HB

25

ALASKA STATE LEGISLATURE

REPRESENTATIVE BRUCE WEYHRAUCH
HOUSE DISTRICT 4

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
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MEMORANDUM

DATE: April 15, 2004
TO: Senator Seekins
FROM: Rep. Bruce Weyhrauch
SUBJECT: SCS for HB 25 (HESS) – Advanced Healthcare Directives
or *The Five Wishes Bill*

My staff has worked closely with Senator Dyson and the HESS committee members and we are confident that the committee will pass HB 25 out on Monday. As such, HB 25 enjoys broad support from the stakeholders and from numerous community health activist groups such as The American Cancer Society, Hospice, AARP and Providence Hospital.

HB 25 has absolutely no fiscal impacts to the State of Alaska as it deals with personal decision making.

At your earliest opportunity, I request a hearing before the Judiciary Committee. I'm available to discuss this with you at your convenience.

CS mail Saturday

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Representative Bruce Weyhrauch

HOUSE DISTRICT 4

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April 22, 2004

Senator Ralph Seekins
Chair, Senate Judiciary Committee
Capitol Building
Room 125
Juneau, Alaska 99801

Regarding: HB 25 Advance Health Care Directives

Dear Senator Seekins:

On Monday, the Senate Judiciary Committee will be taking up HB 25, but before that I wanted to take a moment and offer some introductory words to you regarding this critically important concept. HB 25 ~ Healthcare Directives was inspired by the Five Wishes legislation that has been adopted by 37 states since 1993. HB 25 expands the options for people who want to prepare for the time when they can no longer speak or act on their own behalf.

Additionally, HB 25 takes a more comprehensive approach to advance directives in that it collects all of the existing provisions related to end-of-life healthcare decisions and places them in one chapter under Alaska law. These statutory provisions that are repealed and re-enacted include:

- The organ donation program;
- The Living Will Program;
- The Comfort One Do-Not-Resuscitate program;
- An expanded healthcare durable power of attorney for health care.

Essentially, HB 25 brings all of the health care related provisions into one, easy to access and coordinated site. Something like one stop shopping. In point of fact, the only "new law" introduced by the legislation is the concept of the surrogate for health care decisions found in section 13.52.025.

From the beginning, my office has worked very closely with my colleagues in every committee, especially with members of the HESS committee, as well as a number of stakeholders to ensure that the final product is as faultless as possible. As you join in the review of HB 25 in the Judiciary committee, I wanted you to know whom these individuals are, and I invite you to contact any one of them if you have a particular

question or concern. Of course, you can also discuss any aspect of HB 25 with myself, or my staff.

Panel of Advisors

Subject	***Advisor***
Surrogates, DNRs, Living Wills, optional form, practical aspects & typical scenarios of health care issues that HB 25 touches	**Dr. Maria Wallington, MD** Medical Ethicist Providence Hospital 907 261-6077
Advance directives for mental health treatment & issues related to disability	**Edie Zukauskas** Attorney Disability Law Center 907 565-1002
DNRs, the state's Comfort One Program & issues related to emergency health care out side of the hospital	**Shelley Owens** **Mark Johnson** Dept. of Health & Social Services 907 465-3028
Anatomical gifts	**Bruce Zalneraitis** Life Alaska (Alaska's organ procurement organization) 907-562-5333
Pain treatment	**Carole Edwards, RN** Oncology Nurses Society 907-789-3345

Once again, I want to thank you for your thoughtful work on HB 25 and I look forward to working with you and your staff in committee.

Sincerely,

Bruce

Representative Bruce Weyhrauch

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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

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SCS FOR HB 25 (HESS)

I was asked to sponsor this piece of legislation by people whom I respect and who have long proved worthy of representing good causes. This cause I find very civilized and humanitarian, and as we all age or worse ~ when we encounter health catastrophes, advanced directives become emphatically nothing less short of *critical*.

HB 25 ~ Healthcare Directives was inspired by the Five Wishes legislation that has been adopted by 37 states since 1993. HB 25 expands the options for people who want to prepare for the time when they can no longer speak or act on their own behalf. HB 25 takes all of the current provisions related to end-of-life healthcare decisions and places them in one chapter under Alaska law. These provisions include:

- The organ donation program
- The Living Will Program
- The Comfort One Do-Not-Resuscitate program
- An expanded healthcare durable power of attorney
- Mental Healthcare Directives

Essentially, HB 25 brings all of the healthcare related provisions into one, easy to access and coordinated site. Something like one stop shopping. It is simple in that the directives speak simply to the patient's wishes (the legislation is known nationally as the Five-Wishes) namely: my wish for the person I want to make my health care decisions for me when I can't; the kind of medical treatment I want or don't want; how comfortable I want to be; how I want other people to treat me and what I want my loved ones to know.

Last updated: April 15, 2004

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. 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.

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.

LEGAL SERVICES

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MEMORANDUM April 23, 2004

SUBJECT: SCS CSHB 25(HES) relating to health care decisions
(Work Order No. 23-LS0137\Z)

TO: Representative Jack Coghill
Attn: Rynnieva

FROM: Theresa L. Bannister
Legislative Counsel

You have asked whether the following amendment makes the withholding or withdrawing of nutrition and/or hydration a criminal offense:

> Withholding or withdrawing of nutrition and hydration. (a) It shall be presumed that every person legally incapable of making health care decisions has directed his or her health care provider (agent or surrogate) to provide him or her with nutrition and hydration to a degree that is sufficient to sustain life.
>
> (b) No guardian, surrogate, public or private agency, court, agent, or any other person shall have the authority to make a decision on behalf of a person legally incapable of making health care decisions to withhold or withdraw hydration or nutrition from such a person except in the following circumstances and conditions to the extent that, in reasonable medical judgment:
>
> (1) provision of nutrition and hydration is not medically possible,
> (2) provision of nutrition and hydration,[1] or
> (3) because of the medical condition of the person legally incapable of making health care decisions, that person would be incapable of digesting or absorbing the nutrition and hydration so that its provision would not contribute to sustaining the person's life.
>
> (c) Nutrition and/or hydration may be withheld or withdrawn if the person executed a written advance health care directive, durable power of attorney or other writing that clearly expresses the patient's intent, the patient has a qualifying condition as determined under AS 13.52.160, and

[1] The amendment appears to be missing some language here.

withholding or withdrawing the hydration and/or nutrition would be consistent with the patient's best interest.

The amendment does not make the withholding or withdrawing of nutrition and/or hydration a criminal offense. The amendment does not state that the withholding or withdrawing of nutrition and/or hydration is a criminal offense, a felony, or a misdemeanor. It does not authorize a sentence of imprisonment for the withholding or withdrawal. In AS 11.81.900 (definitions for the criminal law title), "crime" is defined as "an offense for which a sentence of imprisonment is authorized; a crime is either a felony or a misdemeanor." Although this definition does not apply directly to this amendment, it indicates what is considered to be a criminal offense.

If I may be of further assistance, please advise.

TLB:mdr
04-186.mdr

Enclosure

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

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: SCS CSHB 25(HES)
(S) Publish Date: 4/20/04

Revision Date/Time (Note if correction): 1/20/2004
Dept. Affected: Health & Social Services

Title: HEALTH CARE DECISIONS/DO NOT RESUSCITATE ORDERS/DONATION OF BODY PARTS
RDU: Public Health
Component: Community Health/EMS Services

Sponsor: WEYRAUCH
Requester:
Component No.: 2078

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
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	0.0	0.0	0.0	0.0	0.0	0.0
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 (FY2004) 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: Doug A. Bruce
Phone 465-3090
Division: Public Health
Date/Time 01/20/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 01/21/2004
Agency: Department of Health and Social Services

(Revised 9/2002 OMB)

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MEMORANDUM March 3, 2004

SUBJECT: Summary of statutes repealed by draft CSHB 25( ) relating to health care decisions (Work Order No. 23-LS0137\U)

TO: Representative Bruce Weyhrauch
Attn: Linda

FROM: Theresa L. Bannister
Legislative Counsel

You have asked for a summary of each statutory provision repealed by the draft bill described above. As a preliminary matter, note that this is a summary of the provisions and should not be considered an authoritative interpretation of the provisions, and each provision is the best statement of its contents. The provisions described below are repealed by sec. 15 of the bill.

1. **Statutory form of power of attorney.** These three provisions relate to the statutory power of attorney form.

AS 13.26.332(L). Category of power that may be given in statutory power of attorney. Category is "health care services."

AS 13.26.335(1). Additional optional provisions that may be included in the statutory form of power of attorney. These provisions may be used if the person gives an agent authority over health care services in the power of attorney. The provisions include whether the person has a declaration under AS 18.12, a living will, or a declaration regarding mental health treatment.

AS 13.26.344(l). In the statutory form power of attorney, this provision indicates what the language conferring general authority with respect to health care services will be construed to mean.

4. **Uniform Anatomical Gift Act.** These provisions make up the contents of the current chapter dealing with anatomical gifts.

AS 13.50.010. Describes who may make an anatomical gift and when they may make the gift. Prohibits a donee from accepting a gift, if the donee has actual notice of contrary indications by the decedent or if the gift is opposed by certain persons. However, provides that 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. States that a gift authorizes any examination necessary to assure medical acceptability of the gift for the purposes intended. States that the rights of the donee are superior to others' rights but are subject to the state's autopsy laws.

AS 13.50.014. Requires hospitals to make a reasonable search for a document of gift or other information relating to gift donation and to request a gift. States that failure to make a reasonable search is not a basis for liability other than administrative sanctions. Requires a hospital to develop procedures related to anatomical gifts. Exempts certain hospitals that lack the means to properly remove, store, or transport gifts.

AS 13.50.016. Requires law enforcement and medical personnel who respond to the scene of a death to make a reasonable search for a document of gift or other information relating to a gift donation and to inform the hospital of a gift. States that failure to make a reasonable search is not a basis for liability other than administrative sanctions. Exempts responding law enforcement or medical personnel if all hospitals within a reasonable distance are exempt under AS 13.50.014.

AS 13.50.020. Lists approved potential donors and purposes.

AS 13.50.030. Indicates how an anatomical gift can be made, including what documents or other means may be used, how it must be executed, and when the gift takes effect. States that a gift may identify a donee, and who may accept the gift. Allows the donee to identify the doctor to handle the procedure. Sets out an optional form for a gift.

AS 13.50.040. States that delivery of the gift document is not necessary for a valid gift. Allows the gift document, or an executed copy, to be deposited in a hospital, bank or storage facility, or registry office to facilitate the procedure after death. Requires the person in possession of the document to produce it upon request after death.

AS 13.50.050. Indicates how a gift, including one made in a declaration under AS 18.12, may be amended or revoked.

AS 13.50.060. States that a donee may accept or reject a gift. Authorizes the donee of an entire body to authorize embalming and the use of the body in funeral services. Requires that a donated part be removed without unnecessary mutilation. Indicates in whom the possession of the body vests after the removal. Addresses liability for the costs of making the gift. States how the time of death is to be determined. Generally prohibits the physician who determines death from participating in the gift procedures. Addresses the liability of persons who act in good faith under the chapter or another state's or country's laws. Makes the provisions of this chapter subject to state autopsy laws.

AS 13.50.065. Requires the adoption of regulations to implement the chapter.

AS 13.50.068. Recognizes gifts executed, issued, or authorized in other states.

AS 13.50.070. Defines the terms for the chapter.

AS 13.50.080. Requires that the chapter be interpreted to make it uniform with other states enacting the same provisions.

AS 13.50.090. Names the chapter the Uniform Anatomical Gift Act.

