HB

25

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 25(HES)
(H) Publish Date: 3/10/03
Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: HEALTH CARE DECISIONS/DO NOT RESUSCITATE ORDERS/DONATION OF BODY PARTS

BRU: State Health Services
Component: Community Health/EMS Services

Sponsor: WEYRAUCH
Requester: HOUSE (HES)
Component No.: 2078

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

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 (FY2003) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

Currently, various end-of-life provisions are located in different statutes which are narrowly drafted, create confusion for the public, and make it difficult for people to direct their end-of-life care and treatment. The bill establishes a new chapter called the Health Care Decisions Act. The intent of this bill is to provide a tool for end-of-life planning and recording of health care decisions, in one easy to understand chapter of state statute. The Division of Public Health supports the goals of this act. There will be no fiscal impact to the Division by passage of this bill.

Prepared by: Karen E. Pearson, M.S., Director — Phone 465-3090
Division: Public Health — Date/Time 02/13/2003
Approved by: Joel S. Gilbertson, Commissioner — Date 02/13/2003
Agency: Department of Health and Social Services

ALASKA STATE LEGISLATURE

Rep. Lesil McGuire, Chair
Rep. Tom Anderson, Vice-Chair
Rep. Dan Ogg
Rep. Jim Holm
Rep. Ralph Samuels
Rep. Les Gara
Rep. Max Gruenberg

State Capitol, Room 120
Juneau, AK 99801-1182
(907) 465-4990
Fax (907) 465-6592

House Judiciary Committee

Memorandum

To: Leg. Legal

From: Vanessa Tondini, Committee Aide
House Judiciary Committee

Date: March 31, 2003

Re: CS Request

Please create a final draft House Judiciary Committee Substitute for work order # 23-LS0137\I, CSHB 25 (HES): Health Care Services Directives, incorporating the attached seven amendments. The bill was passed out of committee today.

If you have any questions, please call me at 4990. Thank you!

AMENDMENT NO. 1 - Adopted

OFFERED BY: Weyhrauch

1. At page ~~8~~ 8-4. Insert (b)(1) **Except in the case of mental illness,** an individual.....

> **(2) In the case of mental illness, a declaration may be revoked in whole or in part at any time by the principal if the principal is neither incapable nor incompetent. A revocation is effective when a capable, competent principal communicates the revocation to the attending physician or other provider. The attending physician or other provider shall note the revocation as part of the principal's medical record. The authority of a named agent and an alternative agent named in the declaration continues in effect as long as the declaration appointing the agent is in effect or until the agent has withdrawn.**

RATIONALE: The whole intent of an advance directive for an individual with mental illness is to provide rational decision-making while capable because the individual knows s/he may not be able to do so upon becoming incapable. To allow revocation while incapable negates the whole purpose for the individual with mental illness. The language above is drawn almost verbatim from the current mental health treatment statute. *See,* AS 47.30.950 and 47.30.966.

By request of Disability Law Ctr

AMENDMENT NO. 2 - Adopted

OFFERED BY: Weyhrauch

At page 28, line 4, delete "guardian or conservator" and insert "person"

RATIONALE: the current definition in CSHB 25 (HES) of "guardian" is circular, and inclusion of the reference to "conservator" may cause confusion. In an individual case it may overstate the authority of a conservator. For example, a conservator may be appointed for financial matters, but not have authority under the court order to deal with health matters.

By request of the Disability Law Ctr

AMENDMENT NO 3 - Adopted.
OFFERED BY Weyhrauch

1. At page 29, lines 3-4, insert after line 3, **(20) "incompetent" means that, in the opinion of the court in a guardianship proceeding under AS 13.26, in the opinion of two physicians that include a psychiatrist, or in the opinion of a physician and a professional mental health clinician, a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions.**

At page 29, line 9, insert after line 9, **(23) "mental health treatment" means electroconvulsive treatment, treatment with psychotropic medication, and admission to and retention in a facility for a period not to exceed 17 days.**

Rationale: Both definitions are in the current mental health treatment statute, and both comport with the intent of the current bill. Inclusion of the definitions will clarify exactly when an individual with a mental illness loses the ability to effectively communicate decisions for her/himself and yields the decision-making authority to the wishes expressed in the advance directive, or the agent or surrogate.

& renumber accordingly.

By request of the Disability Law Ctr

AMENDMENT NO. 4 - Adopted.

OFFERED BY: Weyhrauch

At page 4, delete lines 20-29, and insert:

Sec. 13.52.030. Decisions by surrogate. (a) Except in the case of mental health treatment, a surrogate may make a health care decision for a patient who is an adult or emancipated minor if an agent or guardian has not been appointed, or the agent or guardian is not reasonably available, if the patient has been determined to lack capacity by the primary physician;

(b) A surrogate may make a decision regarding mental health treatment for a patient who is an adult or emancipated minor if an agent or guardian has not been appointed, or the agent or guardian is not reasonably available, the mental health treatment is needed on an emergency basis, and the patient has been determined to lack capacity by

(1) two physicians that include a psychiatrist; or

(2) one physician and a professional mental health clinician"

ignore line

Reletter accordingly subsections beginning on page 4, lines 30 and following.

RATIONALE: this language is proposed to more clearly define the limits of authority for one to act as a surrogate when the matter involves mental health treatment, and limits surrogate power in that case to emergency care to sustain life. The proposed revision also preserves the criterion existing in current law with regard to who must determine incapacity for mental health treatment purposes.

AMENDMENT #5 - Adopted

OFFERED BY: REP. WEYHRAUCH

Page 2, line 13, after "execute a"
Insert **"durable"**

Page 16, line 22, after "form is a"
Insert **"durable"**

Page 26, line 21,
Insert **"durable"** before "power of attorney"

AMENDMENT #6 - Adopted

OFFERED BY: REP. WEYHRAUCH

Page 17, line11, after, after "disapprove
Insert **"proposed"**

Page 28, line 13, after "disapproval of"
Insert **"proposed"**

AMENDMENT #7 - Adopted

OFFERED BY: REP. WEYHRAUCH

Page 25, line 26, after "facility"
Strike lines 26b, 27, 28, 29 "I am not related..."

ALASKA STATE LEGISLATURE

Representative Bruce Weyhrauch

HOUSE DISTRICT 4

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
99801-1182

(907) 465-3744
FAX (907) 465-2273

MEMORANDUM

DATE: March 28, 2003

TO: Vanessa Tondini
Rep. Lesil McGuire

FROM: Linda Sylvester
Rep. Bruce Weyhrauch

SUBJECT: HB 25 – Healthcare Directives Witness List

In advance of this afternoon's hearing, I would like to inform you about the witnesses we've asked to speak on HB 25.

After the bill has been introduced, Paul Malley, the Executive Director of Aging With Dignity will speak about the background of the Five Wishes movement. Mr. Malley will call in from Florida. Following Mr. Malley, I expect these people to speak in support:

Edie Zaukauskas, Attorney for the Disability Law Center, will call in from Anchorage (mental health),
Richard Rainery, from the Mental Health Board will be in attendance,
Bob Briggs, from the Disability Law Center,
Dick Block, from the Christian Science Church, will call in from Anchorage (the 5 Wishes),
Shelley Owens, from the Comfort One Program with the State of Alaska will be in attendance (DNR orders),
Jens Saakvitne (Saw-quit-ney), from Life Alaska, will be on-line from Anchorage (anatomical gifts),
Sioux Douglas, from Hospice will be in attendance,
Marie Darlin, from AARP will be in attendance.

As well, there may be many others from Hospice and AARP.

Please let me know, in advance of the hearing if you have specific recommendations.

Representative _Bruce_Weyhrauch@legis.state.ak.us
www.akrepublicans.org/weyhrauch/

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

National group criticizes Alaska for poor end-of-life care

By ANN POTEMPA
Anchorage Daily News

Last year, for the first time, the national organization Last Acts rated the states on their treatment of dying patients and gave Alaska a failing grade in several areas.

Last Acts is a coalition of organizations, including the American Medical Association and American Association of Retired Persons, now called AARP, funded by the Robert Wood Johnson Foundation. Last Acts' goal is to improve care for people nearing the end of life.

The coalition's report card for Alaska cited several areas for improvement.

- A low percentage of Alaskans 65 and older died with the help of hospice programs. Hospice emphasizes comfort care for people with terminal illness.
- The state lacks physicians and nurses trained in palliative care, which controls pain and other symptoms and improves quality of life for dying patients.
- The state's hospitals don't have enough pain and palliative care services.
- Alaska laws don't support good care planning, such as living wills and powers of attorney. A medical power of attorney makes health care decisions for patients when they can no longer communicate for themselves.

Local Hospice directors say the grade from Last Acts doesn't tell the whole story.

"Part of me feels like yeah, I agree, we have a long ways to go," said Julia Thorsness, executive director for Hospice of Anchorage. "There's so much to be done."

Even so, Thorsness said the grading system didn't acknowledge the good work being done in Alaska by nontraditional programs. For example, Thorsness said Last Acts focused on hospice programs certified by the Medicare program. In Alaska, only the hospice program in the Mat-Su Borough has such certification, allowing it to bill Medicare for health care services.

But volunteer programs from Juneau to Kenai to Anchorage to Fairbanks offer similar end-of-life care, Thorsness said. In recent years, a group worked with the Bristol Bay Area Health Corp. to start Helping Hands, a unique program that helps terminally ill Bush residents return to their home villages to die.

And now Alaska has Karen Gilley, a nurse trained to offer harp music for people facing death.

"It's a wonderful resource for the community to have," Thorsness said.

"There are a variety of ways of offering that comfort and support. Sometimes it's massage. Sometimes it's music. Sometimes it's pets," she said. "We really strongly support everyone who's willing to offer whatever their gifts are."

Local hospice directors addressed some of Last Acts' concerns. The national coalition cited a lack of participation in hospice programs. In 2001, Hospice of Anchorage served 144 patients, most of whom had cancer, Thorsness said. During the same time period, the hospice in Mat-Su worked with 66 patients, said Babetta Daddino, the program's manager.

Hospice programs also are certifying more caregivers in hospice and palliative care.

Daddino said Hospice of Mat-Su didn't have any certified nurses before last fall, now it has five. Thorsness said two nurses working with the Anchorage program are certified for hospice care.

State legislators are addressing Last Acts' concern that Alaska's laws don't support good care planning. Rep. Bruce Weyhrauch, a Republican from Juneau, is sponsoring House Bill 25 this session. The bill attempts to create a comprehensive approach to making health care directives, such as picking powers of attorney.

Thorsness and Daddino stressed the importance of continuing education for professionals providing end-of-life care and for the community so residents understand what options they have. In May, Dr. Ira Byock, author of "Dying Well: The Prospect for Growth at the End of Life," will spend two days in Alaska visiting hospitals and consulting with Providence Alaska Medical Center about its palliative care team. Byock also will speak at a free public session in Providence's auditorium on May 8.

"I think it's such a new field," Thorsness said. "I think we're in a big group of states that are trying to figure out what's the best way to meet this need, especially with the aging population. There's going to be more people wanting more services."

Anchorage Daily News
2-23-03

Hospice and Home Care of Juneau

419 [illegible] Street, Juneau, AK 99801
(907) 463-3113 • fax (907) 463-3835

March 5, 2003

Re: HB25

Dear Rep. Bruce Weyhrauch and members of the HESS Committee:

Last year, the Hospice and Home Care Board of Directors reviewed and unanimously endorsed HB25's previous incarnation, HB197. Hospice and Home Care continues its support by endorsing HB25.

The State of Alaska already has regulations and guidelines in place regarding Advanced Directives. These statutes have been revisited and amended many times since they were first adopted. The value of HB25 is that it would provide all Alaskans with a comprehensive, user-friendly resource for addressing their end of life needs. Many people find legal documents to be confusing and intimidating, particularly when they are under the kind of stress one might experience when facing a serious illness or the end of life. Having one easy-to-understand document would greatly encourage people to address those issues before they find themselves in a crisis situation.

HB25 would empower all Alaskans, both healthy and terminally-ill, to:

1. appoint the person they want to make care decisions for them if they are unable to;
2. convey the specific kinds of medical treatment they want and/or don't want;
3. indicate their specific preferences for personal comfort and pain management;
4. convey how they want to be treated with regard to their physical and mental needs; and
5. determine what they want loved ones to know about their end of life decisions.

