprocity of patient advance directives across state lines. For example, if an elderly patient moves to another state to be cared for by an adult child, the living will might not be legally valid if the new state does not recognize documents drafted elsewhere.

Question Four

How could legislators improve existing deficiencies and ensure that patients' treatment preferences are carried out?

1. Reduce inefficiency by combining various right-to-die statutes into one comprehensive act.

Figure 13.
States with Combined Advance Directive Statutes

Alabama	Maryland
Arizona	New Jersey*
Connecticut	New Mexico
Delaware	Oklahoma*
Florida	Oregon
Kentucky	Virginia
Maine	

*Does not include surrogate consent.

Source: ABA Commission on Legal Problems of the Elderly, 1997.

Living wills seem likely to be more effective if they include designation of a proxy. Thus, all state advance directive forms should be modified to provide for both proxy designation and treatment preferences. Having two separate forms—one for treatment preferences and one for appointment of a health care proxy—seems inefficient. States could make standard a single form that acts as both a living will and a health care proxy designation (although any patient can choose to complete only one or the other).

Thirteen states have merged their statutes into a combined advance directive law (see figure 13) that covers at least living wills and durable power of attorney and, in most cases, surrogate consent in the absence of an advance directive. Of the 13, four—Alabama, Delaware, Maine and New Mexico—use the Uniform Health Care Decisions Act as a model.

The act—a revised model act created in 1993 by the National Conference of Commissioners on Uniform State Laws to rectify the conflicts among the different state statutes—combines living wills, durable power of attorney and surrogate consent in the absence of an advance directive; allows for instructions to be either written or oral; and does not require that the document be witnessed. It also includes an optional form for the advance directive. It is significantly simpler and more comprehensive than most state statutes and therefore serves as a good model.

Figure 14.
States that Allow Close Friends as Surrogates

Arizona	Maryland
Colorado	New Mexico
Delaware	New York
Florida	North Dakota
Illinois	Oregon
Maine	West Virginia

Source: ABA Commission on Legal Problems of the Elderly, 1998.

States that have more recently enacted comprehensive laws have addressed the issues of family consent and nontraditional family and guardian consent. The laws all create a list of permissible surrogates, in order

of priority. About a fourth of state surrogate consent laws include a "close friend" in the list of permissible surrogates (see figure 14) and Arizona now includes a "patient's domestic partner."

2. Ensure flexibility to allow patients to modify their living wills to become more specific as conditions worsen.

The standard forms used by many states do not include any reference for specific treatment preferences in various contexts. Rather, the language used by the boilerplate forms is often vague and inapplicable to many medical problems. Ideally, advance directives should be modified to allow for flexibility as a patient's needs change. Written preferences should address new issues and become more specific as a disease progresses and worsens.

3. Emphasize the importance of patients' rights and understanding.

Ideally, advance directive forms should be part of a larger process known as "advance care planning," in which a patient's values and wishes are updated repeatedly over time. Additionally, patients must understand what the forms actually entail. It is not enough for a lawyer or physician simply to ask a patient to check a box and sign on the dotted line.

The focus needs to be on the communication and dialogue surrounding the act of filling out a state-based form. Use of a values questionnaire, with questions such as the ones in Figure 15, can facilitate that process.

Figure 15.
Examples of Values Questions

1. *What do you value most about your life?*
2. *Do you think life should be preserved for as long as possible? Why or why not?*
3. *Can you think of any possible scenarios in which you might feel differently about the above question?*
4. *Do your religious beliefs affect the way you feel about death?*
5. *Should financial considerations be important when making decisions about medical care?*
6. *Have you talked with friends and family about these issues?*

The Florida Commission on Aging with Dignity created another model to help individuals make decisions about end-of-life care. Specifically, the Commission developed a form entitled *Five Wishes* which lists five questions to facilitate end-of-life discussions and decision-making. The questions address: 1) the kind of medical treatment you want or do not want; 2) how comfortable you want to be; 3) how you want people to treat you; 4) what you want loved ones to know; and 5) which person you want to make health care decisions for you when you can not make them.