3. Living wills and do not resuscitate orders. These provisions make up the contents of the chapter on living wills and DNR orders.

AS 18.12.010. Allows a competent person who is 18 years or more old to execute a declaration directing that life-sustaining procedures be withheld or withdrawn. States that the declaration is given operative effect only if the declarant's condition is terminal and the declarant is not able to make treatment decisions. However, makes anatomical gifts in the declaration take effect upon death. Requires that the declaration be signed by the declarant or another person at the declarant's direction. Prohibits a person from charging for preparing a declaration. States that, except regarding certain anatomical gift provisions, it is the declarant's responsibility to provide a copy to the physician. Requires the health care provider receiving the copy to put it in the declarant's medical records.

Provides an optional form for a declaration.

AS 18.12.020. States that, except as provided for anatomical gifts, a declaration may be revoked at any time and in any manner without regard to mental or physical condition. States that a revocation is only effective, with regard to health care providers, when communicated to the provider by the declarant or by another person to whom the revocation was communicated. Requires that the revocation be made a part of the declarant's medical record.

AS 18.12.030. Requires an attending physician who has a declaration and determined the declarant to be in a terminal condition to record that determination and the contents of the declaration in the declarant's medical record.

AS 18.12.035. Authorizes an attending physician to issue a DNR order for a patient of the physician. Directs the Department of Health and Social Services to adopt a DNR protocol. Requires the protocol to be approved by the State Medical Board. Requires health care providers other than a physician to comply with the protocol when presented with DNR identification, an oral DNR order issued directly by a physician, or a written DNR order entered on a department form. Prohibits implementing a DNR order until a donated organ can be evaluated. Prohibits a physician from revoking a DNR order under certain conditions. Prohibits a person from making a DNR order ineffective under certain conditions.

AS 18.12.037. Requires the department to develop standardized designs for DNR identification cards, forms, necklaces, and bracelets to signify that the possessor has executed a declaration, that the declaration contains an anatomical gift, or that the possessor has a DNR order.

AS 18.12.040. States that a terminal patient with a declaration or a patient with a DNR order has the right to make decisions regarding use of cardiopulmonary resuscitation and other life-sustaining procedures as long as the patient can. States that if the patient cannot, the declaration or the DNR protocol governs the decisions, unless the DNR order is revoked or made ineffective. States that the chapter does not prohibit medical procedures considered necessary to provide comfort care or alleviation of pain. States that a declaration may provide that the declarant does not want nutrition or hydration administered intravenously or by gastric tube. Provides that the declaration of a terminal patient with a declaration known to the attending physician to be pregnant is not given effect as long as it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining procedures.

AS 18.12.050. Requires an attending physician who is not willing to comply with the requirements of AS 18.12.030 or with the declaration of a qualified patient under AS 18.12.040 to withdraw as attending physician. However, the withdrawal is effective only when the services of another attending physician have been obtained. Requires facilities that are not able to comply with a declaration or are unwilling to recognize DNR identification to take all reasonable steps to notify the patient or the patient's guardian of the facility's policy and to transfer the patient.

AS 18.12.060. States that certain persons, without actual notice of the revocation of a declaration or DNR order, who act in accordance with the DNR protocol or this chapter, are not subject to civil or criminal liability or guilty of unprofessional conduct. States that a physician, a health care professional, or a health care facility is not subject to civil or criminal liability for actions under this chapter that are in accord with reasonable medical standards.

AS 18.12.070. States that an attending physician who fails to comply with a DNR order or a declaration of a terminal patient or to make transfer arrangements under AS 18.12.050 is not entitled to compensation for services provided after the failure. States that the physician may be liable for a civil penalty plus certain actual costs; states that this is the exclusive remedy at law. States that a person who willfully conceals, cancels, defaces, obliterates, or damages DNR identification or a declaration or falsifies or forges a revocation of the DNR identification or declaration may be civilly liable to ertain persons.

8.12.080. States that if death results from the withholding or withdrawal of lmonary resuscitation or other life-sustaining procedures under a DNR order or under a declaration, or upon discovery of DNR identification and in accordance hapter, the death does not constitute a suicide or homicide. States that a DNR

order, DNR identification, or a declaration, does not affect life insurance. Prohibits certain identified persons and entities from requiring a person to execute a declaration, obtain a DNR order, or have DNR identification in order to be insured or receive health care. States that the chapter does not create a presumption about the intention or intended treatment of a person who does not have DNR identification, a declaration, or a DNR order with respect to the use, withholding, or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures. States that the chapter does not increase or decrease a patient's right to make decisions about cardiopulmonary resuscitation or other life-sustaining procedures as long as the patient is able to do so. Also states that the chapter does not impair or supersede a right or responsibility to effect the withholding or withdrawal of medical care in a lawful manner. States that, in that respect, the provisions of the chapter are cumulative. States that the chapter does not condone, authorize, or approve mercy killing or euthanasia.

AS 18.12.090. States that a declaration, DNR order, and DNR identification from another state that complies with that jurisdiction's laws is effective under this chapter.

AS 18.12.100. Defines terms for the chapter.

4. **Mental health treatment declarations.** These sections makes up the article that deals with personal declarations of preferences for mental health treatment.

AS 47.30.950. Allows an adult of sound mind to make a declaration of preferences or instructions for mental health treatment, including consent to or refusal of mental health treatment. Indicates how long a declaration continues and how long the authority of the named attorney-in-fact is in effect.

AS 47.30.952. States that a declaration may designate a competent adult to act as attorney-in-fact to make decisions about mental health treatment. Provides for an alternative attorney-in-fact. Allows the attorney-in-fact to may make decisions about mental health treatment on behalf of the principal only when the principal is incapable. States that the decisions must be consistent with the declaration. Lists who may not serve as attorney-in-fact. Allows an attorney-in-fact to withdraw and to rescind the withdrawal. Establishes certain notice and procedural requirements. Indicates how the designation of an attorney-in-fact under this section relates to previous or subsequent designations of an attorney-in-fact.

AS 47.30.954. Requires a declaration to be signed by the principal and two competent adult witnesses. Indicates who may not serve as a witness.

AS 47.30.956. States when a declaration becomes operative. Indicates when a provider is to act under the declaration and when the provider is to obtain the principal's informed consent or refusal. Requires a provider to make the declaration a part of the principal's medical record. Requires a provider to comply with a declaration consistent with reasonable medical practice, the availability of treatments requested, and applicable law.

Indicates what a provider may do and is required to do if unwilling to comply with the declaration.

AS 47.30.958. States that an attorney-in-fact does not have authority to make mental health treatment decisions unless the principal is incapable. States that an attorney-in-fact is not personally liable for the cost of treatment provided to the principal. Describes the attorney-in-fact's right to receive information and to receive, review, and consent to disclosure of medical records. Explains the attorney-in-fact's duty to act consistently with the declaration, or, if the declarant's wishes are unknown, with what the attorney-in-fact in good faith believes to be the best interests of the principal. States that an attorney-in-fact is not subject to criminal prosecution, civil liability, or professional disciplinary action for an action taken in good faith under a declaration.

AS 47.30.960. Prohibits requiring a person to execute or to refrain from executing a declaration to get insurance, mental or physical health services, or a facility discharge.

AS 47.30.962. Allows a provider to subject the principal to mental health treatment contrary to the principal's wishes in a declaration only under two described situations.

AS 47.30.964. States that a declaration does not limit any authority provided in this chapter to take a person into custody or to admit, retain, or treat a person in a health care facility.

AS 47.30.966. States that a declaration may be revoked at any time by a capable principal. Indicates when the revocation becomes effective.

AS 47.30.968. Provides immunity for a provider who administers or does not administer mental health treatment according to and in good faith reliance upon the validity of a declaration.

AS 47.30.970. Requires the declaration to be in substantially the form provided in the section.

AS 47.30.972. Establishes a class A misdemeanor penalty for certain described activity.

AS 47.30.980. Defines the following terms: "anatomical gift," "attending physician," "cardiopulmonary resuscitation," "declaration," "DNR identification," "do not resuscitate order," "do not resuscitate protocol," "health care provider," "life-sustaining procedure," "physician," "qualified patient," and "terminal condition."

If I may be of further assistance, please advise.

TLB:lmb
04-060.lmb

ALASKA STATE LEGISLATURE

REPRESENTATIVE BRUCE WEYHRAUCH

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
99801-1182

(907) 465-3744
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HOUSE DISTRICT 4

*** For Immediate Release ***

While nation's attention is riveted by the Terri Schiavo drama taking place in Clearwater, Florida, the unfortunate situation is also focusing attention on a problem Alaskans face. The case strikes a chord because it forces us to consider what circumstances will befall us at the end of our life. Most people want to die at home with family members and friends, but according to Aging with Dignity, a national organization that advocates for the elderly, the typical scenario is that people end up in a hospital or nursing home cared for by strangers.

Who will make decisions for you and how do you want to be cared for as death looms? These intense concerns require compassionate treatment by families, healthcare institutions, and particularly government recognition of these things.

"Unfortunately, Alaska is one of 14 states were narrow laws often derail efforts by people to spell out their last wishes," said Juneau Rep. Bruce Weyhrauch.

Recently a national organization gave Alaska a failing grade on its treatment of the dying. The group known as Last Acts, is a coalition of organizations such as the American Medical Association and AARP and is funded by the Robert Wood Johnson Foundation.

During the past Legislative session, Rep. Weyhrauch introduced House Bill 25, to addresses Last Acts' concerns, that Alaska law actually thwarts good care planning. Known as the "Five Wishes Bill," HB 25 provides a comprehensive approach to making healthcare directives. 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 and how comfortable you want to be in terms of pain medication among others. Most importantly, HB 25 stipulates guidelines for named surrogates such as spouses, siblings, or adult children. "For the first time in Alaska, the authority of a surrogate will be supported in law."

"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. It also leaves open the possibility that some sorry person will be without an advocate who can make decisions for them, such as Terri Schiavo," Weyhrauch said. "We should address that."

HB 25, passed the Alaska House of Representatives in May 2003, and is currently in the Senate Health and Social Services Committee. For more information on HB 25, contact Rep. Bruce Weyhrauch at 465-3744.

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March 31, 2003

Via Fax 465-2273

Representative Bruce Weyhrauch
Alaska State Legislature
State Capitol Room 102
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)

AARP Alaska

Honorable Peggy Wilson, Chair
House Health, Education and Social Services Committee
Alaska Capitol, Room 104
Juneau, AK 99801-1182

RE: HB 25 (Weyhrauch) – Support

Dear Chair Wilson:

On behalf of the members of AARP in Alaska, we urge you and your colleagues on the House Health, Education and Social Services 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 Capitol City Task Force; Patrick Luby (907-762-3314), AARP Legislative Representative; or me (907-245-5259).

Thank you for your consideration.

Sincerely,

Marguerite Stetson

Marguerite Stetson
Executive Council Member for Advocacy

Vice-Chair Carl Gatto
Representative Cheryll Heinze
Representative Paul Seaton
Representative Kelly Wolf
Representative Sharon Cissna
Representative Mary Kapsner

Representative Bruce Weyhrauch

Marie Darlin, AARP Capitol City Task Force
Pat Luby, AARP Legislative Representative

AARP Alaska

Health Issue Priorities for 2003 Session

AARP Alaska has over 71,000 members

In a 2002 research survey, AARP members in Alaska list health care as their top legislative concern:

- ✓ In 2001, pharmaceutical prices in Alaska rose over 25%, the highest increase in the nation.
- ✓ Alaska health care routinely costs 20% more than similar care in Seattle, Washington.
- ✓ 1 out of 5 Alaskans aged 50 – 64 has no health insurance.