HB25 really represents a gift to one's family and friends, so they are not left with the burden of having to guess at a loved one's wishes at the end of life. Hospice and Home Care urges you to approve HB25.

Lori Brotherton

Lori Brotherton, Program Coordinator
Hospice and Home Care of Juneau

February 27, 2003

Representative Bruce Weyhrauch
House of Representatives
State Capitol, Room 102
Juneau, Alaska 99801

VIA FAX 465-2273

Dear Represenative Weyhrauch,

I am writing in support of CS HB 25, an act relating to advance directives for personal health care services, and end-of-life medical treatment, as well as do not resuscitate orders, body part donations, mental health treatment decisions, and powers of attorney relating to health care.

I appreciated the opportunity to testify before the House HESS committee and respectfully request that you pass on these written comments to the full committee for their further consideration.

Your legislation is becoming far more comprehensive than was originally intended when the Juneau End of Life Task Force first asked two years ago for it to be introduced. I believe this is a good thing, and that a thoughtful and thorough review and consolidation of various existing statutes will help to make the statuatory language more "user-friendly" about difficult subjects. The law should not be too complicated to find, to understand and to share with others, especially in end-of-life situations.

With the latest amendments, I believe the intent of the legislation is still very good public policy. It is an opportunity for the legislature to legitimately aid Alaskans by improving state laws so that patients and families can have greater choice and quality of life during the dying process. Nowhere in this legislation does it suggest how a person should die; it simply and clearly defines legally available choices.

My husband, brother, mother, father, son and mother-in-law all died in the past four years. I personally know the pain of lingering death and have become quite aware of how last-minute decisions, lack of communication, absence of advance directives, and lack of knowledge and/or experience by health-care professionals can aggravate the difficult and emotional time of dying. Death is indeed part of living, but because it is final, Americans generally have a difficult time talking about it and dealing with it. The fact is, all the circumstances surrounding death *need not be bad.* Your legislation will help to *improve* how Alaskans die.

The original intent of this legislation is based upon a document called *The Five Wishes,* which makes it easier for patients to let family, friends and doctors know in advance how they wish to be treated if they become seriously ill and cannot tell them. Over 35 states

have laws similar to the language in your proposed legislation. *The Five Wishes* originates from the Commission on Aging with Dignity, a non-profit organization in Florida formed to affirm and safeguard human dignity, and to promote better care of the dying in America. With your bill, Alaska now has the opportunity to join with those states in a common-sense, humane effort of compassion.

I urge the HESS Committee to pass out HB 25 and I deeply appreciate your sponsoring it.

Sincerely,

Sioux Douglas

Sioux Douglas
5050 Thane Road
Juneau, Alaska 99801
463-3042

cc: Rep. Peggy Wilson, Chair
and Members, House HESS Committee

Renée Guerin

P. O. Box 20886 Juneau, Alaska 99802 (907) 586 - 2274

February 25, 2003

Representative Bruce Weyhrauch
Alaska State House

Dear Rep. Weyhrauch:

I write in support of HB25. This is such an important piece of legislation for all Alaskans ..... for people everywhere.

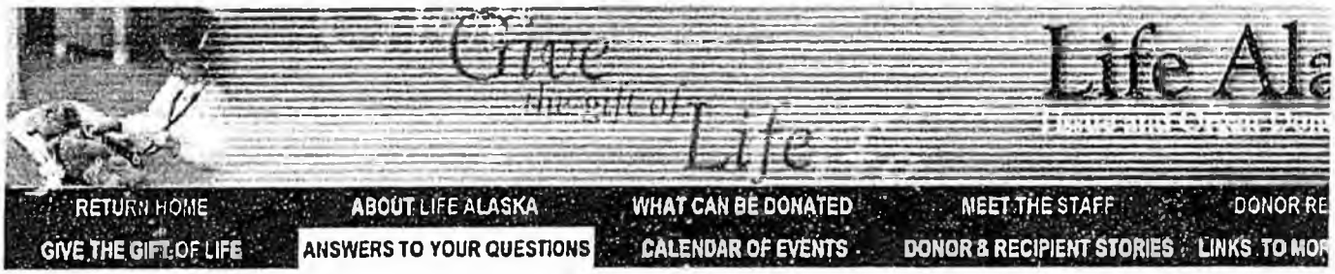
As medicine makes it possible for us to live longer, the way in which we approach our finality becomes even more meaningful. The Five Wishes addresses critical aspects of what we, as individuals, have a right to expect from those in charge of our care when we are incapacitated.

Not everyone is the same. There are believers and non-believers, there are stubborn old coots and helpless weepers, there are those surrounded by caring families, and those who are heartbreakingly alone. We all deserve the dignity of making our own choices while we are able.

Thank you for introducing this bill, and please put all of your effort into helping it become law.

Respectfully,

Renée Guerin



click icon to view a public service ad from the Coalition on Donation.

download an "executable" file of the same ad that you can send to a friend.

Who can become a donor?

You should consider yourself a potential tissue and organ donor. Your medical condition at the time of determine what organs and tissues can be donated.

What organs and tissues can I donate?

Needed organs include the heart, kidneys, pancreas, lungs, liver and intestines. Tissues that can be dona others include the eyes, skin, bone, heart valves and tendons.

Will my decision to become an organ and tissue donor affect the quality of my medical care?

No. Organ and tissue recovery takes place only after all efforts to save your life have been exhausted an has been declared. The doctors working to save your life are entirely separate from the medical team inv recovering your organs and tissues.

Will donation disfigure my body? Can there be an open casket funeral?

Donation neither disfigures the body nor changes the way it looks in a casket.

Are there any costs to my family for donation?

No. Donation costs nothing to the donor's family or estate.

Does my religion approve of donation?

All major religions approve of tissue and organ donation and consider it a gift, an act of charity. If you h questions, contact your religious advisor.

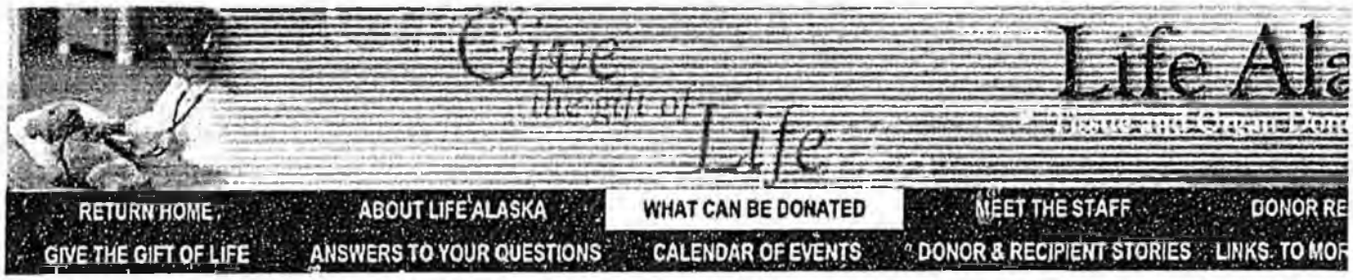
What will happen to my donated organs and tissue?

A national organ sharing system with federal oversight ensures the fair distribution of organs in the Uni Organs are first offered to patients from the Northwest including Alaska. Recipient choice is based upo

type, length of time on the waiting list, location, severity of illness and other medical criteria.

All tissues donated to Life Alaska are first offered to Alaskan patients, then to the person in the greatest across the United States. For organs and tissues that must be transplanted within hours or days, if no sui recipient is found in the United States, then the organs or tissues may be offered for transplant on an int basis.

Click here to request more information from Life Alaska.



What Tissues/Organs Can Be Donated For Transplantation?

TISSUES

Corneas\Eyes
To restore or improve sight.

Humerus
To prevent amputation.

Iliac Crest
Made into several blocks; for spinal fusion and stabilization.

Long Bones
For whole or partial replacement. Sectioned into smaller pieces or made into powder to fill in bone defects.

Patellar Tendon
For knee repair and stabilization surgery

Achilles Tendon
For knee, ankle, and shoulder repairs.

Ear Ossicles
(Incus, Malleus, Stapes) To restore hearing loss.

Heart Valves
To replace defective or diseased valves.

Skin
Life-saving, temporary skin replacement for severely burned patients; also used for dental reconstruction.

Saphenous Veins
To replace blocked arteries in heart bypass surgery; also used for limb saving reconstruction surgeries.

ORGANS

Heart
A heart transplant can return the person to a near normal life. (A heart recipient completed the Boston Marathon.)

Lungs
Single & double lung transplant along with heart lung transplant is a second chance at life.

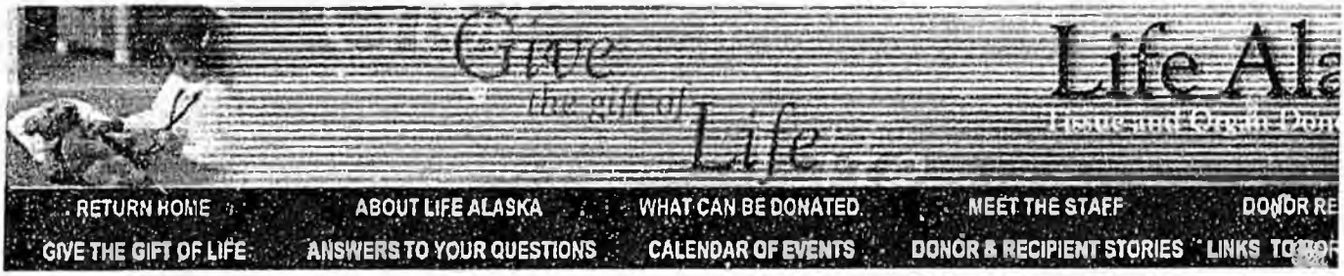
Liver
Infants and adults need this lifesaving transplant.

Pancreas
Can dramatically improve or cure diabetes.

Kidneys
From each organ donor, two people can be free from dialysis.

For more information call Life Alaska
562-5433 or 1 (800) 719-5433
www.lifealaska.org

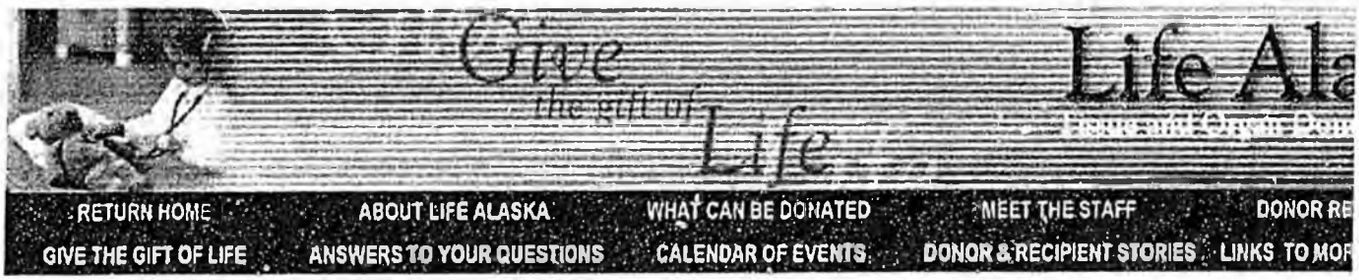
Click here to request more information from Life Alaska.



Zachary Denali Hansen
9 Mar 1983 – 18 Dec 200(

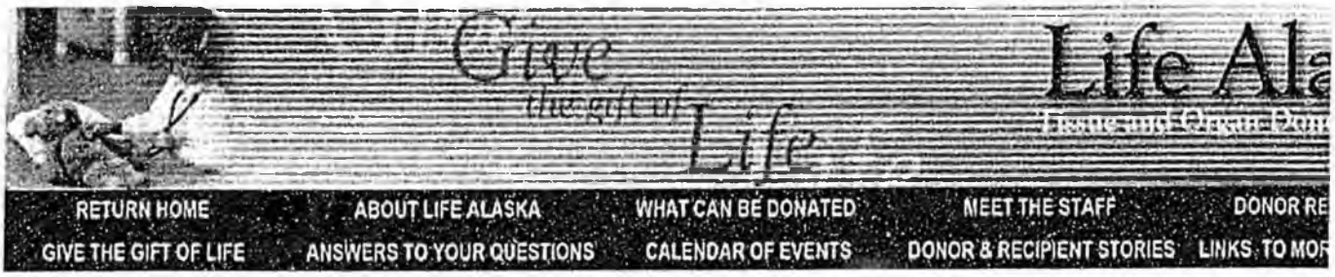
Zach was truly a good young man who brought us so much in the short time he was with us. He walked with a quiet dignity and confidence. He showed us how to be positive and in good humor no matter wh circumstances. He showed a caring, respect and willingness to help others while still living his life in a was right for him. His passion for snowboarding was a joy to see; the perfect day was to make the perfe create the perfect video and set it to the perfect music for others to see and hear. We will miss him deep always remembering the easy-going attitude and large smile.