Legislators could allow these types of questions to be appended to the state's form, thereby reducing the possibility that advance directives will substitute for discussion within families and between health care professionals and patients. Perhaps including advance care planning as a part of health professional education curricula also would help to emphasize its importance.

4. Recognize other states' advance directives.

Advance directives written in one state often are of uncertain force in others, which means that, if a person lives in one state and receives medical care in another, portability can be a problem. Advance directive laws should allow for use of other state and nationally recognized forms, thereby assuring a higher likelihood that a person's preferences will be followed. States can be too restrictive by requiring that certain forms be used, thus creating a problem with reciprocity.

5. Address do-not-resuscitate orders for emergency medical services.

Figure 16.
States with Emergency Medical Service Do-Not-Resuscitate Laws

Alaska	Kansas	Pennsylvania
Arizona	Kentucky	Rhode Island
Arkansas	Maryland	South Carolina
California	Michigan	Tennessee
Colorado	Montana	Texas
Connecticut	Nevada	Utah
Florida	New Hampshire	Virginia
Georgia	New Jersey	Washington
Hawaii	New Mexico	West Virginia
Idaho	New York	Wisconsin
Illinois	Oklahoma	Wyoming

Source: ABA Commission on Legal Problems of the Elderly, January 1998.

A state law on advance directives cannot be considered complete without guidelines for emergency medical service (EMS) technicians. Keeping advance directive forms in patients' medical records is effective for clinical settings. But what of patients who receive home health care? How can they let their preferences be known should they need emergency treatment? It is customary medical practice to perform cardiopulmonary resuscitation (CPR) on anyone found to be in cardiac arrest—even though that action may not coincide with the wishes of all patients.

Thirty-three states have responded to the dilemma (see figure 16) by developing protocols to assist EMS technicians in withholding CPR in appropriate cases, thereby expanding the practical application of advance directives as a whole. Some states issue bracelets indicating a person's wish not to be resuscitated should he or she be found unconscious by EMS personnel. Others recommend to patients that they place the do-not-resuscitate form in a prominent place, so it will be obvious to anyone entering the home. States with laws addressing a variety of situations give their residents the greatest chance that their wishes will be followed.

6. Experiment with different strategies to make advance directives more accessible.

To inform the public of advance directives, some states are beginning to test varied approaches. For example, a handful of states—Alaska, Illinois, Minnesota, Missouri, South Dakota and Texas—allow for display of advance directives on drivers' licenses and identification cards. A few, such as California and Ohio, have even established state repositories and registries for advance directives.

2/5/02 ANC D. NEWS

Five wishes

Alaska law should permit end-of-life care guide

Anyone who has seen a loved one die a painful, lingering death can appreciate what Juneau State Rep. Bill Hudson is asking the Legislature to do. His bill to let Alaskans use the Five Wishes approach to direct their end-of-life medical care deserves speedy passage.

Five Wishes is a quick and easy way to declare in advance what you want, should you become unable to make your own medical decisions.

Five Wishes is a quick and easy way to declare in advance what you want, should you become unable to make your own medical decisions. Using the Five Wishes form, you list the person you want to handle your medical decisions. You write a living will to guide those medical decisions. You describe what you want by way of treatment for pain, having visitors, and notifying other people about your condition. You write down how you wish to be remembered should you die.

It's a simple process for people who want to use it. No need for a lawyer. No need to visit a notary public. Just have the completed form signed by two witnesses.

This quick and easy procedure does not permit someone to request assisted suicide or euthanasia. Rep. Hudson's bill explicitly bars those possibilities.

With that limitation, the bill avoids the most emotional and contentious part of the debate over end-of-life issues. Rep. Hudson's measure is a noncontroversial way to help Alaskans face life-threatening health crises with dignity and respect.