For 2003, We Advocate the Following:

- ➢ A prescription drug assistance program for older persons without insurance. Drug regimen reviews to determine if a prescription is necessary and/or is there a less expensive therapeutic substitute available
- ➢ Provide an insurance pool for small businesses and non-profit agencies so they will have access to less expensive coverage for their employees.
- ➢ Provide comprehensive regulations and oversight for adult day care centers.
- ➢ Provide funding for Pioneer and Veterans' Homes so they can be fully staffed and empty beds can be filled from existing waiting lists.
- ➢ Consolidate existing law on advanced directives and health care decision – making and create easy to use tools for Alaska citizens to communicate how they wish to be treated at the end of their lives.

Proof of Enrollment

Comfort One Identification Form

The Comfort One Identification form is printed on 8.5 " x 11" carbonless paper with the Comfort One logo (see brochure cover page) printed at the top. The form contains the patient's name, address, date of birth, and gender. To be valid, the form must be signed by both the patient, if the patient is able, and the patient's physician.

Comfort One Wallet Card

The wallet card is detached from a larger form and measures approximately 2.5 inches x 3.5 inches. The Comfort One logo is printed at the top. The front of the wallet card contains the patient's name, date of birth, and gender. A serial number for the card is printed vertically on the front side of the card. The reverse side lists the name of the patient's physician and the physician's contact number.

Comfort One Bracelet

The bracelet has a gold chain, gold border, and a green background. The Comfort One logo is prominently displayed on the bracelet in white and gold lettering.

Confirming the Patient's Identity

Under the Alaska DNR Protocol, the following are acceptable methods of confirming the patient's identity:

- ? the patient communicating the patient's name;
- ? the patient's hospital or other institutional identification arm band;
- ? the patient being personally known to the physician or other health care provider;
- ? the patient's driver's license or credit card; or
- ? another person having identified the patient.

If the patient is unconscious or otherwise unresponsive to questions regarding the patient's identity, the physician or other he alth care provider may rely solely on the Comfort One bracelet worn by the patient without using further methods to identify the patient.

Do Not Resuscitate Protocols

Once the DNR status and patient's identity have been confirmed, and the patient is pulseless or apneic, the protocols are easy to follow:

- ? **If the patient does not have a valid DNR order,** the standard treatment and transport protocols, including CPR, should be employed.
- ? If the patient **DOES have** a valid DNR order, resuscitation efforts should not be initiated or, if already in progress, terminated immediately.

Palliative Care

Health care personnel should provide comfort care as appropriate for the patient and within the scope of lawful activities for the individual health care provider.

The Alaska Comfort One Program

Information for Health Care Providers

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

Chapter Four

Advance Directives:

Living Wills, Durable Power of Attorney and Surrogate Consent

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

Introduction

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

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

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

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

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

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

Question One

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

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

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

Question Two

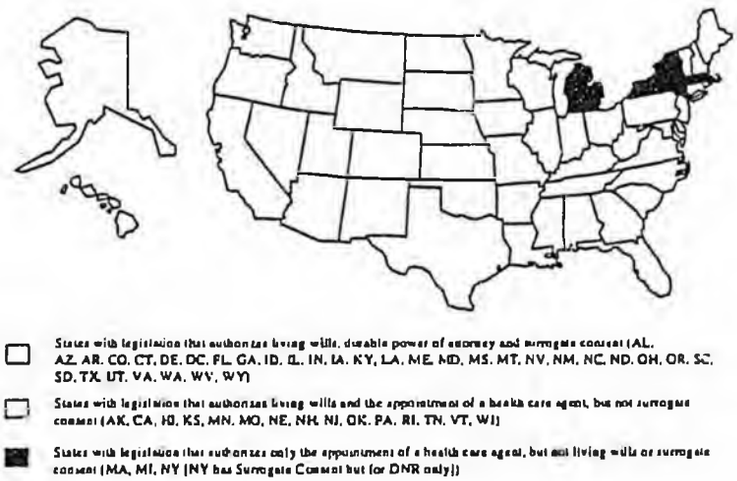
Does your state recognize advance directives?

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

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

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

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



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

Question Three

Are the existing advance directive laws effective?

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

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

Question Four

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

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

Figure 13.
States with Combined Advance Directive Statutes

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

*Does not include surrogate consent.

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

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

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

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

Figure 14.
States that Allow Close Friends as Surrogates

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

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

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

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

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

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

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

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

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

Figure 15.
Examples of Values Questions

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

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

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

4. **Recognize other states' advance directives.**

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

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

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

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

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

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

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

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

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

Too little respect seen for the dying

The Boston Globe

Bereaved kin fault care in US study

By Alice Dembner, Globe Staff, 1/7/2004

Nursing homes and hospitals, where most Americans spend their final days, regularly fail to treat dying patients with respect or provide needed emotional support, according to the most definitive national survey yet of surviving family members. Bereaved relatives also faulted the medical care provided to their loved ones.

Nearly one-quarter of those dying at nursing homes didn't get relief for labored breathing, nearly one-third didn't get enough care for pain, and nearly 20 percent suffered because of the staff's incomplete knowledge of the patient's medical history, the survey found. Patients in hospitals fared only slightly better.

In contrast, families reported much greater satisfaction with hospice care provided to patients at home.

"We're moving toward factory medicine -- get 'em in, get 'em out," said Dr. Joan Teno, a geriatrician and professor at Brown University Medical School, who is the lead author of the paper published today in the Journal of the American Medical Association. "Many family members feel they must be constantly present to ensure quality care of their loved ones. Before the Baby Boomers hit in full force, we have to figure out how to provide adquate care to the dying."

Teno said the survey of relatives or close friends of 1,578 people who died in 2000 was designed to be extrapolated to all 1.9 million people who died of nontraumatic causes that year. While other studies have identified some of the same shortcomings, particularly with medical and pain treatment, this is the most comprehensive survey and the first to compare care in different settings.

"This is really the first high-quality, well-designed study to address what happens to patients and families in the last months of life in the United States. And it is an indictment of the quality of care in most institutional settings," said Dr. Diane E. Meier, director of the Center to Advance Palliative Care, who was not involved with the study.

Hospital and nursing home officials said the study identified problems they are already working on, but they acknowledged they need to do better. At nursing homes, the study authors said, federal gaps in reimbursement and resulting staff shortages have contributed to care problems.

Dr. Susan Block, director of the division of palliative care at Dana-Farber Cancer Institute and Brigham and Women's Hospital, said the study comes after six years of "very vigorous efforts nationwide to improve care" of the dying, including the addition of palliative care programs at about 20 percent of hospitals. "In that context," she said, "the study results are even more dismal."

Teno and her colleagues suggested that more hospitals need to adopt palliative care, which focuses on pain relief and other comfort measures, and that nursing homes need to ensure that their patients have access to hospice care.

But the study also found problems with hospice, which provides care for terminally ill patients who have stopped aggressive treatment. Care is typically provided in hospitals, nursing homes, or the patient's home.

One-third of hospice patients' relatives said it didn't provide enough emotional support, while

more than half of family members of patients who died in hospitals and nursing homes said the patients didn't get enough emotional support, which can include care-givers listening to patients' concerns and expressing sympathy.

About a third of those in nursing homes and 20 percent of those in hospitals weren't always treated with respect, their relatives said.

Among the relatives researchers interviewed was Foxborough resident Janet Roxborough. A nurse-practitioner, she is still seared by her parents' deaths less than a year apart in Boston-area hospitals.

"Up until the few hours prior to death, the care was not kind and not thoughtful," said Roxborough, who said she was routinely ignored when she went to the nurses' station to ask for help with her parents' care. "There was sloppy care and callous indifference."

One day, she said, she was sitting at the bedside of her 89-year-old father and got up to go to the bathroom, leaving the bed rail down.

"A nurse accosted me and said, `You left the side rail down. He could have fallen out of bed and badly hurt himself.' She said that to a person who was losing the most important person in her life. Rather than just putting the rail up, she had to make me feel bad."

The study contained one bit of good news: 71 percent of those dying had completed living wills or health care proxies to spell out what kind of care they wanted at the end. That's up from the 20 percent suggested by earlier studies since 1995. Earlier research also found that these documents were widely ignored by health professionals. Teno said she asked family members about this issue, but she declined to release those results until later publication.

"On advanced directives, we're heading in the right direction," Teno said. "Now, we have to get people to follow them." Extrapolating the study figures to the nation, the researchers said 38 percent of people in 2000 died in hospitals, 31 percent in nursing homes, and 16 percent at home with hospice services. Another 11 percent died at home with no services and 4 percent at home with nursing services.

While the study findings are based on family members' recall of what happened, Meier said they probably underestimate the problems because of people's tendency to try to put the worst behind them and mute their criticism. "What's very striking," she said, "is what they say makes for high-quality care. They're talking about being seen as a human being, being heard, being listened to."

Teno suggests that doctors and other clinicians need to spend more time just talking or sitting with patients and family members. In addition, she and her colleagues call for expanded access to hospice care, and removal of some federal financial restrictions that limit access to hospice. She also said society has to provide more money for nursing home care, which she calls "the frailest part of our health care system" because the facilities are underfunded given the demands placed on them.

"It's not going to be a quick fix," Teno warns. "The most expensive thing in our health care system is staffing, and that's what we're missing."

In Massachusetts, about 18 percent of dying patients in all settings used hospice last year, according to the state hospice federation. Nursing home officials said they have been encouraging patients to use hospice care and welcoming hospice workers. But they said their own staff can't afford to spend as much time as they'd like providing emotional support.

"We probably have gotten much better at the medical side of care, perhaps at the expense of the social side. We've got some work to do," said Scott Plumb, senior vice president of the Massachusetts Extended Care Federation, the state's largest nursing home association.

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Original Contribution

Family Perspectives on End-of-Life Care at the Last Place of Care

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JAMA. 2004;291:88-93.

Context Over the past century, nursing homes and hospitals increasingly have become the site of death, yet no national studies have examined the adequacy or quality of end-of-life care in institutional settings compared with deaths at home.

Objective To evaluate the US dying experience at home and in institutional settings.

Design, Setting, and Participants Mortality follow-back survey of family members or other knowledgeable informants representing 1578 decedents, with a 2-stage probability sample used to estimate end-of-life care outcomes for 1.97 million deaths from chronic illness in the United States in 2000. Informants were asked via telephone about the patient's experience at the last place of care at which the patient spent more than 48 hours.

Main Outcome Measures Patient- and family-centered end-of-life care outcomes, including wl health care workers (1) provided the desired physical comfort and emotional support to the dyin (2) supported shared decision making, (3) treated the dying person with respect, (4) attended t emotional needs of the family, and (5) provided coordinated care.

Results For 1059 of 1578 decedents (67.1%), the last place of care was an institution. Of 519 patients dying at home represented by this sample, 198 (38.2%) did not receive nursing service (12.5%) had home nursing services, and 256 (49.3%) had home hospice services. About one qu patients with pain or dyspnea did not receive adequate treatment, and one quarter reported con physician communication. More than one third of respondents cared for by a home health agenc home, or hospital reported insufficient emotional support for the patient and/or 1 or more conce family emotional support, compared with about one fifth of those receiving home hospice service home residents were less likely than those cared for in a hospital or by home hospice services to have been treated with respect at the end of life (68.2% vs 79.6% and 96.2%, respectively). Fa members of patients receiving hospice services were more satisfied with overall quality of care: rated care as "excellent" compared with less than 50% of those dying in an institutional setting home health services ($P<.001$).