Zach's quilt piece was made by many caring friends. The patch was designed by Tyson Hansen, Zach's brother, for the Zach Hansen Memorial Helmet Fund. This is a fund to provide helmets to the skiers an snowboarders in the area so that they may enjoy their winter fun safely. The colors represent Lathrop H School in Fairbanks. Zach was to graduate from Lathrop High School the spring of 2001. He loved Lat was excited about being a part of that school. Many of the teachers and students at Lathrop have been s wonderful support for our family since we lost Zach.



Monica Messick
4 May 1906 – 10 Oct 200.

Monica Messick was born May 4, 1906 in Lebanon, Pennsylvania and died peacefully October 10, 200 Anchorage, Alaska. She was an extremely loving mother always thinking of others by giving of herself time, love and energy. On many occasions she spoke of organ donations but felt she was "too" old. She to contribute a small part of her love to others who could benefit. Due to her age, her corneas could not but our family was informed that Life Alaska could take samples from her brain, pancreas, liver and he used in research purposes. Her dream of helping others did come through after all and we know that thi important to her.



Dr. David Neal Emerson
6 Apr 1935 – 12 Jul 2001

Dr. David Neal Emerson was born April 6, 1935 in Wisconsin. He earned an associate of arts degree fr Modesto Junior College in 1954; a BS degree in Zoology from the University of California in 1956; a M degree in Zoology from the University of South Dakota in 1965, and a PhD in Zoology from the Univer South Dakota in 1966. His last job, which he loved, was at the Jonathan County Community College in Park, KS.

Our Dad enjoyed walking, hiking, swimming, visiting national parks and studying the Civil War era. H someone who loved to travel, loved life, and loved history. His goal with Volkswalking, a club he'd bee involved in for over five years, was to walk all 50 capitols in all 50 states. His last state was Alaska, an been in Alaska for only 12 hours when he dropped dead of a massive heart attack. So, he died doing wh loved to do, and in a place he had looked forward to revisiting. Per his final wishes, what organs could salvaged went to those people who needed them the most. In death, as in life, he continued to help peop

He enjoyed music, playing piano at almost a concert level. He enjoyed teaching and cared a lot about hi students. He was an excellent teacher, and was always looking for ways to improve his teaching style. H and family alike will miss him.

David Emerson is survived by his daughters, Karen Emerson, Susan Wilson, Judith Emerson, Deidra E and Deisa Emerson; his grandsons Shae Emerson, Joshua Wilson, Daniel VanNatter, Adam VanNatter, unborn child (as of August 2002). All of us surround my father in the picture that was sent for the quilt. brother, Crague, also survives him.

Bill Thornton
Heart Recipient

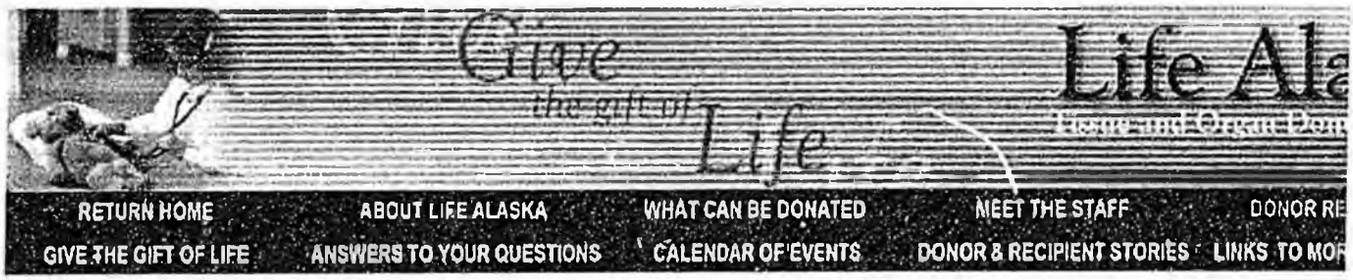
In December of 1994, after going through weeks of being short of breath and having dizzy spells, I fina in and went to see a doctor. After several weeks of guessing and wondering, they performed and EKG a request of my wife. I was then hospitalized immediately and after many tests, I was diagnosed being in failure. I later found that this was due to a virus that I caught somewhere earlier that year. This virus pr to destroy the left ventricle of my heart and caused fluid to build up in my lungs. In December of 1994, being diagnosed as being in heart failure, I was told that somewhere down the road I might need a heart transplant. My immediate response was "NO WAY." During this time in my life I was having what I th was a great time, a great job, money, fun, and partying. Besides, there was no reason for me to be in hea I had just had a perfect physical. There were no signs of anything wrong with my heart, no clogged arte shortness of breath, no history of heart attacks, and no sign of irregular heart rhythms.

In July of 1995, we moved to Alaska from Pennsylvania. We drove all the way on one of the most exci journeys of my life. Prior to my leaving Pennsylvania, my condition took a turn for the better and my ir heart rhythms became normal again and my shortness of breath disappeared. All was normal again. By we reached Alaska, my condition worsened and once again I was short of breath with irregular heart rh Over the next two years, my health and heart condition deteriorated. During the months before my tran spent several days in the hospital solving one problem after another. Finally, on the 11th of July 1997 I flown to the University of Washington Medical Center to be evaluated and hopefully be placed on the t list. On the 20th of July 1997, I had a heart transplant.

It was like starting life over again. I remember thinking about the donor. I still find it somewhat hard to that this young man, at some point in his life, decided to become a donor. When he passed away at the I received his heart. I do not think I will ever be able to express my feelings for his act. I just hope that looks down from heaven, he smiles at me. I think he knows just how truly thankful I am. My life is nov absorbed in helping others to learn how much this gift is needed and how to pass this gift to others in n

is the only way I know how to say THANK YOU to this young man and our God who I believe is holdi young man's hand.

There are several sayings that relate to how I feel. Some are, "No greater love hath as man than to lay d life for a friend", "He ain't heavy, he's my brother", and the 11th commandment, "Love ye one another loved you, love ye also". These quotes mean much more to me than ever. I feel that if God did this for gave me another chance, than I can live these sayings for him and help my fellow humans.



Dennis Morgan
Heart Recipient

In the spring of 1998, I was on a flight from Portland, Oregon to Anchorage, Alaska with two kids behi who sneezed all the way. As a result, I caught the flu - the type that takes everything out of you. Having resistance, the virus got into my heart and started to weaken it. This continued until July when I asked r cardiologist if I would get any better. He informed me that I would not, and that it was time to get a nev asked him what the procedure was, and he set me up with a September 23 appointment at the Stanford Center-the earliest time I could get.

By September my heart had a 55 percent output and I had to be put on a special battery pack IV drug th my heart an extra boost (sort of like nitro in the gas tank). When I checked into the Stanford Medical C transplant clinic, the chief physician could not believe I had survived the flight. He told me I was the m fragile person who had ever walked into his office. This meant I was too weak to go through an operati less even considered for a heart transplant.

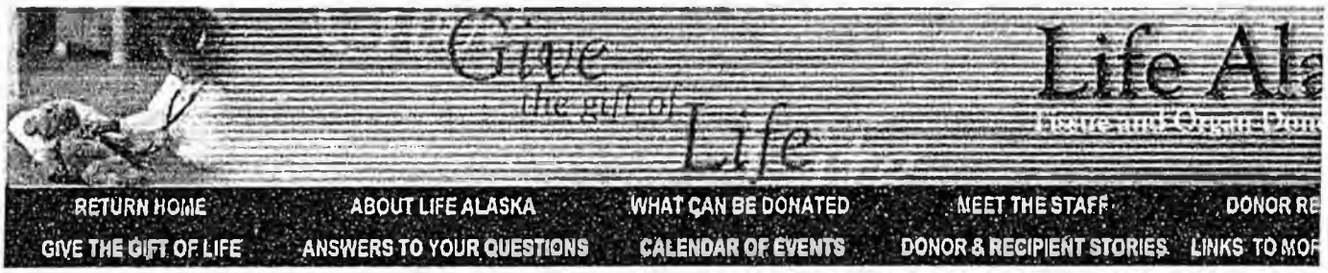
Well, I set up house in a room in the cardiac unit to get stronger. After a week, I had improved so much committee considered me for a transplant and put me on the 1A list. This meant I was kept in the hospi the first match was available.

Two months went by and still I waited for the right heart. With a common blood type and body size (th main points for a match), I was still there. November 24 was my birthday and I thought I might get a gr present. I also had an after thought - that it would be nice to be 56 years old and have a heart half my ag

November 24 arrived and all the nurses and doctors kept coming into my room to wish me a Happy Bir The festivities lasted until dinner when a nurse came and took my meal away. I told her she knows bett tended to get a little cranky if I don't get something to eat! She happily told me I had another present as informed of a heart that was a match.

The transplant operation only took 2.5 hours and all went well. I woke up on Thanksgiving Day with a to be thankful. My greatest thanks go out to the family of the donor for the gift of life. This 28-year-old also gave this gift to others in the forms of other needed organs.

I hope all of you would make this choice, and you need to discuss it with your family so they will hono request. For more information in Anchorage, contact Life Alaska. Their phone number is (907) 562-54 toll-free (800) 719-5433.



Erin Hall Meade
Tissue Recipient

In August 2001 I was in a small plane crash here in Alaska. I sustained serious injuries, including a sha leg, a crushed left ankle, a badly broken right ankle, and two broken arms. I was airlifted to Providence by a Life Guard helicopter, where I underwent several surgeries. My lower left leg was broken into so n pieces that it needed some sort of scaffolding to show the new bone where to grow. I was very lucky - I first bone tissue transplant the day after I arrived. Pieces of donated bone were placed in my left leg, an made of donated bone tissue was used to repair my right ankle. There is a high probability that all this b tissue came from Alaskan donors.

Even with these transplants, my doctors thought it was likely I'd never walk again. I had no ankle joint leg, and a badly damaged one in my right leg. I left the hospital a few weeks later, with casts on both ar both legs. Despite the doctors' opinions, I knew I was not going to spend the rest of my life in a wheelcl there was any way I could get out. I could get both ankles fused, but that would subject me to a life of p awkward walking, and potentially several more surgeries in the future.

I heard about an experimental ankle transplant program at the University of California San Diego's Orthomedicine Clinic; donated ankle joints were being transplanted into people with damaged or ruine joints. I contacted the head of the transplant team, and one year after my accident I flew down to San D see if I could qualify for the program.
I was lucky again - I was accepted into the program. I flew back to Anchorage and waited for the phone telling me they had found a matching donor. The call came in early October of 2002. I flew down and g donated ankle transplanted into my left leg. I was the 41st ankle transplant done in the U.S. Three mont stood up on it for the first time.

I am now walking again, and I am hoping to qualify for another transplant - this time, for my right ankl grateful to the people who gave me this gift; the people who donated bone tissue so my surgeon could r

leg and ankle well enough that I qualified for an ankle transplant, and the person who donated the ankle itself a year later. Without all of them, I would spend the rest of my life in a wheelchair.

When I get my second ankle transplant, I will know that it's because some wonderful person somewher their organ and tissue donor card and told their family of their wishes; they gave the final, greatest gift can give - the gift of giving other people a second chance.

Life Alaska Summary

Life Alaska is the tissue and organ donation agency serving Alaska, offering the option of organ and tissue donation to families who have suffered a death in Alaska. Life Alaska was established in 1992 as the state's tissue donor program. Beginning in the year 2000, Life Alaska assumed responsibility for organ procurement under the direction of LifeCenter Northwest Donor Network, the federally designated organ procurement agency based in Washington. Since 1992, Life Alaska has had more than 1,800 donors and has supplied more than 4,800 tissues for transplantation to Alaskan patients. These include corneal, bone, tendon, and heart valve transplants throughout the state. Organ and tissue donations have taken place across the state from Barrow to Ketchikan.