The Five Wishes Web site is www.agingwithdignity.org/5wishes.html. To read Rep. Hudson's bill, visit www.legis.state.ak.us/basis/start.asp and enter HB197 in the box labeled "Bill Root."

AARP Alaska

MAR 04 2002

Honorable Norman Rokeberg, Chair
House Judiciary Committee
Alaska Capitol Room 118 (MS 3100)
Juneau, AK 99801-1182

RE: HB 197 (Hudson) – Support

Dear Chair Rokeberg:

On behalf of the 112,000 members of AARP in Alaska, we urge you and your colleagues on the House Judiciary Committee to support HB 197, authored by Representative Bill Hudson and cosponsored by Representatives Beth Kerttula, Harry Crawford, and Ken Lancaster.

AARP believes that states should provide a comprehensive approach to health care decision making, such as that contained in the Uniform Health Care Decisions Act designed by the National Conference of Commissioners on Uniformed State Laws. Competent adults should be allowed and encouraged to communicate their medical treatment wishes and/or appoint a surrogate to make the treatment decisions for them in the event of their incapacity.

Representative Hudson's HB 197 will enable Alaskans to take advantage of the user-friendly "Five Wishes" document to communicate their desires.

AARP recommends an "AYE" vote on HB 197.

Should you have any questions about our position, please feel free to contact Marie Darlin (586-3637), Coordinator of the AARP Capitol City Task Force; Patrick Luby (907-762-3314), AARP Legislative Representative; or me (907-245-5259).

Thank you for your consideration.

Sincerely,

Marguerite Stetson

Marguerite Stetson
Executive Council Member for Advocacy

cc: Representative Ogan
Representative Coghill
Representative James
Representative Meyer
Representative Berkowitz
Representative Kookesh
Representative Hudson
Representative Kerttula
Representative Crawford
Representative Lancaster
Marie Darlin, AARP Capitol City Task Force
Pat Luby, AARP Legislative Representative

APR 1 7 2001

INTERNET ADDRESS:
acoa@admin.state.ak.us

P.O. BOX 110209
JUNEAU, AK 99811-0209
(907) 465-3250
FAX: 465-4716

Alaska Commission on Aging

RESOLUTION 01-07

In support of HB 197 - An Act relating to directives for personal health care services and for medical treatment.

Whereas, HB 197 will assist Alaskans to thoughtfully state their intent regarding the kind of medical, personal, emotional, and spiritual care they wish to receive in the last stages of their lives if they are no longer able to express their wishes, and

Whereas HB 197 provides a clear and helpful format to guide an individual in defining their wishes in this regard, and sharing that information with their loved ones, and

Whereas HB 197 draws upon the experience of thirty-six other states that have adopted this format,

Now therefore the Alaska Commission on Aging urges the 22nd Alaska Legislature to pass HB 197.

Adopted this 10th day of April 2001.

Marjorie J. Hays

Marjorie J. Hays, Chair

House HEALTH, EDUCATION & SOCIAL SERVICES Minute

H

Apr 17, 2001

HB 197-HEALTH CARE SERVICES DIRECTIVES

CHAIR DYSON announced that the first order of business would be HOUSE BILL NO. 197, "An Act relating to directives for personal health care services and for medical treatment."

Number 0019

MELANIE LESH, Staff to Representative Bill Hudson, Alaska State Legislature, came forth on behalf of the sponsor of HB 197. She read to the committee a statement written by Representative Hudson:

> I was asked to support this legislation by people I respect and who have long proved worthy of representing good causes. This cause I find to be very civilized and humanitarian. You will hear testimony from several persons in agencies that wish to enable others to give a voice to others who can no longer offer their own through the preparation of a list of their wishes for their final days. This bill expands the options for people who want to prepare themselves for when they can no longer speak or act on their own behalf. These expanded directives do not interfere with the current statutes concerning living wills and "do not resuscitate" orders. They simply provide for a form to be circulated with which the patient(s) can determine what they will need in respect to their comforts - emotional, spiritual, and physical. This bill will enable agencies that assist terminally ill patients by providing a document contained in the bill that spells out choices for them to consider with their family and their loved ones. It is hope that this document will continue to gain attention, as it has in 37 other states, and broach a subject that is uncomfortable for most of us, but necessary for all of us.