March 2000

State Statutes Governing Living Wills and Appointment of Health Care Agents

Jurisdictions with legislation that authorizes both living wills and the appointment of a health care agent (**the District of Columbia and 46 states: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming**).

State with legislation that authorizes only living wills (**1 state: Alaska**).

States with legislation that authorizes only the appointment of a health care agent (**3 states: Massachusetts, Michigan and New York**).

Note: The specifics of living will and health care agent legislation vary greatly from state to state. In addition, many states also have court-made law that affects residents' rights. For information about specific state laws, please contact Partnership for Caring.

HEALTH CARE SURROGATE DECISION-MAKING LEGISLATION

July 1, 2001

LIVING WILL STATUTES	PROXY STATUTES	DEFAULT SURROGATE CONSENT STATUTES	EMS-DNR STATUTES (NON-HOSPITAL DNR ORDERS)
48 STATES	**51 STATES**	**37 STATES**	**34 STATES**
Alabama	Alabama	Alabama	...
† Alaska	† Alaska	...	Alaska
Arizona	Arizona	Arizona	Arizona
Arkansas	* Arkansas	Arkansas	Arkansas
California	California	(California – Limited)	California
Colorado	Colorado	Colorado	Colorado
Connecticut	Connecticut	Connecticut	Connecticut
Delaware	Delaware	Delaware	...
†D.C.	D.C.	D.C.	...
Florida	Florida	Florida	Florida
Georgia	Georgia	Georgia	Georgia
† Hawaii	† Hawaii	Hawaii	Hawaii
† Idaho	† Idaho	Idaho	Idaho
† Illinois	† Illinois	Illinois	Illinois
Indiana	Indiana	Indiana	Indiana
Iowa	Iowa	Iowa	...
Kansas	Kansas	...	Kansas
Kentucky	Kentucky	Kentucky	Kentucky
Louisiana	Louisiana	Louisiana	...
Maine	Maine	Maine	...
† Maryland	† Maryland	Maryland	Maryland
...	Massachusetts	...	...
...	Michigan	...	Michigan
† Minnesota	† Minnesota	...	...
Mississippi	Mississippi	Mississippi	...
Missouri	Missouri	...	...
† Montana	†*Montana	Montana	Montana
Nebraska	Nebraska	...	...
Nevada	Nevada	Nevada	Nevada
New Hamp.	New Hamp.	...	New Hamp.
New Jersey	New Jersey	...	...
New Mexico	New Mexico	New Mexico	New Mexico
...	New York	(New York - Limited)	New York
† North Carolina	North Carolina	North Carolina	North Carolina
North Dakota	North Dakota	North Dakota	...
Ohio	Ohio	Ohio	Ohio
† Oklahoma	† Oklahoma	(Oklahoma – Limited)	Oklahoma
† Oregon	‡ Oregon	Oregon	...
Pennsylvania	* Pennsylvania	...	...
Rhode Island	Rhode Island	...	Rhode Island
South Carolina	South Carolina	South Carolina	South Carolina
South Dakota	South Dakota	South Dakota	...
† Tennessee	† Tennessee	...	Tennessee
† Texas	† Texas	Texas	Texas
† Utah	† Utah	Utah	Utah
Vermont	Vermont	...	...
Virginia	Virginia	Virginia	Virginia
Washington	Washington	Washington	Washington
West Virginia	West Virginia	West Virginia	West Virginia
Wisconsin	Wisconsin	...	Wisconsin
† Wyoming	† Wyoming	Wyoming	Wyoming

Code:

Underlined states have a combined advance directive statute merging Health Care Proxies, Living Wills, and (if Surrogate column is underlined) surrogate provisions applicable in the absence of an advance directive.

* Health care proxy is contained only within living will statute. Thus, proxy authority may be limited to terminal illness or PVS.

† State has special mental health advance directive statute.

ABA Commission on Legal Problems of the Elderly, Washington, D.C. (2000).

Health-Care Decisions Statutes Citations
July1, 2001

Living Will Statutes

Ala. Code §§ 22-8A-1 to -10 (1997) combined health decisions act, enacted in 1997 (amends earlier statute);
Alaska Stat. §§ 18.12.010 to -.100 (Supp. 1990);
Ariz. Rev. Stat. Ann. §§ 36-3201 to -3262 (1992), combined health decisions act, enacted in 1992 (replaces '86 law);
Ark. Code Ann. §§ 20-17-201 to -218 (Supp. 1989);
Cal. Probate Code §§ 4600 to 4948 (West 1999), combined health decisions act, enacted 1999;
Colo. Rev. Stat. §§ 15-18-101 to -113 (1987 & Supp. 1990);
Conn. Gen Stat. §§ 19a-570 to -575 (1992), as amended by 1993 Conn. Acts 93-407 (H.B. 7244) (Reg. Sess.);
Del. Code Ann. tit. 16, §§ 2501-2517 (substantially revised 1996);
D.C. Code Ann. §§ 6-2421 to 2430 (1989);
Fla. Stat. Ann. §§ 765.101 to .404 (West 1999), combined health decisions act enacted in 1992;
Ga. Code Ann §§ 31-32-1 to 12 (1985 & Supp. 1989);
Hawaii Rev. Stat §§ 327E-1 to –16 (West 1999), combined health decisions act, enacted 1999, replacing more limited statute.
Idaho Code §§ 39-4501 to -4509 (1985 & Supp. 1989);
Illinois -- 755 ILCS 35/1 to 35/10 (formerly Ill. Ann. Stat. ch. 110 1/2 para. §701-710);
Ind. Code Ann.§§ 16-36-4-1 to -21 (West 1994);
Iowa Code Ann §§ 144A.1 to -11 (West Supp. 1989);
Kan. Stat. Ann §§ 65-28,101 to -28,109 (1985);
Ky. Rev. Stat. §§ 311.621 to .643 (Supp. 1994), combined health decisions act enacted in 1994 (replaces 1990 law);
La. Rev. Stat. Ann. §§ 40:1299.58.1 to -10 (West Supp. 1987);
Me. Rev. Stat. Ann. tit. 18-A, §§ 5-801 to -817 (Supp. 1996), enacted in 1995; combined health decisions act;
Md. Health-Gen. Code Ann. §§ 5-601 to -608 (1993), combined health decisions statute, enacted 1993;
Minn. Stat. §§ 145C.01 to -.16 (Supp. 1998), combined health decisions act enacted 1998, replacing former living will and durable power acts; see also mental health advance directive at §253B.03, Subd. 6b.;
Miss. Code Ann. §§41-41-201 to -229 (Supp. 1998),enacted in 1998; combined health decisions act;
Mo. Ann. Stat. §§ 459.010 to -055 (Vernon Supp. 1990);
Mont. Code Ann. §§ 50-9-101 to -111, -201 to -206 (1992);
Neb. Rev. Stat. §§ 20-401 to -416 (1993), enacted 1992;
Nev. Rev. Stat. §§ 449.535 to .690 (1991);
N.H. Rev. Stat. Ann. §§ 137-H:1 to -H:16 (Supp. 1988);
N.J. Stat. Ann. §§ 26:2H-53 to -78 (West 1993), combined advance directive act, enacted 1991;
N.M. Laws Ch. 182 (H.B. 483), combined health decisions act, enacted 1995;
N.C. Gen. Stat. Ann. §§ 90-320 to -322 (1991);
N.D. Cent. Code §§ 23-06.4-01 to -14 (Supp. 1993);
Ohio Rev. Code Ann. §§ 2133.01 to -15 (Anderson Supp. 1991);
Okla. Stat. Ann. tit. 63, §§ 3101.1 to .16 (West 1993), combined advance directive act, enacted 1993; see also mental health advance directive act at Okla. Sess. Law Serv. Ch. 251 (H.B. 1353), enacted 1995;
Or. Rev. Stat. §§ 127.505 to 127.660, and 127.995 (West 1996), combined health decisions act, enacted 1993;
Pa. Stat. Ann. tit. 20, §§ 5401 to 5416 (Purdon 1993), enacted 1992;
R.I. Gen Laws §§ 23-4.11-1 to -14 (1992);
S.C. Code Ann. §§ 44-77-10 to -160 (Law. Co-op Supp. 1988);
S.D. Codified Laws Ann. §§ 34-12D-1 to -17 (1991);
Tenn. Code Ann. §§ 32-11-101 to -110 (Supp. 1988);
Tex. Health & Safety Code Ann. §§ 166.031 to .051 (Vernon Supp. 1990);
Utah Code Ann. §§ 75-2-1101 to 1119 (Supp. 1993);
Vt. Stat. Ann. tit. 18, §§ 5251-5262 and tit. 13, §1801 (Supp. 1987);
Va. Code §§ 54.1-2981 to -2993 (Supp. 1992), combined health decisions act, enacted 1992;
Wash. Rev. Code Ann. §§ 70.122.010 to -.905 (Supp. 1989);
W. Va. Code §§ 16-30-1 to -10 (1985);
Wisc. Stat. Ann. §§ 154.01 to -.15 (West 1989);
Wyo. Stat §§ 35-22-101 to -109 (Supp. 1990).

Health Care Power of Attorney Statutes

Ala. Code §§ 22-8A-1 to -10 (1997) combined health decisions act, enacted in 1997 (amends earlier statute that did not contain power of attorney provisions); must be read in combination with Durable Power of Attorney Act, §26-1-2, revised 1997.
Alaska Stat. §§13.26.332 to -.356 (Supp. 1990), particularly § 13.26.344(l), health care agent authority enacted 1988;
Ariz. Rev. Stat. Ann. §§ 36-3201 to -3262 (1992), combined health decisions act, enacted in 1992;
1999 Arkansas Laws Act 1448 (H.B. 1331), enacted 4/15/99. See also proxy authorization in Living Will statute, Ark. Code Ann. §§ 20-17-201 to -218 (Supp. 1989);
Cal. Probate Code §§ 4600 to 4948 (West 1999), combined health decisions act, enacted 1999;
Colo. Rev. Stat., §§ 15-14-501 to -509 (1992), enacted 1992;