Life Alaska has a multi-year donor family support program including an annual remembrance service with family participation in creating donor quilts, a memory wall, and memory albums. The family support program interacts with families through phone calls, personal contact, letters, and access to our bereavement library. The family support program is available to all families who have suffered a death and is independent of consent for donation.

Life Alaska offers statewide training to hospital personnel for the referral, donation and family care process. Approximately 75% of Alaskan families have accepted the donation option when given the choice by Life Alaska. The State Medical Examiner's Office supports families' wishes for donation and if possible works closely with Life Alaska to honor a family's wish for donation. The recovery procedure is performed under sterile conditions with full restoration taking place immediately following donor surgery. The donor maintains a normal appearance with no restrictions in funeral arrangements. The donor family is never charged for any donation related costs. All donation information is kept confidential.

Organ donation occurs when a patient has died from an irreversible brain injury resulting in brain death. These patients are kept on mechanical support until organ donor surgery. Tissue donation can take place up to 24 hours after the heart has stopped. The age criteria for transplantable organs and tissues are generally from birth to the mid 70's with patients of any age being candidates for research. All tissues donated to Life Alaska are first offered to Alaskan patients and physicians before being made available outside the state. Organs are shared using a Federally mandated national sharing system.

Life Alaska is committed to Alaskan donor families while striving to meet the transplant needs for all Alaskans. The need for transplantable organs and tissues continues to grow and we need your continued help and support. Please call Life Alaska with any questions, comments, or to sign up on the donor registry. We are available 24 hours a day to discuss donor suitability, bereavement support, critical incident stress debriefing, and tissue transplantation in Alaska. Together, we are making a difference.

Life Alaska
Tissue and Organ Donation
P.O. Box 231809
Anchorage, Alaska 99523-1809
(907) 562-5433 (800) 719-5433
Fax (907) 562-5333

Pub Ed 8/02

Life Alaska, Inc.
Tissue Procurement Service
P. O. Box 230785
Anchorage, AK 99523
1-907-562-5433 • 1-800-719-5433
Fax 1-907-562-5333

TISSUE TRANSPLANT FACTS

DEFINITION

Allograft: Tissue graft transplanted from another person after their death, to you.
Autograft: Tissue graft from one part of your body to another.

HISTORY

Tissue (including bone, tendon, skin, cornea, heart-valve and vein) transplant have been performed for over 40 years with great success. Bone and tendon transplants are the most common transplants today, with over 1,000,000 having been performed during the last 5 years.

RISK

While the risk is exceedingly small, no surgical procedure or transplant is without any risk. Risk factors include graft failure, and the small chance of infection (from bacteria or virus, such as AIDS or hepatitis). The risk of bacterial infection is considered the same with an autograft or an allograft. The following steps are taken with *every transplant donor* to help insure your safety:

1) Extensive evaluation of the donor's medical and social history to rule out infectious disease, cancer, IV drug abuse and any other high risk factors per the National Center for Disease Control.

2) A thorough exam of the donor body and tissue is conducted to rule out any disease process.

3) Laboratory tests are conducted with much greater sensitivity than for blood donation, to rule out any infection with HIV (AIDS), hepatitis, and syphilis. Donor blood and every piece of tissue is cultured at the time of removal and after final processing to screen for infection.

4) Tissue processing removes nearly all blood and extra tissue. Anti-bacterial and viral washes take place. Freeze dried tissue has never transmitted AIDS or hepatitis.

5) All donation is altruistic and voluntary. There is no donor family compensation.

The extensive screening, testing and processing helps to make tissue transplant even safer than blood transfusion. You may discuss the options with your physical and nurse, but the final decision is up to you.

What You Need To Know About
ORGAN AND TISSUE DONATION

Signing your organ donor card is not enough.

Even if you have signed a donor card or indicated your wish to donate on your driver's license, you need to tell your family since they will be consulted before donation can take place.

COMMON QUESTIONS

Will my decision to become a donor affect the quality of my medical care?
No. A transplant team does not become involved until other physicians involved in the patient's care have determined that all possible efforts to save the patient's life have failed.

Do celebrities and VIPs get special treatment in receiving organs?
Absolutely not. The United Network for Organ Sharing was created to ensure the equitable allocation of organs for transplantation. Patients on the waiting list are matched with organs anonymously, using medical criteria such as severity of illness, blood type, body size and weight.

Will donation disfigure my body? Can there be an open casket funeral?
Donation does not disfigure the body nor change the way it looks in the casket. Donation does not interfere with funeral arrangements.

Does my religion approve of donation?
Most major religious groups in the U.S. approve and support organ and tissue donation.

Is it permissible to sell human organs?
No. The National Organ Transplant Act (Public Law 98-507) prohibits the sale of human organs.

Is my family responsible for any of the costs of donation?
No. The donor's family is responsible only for hospital charges not involved with the donation and the funeral arrangements.

NATIONAL FACTS

- As of August 2002, there were 80,294 people on the national waiting list for an organ transplant.
- Approximately 15 men, women and children die *each day* on the waiting list because there are not enough organs donated.
- It is possible for one person to donate their heart, liver, lungs, kidneys, pancreas, heart valves, skin, corneas, bone, as well as cartilage and other tissues in order to save or greatly improve the lives of over 50 people.
- In 2001 there were 24,076 organ transplants.
- In 2001 there were 46,532 cornea transplants.
- In 2001 nearly 900,000 tissues transplants were performed.
- The one year survival rate for heart transplants is over 82%.
- Most people who have become organ donors died from an unexpected accident or medical problem. This is why it is important to discuss your wishes with your family.

ALASKA FACTS

- Life Alaska has the highest consent rate in the nation.
- Since 1992, Life Alaska has had over 1,800 donors.
- Life Alaska has supplied more than 4,100 tissue transplants to Alaskan patients.

DONATE LIFE SM

Life Alaska
Tissue and Organ Donation
P.O. Box 231809
Anchorage, Alaska 99523-1809
(907) 562-5433 (800) 719-5433
Fax (907) 562-5333
www.lifealaska.org

Source: www.unos.org
www.shareyourlife.org

10

HOUSE COMMITTEE REPORT

3·10·03

(7)

Date Referred to Committee: January 21, 2003

FURTHER REFERRALS: Judiciary, Finance

Date of Committee Action: 3/6/03

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 25**

HOUSE BILL NO. 25 **HEALTH CARE SERVICES DIRECTIVES**

"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."

Recommends it be replaced with [ ] HCS *or* [X] CS *for* HB 25 (HES)

For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [X] New Title**

[ ] 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
*Assigned by Chief Clerk's Office

List by Dept(s):	*FN#	Fiscal	Indet.	Zero
HSS	1			✓

PREVIOUS FISCAL NOTES

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

Signing with recommendations	Printed Last Name	DP (7)	DNP	NR	AM
	GATTO	X			
	WOLK	✓			
	HEINZ	✓			
	Wilson	✓			
	CISSNA	✓			
	KAPSNER	✓			
Chair: Peggy Wilson	Wilson	✓			
Chair:					

ALASKA STATE LEGISLATURE

Representative Bruce Weyhrauch

HOUSE DISTRICT 4

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
99801-1182

(907) 465-3744
FAX (907) 465-2273

MEMORANDUM

DATE: March 7, 2003

TO: Rep. Lesil McGuire

FROM: Rep. Bruce Weyhrauch

SUBJECT: HB 25 – Healthcare Directives, or "The 5 Wishes Bill"

Attached are materials in support of HB 25. At this time I respectfully request a hearing before your committee on this very important piece of legislation. This bill passed out of the HESS committee on Thursday, March 6, 2003.

My predecessor, the Honorable Representative Bill Hudson requested that I take over this piece of unfinished work from his career. Rep. Hudson felt so strongly that his Alaskan AARP constituent's top priority be carried out to completion. For your information, HB 25 passed the House during the 22nd Legislature as HB 197.

If you have any questions or need further information, I invite you to contact myself, or my aide, Linda Sylvester.

Thank you for your kind attention to this matter.

Representative _Bruce_Weyhrauch@legis.state.ak.us
www.akrepublicans.org/weyhrauch/

ALASKA STATE LEGISLATURE

REPRESENTATIVE BRUCE WEYHRAUCH

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
99801-1182

(907) 465-3744
FAX (907) 465-2273

HB 25

HB 25 offers a "comprehensive simplified" alternative to the power of attorney enacted in Alaska in 1996 relating to health care services and directives for the terminally ill patient. That was not an oxymoron. 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 Five Wishes contained in this bill, will produce a document 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.

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.

Last updated: January 19, 2003

ALASKA STATE LEGISLATURE

Representative Bruce Weyhrauch

HOUSE DISTRICT 4

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
99801-1182

(907) 465-3744
FAX (907) 465-2273

Sectional Analysis

HB 25

"The Five Wishes Bill"

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 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.

Representative _Bruce_Weyhrauch@legis.state.ak.us
www.akrepublicans.org/weyhrauch/

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 decisions 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 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 designation is not reasonably available, establishes the priority of persons who may act as a 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 employer 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 judical 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 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 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, 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 of health care under this chapter who 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

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 affect other statutes governing treatment for mental illness of involuntary committed individuals.

Sec. 13.52.120(g). States that this chapter does not apply to a pregnant woman.

Sec. 13.52.120(h). 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 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 former will chapters.

Section 5. Makes changes to conform the section 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 the 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.

25-LS0153\H
Bannister
3/6/03

Version H
3/6/03

CS FOR HOUSE BILL NO. 25( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE WEYHRAUCH

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care decisions, including do not resuscitate orders, anatomical gifts, and mental health treatment decisions, and to powers of attorney relating to health care, including anatomical gifts and mental health treatment decisions; 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 anatomical gifts. 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) Except as provided in AS 13.52.170(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

(1) the primary physician, except in the case of mental illness;

(2) a court in the case of mental illness, unless the situation is an emergency; or

(3) the primary physician or another health care provider in the case of mental illness where the situation is an emergency.

(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. 13.52.025. Rescission of withdrawal by agent. A person who has withdrawn as an agent may rescind the withdrawal by executing an acceptance after the date of the withdrawal. A person who rescinds a withdrawal shall give notice to the principal if the principal is capable or to the principal's health care provider if the principal is incapable.

Sec. 13.52.030. Decisions by surrogate. (a) Except in the case of mental health treatment, a surrogate may make a health care decision for a patient who is an adult or emancipated minor if an agent or guardian has not been appointed or the agent or guardian is not reasonably available, and if the patient has been determined to lack capacity by

(1) the primary physician, except in the case of mental illness;

(2) a court in the case of mental illness, unless the situation is an emergency; or

(3) the primary physician or another health care provider in the case of mental illness where the situation is an emergency.

(b) Except as provided for anatomical gifts in AS 13.52.170(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, and the primary physician shall make the decision based on the best interests of the patient.

(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.

(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 that 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, except for a do not resuscitate order. 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) Except as provided for civil commitments under AS 47.30.817, 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 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 an anatomical gift 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 subject of the anatomical gift 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 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.

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 reasonable belief that the person then lacked authority;

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

(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;

(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 an anatomical gift; 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; or

(6) acting in good faith under the terms of this chapter or the law of

another state relating to anatomical gifts.

(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.

(c) 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 and other life-sustaining procedures as long as the individual is able to make the decision. If an individual who is a qualified patient, including an individual for whom a physician 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.

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) 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.

(f) 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.

(g) 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.

(h) 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.

(i) 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.

Sec. 13.52.130. 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.

Sec. 13.52.140. 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. 13.52.150. 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. 13.52.160. 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.

Sec. 13.52.170. Persons who may make an anatomical gift. (a) A person who is 18 years of age or older and who has capacity may make an anatomical gift to

take effect upon the person's death of all or a part of the person's body.

(b) Notwithstanding AS 13.52.030(b), when, in the priority list set out in this section, there is not a person in a prior class who is available at the time of death, and in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, any of the following persons, listed in order of priority, may make an anatomical gift of all or a part of a decedent's body for a purpose specified in AS 13.52.220:

(1) the spouse;

(2) an adult son or daughter;

(3) a parent;

(4) an adult brother or sister;

(5) a guardian of the decedent at the time of death;

(6) another person authorized or under obligation to dispose of the body.

(c) The persons authorized by (b) of this section may make the anatomical gift after or immediately before death.

Sec. 13.52.180. Acceptance of anatomical gift. If the donee of an anatomical gift has actual notice of a contrary indication by the decedent or that a gift by a member of a class identified in AS 13.52.170(b) is opposed by a member of the same class or a prior class, the donee may not accept the gift. However, an anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death.