CHAIR DYSON asked what keeps people from doing this now.

MS. LESH responded that she would rather somebody else spoke to that. She said there are limited allowances in statutes now that provide for living wills, but nothing sets forth a form providing choices and options.

Number 0300

SIOUX PLUMMER, Juneau End of Life Task Force, came forth and stated that [HB 197] is easily a piece of legislation that can be supported by a variety of people in [Alaska]. She explained that this enables the legislature to aid Alaskans in having more clear and defined choices in how they want the end of their lives to be. She said 35 other states have laws that have a similar concept. This is based on the Five Wishes, a document of a few pages of statements that talks about what a person might want to think about and want the family or doctor to know when he or she is terminally ill. She stated that Five Wishes

was created by an organization out of Florida called Aging With Dignity. The gentleman who formed the Five Wishes worked with Mother Theresa for several years. She added that the intent of HB 197 is good public policy.

CHAIR DYSON asked why this needs to be in law.

MS. PLUMMER responded that to her understanding this improves and expands existing state statutes so it is clearer as to what the choices are. This aids someone in thinking about these things and legally enables him or her to do it.

CHAIR DYSON stated that the value of law is not to aid people in thinking. He asked who would go to jail if someone were to fill this out and it was not followed through.

MS. PLUMMER answered that she does not know of any language in this law or the new proposed law that would say that if it weren't followed, somebody would go to [jail].

CHAIR DYSON asked why this should be put in law, then.

MS. PLUMMER replied that she thinks the Department of Health & Social Services or the Department of Administration might have some suggestions that it merely be in regulation.

CHAIR DYSON asked why the state needs to be involved in this.

MS. PLUMMER remarked that she was hoping someone from Aging With Dignity could talk about what other states have done and why this was put it into law. She added that she wants to urge [the legislature] to understand and support the concept and the intent of [HB 197].

Number 0573

REPRESENTATIVE STEVENS stated that he thinks Chair Dyson is getting at a good point. He said he had just received from his mother a power of attorney and a living will and would like to know what [the proposed legislation] would do that the power of attorney and the living will do not do.

MS. PLUMMER stated that she believes this language just expands on what already exists and gives a greater clarity to what a living will could include.

REPRESENTATIVE STEVENS asked if there is a contradiction among the living will, the power of attorney, and this [proposed] form. He asked what legally would take precedence.

Number 0671

JANE DEMMERT, Executive Director, Alaska Commission on Aging, Department of Administration, came forth and stated, in response to Representative Stevens' questions, that it might be helpful to take a look at some of the statements that begin on page 13 of the bill. She said:

> I'll just speak for myself as an individual. Acknowledging that I will die is a hard thing to come to grips with; it's even harder to think about how - to the extent that it could happen - I would like to be cared for and treated when I can no longer, through a discussion like this, tell people what I'm seeking. One of the steps that this takes is to - based on the

> experience of people in many different settings now - pose some statements here that would help me ... to anticipate the kinds of circumstances that I would experience. And then to, based on that, say, "And here's how I'd like you to support me as I'm going through these last stages of my life."

CHAIR DYSON asked what would take precedence and if this has any legal standing.

MS. DEMMERT explained that there is a reference on page 17 about how this would phase in. It states:

> ... a person who, by a statutory form power of attorney executed under AS 13.26.332 before the effective date of this Act, has been given powers to make health care decisions under and consistent with authority set out in the repealed provisions, may continue to exercise those powers under and consistent with the authority set out in the repealed provisions until the appointment made by the statutory form power of attorney with respect to health care services terminates or is revoked.