Conn. Gen. Stat. § 1-43 (1991) re durable powers of attorney, and Conn. Gen. Stat. §§ 19a-570 to -575 (1992), re health care agents, both amended by 1993 Conn. Acts 93-407 (H.B.7244) (Reg. Sess.);
Del. Code Ann. tit. 16, § 2501-2509 (1983);
D.C. Code Ann., §§ 21-2201 to -2213 (1989), enacted 1989;
Fla. Stat. Ann. §§ 765.101 to .404 (West 1999), combined health decisions act enacted in 1992;
Ga. Code Ann., §§ 31-36-1 to -13 (1990), enacted 1990;
Hawaii Rev. Stat §§ 327E-1 to –16 (West 1999), combined health decisions act, enacted 1999, replacing more limited statute.
Idaho Code, §§ 39-4501 to -4509, specifically § 39-4505 (Supp. 1990), enacted 1988;
Illinois -- 755 ILCS 45/4-1 to 4-12 (formerly Ill. Ann. Stat. Ann. ch. 110 1/2,, para. 804-1 to -12, enacted 1987);
Ind. Code Ann., §§ 30-5-1 to 30-5-10 (West 1991), particularly 30-5-5-17 re health care agent authority, enacted in 1991, and see also § 16-36-1-1 to -14 (West 1994) re health care consent;
Iowa Code Ann. §§ 144B.1 to .12 (West Supp. 1991), enacted 1991;
Kan. Stat. Ann. §§ 58-625 to -632 (Supp. 1989), enacted in 1989;
Ky. Rev. Stat. §§ 311.621 to 311.643 (Supp. 1994), enacted in 1994 (replaces a 1990 law);
La. Civ. Code Ann. Art. 2997 (West 1990);
Me. Rev. Stat. Ann. tit. 18A, §§ 5-801 to -817 (Supp. 1996), enacted in 1995, replacing more limited statute;
Md. Health-Gen. Code Ann. §§ 5-601 to -608 (1993), combined health decisions statute enacted 1993;
Mass. Gen. Laws Ann. ch. 201D (West Supp. 1991), enacted 1990;
Mich. Comp. Laws Ann. §§ 333.5651 (West 2001), enacted 1996, and §§700.5501 to.-5520 (West 2001), enacted 1998, effective 4/1/00.
Minn. Stat. §§ 145C.01 to -.16 (Supp. 1998), combined health decisions act enacted 1998, replacing former living will and durable power acts; see also mental health advance directive at §253B.03, Subd. 6b.;
Miss. Code Ann. §§41-41-201 to -229 (Supp. 1998),enacted in 1998, replacing 1990 act; combined health decisions act;
Mo. Ann. Stat. §§ 404.700 to .735 (West 1991), health care agent authority enacted 1991;
Mont. Code Ann. §§ 50-9-101 to -111, and 50-9-201 to -206 (1993), enacted 1985 with proxy added 1991;
Neb. Rev. Stat. §§ 30-3401 to -3432 (1993), enacted 1992;
Nev. Rev. Stat., §§ 449.800 to .860 (Supp. 1991) enacted 1987;
N.H. Rev. Stat. Ann. §§ 137-J:1 to -J:16 (1993), enacted 1991;
N.J. Stat. Ann. §§ 26:2H-53 to -78 (West 1993), combined advance directive act, enacted 1991;
N.M. Laws Ch. 182 (H.B. 483), combined health decisions act, enacted 1995; see also durable power of attorney for health care act at N.M. Stat. Ann. §§ 45-5-501 and -502 (1989);
N.Y. Pub. Health Law §§ 2980 to 2994 (McKinney Supp. 1991), enacted 1990;
N.C. Gen. Stat. §§ 32A-15 to -26 (1991), enacted 1991;
N.D. Cent. Code §§ 23-06.5-01 to -18 (Supp. 1993), enacted April 18, 1991;
Ohio Rev. Code, §§ 1337.11 to .17 (Anderson Supp. 1991), enacted 1989;
Okla. Stat. Ann. tit. 63, §§ 3101.1 to .16 (West 1993), combined advance directive act, enacted 1992;
Or. Rev. Stat. §§ 127.505 to .660, and 127.995 (West 1996), combined health decisions act created 1993;
20 Pa. Cons. Stat. Ann. §§ 5601-5607 (Purdon's Supp. 1990), enacted in 1982, and see Pa. Stat. Ann. tit. 20, §§ 5401 to 5416 (1993), enacted 1992;
R.I. Gen. Laws §§ 23-4.10-1 to -2 (Supp. 1993), enacted 1986;
S.C. Code §§ 62-5-504, enacted April 8, 1992 (S.B. 541) (See also § 62-5-501 re durable power of attorney);
S.D. Codified Laws Ann. §§ 34-12C-1 to -8, and §§ 59-7-2.1 to -2.8 (Supp. 1992), health care agent authority enacted 1990;
Tenn. Code Ann. §§ 34-6-201 to -214 (Supp. 1991), enacted 1990;
Tex. Health & Safety Code Ann. §§ 166.151 to .166 (West 1993), enacted 1989;
Utah Code Ann. §§ 75-2-1101 to -1119 (Supp. 1993), enacted 1985;
Vt. Stat. Ann. tit. 14, §§ 3451 to 3467 (1989), enacted 1988;
Va. Code §§ 54.1-2981 to -2993 (Supp. 1992), combined health decisions act, enacted 1992, replacing a 1989 act;
Wash. Rev. Code Ann. §§ 11.94.010 to .900 (Supp. 1990) (health care agent authority enacted 1989);
W. Va. Code §§ 16-30A-1 to -20 (Supp. 1990), enacted in 1990;
Wis. Stat. Ann. §§ 155.01 to .80, and 11.243.07(6m) (West 1990), enacted 1990;
Wyo. Stat. §§ 3-5-201 to -214 (Supp. 1993).

Special Mental Health Advance Directives

1996 Alaska Laws Ch. 63 (S.B. 159), enacted 6/17/96, effective 9/15/96, and codified at Alaska Stat. §47.30.950 to .980 (1996);
1999 Arizona Laws Ch. 83, § 17, effective August 6, 1999, codified at Ariz. Rev. Stat. Ann. §§ 36- 3281 to 36-3287.
Idaho, 1998 Idaho Laws Ch. 81 (S.B. 1358), enacted 3/18/98 and effective 7/1/99, codified at Idaho Code §§66-601 to 66-613
Illinois. 755 ILCS 43/1 to 43/115 enacted Dec. 15, 1995, effective June 1, 1996.
Haw. Rev. Stat. §327F (Michie 1995). enacted 1992;
Md. Laws Ch. 189 (H.B. 127), approved April 20, 2001.
Minn. Stat. Ann. §253B.03 (West 1995), enacted 1991;
2001 Montana Laws Ch. 533 (H.B. 583), approved May 1, 2001.
N.C. Session Laws 1997-442, effective January 1, 1998, codified at N.C. Gen. Stat. §§122C-71 to –77.
Okla. Stat. Ann. tit. 43A §§11-101 to 11-113, enacted 1995;
Or. Rev. Stat. §§127.700 to 127.735 and 127.995 (West 1996), enacted 1993.
2000 Tenn. Laws Pub. Ch. 947 (H.B. 3004). Eff. June 23, 2000.

Vernon's Texas Code Ann., Civil Practice & Remedies Code § 137.001 to -.011, enacted 1997.
Utah Code Ann. 1953 § 62A-12-501 to –504, enacted 1996.
1999 Wyoming Laws Ch. 167 (H.B. 26), approved 3/3/99.

Surrogate Consent Statutes

Ala. Code §§ 22-8A-1 to -10 (1997), specifically §22-8A-10, combined health decisions act, enacted in 1997 (amends earlier statute that did not contain surrogate provisions);
Ariz. Rev. Stat. Ann. § 36-3231 (1992), enacted in 1992 as part of combined health decisions act;
Ark. Stat. Ann. § 20-17-214 (1991) and § 20-9-602 (1987), addresses consent generally;
Cal. Probate Code §§ 4711 to 4727 (West 1999), enacted 1999 as part of combined health decisions act; see also Cal. Health & Safety Code §1418.8 (1996) re: medical interventions affecting nursing facility residents.
Colo. Rev. Stat. §§ 15-18.5-101 to -104 (1992);
Conn. Gen Stat. §§ 19a-570 to -571 (Supp. 1991);
Del. Code Ann. tit. 16, §2507 (1996)
D.C. Code Ann. § 21-2210 (1989);
Fla. Stat. Ann. §§ 765.401 to .404 (West 1999), enacted as part of combined health decisions act;
Ga. Code Ann § 31-9-2 (1991), addresses consent generally; *see also* Ga. Code Ann. §31-36A-1 to A-7, enacted 1999, which applies to facility admission, discharge, and transfer decisions.
Hawaii Rev. Stat §§ 327E-1 to –16 (West 1999), combined health decisions act, enacted 1999, replacing more limited statute.
Idaho Code § 39-4303 (1985), addresses consent generally;
Illinois -- 755 ILCS 40/1 to 40/55 (1997);
Ind. Code Ann § 16-8-12-4 (1988);
Iowa Code Ann. § 144A.7 (West 1991);
Ky. Rev. Stat. § 311.631(Supp. 1994), enacted in 1994 as part of combined health decisions act;
La. Rev. Stat Ann. § 40:1299.53 (1975);
Me. Rev. Stat. Ann. tit. 18a, §§ 5-801 to 5-817 (1996) (see especially § 5-805); and tit. 24, §2905 (1988), addresses consent generally;
Md. Health-Gen. Code Ann. § 5-605 (1993), enacted 1993 as part of combined health decisions act;
Miss. Code Ann. §41-41-211 (Supp. 1998),enacted in 1998 and §41-41-215, enacted 1999; part of combined health decisions act;
Mont. Code Ann. § 50-9-106 (1992);
Nev. Rev. Stat. §§ 449.535 to .690 (1991), specifically § 449.626;
N.M. Laws Ch. 182 (H.B. '83), combined health decisions act, enacted 1995; see also living will act at N.M. Stat. Ann. § 24-7-8.1 (1984);
N.Y. Pub. Health Law § 2965 (McKinney Supp. 1991), restricted to do-not-resuscitate decisions;
N.C. Gen. Stat. § 90-322 (1991);
N.D. Cent. Code §§ 23-12-13 (1991), addresses consent generally;
Ohio Rev. Code Ann. § 2133.08(B) (Anderson Supp. 1992);
Okla. Stat. Ann. Tit. 63, §3102A, enacted April 16, 1997, effective Nov. 1, 1997, establishes limited surrogate consent, applicable only to experimental treatments, tests or drugs.
Or. Rev. Stat. § 127.635 (1993), part of combined health decisions act created 1993;
S.C. Code Ann. §§ 44-66-10 to -80 (1990);
S. D. Codified Laws §§ 34-12C-3 (1991), addresses consent generally;
Tex. [Health & Safety] Code Ann. §§ 166.035 and 116.039 (Vernon 1989) and Tex. [Health & Safety] Code §§313.001 to -007 (Vernon 1993);
Utah Code Ann. § 75-2-1105(2), and § 78-14-5(4) (1991), addresses consent generally;
Va. Code § 54.1-2986 (Supp. 1992);
Wash. Rev. code Ann. § 7.70.065 (West 1991), addresses consent generally;
W. Va. Code §§ 16-30B-1 to -16 (1992), enacted 1992, replacing a more limited provision; revised 1997.
Wyo. Stat. §§ 3-5-201 and -209, and §§ 35-22-101 and -105 (1992).

EMS DNR Statutes

Alaska Stat. §§18.12.010 to .100 (Michie 1998);
Ariz. Rev. Stat. Ann. §§36-3251 (West 1999);
Ark. Code Ann. §§20-13-901 to -911 (1997);
Cal. Probate Code §4753 (West 1999);
Colo. Rev. Stat. Ann. §§15-18.6-101 to -108 (West 1999);
Conn. Gen Stat. §§ 19a-580d (1998);
Fla. Stat. Ann. §401.45(3)(West 1999), but see §§395.1041(3); 400.142(3); 400.4255(3); 400.487(7); 400.6095(8); and 400.621(3) for its application to various health care providers;
Ga. Code Ann. §§31-39-1 to-9 (1999);
Hawaii Rev. Stat. §321-222 and §321-229.5 (Michie 1998);

Idaho Code Ann. §§39-150 to -165 (1998);
210 ILCS 50/3.30(a)(7), implemented by 77 Ill. Admin. Code §515.380 *et seq.;*
Ind. Code Ann. §16-36-5-1 to –24 (West 199);
Kan. Stat. Ann. §§65-4941 to -4949 (1997);
Ky. Rev. Stat. §311.623(3) (Banks-Baldwin 1999);
La. Rev. Stat. Ann. §§40:1299.58.1 to -.10 (West 1999);
Md. Health-General Code Ann. §§5-601, 5-608 and 5-617 (1998);
Mich. Comp. Laws Ann. §§333.1051 to .1067 (West 1998);
Mont. Code Ann. §§50-10-101 to -106 (1997);
Nev. Rev. Stat. §§450B.400 to -.490 (1997);
N.H. Rev. Stat. Ann. §151-B:18 (1998);
N.M. Sta. Ann. §24-10B-4(J) (1998);
N.Y. Pub. Health Law §§2960-2978 (McKinney 1999);
N.C. Gen. Stat. §§32A-15 to -26 and §§90-320 to –322 (applicable to DNR orders according to health an Attorney General Advisory Opinion 1997 WL 858260 (N.C.A.G.) (December 22, 1997)
Ohio Rev. Code §§2133.01 to -.26 (Banks-Baldwin 1999);
Okla. Stat. Ann. tit. 63, §3131.1 to .14 (West 1999);
R.I. Gen Laws §23-4.11-1 to .14 ((1998):
S.C. Code Ann. §§44-78-10 to -65 (Law. Coop. 1998);
Tenn. Code Ann. §§68-140-601 to -604, and 68-11-224 (1998);
Texas Health & Safety Code §§166.081 to -.101(West 1999);
Utah Code Ann. §§75-2-1105.5 (1998);
Va. Code §§54.1-2987.1, -2988, -2989, and –2982 (Lexis 1999);
Wash. Rev.Code §43.70.480 (199West 1998);
W. VA. Code §§16-30C-1 to -16 (1998);
Wis. Stat. §§154.19 to -.29 (West 1999);
Wyo. Stat. Ann. §§35-22-201 to -208 (Michie 1998).