Sec. 13.52.190. Examination authorized. An anatomical gift authorizes an examination necessary to assure medical acceptability of the gift for the purposes intended.

Sec. 13.52.200. Superiority of donee's rights. The rights of the donee created by the gift are superior to the rights of other persons, except as provided for autopsies under AS 13.52.270.

Sec. 13.52.210. Investigations by law enforcement and medical personnel. Law enforcement or medical personnel who respond to the scene of an accident or emergency involving the death of a person shall make a reasonable search for an

anatomical gift document or other information identifying the bearer as a donor or as an individual who has refused to make an anatomical gift. If the law enforcement or medical personnel know that the person executed an anatomical gift, they shall inform appropriate hospital personnel or an appropriate organization that arranges for or otherwise handles anatomical gifts of the gift. Failure to make a reasonable search required under this section is not a basis for civil or criminal liability but may be the basis for appropriate disciplinary sanctions.

Sec. 13.52.220. Manner of making anatomical gifts. (a) An anatomical gift may be made by will. If made by will, the gift takes effect upon the death of the testator before probate. If the will is not probated or is declared invalid for testamentary purposes, the gift, to the extent that it has been acted upon in good faith, is valid and effective.

(b) An anatomical gift may be made by a document other than a will, including an advance health care directive under AS 13.52.300. The gift takes effect upon the death of a donor. The document, which may be a card designed to be carried on a person, shall be signed by a donor, or by another person at the donor's direction, although the execution of an advance health care directive under AS 13.52.010(b) may not be done by one person at the direction of another person. If signed by another person at a donor's direction, the signer shall sign in the presence of two persons or a person who is qualified to take acknowledgments under AS 09.63.010. Delivery of the document of an anatomical gift during a donor's lifetime is not necessary to make the gift valid.

Sec. 13.52.230. Anatomical gifts without specified donees. An anatomical gift may be made to a specified donee or without specifying a donee. If a donee is not specified, the gift may be accepted by the attending physician as donee upon or after the death of a donor. If the gift is made to a specified donee who is not available at the time and place of death of a donor, the attending physician, upon or following the death of a donor, in the absence of any express indication that the donor desired otherwise, may accept the gift as donee.

Sec. 13.52.240. Anatomical gifts by other persons. An anatomical gift by a person designated in AS 13.52.170(b) shall be made by a document signed by the

person or made by the person's telegraphic message, recorded telephonic message, witnessed telephonic consent, or another recorded message.

Sec. 13.52.250. Delivery of document of an anatomical gift. If an anatomical gift is made by a donor to a specified donee, the will, card, or other document, or an executed copy of it, may be delivered to a donee to expedite the appropriate procedure for removing or transplanting a part of the donor's body immediately after death. Delivery of a document is not necessary for a valid gift. The will, card, or other document, or an executed copy of it, may be deposited in a hospital, bank, storage facility, or registry office to facilitate the procedure for removing or transplanting a part of a donor's body after death. On the request of an interested person on or after a donor's death, the person in possession of the document shall produce the document for examination. In this section, the terms "bank" and "storage facility" mean a facility licensed, accredited, or approved under the laws of any state for storage of human bodies or parts of human bodies.

Sec. 13.52.260. Rights and duties at death. (a) The time of death shall be determined by a physician who attends a donor at death, or, if a physician is not attending a donor at death, by the physician who certifies the death. The physician may not participate in the procedures for removing or transplanting a part of the body.

(b) A donee may accept or reject an anatomical gift. If a donee accepts a gift of an entire body, a donee may, subject to the terms of the gift, authorize embalming and the use of the body in funeral services. If a gift is of a part of the body, a donee, upon the death of a donor and, before embalming, shall have the part removed without unnecessary mutilation.

(c) After removal of the part of the body, custody of the remainder of the body vests in the surviving spouse, next of kin, or a person other than the spouse or next of kin who is authorized to dispose of the body. A person described in AS 13.52.170(b) and the estate of a donor may not be held liable for the cost of an examination under AS 13.52.190 or any costs related to the removal, storage, or transportation of an anatomical gift.

Sec. 13.52.280. State autopsy laws. The provisions of AS 13.52.170 - 13.52.260 are subject to the autopsy provisions of AS 12.65.

Sec. 13.52.280. Recognition of anatomical gifts executed, issued, or authorized in other states. An anatomical gift executed, issued, or authorized in another state in compliance with the law of that jurisdiction is effective for the purposes of this chapter.

Sec. 13.52.300. Optional form. The following sample form may be used to create an advance health care directive. The other sections of this chapter govern the effect of this or any other writing used to create an advance health care directive. This form may be duplicated. This form may be modified to suit the needs of the person, or a completely different form may be used that contains the substance of the following form or otherwise complies with this chapter:

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 or otherwise complies with the requirements of AS 13.52.

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, including the administration or discontinuation of psychotropic medication;

(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) make an anatomical gift following your death.

Part 2 of this form lets you give specific instructions for your end-of-life 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 make an anatomical gift following your death.

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

Part 5 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, except that you may not revoke this declaration when you are determined to be incapable by a court, by two physicians, at least one of whom shall be a psychiatrist, or by both a physician and a professional mental health clinician.

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: Except in the case of mental illness, 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. In the case of mental illness, unless I mark the following box, my agent's authority becomes effective when a court determines I am unable to make my own decisions, or, in an emergency, if my primary physician or another health care provider determines I am unable to make my own decisions. 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 health care 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. 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.

(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

_____

_____

Conditions or limitations: _____

_____.

(Add additional sheets if needed.)

PART 3

ANATOMICAL GIFT AT DEATH

(OPTIONAL)

If you are satisfied to allow your agent to determine whether to make an anatomical gift 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

MENTAL HEALTH TREATMENT

This part of the declaration allows you to make decisions in advance about mental health treatment. The instructions that you include in this declaration will be followed only if a court, two physicians that include a psychiatrist, or a physician and a professional mental health clinician believe that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

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

(11) PSYCHOTROPIC MEDICATIONS. If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

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

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

Conditions or limitations:_____

_____.

(12) ELECTROCONVULSIVE TREATMENT. If I become incapable of giving or withholding informed consent for

mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

_____ I consent to the administration of electroconvulsive treatment.

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

Conditions or limitations: _____

_____.

(13) ADMISSION TO AND RETENTION IN FACILITY. If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

_____ I consent to being admitted to a health care facility for mental health treatment for up to _____ days.

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

Conditions or limitations:_____

_____.

OTHER WISHES OR INSTRUCTIONS

_____

_____

_____

Conditions or limitations:_____

_____.

PART 5

PRIMARY PHYSICIAN

(OPTIONAL)

(14) 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)

(15) EFFECT OF COPY: A copy of this form has the same effect as the original.

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

_____

(date)(sign your name)

_____

(print your name)

_____

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

(17) WITNESSES: This advance care health directive 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)

_____

(printed name of witness)

_____

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

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)

_____

(printed name of witness)

_____

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

ALTERNATIVE NO. 2

State of Alaska

_____ Judicial District

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

Notary Seal

_____

(Signature of Notary Public)

Sec. 13.52.390. 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) "anatomical gift" means an individual instruction that makes a gift of all or a part of a person's body;

(4) "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;

(5) "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;

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

(7) "decedent" means a deceased individual, stillborn infant, or fetus;

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

(9) "donor" means an individual who makes an anatomical gift;

(10) "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;

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

(12) "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;

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

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

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

(16) "health care decision" means a decision made by an individual or the individual's agent, guardian, or surrogate regarding the individual's health care, 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, artificial hydration, or artificial nutrition and hydration is in accord with generally accepted health care standards applicable to health care providers or institutions; and

(D) the administration or withdrawal of psychotropic medications, the use of electroconvulsive treatment, and the admission to a mental health facility;

(E) making an anatomical gift at death;

(17) "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;

(18) "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;

(19) "hospital" means

(A) a hospital licensed, accredited, or approved under the laws of a state; or

(B) a hospital operated by the United States government or a subdivision of the United States government;

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

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

(22) "mental health facility" has the meaning given to "designated treatment facility" in AS 47.30.915;

(23) "part" means organs, tissues, eyes, bones, arteries, blood, fluids, or another portion of a human body;

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

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

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

(27) "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;

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

(29) "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;

(30) "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;

(31) "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;

(32) "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. 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 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 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 **an anatomical** [A] 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 an anatomical gift [OR A LIVING WILL]. The department shall make known to all applicants the procedure for executing **an anatomical** [A] 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 an anatomical gift [OR A LIVING WILL]. The department shall make known to all applicants the procedure for executing **an anatomical** [A] 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 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 **anatomical** 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 is amended by adding a new section to article 9 to read:

Sec. 47.30.817. Advance health care directives. A health care provider or a health care institution may not require or prohibit the execution or revocation of an advance health care directive as a condition for admission, discharge, or providing health care. In this section, "advance health care directive," "health care institution," and "health care provider" have the meanings given in AS 13.52.390.

* **Sec. 9.** 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. 10.** 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. 11.** 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. 12.** 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. 13.** 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. 14.** 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. 15.** 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. 16.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONTINUING EFFECT OF EXISTING DOCUMENTS. (a) An anatomical gift made under AS 13.50 or AS 18.12, repealed by sec. 15 of this Act, before the effective date of secs. 1 - 15 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 - 15 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. 15 of this Act, before the effective date of secs. 1 - 15 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. 15 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 - 15 of this Act, until the power of attorney is revoked.

(c) A declaration made under AS 18.12, repealed by sec. 15 of this Act, before the effective date of secs. 1 - 15 of this Act continues in effect under AS 18.12, as that chapter exists before the effective date of secs. 1 - 15 of this Act, until the declaration is revoked.

(d) A declaration made under AS 47.30.950 - 47.30.980, repealed by sec. 15 of this Act, before the effective date of secs. 1 - 15 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 - 15 of this Act, until the declaration is revoked.

* **Sec. 17.** 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(c), 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 - 15 of this Act.

* **Sec. 18.** 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 - 15 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before January 1, 2004.

* **Sec. 19.** 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, 2004, until the Department of Health and Social Services adopts the regulations authorized under sec. 18 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 13.52.160";

(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 13.52.390";

(5) in 7 AAC 16.090(3), replace ""do-not-resuscitate order" in AS 18.12.100" with ""do not resuscitate order" in AS 13.52.390."

* **Sec. 20.** Section 18 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 21.** Except as provided in sec. 20 of this Act, this Act takes effect January 1, 2004.

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 25(HES)
(H) Publish Date: 3/10/03
Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: HEALTH CARE DECISIONS/DO NOT RESUSCITATE ORDERS/DONATION OF BODY PARTS

BRU: State Health Services
Component: Community Health/EMS Services

Sponsor: WEYRAUCH
Requester: HOUSE (HES)
Component No.: 2078

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

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 (FY2003) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

Currently, various end-of-life provisions are located in different statutes which are narrowly drafted, create confusion for the public, and make it difficult for people to direct their end-of-life care and treatment. The bill establishes a new chapter called the Health Care Decisions Act. The intent of this bill is to provide a tool for end-of-life planning and recording of health care decisions, in one easy to understand chapter of state statute. The Division of Public Health supports the goals of this act. There will be no fiscal impact to the Division by passage of this bill.

Prepared by: Karen E. Pearson, M.S., Director — Phone 465-3090
Division: Public Health — Date/Time 02/13/2003
Approved by: Joel S. Gilbertson, Commissioner — Date 02/13/2003
Agency: Department of Health and Social Services

(Revised 9/2002 OMB)

THE LAW FIRM OF
Faulkner Banfield
A PROFESSIONAL CORPORATION

One Sealaska Plaza, Suite 202 ♦ Juneau, Alaska 99801-1245
(907) 586-2210 ♦ Fax (907) 586-8090
www.faulknerbanfield.com

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

March 31, 2003

Via Fax 465-2273

Representative Lesli McGuire
Chair, House Judiciary Committee
Alaska State Legislature
State Capitol Room 118
Juneau, AK 99801-1182

Re: CSHB 25

Dear Representative Weyhrauch:

I am writing in support of CSHB 25 regarding health care decisions and advance directives. I am an attorney and practice extensively in the area of estate planning and long-term care planning. In my practice, more than 95% of my clients sign durable powers of attorney and living wills. While current Alaska law authorizes an individual to execute a power of attorney and living will, I believe CSHB 25 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 who wishes to appoint an agent to make his or her health care decisions must sign a durable power of attorney. This power of attorney may authorize a person to make both financial and health care decisions. In addition, an individual who wishes to express his or her wishes regarding life-sustaining measures must sign a living will. Signing one document and not the other may 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 the individual 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. Merging these equally important 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 health care decisions by a surrogate, is a vast improvement over current law and will allow family members to participate in health care decisions even if the incapacitated individual failed to sign a

health care power of attorney. This law will ease the burden on family members when faced with difficult health care decisions. The family will no longer be required to commence a guardianship proceeding and may actively participate in another family member's health care decisions.