MS. DEMMERT stated that she thinks this speaks to one of the considerations in terms of how this would articulate with current statutes.

Number 0880

CHAIR DYSON remarked that there is no "or else." He asked if there is anything that binds the caregiver to obey it, besides helping people think this through. He asked what the penalty would be for disobedience.

MS. DEMMERT responded that she does not know. She asked, "Philosophically, do you think there should be, if there's not?"

CHAIR DYSON answered absolutely, if it is going to be put into law.

MS. DEMMERT remarked that this is very interesting because it brings together a number of provisions as well as charts some new ground. She said she believes everyone is thinking about this in a more comprehensive fashion.

Number 0981

REPRESENTATIVE CISSNA asked if this is a general power of attorney. She said that would mean the person who has been designated as having the power of attorney can do the things that are listed here; therefore, there would be some statutory strength. She also asked if there are additional things in [the proposed form] beyond a normal power of attorney

MS. DEMMERT answered yes.

REPRESENTATIVE CISSNA remarked that she personally thinks this is useful. She shared that her late husband had a power of attorney and a living will, and one of the horrendous things she went through was trying to figure out what he meant. She said she can see a real need for trying to make that very end decision a clear one.

CHAIR DYSON stated that it certainly is a power of attorney and

covers a lot of things. He said that he suspects [the committee] will pass the bill and let [the House Judiciary Standing Committee] wrestle with whether or not there should be a form in state law.

MS. LESH commented that Representative Hudson has acknowledged that the directive could be maintained in the bill and that the form could be brought about through a regulatory direction through the legislature. She said Representative Hudson was willing to work with the national Dying with Dignity group because there is some legislation in other states that enables the state agency to create the form with the direction of the legislature. She added that Representative Hudson has also wrestled with the idea that the form's being in the statute may not be the best method.

Number 1245

CHAIR DYSON stated that he appreciates that. He remarked that he is particularly interested in how the [medical] industry feels when somebody says, "I don't want pain killers," and yet the whole tradition has been to make the patient comfortable. He asked if [the industry] will be afraid of liabilities.

MS. PLUMMER stated that the Juneau End of Life Task Force is a group of people that began talking with Representative Hudson about this legislation. She said she also serves on the Hospice Foundation Board for Juneau, which endorses HB 197. She read from a document from the Hospice Foundation Board:

> The meaning of HB 197 is really a gift to one's family members and friends so they won't have to guess what you want. The Hospice and Homecare of Juneau's board of directors urges approval of HB 197.

CHAIR DYSON remarked that the two times he has been involved in cases like this, there weren't elderly people involved. He noted that nothing has been put in [the bill] that refers to children.

MS. PLUMMER responded that those are the kinds of things that people often include in their durable powers of attorney or their wills. She said this is only addressing the very intimate end of life decisions a person makes.

CHAIR DYSON stated that he is confused because page 2 [of the bill] lists a lot of important things such as banking transactions, real estate, claims, and litigation.

MS. LESH responded that those provisions stay in statute just as they are. [House Bill 197] creates a new section that deals with health care directives.

REPRESENTATIVE CISSNA stated that she is assuming the line here is between the [the person the] power of attorney that is in place while the person in question is alive and the executor of the will who is there after that transition.

MS. PLUMMER responded that sometimes it is the same person [who is named in the durable power of attorney], but that is up to each individual.

Number 1444

MOLLY EIDEM, Long Term Care Ombudsman, testified via

teleconference on behalf of Suzan Armstrong. She read to the committee:

> The Office of the Long Term Care Ombudsman (OLTCO) supports HB 197, "An Act relating to directives for personal health care services and for medical treatment." Long Term Care Ombudsmen from around the country have been extolling the benefits of Five Wishes for some time now. Our clients, the elderly of Alaska, need clear tools, written in specific language, that [direct] our health care providers and others on how to administer to our clients' final needs. Too often, the OLTCO has attempted to help family and friends struggling to determine what their loved one would want and not want, and having little, if any, input from the elder. Sadly, acute conditions that inhibit worthwhile communication or chronic conditions such as dementia prevent our clients from expressing their wishes and desires during their final days and hours. The Five Wishes format would be a priceless gift to all of our Alaska families and would greatly enhance our capabilities to administer to our dying Alaskans' final wishes and to plan for our own.