Prepared by the ABA Commission on Legal Problems of the Elderly (2000)

SURROGATE CONSENT IN THE ABSENCE OF AN ADVANCE DIRECTIVE

January 1, 2002

State & Citation	General Type of Statute	Priority of Surrogates (in absence of appointed proxy or guardian with health powers)	Limitations on Types of Decisions	Disagreement Process Among Priority Surrogates
1. ALABAMA Ala. Code 1975 §22-8A-11 and -6 (1997), enacted 1997	Comprehensive Health Care Decisions Act	• Spouse • Adult child • Parent • Sibling • Nearest relative • Attending physician & ethics committee	Patient must be in terminal condition or permanently unconscious	Consensus required
2. ARIZONA Ariz. Rev. Stat. Ann. §36-3231 (West 1998), enacted 1992	Comprehensive Health Care Decisions Act	• Spouse • Adult child • Parent • Domestic partner • Sibling • Close friend • Attending physician in consult with ethics committee or, if none, 2nd physician	N/A to decisions to withdraw nutrition or hydration	Majority rule
3. ARKANSAS Ark. Code Ann. §20-17-214 (1997)	Living Will Statute	• Parents of unmarried minor • Spouse • Adult child • Parents • Sibling • Persons in loco parentis • Adult heirs	Patient must be in terminal condition or permanently unconscious N/A if pregnant	Majority rule
4. CALIFORNIA Cal. Probate Code §4711 – 4727 (West 1999)	Comprehensive Health Care Decisions Act	An individual *orally* designated as surrogate. No others.	Effective "only during the course of treatment or illness or during the stay in the health care institution when the designation is made." N/A to civil commitment, electro-convulsive therapy, psychosurgery, sterilization, and abortion.	None listed
5. COLORADO Colo. Rev. Stat. Ann. §15-18.5-103 (West 1999)	Separate Surrogate Consent Act	The following "interested persons" must decide who among them shall be surrogate decision-maker: • Spouse • Either parent • Adult child • Sibling • Grandchild • Close friend	N/A to withholding or withdrawal of artificial nourishment and hydration unless specified conditions are met	Consensus required
6. CONNECTICUT Conn. Gen. Stat. Ann. §19a-571 (West 1998)	Comprehensive Health Care Decisions Act	Physician authorized in consultation with next of kin	Limited to the removal or withholding of life support systems, and patient is in terminal condition or permanently unconscious N/A if pregnant	None listed

State & Citation	General Type of Statute	Priority of Surrogates (in absence of appointed proxy or guardian with health powers)	Limitations on Types of Decisions	Disagreement Process Among Priority Surrogates
7. DELAWARE Del. Code Ann. tit. 16, §2507 (1998)	Comprehensive Health Care Decisions Act	• An individual orally designated as surrogate • Spouse • Adult child • Parent • Sibling • Grandchild • Close friend	Patient must be in terminal condition or permanently unconscious N/A if pregnant	If in health care institution, refer to "appropriate committee" for a recommendation
8. DISTRICT OF COLUMBIA D.C. Code 1981 §21-2210 (1998)	Durable Power of Attorney for Health Care Act	• Spouse • Adult child • Parent • Sibling • Religious superior if patient is member of a religious order or a diocesan priest • Nearest living relative	N/A to abortion, sterilization, or psycho-surgery, convulsive therapy or behavior modification programs involving aversive stimuli are excluded	None listed
9. FLORIDA Fla. Stat Ann. §765.401 and .404 (West 2001) Last amended 2000	Comprehensive Health Care Decisions Act	• Spouse • Adult child • Parent • Sibling • Close adult relative • Close friend	N/A to abortion, sterilization, electroshock therapy, psychosurgery, experimental treatment, or voluntary admission to a mental health facility. A decision to withhold or withdraw life-prolonging procedures must be supported by clear and convincing evidence. N/A if pregnant	Majority rule
10. GEORGIA Ga. Code Ann. §31-9-2 (1998)	Informed Consent Statute	• Spouse • Adult child • Parent • Sibling • Grandparent	Not explicitly applicable to refusals of treatment	None listed
Ga. Code Ann. "31-36A-1 to A-7, enacted 1999	"Temporary Health Care Placement Decision Maker for an Adult Act"	Same as above but priority list continues with: • Adult grandchild • Uncle or Aunt • Adult nephew or niece	Applies only to decisions regarding admission to or discharge from one health care facility or placement, or transfer to another health care facility or placement. Excludes involuntary placement for mental illness.	None listed
11. HAWAII Hawaii Rev. Stat. "" 327E-1 to -16 (West 1999) Enacted 1999.	Comprehensive Health Care Decisions Act	• An individual orally designated as surrogate If none, the following "interested persons" must decide who among them shall be surrogate decision-maker: • Spouse • Reciprocal beneficiary • Adult child • Parent • Sibling • Grandchild • Close friend	None, except an "interested person" may make a decision to withhold or withdraw nutrition and hydration only if two physicians certify that providing it will merely prolong the act of dying and the patient is highly unlikely to have any neurological response in the future.	Consensus required

State & Citation	General Type of Statute	Priority of Surrogates (in absence of appointed proxy or guardian with health powers)	Limitations on Types of Decisions	Disagreement Process Among Priority Surrogates
12. IDAHO Idaho Code §39-4303 (Lexis 1998)	Informed Consent Statute	Either: • Parent • Spouse If none, then any relative or ... any other person representing himself or herself responsible for the health care of such person	None listed	None listed
13. ILLINOIS 755 ILCS 40/25 (Smith-Hurd 1998)	Separate Surrogate Consent Act	• Spouse • Adult child • Either parent • Sibling • Adult grandchild • Close friend • Guardian of the estate	N/A to admission to mental health facility, psychotropic medication or electo-convulsive therapy (see 405 ILCS 5/1-121.5; 5/2 02; 5/3-601.2, amended 1997) If decision concerns forgoing life-sustaining treatment, patient must be in terminal condition, permanently unconscious, or incurable or irreversible condition	Majority rule
14. INDIANA Ind. Code Ann. §16-36-1-1 to -14 (West 1998)	Health Care Agency and Surrogate Consent Act	Any of the following: • Spouse • Parent • Adult child • Sibling • Religious superior if the individual is a member of a religious order	None listed	None listed
15. IOWA Iowa Code Ann. §144A.7 (West 1998)	Living Will Statute	• Spouse • Adult child • Parent or both parents, if reasonably available • Adult sibling	Limited to the withholding or withdrawal of life-sustaining procedures, and patient is in terminal condition or comatose N/A if pregnant	Majority rule
16. KENTUCKY Ky. Rev. Stat. §311.631 (Baldwin 1999)	Living Will Statute	• Spouse • Adult child • Parents • Nearest relative	N/A to withholding or withdrawal artificial nutrition and hydration unless specified conditions are met	Majority rule
17. LOUISIANA La. Rev. Stat. Ann. §40:1299.58.1 to .10 (West 1999)	Living Will Statute	• Spouse • Adult child • Parents • Sibling • Other relatives	Limited to patient in terminal and irreversible condition and comatose	Consensus required
18. MAINE Me. Rev. Stat. Ann tit. 18-A, §5-801 to §5-817 (West 1999)	Comprehensive Health Care Decisions Act	• Spouse • Adult in spouse-like relationship • Adult child • Parent • Sibling • Adult grandchild • Adult niece or nephew • Adult relative familiar with patient's values • Close friend	If decision pertains to withdrawal or withholding of life-sustaining treatment , patient must be in terminal condition or persistent vegetative state N/A to denial of surgery, procedures, or other interventions that are deemed medically necessary.	Majority rule, although referral to dispute resolution assistance is mentioned as option

State & Citation	General Type of Statute	Priority of Surrogates (in absence of appointed proxy or guardian with health powers)	Limitations on Types of Decisions	Disagreement Process Among Priority Surrogates
19. MARYLAND Md. Health-Gen. Code Ann., §5-605 (Lexis 1998)	Comprehensive Health Care Decisions Act	• Spouse • Adult child • Parent • Sibling • Friend or relative who has maintained regular contact with the patient	N/A to sterilization or treatment for mental disorder Applicable to life-sustaining procedure only if the patient as been certified to be in a terminal condition, persistent vegetative state, or end-stage condition Applicable to DNR order only under certain conditions	If in hospital or nursing home, refer to ethics committee If elsewhere, consensus required
21. MISSISSIPPI Miss. Code 1972 Ann. §41-41-211, •41-41-215(9) (1998)	Comprehensive Health Care Decisions Act	• Individual orally designated by patient • Spouse • Adult child • Parent • Sibling • Close friend • Owner, operator, or employee of residential long-term care institution (but see limitations)	If surrogate is owner, operator, or employee of residential long-term care institution, then the authority does not extend to decisions to withhold or discontinue life support, nutrition, hydration, or other treatment, care, or support.	Majority rule.
22. MONTANA Mont. Code Ann. §50-9-106 (1997)	Living Will Statute	• Spouse • Adult child • Parents • Sibling • Nearest adult relative	Limited to withholding or withdrawal of life-sustaining treatment , and patient is in terminal condition N/A if pregnant	Majority rule
23. NEVADA Nev. Rev. Stat. §449.626 (1997)	Living Will Statute	• Spouse • Adult child • Parents • Sibling • Nearest adult relative	Limited to withholding or withdrawal of life-sustaining treatment, and patient is in terminal condition N/A if pregnant	Majority rule
24. NEW MEXICO N.M. Stat. Ann. 1978 •24-7A-5 (1998)	Comprehensive Health Care Decisions Act	• An individual designated as surrogate • Spouse • Individual in long-term spouse-like relationship • Adult child • Parent • Sibling • Grandparent • Close friend	None listed	Majority rule
25. NEW YORK N.Y. Pub. Health Law §2965 (McKinney 1999)	Specialized Surrogate Consent Statute (applicable only to DNR orders)	• Spouse • Adult child • Parent • Sibling • Close friend	Limited to consent to a DNR order, and patient is in terminal condition, or permanently unconscious, or where resuscitation is futile or extraordinarily burdensome	Refer to dispute mediation system
26. NORTH CAROLINA N.C. Gen. Stat. §90-322 (Michie 1997)	Living Will Statute	• Spouse • Majority of relatives of the first degree • Attending physician	Limited to the withholding or discontinuance of extraordinary means or artificial nutrition or hydration, and patient is in terminal condition, or persistent vegetative state, and meets other conditions	Majority rule