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 for the benefit all Alaskans.

Thank you for your consideration of my comments.

Sincerely,

BethAnn Boudah Chapman

c: Representative Beth Kerttula (via fax)
Representative Bruce Weyhrauch (via fax)

www.alaskaaging.org

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

Alaska Commission on Aging

Resolution 2003-04

In support of HB25 – An Act relating to directives for personal health care services and for medical treatment.

Whereas HB 25 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 25 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 25 draws upon the experience of thirty-six other states that have adopted this format, and it is strictly a voluntary program,

Now, therefore, the Alaska Commission on Aging urges the 23rd Alaska Legislature to pass HB 25.

Adopted this 21st day of February, 2003.

Marjorie J. Hays

Marjorie J. Hays, Chair

AARP Alaska

Honorable Lesil McGuire, Chair
House Judiciary Committee
Alaska Capitol, Room 118
Juneau, AK 99801-1182

March 24, 2003

RE: HB 25 (Weyhrauch) – Support

Dear Chair McGuire:

On behalf of the members of AARP in Alaska, we urge you and your colleagues on the House Judiciary Committee to support HB 25, authored by Representative Bruce Weyhrauch.

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 Weyhrauch's HB 25 will enable Alaskans to take advantage of the user-friendly "Five Wishes" document to communicate their desires.

AARP recommends an "AYE" vote on HB 25.

Should you have any questions about our position, please feel free to contact Marie Darlin (586-3637), Coordinator of the AARP Capital 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: Vice Chair Tom Anderson
Representative Dan Ogg
Representative Jim Holm
Representative Ralph Samuels
Representative Les Gara
Representative Max Gruenberg
Representative Bruce Weyhrauch
Marie Darlin
Patrick Luby

Subject: HB 25 appeal2
Date: Wed, 26 Feb 2003 16:09:56 -0900
From: "Wallington, Maria Dr." <MWalling@provak.org>
To: "'linda_sylvester@legis.state.ak.us'" <linda_sylvester@legis.state.ak.us>

Testimony to be presented by Dr. Maria Wallington, MD to the House HESS committee on February 13, 2003 at 3:00PM concerning HB 25 HEALTH CARE SERVICES DIRECTIVES:

I am a physician who practiced Pediatric Cardiology and Pediatric Intensive Care here in Anchorage for 20 years. Three years ago I completed a Masters in Ethics and began working for the Providence Health System in Alaska as their medical ethicist. One of my duties is to help patients, families, and health care providers who are faced with challenging decisions at the end of life. In this capacity I have encountered families and physicians whose efforts to do the right thing for patients has been complicated by lack of clear, unambiguous, supportive laws.

I would like to point out to you that Alaska, along with three other states, received the lowest possible grade on this part of a national report evaluating states on the care provided to residents near the end of life. Last November, Last Acts, a coalition of more than 1000 organizations such as the AMA and the American Hospital Association, issued a report card for all 50 states on how end of life care is encouraged in each state. Alaska received the lowest possible grade on "State Advance Directive Policies". They found, as many of my colleagues and I have, that Alaska's current laws do not support good advance care planning. Of the 6 criteria that were evaluated, Alaska's current laws only provides for one. (That is the out of hospital Do-Not-Resuscitate order protocol of Comfort One). The passage of HB 25 will provide for top marks in all of the criteria.

Those criteria, which follow the recommendations for state policies contained in the federal Uniform Health Care Decisions Act, are:

1. To recommend a single, comprehensive advance directive, which reduces confusion. (Currently the Power of Attorney and Living Will laws are not connected in any way.)
2. Avoid mandatory forms or language for medical powers of attorney or combined living wills/medical powers of attorney, giving residents the freedom to express their wishes in their own way. (Current POA forms are complex and difficult.)
3. Give precedence to the agent's authority or most recent directive over the living will, recognizing that an agent has the advantage of being able to weigh all the facts and medical opinions in light of the patient's wishes at the time a decision needs to be made.
4. Authorize default surrogates (typically next of kin) to make health care decisions, including decisions about life support if the patient has not named someone. (No current support in Alaska Law for surrogates)
5. Include "close friend" in the list of permissible default surrogates, recognizing that family in today's world often extends beyond the nuclear family. (Currently no clear status for

decision-making.)

6. Have a statewide (non-hospital) DNR order protocol for emergency medical service personnel to ensure that EMS personnel can follow the wishes of terminally ill patients out in the community. (This is handled through the Comfort One protocol.)

The current Alaska Statutes covering Living Will and Power of Attorney are limited and confusing, and can, in fact, discourage people from making a living will. This means patients' wishes are often not documented for those who would be called upon to make decision for them. I was delighted last year when I discovered this bill making its way through the legislature. It would have handled so many of the issues that were troubling me. I was very disappointed time ran out so it only made it through the House and did not get acted on in the Senate. It solves several of the troubling issues involving end of life decision making that have been causing problems for families and health care providers.

Specifically, I particularly like the example Advance Health Care Directive provided in the bill. (Page 12). It encourages individuals to think though some of the difficult decision that might need to be made and to provide guidance on how to make those decision on their behalf. The current Living Will law only addresses whether or not to prolong one's dying process. Often direction is needed for patient's unable to communicate desires but the patient is not dying. This directive will help make those preferences known.

Secondly, it ties the appointment of an agent for health care decision making to the patient's wishes for how those decisions should be made. It also expressly tells the agent what criteria should be used for making decisions. (Page 3 line 12 (h) and Page 15 line 25 (4) Agent's Obligation). The agent's obligation is to decide on the behalf of the patient as the patient would have decided for himself, to the extent known. This form of the Advance Directive encourages the individual to make those wishes known. Sometimes we have decision-makers requesting what they want instead of what they know the patient would have wanted.

The other major problem that as health care providers we have struggled with which this legislation will solve, is the problem of surrogate decision makers for patients without a legal guardian or a Power of Attorney. Most of our unconscious patients fall into this category. Currently there is no statute to support the common practice of using a relative or, sometimes a good friend, to give consent for treatment. This legislation corrects that shortage by legalizing the use of surrogates and delineating how they are identified and how they may act on a patient's behalf. This act will give surrogates legal support for doing this very difficult job.

As it stands, this is a good bill. However it can be an excellent bill with a few minor changes. The first is very simple. On page 22, in the definitions, lines 12 through 20, which are A through D under "health care", actually belong under "Health care decision". They represent decisions that need to be made, not care or treatment.

The second issue is a little more complex. On the bottom of page 4, top of page 5 under "decisions by surrogate" a class of surrogates and all classes with less priority are disqualified from making a decision if there are an even number of members in that class and they are evenly divided on a decision. For instance, consider an elderly widow who has had a stroke and can not communicate and needs decisions made for her on where she will be . ired for long term. She has two adult children who cannot agree despite the best efforts of the health care professional to get agreement. Who makes the decision? After giving us surrogates, this section takes them away again and does not give any guidance for what the health care provider can do. Please consider authorizing the primary physician to break the tie by siding with the surrogate who, in his/her professional judgment, is acting in the best interest of the patient.

One of the most challenging duties anyone can ever be called on to undertake is to make difficult medical decisions for another person. One of the best gifts we can give those who shoulder this burden on our behalf is having in place a good, informative Advance Health Care Directive. HB 25 will allow individuals to do this job of preparing for these end of life challenges better and will help health care providers better serve patients and their families when these challenges occur.

In conclusion, as a medical professional who daily experience the reality of life and death, as an Ethicist, and as a representative of Providence Health System in Alaska I urge that you help all Alaskans who will someday face difficult health care decisions by supporting HB 25. Thank you for your attention.

3

Life Alaska
Tissue and Organ Donation
P.O. Box 231809
Anchorage, AK 99523-1809
1-907-562-5433 • 1-800-719-5433
Fax 1-907-562-5333

February 27, 2003

The Honorable Bruce Weyhrauch
Alaska State Legislature
Alaska State Capitol
Juneau, AK 99801-1182

Dear Mr. Weyhrauch:

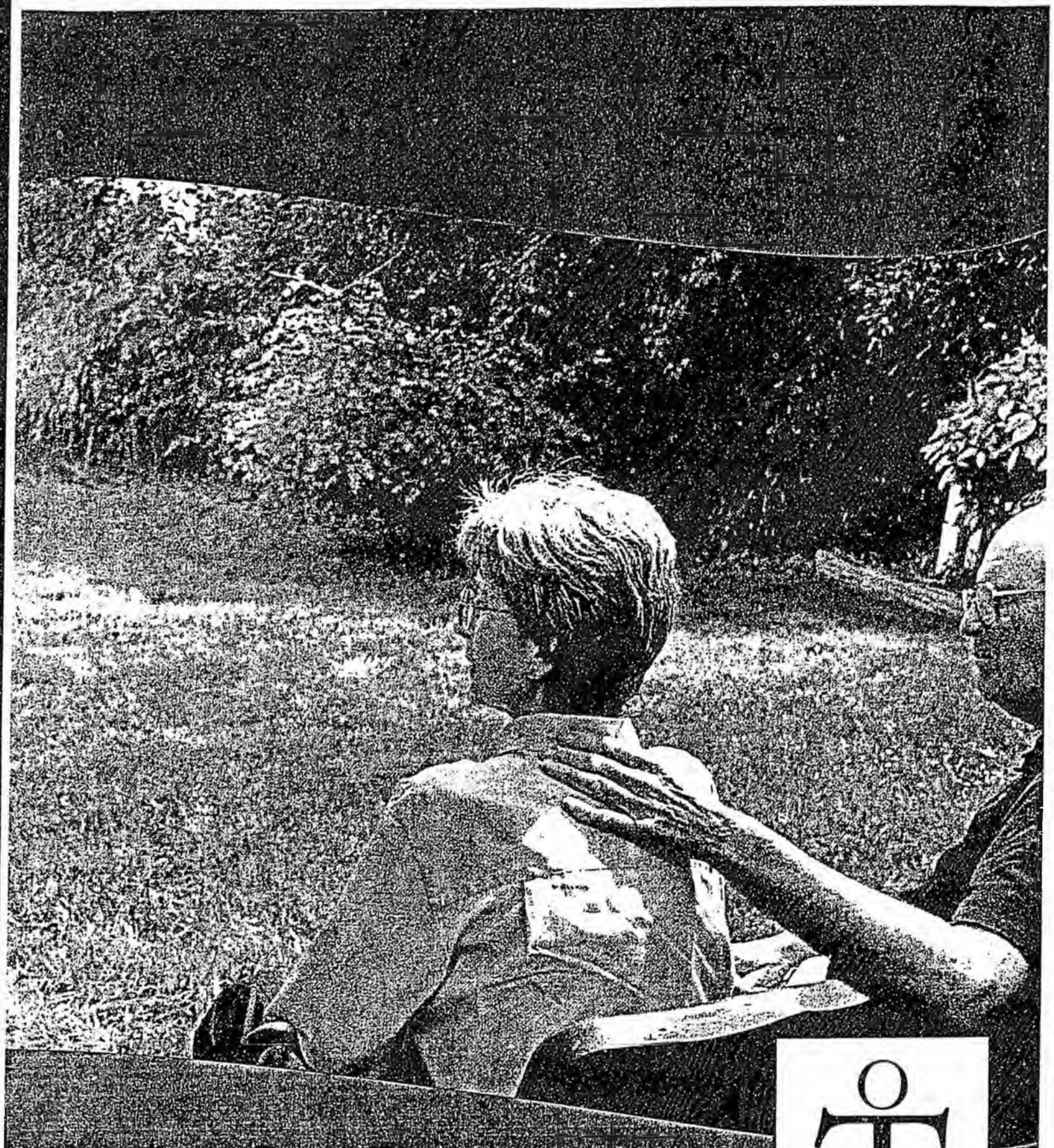
Thank you and your committee for your dedication and interest in simplifying patient directives through HB 25. As the Director of Life Alaska, the agency responsible for donation and transplant in Alaska, I want to share some facts. We work in partnership with LifeCenterNorthWest Organ Donor Network out of Seattle. With 18 organ donors and 207 tissue donors in 2002, Alaska has one of the highest rates of donations in the country. This resulted in 62 organ transplants and 1281 tissue transplants occurring. Of these, 17 Alaskans received an organ transplant and 805 Alaskans received a tissue transplant in 2002.