Number 1529

CHAIR DYSON called for an at-ease at 3:28 p.m. The meeting was called back to order at 3:40 p.m.

[HB 197 was held over.]

House HEALTH, EDUCATION & SOCIAL SERVICES Minute

H

Apr 19, 2001

HB 197-HEALTH CARE SERVICES DIRECTIVES

CHAIR DYSON announced that the first order of business would be HOUSE BILL NO. 197, "An Act relating to directives for personal health care services and for medical treatment."

Number 0086

PAUL MALLEY, Program Manager, Aging with Dignity, testified via teleconference. He stated that [Aging with Dignity] is a national nonprofit organization with offices in Washington [D.C.] and Miami. The headquarters in Tallahassee, Florida, are where the Five Wishes advanced directive is distributed throughout the country. He explained that within two weeks of Five Wishes being introduced in Florida in 1997, there were more than 50,000 requests from people all over the country who wanted a copy of the Five Wishes. So many people were interested because it is easy to use and it includes many of the issues that matter most to people, including some of the non-medical issues.

MR. MALLEY stated that once [Aging with Dignity] started receiving requests, it began to work with the American Bar Association to make the document completely valid. It added a commission dealing with legal problems of the elderly and expanded the law of 50 states regarding advanced care planning. He stated that when Five Wishes was introduced in 1998, it was valid in 33 states. All of the 33 states had a suggested advanced directive form, but the residents were given the opportunity to put their wishes in their own words. Since then it has become legally valid in an additional two states - California and West Virginia. Both of those states enacted laws in the past two years that made Five Wishes valid, but they did not include Five Wishes in the state statutes. He noted that in some cases it was a matter of changing one word, from "the advanced directive must be in the following form" to "the advanced directive may be in the following form."

MR. MALLEY said [Aging with Dignity] is now working with people in several states who are trying to change their [state] laws to make Five Wishes legally valid. [Aging with Dignity] is also working with more than one million American families and 3,000 organizations, all of which have copies of Five Wishes and are using it. The greatest interest is coming from some states where Five Wishes is not legally valid. He stated, in closing, that he would like to congratulate and thank the committee for even considering this legislation, which [Aging wich Dignity] believes will greatly help the people of Alaska put their wishes in their own words and therefore get the kind of care they want at the end of life.

Number 0376

CHAIR DYSON asked what forces a hospital to comply [with the advanced directive].

MR. MALLEY responded that [hospitals] are bound by the laws of

the state, which require that the advanced directive be followed if it meets requirements in the state statute. He said counsel for the Council of the American Bar Association believe that Five Wishes would stand up in court in all 50 states because of the so-called Patient Self-determination Act, which is a national Act that requires health care providers to be involved with individuals' wishes. He added that [Aging with Dignity] has not had one instance in which an individual who filled out Five Wishes did not have his or her wishes honored.

CHAIR DYSON asked what the penalty is if an institution does not [honor the Five Wishes].

MR. MALLEY answered that he believes that would probably vary by state.

CHAIR DYSON asked whether Mr. Malley knows of any states that have criminal or civil penalties if the directives are not followed.

MR. MALLEY responded that he knows there have been several instances in which criminal suits have been filed against health care providers who have not followed an individual's wishes that were spelled out in a legally valid advanced directive.

CHAIR DYSON stated that it appears to him that this form is directed to elderly people and not necessarily to those who are facing life-threatening diseases earlier in life.