State & Citation	General Type of Statute	Priority of Surrogates (in absence of appointed proxy or guardian with health powers)	Limitations on Types of Decisions	Disagreement Process Among Priority Surrogates
27. North Dakota N.D. Cent. Code §23-12-13 (Michie 1997)	Informed Consent Statute	• Spouse • Adult children • Parents • Siblings • Grandparents • Adult grandchildren • Close adult relative or friend	Not explicitly applicable to refusals of treatment N/A to sterilization, abortion, psychosurgery, and some admissions to a state mental facility	None listed
28. Ohio Ohio Rev. Code Ann. §2133.08 (Baldwin 1999)	Living Will Statute	• Spouse • Adult child • Parents • Sibling • Nearest adult relative	Limited to consent for withdrawal or withholding of life-sustaining treatment, and patient is in terminal condition or permanently unconscious Nutrition and hydration may be withheld only upon the issuance of an order of the probate court N/A if pregnant	Majority rule
29. Oklahoma Okla. Stat. Ann. tit. 63 §3102A (West 1999)	Specialized provision (applicable only to experimental treatments)	• Spouse • Adult child • Parent • Sibling • Relative	Limited to experimental treatment, test or drug approved by a local institutional revew board.	None listed
30. Oregon Or. Rev. Stat. §127.635 (1998)	Comprehensive Health Care Decisions Act	• Spouse • Adult designated by others on this list, without objection by anyone on list • Majority of adult children • Either parent • Majority of siblings • Adult relative or adult friend • Attending physician	Limited to withdrawal or withholding of life-sustaining procedures, and patient is in terminal condition, or permanently unconscious, or meets other conditions	Majority rule
31. South Carolina S.C. Code 1976 Ann. §44-66-30 (1998)	Separate Surrogate Consent Act	• Person given priority to make health-care decisions for the patient by another statute • Spouse • Parent or adult child • Sibling, grandparent, or adult grandchild • Other close relative • Person given authority to make health-care decisions for the patient by another statutory provision	N/A if patient's inability to consent is temporary and delay of treatment will not result in significant detriment to the patient's health	None listed
32. South Dakota S.D. Codified Laws Ann. §34-12C-1 to -8 (1998)	Separate Surrogate Consent Act	• Spouse • Adult child • Parent • Sibling • Grandparent or adult grandchild • Aunt or uncle or adult niece or nephew	None listed	None listed
33. Texas Tex. [Health & Safety] Code Ann. §166.039 (West (1997)	Advance Directive Act	• Spouse • Reasonably available adult children • Parents • Nearest relative	N/A if pregnant	None listed

State & Citation	General Type of Statute	Priority of Surrogates (in absence of appointed proxy or guardian with health powers)	Limitations on Types of Decisions	Disagreement Process Among Priority Surrogates
Tex. [Health & Safety] Code Ann. §166.081 to .101, specifically §166.088(b) (West (1997)	Specialized provision (applicable to DNR orders)	(Same as above. Incorporates the terms of §672.009)	(Same as above)	(Same as above)
34. UTAH Utah Code Ann. 1953 §75-2-1105, -1105.5, -1107 (Lexis 1998)	Comprehensive Health Care Decisions Act	• Spouse • Parents or surviving parent • Adult child • Nearest reasonably available relative When patient is terminal or in a permanent vegetative state: • Spouse • Parent • Adult children	N/A if pregnant	Majority rule
35. VIRGINIA Va. Code 1950 §54.1-2986 (Michie 1997)	Comprehensive Health Care Decisions Act	• Spouse • Adult child • Parent • Sibling • Other relative in the descending order or blood relationship	N/A to non-therapeutic sterilization, abortion, psychosurgery, or admission to a mental retardation facility or psychiatric hospital	Majority rule
36. WASHINGTON Wash. Rev. Code Ann. §7.70.065 (West 1998)	Informed Consent Statute	• Spouse • Adult children • Parents • Siblings	Not explicitly applicable to refusals of treatment	Consensus required
37. WEST VIRGINIA W. Va. Code 1966 §16-30-8 and -9 (2000) Last amended 2000	Comprehensive Health Care Decisions Act	• Spouse • Adult child • Parent • Sibling • Adult grandchild • Close friend • Any other person or entity according to DHHR rules If there are multiple surrogates at the same priority level, the attending physician must choose one who appears best qualified according to statutory criteria. May also choose lower level surrogate if deemed best qualified.	None listed	Conflict among multiple surrogates pre-empted by physician's authority to select one surrogate. Other permissible surrogates have a 72-hour window to seek court challenge of a decision made by selected surrogate.
38. WYOMING Wyo. Stat. 1997 §3-5-209 and §35-22-105(b) (1998)	Durable Power of Attorney Statute and Living Will Statute (Identical provisions)	• All family members who can be contacted through reasonable diligence	Limited to withholding or withdrawal of life-sustaining procedures, and patient is in terminal condition or irreversible coma	Consensus required

State & Citation	General Type of Statute	Priority of Surrogates (in absence of appointed proxy or guardian with health powers)	Limitations on Types of Decisions	Disagreement Process Among Priority Surrogates
UNIFORM HEALTH-CARE DECISIONS ACT	Comprehensive Health Care Decisions Act	• Individual orally designated by patient • Spouse • Adult child • Parent • Sibling • Close friend	None listed	Majority rule

Bartlett Regional Hospital

Patient's Advance Directives Inquiry

1. Have you executed an Advance Directive such as a Living Will or a Durable Power of Attorney for Health Care?
   - ☐ Living Will
   - ☐ Durable Power of Attorney
   - ☐ Organ Donation
   - ☐ None

2. Are you registered with the US Living Will Registry? ☐ Yes ☐ No

3. Do you have a current copy of any Advance Directive to include in your medical records for this hospitalization?
   ☐ Yes ☐ No

If I have executed an Advance Directive I understand that it is my responsibility to notify my physician of such a directive.

Bartlett Regional Hospital has provided me with information concerning my right to execute Advance Directives, as required by the Patient Self-Determination Act of 1990, and about hospital policy relating to the implementation of Advance Directives.

_____ _____
Patient's Signature Date

_____ is unable to comprehend and/or sign this document. I am aware of this person's status regarding Advance Directives execution, have responded to these questions for the patient, and have received the information regarding the patient's right to execute Advanced Directives.

_____ _____
Signature Date

_____
Relationship to Patient

COMMENTS (when no signature is obtained): _____

_____

_____

_____

BRH 280 Rev. 8/00

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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Section 1. DESIGNATION OF AGENT

I _____ (Principal), residing

at _____
Street Address City State Zip

hereby appoint: _____
Name

_____
Street Address City State Zip

Work Phone Home Phone

as my agent with the powers set out below.

If the agent named above is unable or unwilling to serve or continue to serve, then I appoint the following agent(s) to serve with the same powers:

First Alternate:

_____
Name

_____
Street Address City State

_____
Work Phone Home Phone

Second Alternate:

_____
Name

_____
Street Address City State

_____
Work Phone Home Phone

Section 2. STATEMENT OF POWERS

I hereby grant to my Agent named above full power and authority to make health care decisions on my behalf when I have been determined to be incapable of making an informed decision on my own behalf. My Agent is to have the same authority to make health care decisions for me as I would have had if I had the capacity to make them. My Agent's authority is effective as long as I am incapable of making an informed decision.

The powers of my Agent shall include, but not be limited to, the following:

PATIENT'S RIGHTS
BARTLETT REGIONAL HOSPITAL

Bartlett Regional Hospital will abide by the following Patient's rights (as set forth in 7 AAC 12.890, 42 CFR Part 482; AS 18.05.040; AS 18.20.10)

While you are a patient at Bartlett Regional Hospital, we will do our best to respect your personal rights. You or your representative may expect:

1. Considerate and respectful care, that recognizes your dignity and individuality.
2. Protection of your right to privacy and confidentiality of information related to your medical care; including access to a telephone to make and receive confidential calls; and the ability to send or receive unopened correspondence.
3. Clear explanations of your condition, proposed treatments or procedures, the benefits or drawbacks of the proposed treatment, expected recuperation and the likelihood of success of treatments or procedures.
4. Willingness to let you and your family take the lead in decision making regarding your care and treatment.
5. A safe and secure setting free from abuse/ harassment.
6. Compliance with your request to refuse treatment or to have medically necessary and appropriate treatment provided.
7. Our compliance with your advance directives, per Alaska Law.
8. Freedom from any type of discrimination on the basis of age, race, color, sex, creed, national origin, martial status, sexual orientation or disability.
9. Access to protective services, from counseling to guardianship, to help you reach your maximum level of independence.
10. Access to an interpreter, your own of the hospitals.
11. Services of the hospital chaplain when you request them.
12. Assistance in obtaining financial aid or counseling, if needed.
13. Attentive, courteous response to any concerns or complaints you and your family may have.
14. Freedom from seclusion or restraints that are not medically necessary.
15. Access to the information contained in your medical record within a reasonable timeframe.
16. Upon request, information regarding services that are available in the hospital and their cost, including any costs for services or personal care items not covered by the facility's basic per diem rate or not covered under title XVII or Title XIX of the Social Security Act.
17. To have the rights of minors assured by prompt and consistent interpretation of patient rights to a patient or legal guardian.

PATIENT AND FAMILY GRIEVANCE

Patients and their families have the right to file a grievance regarding events occurring during their stay at BRH when a complaint is not mutually resolved. The Patient and Family Grievance Policy will be followed in the event of a grievance. In addition, you have the right to lodge a compliant with the Office of Health Facilities Licensing & Certification, Department of Health and Social Services, 4730 Business Park Blvd, Suite 18, Anchorage, Alaska 99503-7137, 907 561-8081. Your presentation of a complaint will not impact the future availability of care or services at BRH.

"ALASKA LIVING WILL DECLARATION"

I, _____
(Name of Declarant)

of _____
(Address of Declarant)

declare that if I should have an incurable or irreversible condition that will cause my death within a relatively short time, it is my desire that my life not be prolonged by administration of life-sustaining procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain.

I desire to include the following options.

(Please place your initials in the blank opposite the category desired.)

___ __ I do desire that nutrition or hydration (food and water) be provided by gastric tube or intravenously if necessary.

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

_____ Other directives:

_____

_____

_____

ORGAN DONATION (OPTIONAL)

In the event of my death, I donate the following part(s) of my body for the purposes identified in AS 13.50.020:

Tissue:
_____ Eyes
_____ Bone and connective tissue
_____ Skin
_____ Heart
_____ Other: _____

Limitations: _____

Organ:
_____ Heart
_____ Kidney(s)
_____ Liver
_____ Lung(s)
_____ Pancreas
_____ Other: _____

Signed this _____ day of _____, _____.

_____
(Signature)

_____
(Address)

_____
(Date of Birth) (Social Security Number)

Advance Directives—

Putting your health care choices in writing

Make your own decisions about your health care.

On December 1, 1991 new federal legislation went into effect requiring hospitals, nursing homes, and home health agencies to ask all adults (at the time of admission) if they have completed any "Advance Directives" and to tell them that they have the right to do so if they have not. Advance Directives are documents such as a Durable Power of Attorney, Living Will, or an Anatomical Gift Declaration. The Living Will and Anatomical Gift Declaration can be combined into a document known as "Alaska Living Will Declaration".