The success of the Alaska donor program remains strongly tied to wonderful support by hospitals, the Alaska State Medical Examiner, and most important – the community.

The current Uniform Anatomical Gift Act (UAG), Sec. 13.50.10 - .90, along with federal regulations, has been the backbone of our program.

I (briefly) reviewed HB 25 along with the current 13.50 UAG. The attached sheet indicates what sections of the UAG that are no longer needed, and the sections that I believe remain important to a successful donor and transplant program. I respectfully request that section 13.50.10 remains as a statute. Currently, most deaths in Alaska do not involve any type of healthcare proxy. Most donors tend to be healthy individuals who die from a very sudden event. These are the people least likely to have made an advance directive. Section 10 also states very clearly that a first person consent allows such a gift to be irrevocable by other family members.

Section 13.50.16 encourages law enforcement personnel to check for a donor card on fatalities. I request that they be directed to contact a hospital or the state's donor program.



On Our Own Terms: Moyers on Dying

Produced by Public Affairs Television, Inc.
and presented on PBS by Thirteen/WNET New York

Discussion Guide

How to Talk About End-Of-Life Concerns

by Joanne Lynn, M.D., Americans for Better Care of the Dying

It is hard to talk about dying, death, and bereavement. Virtually everyone wants those conversations to have happened, but no one wants to "have that conversation today." Talking about death seems at first to make it more real, more threatening. Afterwards, though, most people find that talking ends up being very helpful and reassuring. Having some strategies may help.

First, push yourself to take the openings that come up. When Dad says, "I think the doctor thinks things are not going well," the family member is prone to say, "Don't talk that way. Everything is going to be fine." Instead, try, "Really? Why do you think that?" or try "What do you think the doctor is trying to say?" (Other sets of openings and responses are in *Handbook for Mortals*, p.11.)

Second, you should talk naturally about a time when the person will no longer be alive, even if at first you talk about some unreasonably long time into the future. "Mom, is there something that you want your granddaughter to have on her wedding day?" Often, a sick person will take the lead gratefully and say something like, "I wish I could see that, but I don't think I'll even see her at Christmas this year. I hope she finds someone half as good as your father. I wonder—if I could find that apron that my grandmother gave me when we married, would you keep it and give it to her then?" Obviously, that opens the gates to all sorts of conversations over the ensuing hours and days.

Third, talk about the patient's current hopes and fears. Ask something like, "Do you think this pain will get worse?" or "What do you think will happen as time goes on?" When you and the patient are not sure what you face, set up a way to find out (like letting the physician know that you want to discuss this at the next visit).

Remember, you need not use blunt or cold terms. Many Biblical phrases, poetry, songs, and metaphors deal with dying. And you need not talk of death most of the time. You can also reminisce, talk about daily life, and talk about plans and hopes.

How can you start? First, recognize that you or your loved one is still living and has a past, a present, and a future. Talk some about the past—share stories about what is important or what shaped this particular person or family. Talk some about the present—what is going well and what is going badly for patient and family. And, even though it may seem awkward, talk about the future—what hopes and dreams lie there, what practical problems, and how long the patient may live. In addition, you might find it useful to consider a list of important issues that are usually appropriate to consider.

(see "Talking About the Future" on page 16)

What to Talk About...

There are specific issues that should be decided in advance. Without advance planning, emergency responses to sudden changes in the patient's condition can be inappropriate. Virtually every seriously ill patient and his or her family should have decided the following issues.

1. **Proxy**—Someone needs to have the authority to speak on the patient's behalf when he or she is too sick to do so. Any hospital, nursing home, hospice, or home care agency can help with a form called a "healthcare proxy" or "durable power of attorney" that allows the patient to name someone as their proxy or surrogate in a legally binding way.

2. **Resuscitation**—Ambulance technicians and hospital personnel will immediately try to resuscitate anyone who collapses and is near death. However, resuscitation may not be desired if the collapsed person has been quite sick with an illness that is expected to worsen and lead to death. In order to keep anyone from trying resuscitation, the patient should ask his or her physician to write an order "not to attempt resuscitation" (often called "DNR" for "Do Not Resuscitate"). This order does not affect whether the patient can get hospital care or other treatments. Most states now provide a way to have an order against resuscitation put into effect when the patient is at home or anywhere else.

3. **Hospitalization**—Many seriously ill people come to the point where they cannot imagine a surgery or test that they would still want to have. At that point, they should ask their physician's advice on avoiding hospitalization, except to relieve suffering (e.g., to set a broken bone or relieve shortness of breath).

4. **Specific Treatments**—Many patients fear specific treatments such as breathing by machine, having a kidney machine, or having artificial nutrition or hydration ("tube feedings"). The merits of these should be discussed in advance. If the patient wants to forgo these treatments, he or she can write that down. If the patient is unclear about their merits, he or she can opt for a "trial of treatment." For a limited time, the treatment would be carried out. That trial allows the patient, family, and care team time to make a final decision. The treatment can then be stopped or continued based on how the patient responds to treatment.

The DNR ("do-not-resuscitate") MedicAlert® bracelet is imprinted with the MedicAlert® emblem on one side and DNR wording on the other. It is backed by a fully staffed 24-hour Emergency Call Center and recognized as a valid pre-hospital DNR order by emergency medical services in eight states: Arkansas, California, Indiana, Kansas, Maryland, Nevada, New Mexico, and Wisconsin. "DNR-EMS ON FILE" or similar wording is engraved for residents of other states.
For more information about DNR and advance directives repository services contact MedicAlert® Foundation at 1-800-432-5378 or on the Web at www.medicalert.org.

photo © Geraldine Rubio

5. Financial Issues—All patients need to consider the effects of treatment costs on their surviving family, the bequests that the patient wants, and how to deal with other costs. Often, a financial planner, lawyer, or social worker really helps. Your professional caregivers, local hospice programs, local aging services (Agencies on Aging, for example), and your friends will often have suggestions of people who are knowledgeable, affordable, and helpful. While some people consider these issues impolite to mention, a little planning can prevent financial chaos for the bereaved family.

6. Events Near Death—As patients and families converse about the upcoming death, they may find they have strong ideas of how things should proceed. It can be helpful to plan who will be with the patient at the time of death or shortly thereafter, who will be notified, how the memorial services will proceed, and so on—in as much detail as possible.

Talking About the Future

Pointers on conversations about the future between seriously ill patients and those who love them:

- Use language that everyone is comfortable in using.
- Take your time. Pauses and shared quiet time can communicate too.
- Encourage the patient to talk in his or her own way.
- Check what one another understands and feels.
- Talk of the time near death and just after in a natural way.
- Talk of practical matters and also of emotions and spiritual issues.

Writing It Down
Advance Directives

- Think about what you really want to happen, given your medical condition and your family situation.
- Talk about your choices with those who matter to you and who will be around you when problems arise or death comes close.
- Have your doctor or nurse help you write down your wishes in ways that laws reinforce. In general, state laws allow for two kinds of written advance directives—naming a decision-maker (or "proxy" or "surrogate"), and giving specific instructions about treatment. Naming a surrogate is especially important if you live in certain states or if your family situation is confusing as to who would be "next of kin."
- Write down at least your spokesperson and your most important choices, using the formats accepted in your state's advance-directive statutes (see www.choices.org) —living will, durable powers of attorney, and health care proxy laws.
- For a "checklist" form, go to Five Wishes on the Web at www.agingwithdignity.org.

Issues for Further Consideration

1. If you were to become terminally ill, would you want to choose your time of death? How much input would you want a doctor or other healthcare provider to have if you could no longer speak for yourself? Have you shared your thoughts with your family?
2. A doctor's oath is to "do no harm." How can a doctor best abide by this oath in the final stages of terminal illness?
3. What issues are raised for you when you consider terminal sedation, physician-assisted suicide, and dying assisted only by palliative care?
4. What choices about death do terminally ill people, their loved ones, and doctors have in your community? Do you feel they are sufficient or insufficient? Why?
5. Why might disabled, poor, and mentally ill people oppose physician-assisted suicide? Is legalizing physician-assisted suicide good public policy?

Five Wishes
The popular document that helps you get the care you want - when you need it.

Five Wishes

Five Wishes is a document 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 lets your family and doctors know:

1. Which person you want to make health care decisions for you when you can't make them.
2. The kind of medical treatment you want or don't want.
3. How comfortable you want to be.
4. How you want people to treat you.
5. What you want your loved ones to know.

Five Wishes is changing the way America talks about and plans for care at the end of life. More than 1.5 MILLION copies of the document are circulating throughout the nation, and more than 3,500 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 and have those delicate discussions with their aging parents.

Five Wishes speaks to people in their own language, not in "doctor speak" or "lawyer talk." It can be used in the living room instead of the emergency room. And it helps families talk with their physician about a subject that before was 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

FIVE wishes Order Five Wishes!

Are you an HR Professional?
click here for "Five Wishes at Work"

Preview Five Wishes

View a non-printable example of Five Wishes.

This requires Adobe Acrobat Reader, which is provided for free from their website (click button below).

Get Adobe Acrobat Reader

Five Wishes At Work

This innovative work-life educational program helps employees plan ahead for a serious illness - both for themselves and their aging family members. Learn more.

Five Wishes Video

have a duty to listen to the wishes of their patients no matter how they are expressed.

Five Wishes is available thanks to a generous grant by The Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to health and health care.

Order now!

1-888-5-WISHES e-mail: fivewishes@agingwithdignity.org

888-594-74

Americas most popular living will is now available on video! Those who complete Five Wishes, and groups that distribute the document, should have this important tool.

Five Wishes Q&A

Answers to the most commonly asked questions about Five Wishes.

Five Wishes States

The complete listing of states that Five Wishes is legally valid in.

Five Wishes Feedback

Let us know how you feel about Five Wishes and hear what others have said.

Projects News 5 Wishes™ Get Involved Resources Links

five wishes Order Five Wishes!

Five Wishes States

Valid States

Legally valid in:

Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, South Dakota, Tennessee, Virginia, Washington, West Virginia, Wyoming

1-888-5-WISHES e-mail: fivewishes@agingwithdignity.org

Alaska IS NOT a Five Wishes State

Five Wishes

What is Five Wishes?

Five Wishes is an easy-to-use legal document that lets you plan in advance for how you want to be cared for in case you become seriously ill. Some people refer to it as an "advance directive" because when you complete Five Wishes you give direction to you doctor and family, in advance, on how you want to be treated. There are five wishes in this document:

Wish One lets you choose the person you want to make decisions for you when you can't make them for yourself. Lawyers call it a "durable power of attorney for health care."

Wish Two is a living will. It lets you put in writing the kind of medical treatment you want or don't want if you become seriously ill and can't communicate to anyone.

Wishes Three and Four let you describe in detail how you want to be treated so that your dignity can be maintained.

Wish Five gives you a chance to tell others how you want to be remembered, and express other things that might be in your heart, like forgiveness.

Why should I fill out Five Wishes?

Without an advance directive like Five Wishes, you may have no control over important medical care decisions that will be made if you ever get seriously ill - such as whether to give you life-support treatment or aggressively treat your pain. You may think your wishes are similar to those of other people and that your loved ones and doctors will automatically know what you want when you are very ill. That's not true. In reality, everyone has different wishes and yours won't be followed unless you make them clear. For example, your dying process could be artificially prolonged even though you may have wanted a natural death. Not expressing your wishes can put your family, friends and doctor in the difficult position of guessing what kind of treatment you want, which could lead to disagreements. Completing Five Wishes gives you control over your care and peace of mind for you and your loved ones.

When do I need to use Five Wishes?

The best time to fill out Five Wishes is before you face a health crisis. The best place to fill out Five Wishes is at home – not a hospital. You never know when you are going to need Five Wishes, and many people put it off until it's too late. If you are over age 18, you should complete Five Wishes now. If you are married, both you and your spouse need to fill out your own Five Wishes.