MR. MALLEY stated that this is good for anyone who is 18 or older. He remarked that [Aging with Dignity] is working with companies to institute a program that would provide Five Wishes as an employee benefit. He said [Aging with Dignity] encourages people to fill out Five Wishes, or any advanced directive, before they get seriously ill.

CHAIR DYSON stated that in the first hearing of this bill [the committee] discussed whether or not the form itself ought to be put in state law, as opposed to being referenced in law.

MR. MALLEY stated that he thinks it would be better to reference the form rather than including the actual document, word for word, in the state's statute. He said there hasn't been a state to do that yet. He explained that if there were any changes to Five Wishes, [Aging with Dignity] would have to come back to [the legislature] and ask for another statute to be passed for the revisions.

[HB 197 was suspended temporarily in order to hear other legislative business.]

House HEALTH, EDUCATION & SOCIAL SERVICES Minute

H

Apr 19, 2001

HB 197-HEALTH CARE SERVICES DIRECTIVES

[CHAIR DYSON returned the committee's attention to HOUSE BILL NO. 197, "An Act relating to directives for personal health care services and for medical treatment."]

MELANIE LESH, Staff to Representative Bill Hudson, Alaska State Legislature, stated that Representative Hudson, sponsor, would like to continue to work on amending HB 197.

Number 0370

MARIE DARLIN, AARP (formerly the American Association for Retired People), came forth and stated that AARP has been interested in the additional help given to families by use of the Five Wishes outline. She said it definitely helps in planning for health care needs with more complete advanced directives from the elderly or disabled person. She added that she would also like to direct [the committee's] attention to recommendation 10 of the January 1999 Long Term Care Task Force Report, which speaks to the importance of advanced directives and the need for public education regarding their availability.

LORILYN SWANSON, Manager, Fireweed Place, came forth and stated that she is also a member of the Commission on Aging. She said:

> I am here today to express to you, from the viewpoint of a service provider, the importance of advanced directives and how HB 197 will meet and assist Alaskans in encouraging people to discuss with their families and friends their personal wishes for care prior to ... becoming incapacitated. I have watched many families find it necessary to make decisions with regard to loved ones and their care at a time when they are not prepared to do so, due to death, due to the imminent prospect of the loss, guilt, denial, grief, or family dissention. Many times these decisions needed to be made immediately or quickly without knowing or having even spoken to the person concerned because no one wanted to address the subject or talk about [it]. It was just too difficult to discuss. When it [it] almost too late and all the forms [needed] to be found, it's extremely difficult to find the forms in one place.
>
> No one form or collection of forms at this time addresses the directives as well as HB 197. It is written and encourages discussions with families in an open and dignified way, with options one might not think of on one's own. It offers a clear reconciliation at the close of life of one's wishes. It prompts one to think of options and gives an opportunity to express oneself.

Number 0612

EUGENE DAU, Volunteer, AARP, came forth and stated that every

time people talk about this, they think about money. He said he thinks filling out the form will get more people to do what they should do, instead of holding back because they think it will cost them $300.

LINDA FINK, Assistant Director, Alaska State Hospital and Nursing Home Association (ASHNA), came forth and stated that in concept [ASHNA] supports the legislation but does not support how it is drafted. She said [ASHNA] would like to work with the sponsor over the interim in order for the bill to work for the providers who have to deal with the forms as well as the people who are filling the forms out.

[HB 197 was held over.]

Bill Root: Display Bill Root

House HEALTH, EDUCATION & SOCIAL SERVICES Minute

H

Apr 24, 2001

HB 197-HEALTH CARE SERVICES DIRECTIVES

CHAIR DYSON announced that the final order of business would be HOUSE BILL NO. 197, "An Act relating to directives for personal health care services and for medical treatment."

MELANIE LESH, Staff to Representative Bill Hudson, Alaska State Legislature, came forth on behalf of the sponsor of HB 197 and stated that reference has been made in the bill on page 2, Section 2 [of the proposes committee substitute (CS) for HB 197, 22-LS0712\C, Bannister, 4/12/01], that the Five Wishes form containing the health care directives is more or less sanctioned by the state. It states, "a person may use a form that is substantially similar to the Five Wishes form for making directives [related to the person's health care and death,] including designating another person to act as an attorney-in-fact or other agent".