When does Five Wishes take effect?

You will always make your own health care decisions if you are able to talk with your doctor and understand what is being said. Five Wishes only takes effect when you are too ill to communicate. So if you have a stroke and can't speak, or are in a coma, then your Five Wishes, and the person you chose to be your health care agent, can help direct your care with your doctor.

Is Five Wishes a legal document?

Yes. It was written with the help of the American Bar Association's Commission on the Legal Problems of the Elderly. It is legally valid under the advance directive statutes in most states (see list on page 3 of the Five Wishes document). Just follow the directions when you sign it.

What if I don't live in a Five Wishes state?

There are some states that require you to use their own legal forms to express your wishes and so you should use their forms and sign those forms. But you should also fill out Five Wishes because it can help make clear to your family, friends and doctor what you want.

How do I use Five Wishes?

Take the following steps to use Five Wishes:

- Review the document
- Fill it out
- Follow directions for signing it
- Discuss it with your health care agent and doctor and give each of them a copy
- Make sure a copy of your Five Wishes is placed in your medical file by your doctor
- Discuss Five Wishes with your family and friends and give them a copy

Does filling out Five Wishes guarantee that my wishes will be followed?

Your doctor is required to follow your wishes according to the laws of your state. Each state has its own rules and conditions that a doctor must observe, and so your doctor has the final word on when your living will takes effect. To do all you can to have your wishes followed, make sure your do three things:

1. Pick a health care agent (Wish One), tell him or her about your wishes and confirm they will speak for you if you ever get sick
2. Tell this person that hospitals, hospices and nursing homes have ethics committees that can help settle any disagreements with doctors or family members.
3. Discuss your wishes with your doctor, family and friends before you get sick

Which is better to have: a living will or a health care agent?

The health care agent and the living will go hand-in-hand, and you are usually better off with both. You need to have a health care agent there to speak for you when you can't speak for yourself, and you need a living will that expresses in writing your wishes. When you are sick, your medical condition can be very complicated and can change suddenly. The law generally requires your agent to make decisions that he or she feels you would have made if you could talk. The more information your agent has, the better.

What if I fill out Five Wishes and later change my mind?

You can change your wishes any time you want. It is a good idea to review and update your Five Wishes at least once a year. You may want to do that more often if your health changes or you change your mind. When you make changes, be sure to inform your health care agent, family, friends and doctor. Destroy all out-of-date copies of the document and distribute copies of your new Five Wishes.

If I am seriously ill, what can I do to make sure that I won't be in pain?

Most people who are very sick want to be kept comfortable and alert, and surrounded by friends. Great progress has been made in our health care system to treat illnesses, but unfortunately there can be more attention paid to your treatment than your comfort. So make it very clear to you doctor, health care agent and family that you don't want to be in pain.

Do I have to have my Five Wishes notarized?

Not unless you live in one of the few states that is listed in the notarization section of Five Wishes. Simply follow the directions on the signature page and you'll be safe.

What if I travel a lot? Will my Five Wishes be honored wherever I go?

If you travel a lot, take a copy of Five Wishes with you in case you become seriously ill. Your document will be legally valid in any of the states listed on page 3 of Five Wishes. If you travel to a state that is not listed, then you still may be protected by your Five Wishes document. Most states have laws that are designed to honor your wishes no matter how you express them. But to be safe, if you are going to be staying for an extended period of time in a non-Five Wishes state, then it's a good idea to fill out that state's required forms.

Who developed Five Wishes?

Five Wishes was created by the non-profit Aging with Dignity, a leading advocate for the needs of elders and those who care for them. Aging with Dignity founder Jim Towey created Five Wishes with the help of doctors, nurses, lawyers and other experts in end-of-life care to help people of all ages get the treatment they want if they get seriously ill. Jim is an attorney who worked twelve years for Mother Teresa of Calcutta and worked one year in her home for the dying in Washington, D.C. His experiences with Mother Teresa and her home are why Five Wishes looks at the personal, emotional, and spiritual needs of a person - and not just the medical ones. This is important because people are most concerned about maintaining comfort and dignity when they are very sick.

What if I have more questions?

You may talk with a lawyer or health care professional for advice. If you want more information, visit our web site at:
http://www.agingwithdignity.org/5wishes.pdf
or
http://www.agingwithdignity.org/order.html

National group criticizes Alaska for poor end-of-life care

By ANN POTEMPA
Anchorage Daily News

Last year, for the first time, the national organization Last Acts rated the states on their treatment of dying patients and gave Alaska a failing grade in several areas.

Last Acts is a coalition of organizations, including the American Medical Association and American Association of Retired Persons, now called AARP, funded by the Robert Wood Johnson Foundation. Last Acts' goal is to improve care for people nearing the end of life.

The coalition's report card for Alaska cited several areas for improvement.

- A low percentage of Alaskans 65 and older died with the help of hospice programs. Hospice emphasizes comfort care for people with terminal illness.
- The state lacks physicians and nurses trained in palliative care, which controls pain and other symptoms and improves quality of life for dying patients.
- The state's hospitals don't have enough pain and palliative care services.
- Alaska laws don't support good care planning, such as living wills and powers of attorney. A medical power of attorney makes health care decisions for patients when they can no longer communicate for themselves.

Local Hospice directors say the grade from Last Acts doesn't tell the whole story.

"Part of me feels like yeah, I agree, we have a long ways to go," said Julia Thorsness, executive director for Hospice of Anchorage. "There's so much to be done."

Even so, Thorsness said the grading system didn't acknowledge the good work being done in Alaska by nontraditional programs. For example, Thorsness said Last Acts focused on hospice programs certified by the Medicare program. In Alaska, only the hospice program in the Mat-Su Borough has such certification, allowing it to bill Medicare for health care services.

But volunteer programs from Juneau to Kenai to Anchorage to Fairbanks offer similar end-of-life care, Thorsness said. In recent years, a group worked with the Bristol Bay Area Health Corp. to start Helping Hands, a unique program that helps terminally ill Bush residents return to their home villages to die.

And now Alaska has Karen Gilley, a nurse trained to offer harp music for people facing death.

"It's a wonderful resource for the community to have," Thorsness said.

"There are a variety of ways of offering that comfort and support. Sometimes it's massage. Sometimes it's music. Sometimes it's pets," she said. "We really strongly support everyone who's willing to offer whatever their gifts are."

Local hospice directors addressed some of Last Acts' concerns. The national coalition cited a lack of participation in hospice programs. In 2001, Hospice of Anchorage served 144 patients, most of whom had cancer, Thorsness said. During the same time period, the hospice in Mat-Su worked with 66 patients, said Babetta Daddino, the program's manager.

Hospice programs also are certifying more caregivers in hospice and palliative care.

Daddino said Hospice of Mat-Su didn't have any certified nurses before last fall; now it has five. Thorsness said two nurses working with the Anchorage program are certified for hospice care.

State legislators are addressing Last Acts' concern that Alaska's laws don't support good care planning. Rep. Bruce Weyhrauch, a Republican from Juneau, is sponsoring House Bill 25 this session. The bill attempts to create a comprehensive approach to making health care directives, such as picking powers of attorney.

Thorsness and Daddino stressed the importance of continuing education for professionals providing end-of-life care and for the community so residents understand what options they have. In May, Dr. Ira Byock, author of "Dying Well: The Prospect for Growth at the End of Life," will spend two days in Alaska visiting hospitals and consulting with Providence Alaska Medical Center about its palliative care team. Byock also will speak at a free public session in Providence's auditorium on May 8.

"I think it's such a new field," Thorsness said. "I think we're in a big group of states that are trying to figure out what's the best way to meet this need, especially with the aging population. There's going to be more people wanting more services."

Anchr. Daily News
2-23-03

Anchorage Daily News Award winning sports coverage

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

Emergency Medical Care

If a health care provider finds evidence of enrollment in the Alaska Comfort One program, and confirms the patient's identity, the health care provider will not start CPR. If CPR had been started prior to determining the patient is enrolled in the Comfort One program, it will be stopped.

If the health care providers are unable to confirm that the patient is enrolled in the Comfort One program, they will provide emergency medical care, including CPR, according to their normal guidelines. **The Alaska Comfort One protocols do not affect the provision of medical care other than CPR.**

A person may revoke his or her status as a Comfort One patient at any time. For example, the person enrolled in the Comfort One program may destroy the wallet card and form, and may choose not to wear the optional Comfort One Bracelet. The person's attending physician should be notified by the patient that such actions have been taken to avoid any confusion in the event the health care providers contact the physician for advice. Patients who are receiving care from Hospice organizations or from other health care providers should ensure that these personnel are notified of the revocation as well. In addition, the patient may communicate the intent to revoke the Comfort One status directly to the health care provider.

Other Related Programs

Some emergency medical services agencies and fire departments in Alaska have programs which can provide additional services to those enrolled in the Comfort One program. In most circumstances, these programs inform law enforcement, medical, and other key personnel of an expected home death to provide for the least intrusive response. Persons interested in these types of services should ask their physicians to contact the local fire department or ambulance service for additional information.

For more information about the Alaska Comfort One program, contact the Alaska Section of Community Health and Emergency Medical Services at (907)465-3027 or visit its website at http://www.chems.alaska.gov.

Comfort One forms and bracelets are available to authorized health care providers from:

Southern Region EMS Council, Inc.
6130 Tuttle Place
Anchorage, AK 99507-2140
(907)562-6449/FAX: (907)562-9893

Interior Region EMS Council, Inc.
3522 Industrial Avenue
Fairbanks, AK 99701
(907)456-3978/FAX: (907)456-3970

Southeast Region EMS Council, Inc.
P. O. Box 259
Sitka, AK 99835
(907)747-8005/FAX:(907)747-1406

The Alaska Comfort One Program

Information for Patients and Families

comfort ONE®

Alaska Department of Health and Social Services
Division of Public Health
Section of Community Health and EMS
Box 110616
Juneau, AK 99811-0616
(907)465-3027/FAX: 465-4101

The Alaska Comfort One Program

Information for Patients and Families

Overview

Some individuals who are terminally ill do not wish to have life saving measures, such as cardiopulmonary resuscitation (CPR), performed when their breathing and heartbeat stop.

In October, 1996, Alaska laws and regulations established the "Comfort One Program" to help health care providers identify terminally ill persons who have expressed these wishes. In addition, the program establishes a protocol for health care providers to respect these wishes once the person has been identified as being enrolled in the program.

A standardized form, wallet card, and optional bracelet, obtained through a physician, serve to alert health care providers that the patient has been issued a valid Do Not Resuscitate order and that CPR should not be performed or should be stopped when the identification is discovered. This is particularly helpful for prehospital emergency care providers, such as Emergency Medical Technicians and paramedics who often must make split second decisions regarding whether to start CPR.

A Do Not Resuscitate order is different from a "living will." Living wills are designed to allow the patient to express his or her wishes regarding life sustaining treatments and other medical care when unable to make treatment decisions. However, they do not go into effect until the patient is determined to be in a terminal condition and is unable to make treatment decisions. The Alaska Comfort One program removes the uncertainty of whether the person has a terminal condition and wishes to have CPR performed or not. By preventing unwanted resuscitation efforts, the program provides benefit to patients and their families, as well as to health care providers, during the time surrounding the patient's death.

A terminally ill person who is considering enrolling in the Alaska Comfort One program should discuss this program and other "advance directives," such as living wills, with his or her physician.

A Do Not Resuscitate order is different from a "living will."

Optional Bracelet

Enrolling in the Comfort One Program

To enroll in the Alaska Comfort One program, a person must have a terminal condition and must complete a simple form which may be obtained from the patient's physician. The form must be signed by both the patient and the patient's physician. The top copy of the form is kept by the patient, a second copy is retained by the physician for the person's medical file. The remaining copies may be provided, by the patient or physician, to other health care professionals, such as hospice workers and/or the dispatch center of the local fire department/emergency medical service.

Proof of Enrollment

At the time the physician enrolls the patient in the Comfort One program, the patient is given a copy of the enrollment form and a wallet card. These should be kept in a visible or easily accessible location.

The person may choose to purchase a Comfort One bracelet. Bracelets are only available to those enrolled in the Comfort One program and are particularly useful for persons who travel outside the home. Bracelets may be purchased through the patient's attending physician.

The Comfort One form, wallet card, and optional bracelet serve as proof to the health care provider that the person is enrolled in the program.