Number 0628

REPRESENTATIVE JOULE made a motion to adopt the proposed CS for HB 197, 22-LS0712\C, Bannister, 4/12/01, as a work draft. There being no objection, Version C was before the committee.

REPRESENTATIVE WILSON stated that she wasn't present during [the first hearing of the bill], and asked for an explanation.

CHAIR DYSON explained that a group of people who have been in hospice care and deal with people who are dying have come up with the Five Wishes of what people can indicate what they would like to have done as they are dying.

Number 0743

REPRESENTATIVE STEVENS moved to report [CS]HB 197 out of committee with individual recommendations and the accompanying zero fiscal note. [His motion was not addressed.]

REPRESENTATIVE COGHILL stated that he thinks referencing the form and having a list of definitions is good. He asked, if everything [in the bill] is permissive and nothing is mandated, whether this is going to be sufficient.

MS. LESH responded that the other states that have implemented this also have a more permissive statutory structure that enables this to be something a citizen can take advantage of, but it's not a mandatory form. People in the legal field [in Alaska] have weighed in on this and said that they do wills and trusts for businesses, but would like this form to be available for people who can't hire attorneys.

REPRESENTATIVE COGHILL stated that this is a contractual framework that would already be legitimate if the [legislature didn't pass this bill]. He said he is trying to understand that logic.

MS. LESH stated that it is her understanding, through the

information received from Aging With Dignity, that Alaska's laws do conflict and don't allow this. [Alaska] is one of the only states that has statutory inhibitions to allowing this form to be used legally by the average person who wants to find it himself or herself.

Number 0920

REPRESENTATIVE CISSNA moved to report [CS]HB 197 out of committee with individual recommendations and the accompanying zero fiscal note.

REPRESENTATIVE WILSON stated that [the hospital she works in] already has advanced directives. She asked if most hospitals have them.

MS. LESH responded that the advanced directives [in hospitals] are living-will advanced directives that don't go to the extent of the Five Wishes. This expands extensively the options for terminally ill individuals.

REPRESENTATIVE COGHILL remarked that it has to be expressed with caution that many times these forms can be filled out in a very leading way.

Number 1017

CHAIR DYSON announced that there being no objection, CSHB 197 (HES) was moved from the House Health, Education and Social Services Standing Committee.

Bill Root: _____ Display Bill Root

Alaska State Legislature

REPRESENTATIVE BILL HUDSON
House Finance Committee

State Capitol
Juneau, Alaska
99801-1182
(907) 465-3744
Fax (907) 465-2273

MEMORANDUM

TO: Representative Norm Rokeberg, Chairman
House State Affairs Committee

FROM: Representative Bill Hudson
Alaska State Legislature

SUBJECT: HB 197 Hearing Request

DATE: February 27, 2002

I respectfully request that you schedule HB 197 before your committee at your earliest possible convenience.

The attached proposed committee substitute is the result of an effort over the interim to work with interested supporters of the "Five Wishes" form for end-of-life health care decisions to remedy the limitations presented by the current mish-mash of Alaska's statutes. The draft CS incorporates the Uniform Health Care Decisions Act into HB 197 to align existing state statutes concerning living wills, do not resuscitate orders and a new durable power of attorney for health care decisions, into a new Chapter designed to allow the patient to specify their "Wishes" relating to these personal decisions.

Also attached is a new sponsor statement for the draft CS, a sectional analysis, the original bill, the HESS Committee Substitute and relevant background information. To date I have received only positive public opinion on the bill and have included in the background information a small sample of letters of support.

If you have any questions regarding this request please contact my staff member handling this legislation, Melanie Lesh at 465-4230.

Thank you for your consideration.