What kinds of decisions need to be considered?

National headlines and court cases have focused on difficult decisions families face when a loved one hasn't given Advance Directives. These decisions may include your preferences about withholding or removing life sustaining equipment and nutrition, or donating organs or tissue. Although we often think that these choices don't apply to young people, the Patient Self-Determination Act applies to all adults.

What is a Living Will?

A Living Will is an Advance Directive which states the type of medical care you want (or do not want) if you become unable to make your own decisions. It is called a "Living Will" because it takes effect while you are still living. The Living Will goes into effect if you are unable to participate in decision making and your condition is considered to be incurable or irreversible and terminal within a "relatively short time".

What is a Durable Power of Attorney for Health Care?

A Durable Attorney for Health Care is an Advance Directive which gives someone you trust the authority to make health care decisions on your behalf should you become unable to make them for yourself. It is called durable because it continues in effect if you should become unable to act in your own behalf. It is very important that the person you designate as your agent understand the health care decisions you would like to have made for you.

What is an Anatomical Gift Declaration?

An Anatomical Gift Declaration allows a person to donate tissue or organs at the time of their death. It also allows a physician to carry out the appropriate procedures for removing and/or transplanting the designated organs or tissue. If a person has both a Living Will and an Anatomical Gift Declaration, the Anatomical Gift Declaration takes precedence until the donated organ(s) can be evaluated.

Do I need to have all three of these documents?

The Living Will, Durable Power of Attorney, and Anatomical Gift Declaration are three distinctly different documents. Each person must decide which of these documents (described above) will assure that their specific wishes will be carried out.

What is the hospital's policy regarding Advance Directives?

It is the hospital's policy to honor properly executed Advance Directives. If a patient's attending physician cannot carry out the patient's wishes, it is the responsibility of that physician to assist the patient and/or family in obtaining the services of another physician who can.

The hospital will not discriminate against any patient because of the content of their properly executed Advance directive or their lack of any of these documents.

What should I do with my Advance Directives after completing them?

Keep the original documents in a safe place where a family member or your agent can easily retrieve them if necessary. Give copies to your agent, physician, attorney, family members, clergy member or anyone you want to know the decisions you have made for yourself.

Who may serve as a witness to my Advance Directives?

Living Wills and Anatomical Gift Declarations can either be signed by two witnesses or by a notary. A Durable Power of Attorney must be notarized. These witnesses must be at least 18 years of age and cannot be related to you by blood or marriage. By hospital policy no hospital employee or attending physician can witness or notarize these documents.

Can I change my mind after I have executed an Advance Directive?

You may change or cancel these documents at any time. Any change should be written, signed, and dated and copies should be given to your physician and to others who received your original documents.

If you wish to change an Advance Directive while you are in the hospital, you should notify your physician. Even without a change in writing, your wishes will be honored as long as you can communicate them to your care providers.

What if I execute an Advance Directive in one State and am hospitalized in another?

The laws in most States are similar to one another. Your Advance directives may be honored in another State. If you spend a great deal of time in a State other than the one where your Advance Directives were executed, you may wish to make sure that your documents adhere to the laws of both States.

Who should I ask if I have questions?

Questions about Advance Directives can be discussed with your physician, your pastor, your attorney, and/or members of your family. If you have questions while you are in the hospital, the staff of the Social Work Services Department is available to assist in answering those questions.

Sample forms

The sample forms provided are taken directly from the Alaska law. If you wish to make changes to these documents, please consult an attorney to ensure that your documents adhere to State law.

BRH 281
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delegate of your physician of the continuing healthcare requirements following your discharge from the hospital.

- Examine and receive an explanation of your bill regardless of source of payment.
- Know which hospital rules and policies apply to your conduct while a patient.
- Have all patient's rights apply to the person who may have legal responsibili(to make decisions regarding medical care on behalf of the patient.

Patient Responsibilities
These responsibilities are presented to the patient in the spirit of mutual trust and respect:

- The patient has the responsibility to provide accurate and complete information concerning present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
- The patient is responsible for reporting perceived risks in their care and unexpected changes in their condition to their responsible practitioner.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by the physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the hospital or physician when unable to do so.
- The patient is responsible for his/her actions should he/she refuse treatment or r follow the physician's orders.
- The patient is responsible for assuring that the financial obligations of hospital care are fulfilled as promptly as possible.
- The patient is responsible for following hospital policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and hospital personnel.
- The patient is responsible for being careful with personal property and that of other persons in the hospital.

Patient and Family Grievances
The staff and management of BRH welcome your comments regarding our services and personnel. Our goal is to provide you with quality services and we need to know those things that you like and those things that are less than satisf ory in order to continually improve. BRH is committed to Continuous Quality Improvement. Your presentation of a concern or suggestion assists us to improve our services and will, in no way jeopardize your future care at BRH.
If you have immediate concerns, you are encouraged to communicate this to any of the following:

- The person providing you with the service
- The Department Manager or House Supervisor
- The Quality/Risk Manager, Barb Sharp at 463-8695 (in-house 8695).

If you feel your concern has not been addressed to your satisfaction, you may request a written response. You will receive a written response within 14 working days with the name of the hospital contact person, the investigation into the grievance, the results of the investigation and the completion date of your request.

You also may address your concerns to: Administrator, Office of Health Facilities Licensing and Certification, Department of Health and Social Services, 4730 Business Park Blvd. Suite #18, Anchorage, Alaska 99503-7137 or phone 907-561-8081.

Medicare and Medicaid beneficiaries may contact the Beneficiary hotline at 1-800-445-6941

Bartlett Regional Hospital
3260 Hospital Drive, Juneau, Alaska 99801
907-796-8900
Web site: www.bartletthospital.org

Patient Rights and Responsibilities

Patient Rights
As a patient at Bartlett Regional Hospital you have the right to:

■ Become informed of your rights as patient in advance of receiving care. You, the patient may appoint a representative to receive this information should you so desire.

■ Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.

■ Considerate and respectful care, provided in a safe environment, free from all forms of abuse or harassment.

■ Appropriate assessment and ongoing reassessment and management of pain.

■ Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

■ Know the name of the physician w has primary responsibility for coordinating your care and the names and professional relationships of other physicians and healthcare providers who will care for you.

■ Receive information from your physician about your illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that you can understand.

■ Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information:

a. Shall include a description of the procedure or treatment,
b. Shall include the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and
c. Shall include the name of the person who will carry out the procedure or treatment.

■ Participate in the development and implementations of your plan of care and actively participate in decisions regarding your medical care. To the extent permitted by law, this includes

the right to request and/or refuse treatment.

■ Formulate advance directives regarding your healthcare, and have hospital staff and practitioners who provide care in the hospital comply with these directives (to the extent provided by state laws and regulations).

■ Have a family member or representative of your choice notified promptly of your admission to the hospital.

■ Have your personal physician notified promptly of your admission to the hospital.

■ Privacy concerning your medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. You have the right to be advised as to the reason for tl presence of a.ıy individual involvec your healthcare.

■ Confidential treatment of all com munications and records pertaining your care and your stay in the hosp tal. Your written permission will be obtained before your medical recor can be made available to anyone n directly concerned with your care.

■ Access to information contained your medical record within a reaso able time frame.

■ Reasonable responses to any rea sonable request you may make for vice.

■ Leave the hospital even against t advice of your physician.

■ Reasonable continuity of care.

■ Be advised of the hospital grieva process, should you wish to commu cate a concern regarding the quality the care you receives or if you feel t determined discharge date is prema ture.

■ Be advised if the hospital or your personal physician proposes to eng in or perform human experimentati affecting your care or treatment. Yo have the right to refuse to participat in such research projects.

■ Be informed by your physician o

Bartlett Regional Hospital

Patient's Advance Directives Inquiry

1. Have you executed an Advance Directive such as a Living Will or a Durable Power of Attorney for Health Care?

   ☐ Living Will ☐ Organ Donation

   ☐ Durable Power of Attorney ☐ None

2. Are you registered with the US Living Will Registry? ☐ Yes ☐ No

3. Do you have a current copy of any Advance Directive to include in your medical records for this hospitalization?

   ☐ Yes ☐ No

If I have executed an Advance Directive I understand that it is my responsibility to notify my physician of such a directive.

Bartlett Regional Hospital has provided me with information concerning my right to execute Advance Directives, as required by the Patient Self-Determination Act of 1990, and about hospital policy relating to the implementation of Advance Directives.

_____ _____

Patient's Signature Date

_____ is unable to comprehend and/or sign this document. I am aware of this person's status regarding Advance Directives execution, have responded to these questions for the patient, and have received the information regarding the patient's right to execute Advanced Directives.

_____ _____

Signature Date

_____

Relationship to Patient

COMMENTS (when no signature is obtained): _____

_____

_____

_____

BRH 280 Rev. 8/00

Printing Trade Company

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Section 1. DESIGNATION OF AGENT

I _____ (Principal), residing

at _____
Street Address City State Zip

hereby appoint: _____
Name

_____
Street Address City State Zip

Work Phone Home Phone

as my agent with the powers set out below.

If the agent named above is unable or unwilling to serve or continue to serve, then I appoint the following agent(s) to serve with the same powers:

First Alternate:

_____
Name

_____
Street Address City State

_____
Work Phone Home Phone

Second Alternate:

_____
Name

_____
Street Address City State

_____
Work Phone Home Phone

Section 2. STATEMENT OF POWERS

I hereby grant to my Agent named above full power and authority to make health care decisions on my behalf when I have been determined to be incapable of making an informed decision on my own behalf. My Agent is to have the same authority to make health care decisions for me as I would have had if I had the capacity to make them. My Agent's authority is effective as long as I am incapable of making an informed decision.

The powers of my Agent shall include, but not be limited to, the following:

a. To consent to, refuse, or withdraw consent to any or all types of medical care, treatment, surgical procedures, diagnostic procedures, medication and the use of mechanical or other procedures related to my health care.

This authorization specifically includes the power to consent to pain relieving medication agents for the relief of severe and intractable pain.

b. To request, review and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and to consent to the disclosure of this information.

c. To employ and/or discharge my health care providers.

d. To authorize my admission to or discharge (including transfer to another facility) from any hospital, nursing home, or other medical care facility.

e. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

Section 3. ADDITIONAL PROVISIONS
(Please initial one of the following:)

_____ I have executed a separate "Living Will."

_____ I have NOT executed a "Living Will."

Section 4. NOTICE TO THIRD PARTIES

Any third party who relies on the reasonable representations of my agent as to a matter relating to a power granted this power of attorney will not incur any liability to me or to my heirs, assigns, or estate as a result of permitting my agent to exercise the authority granted by this power of attorney.

IN WITNESS WHEREOF, I have hereunto signed my name this day of _____ , 20 _____

_____
(Signature of Principal)

****

STATE OF ALASKA)
)ss
___ JUDICIAL DISTRICT)

The foregoing instrument, for the purposes stated therein, was signed, subscribed, sworn to and acknowledged before me by _____ the _____ day of_____ , 20____ at _____, Alaska.

_____

Signature of person taking acknowledgement Title or rank Serial number, if any; date commission expires

"ALASKA LIVING WILL DECLARATION"

I, _____
(Name of Declarant)

of _____
(Address of Declarant)

declare that if I should have an incurable or irreversible condition that will cause my death within a relatively short time, it is my desire that my life not be prolonged by administration of life-sustaining procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain.

I desire to include the following options.

(Please place your initials in the blank opposite the category desired.)

_____ I do desire that nutrition or hydration (food and water) be provided by gastric tube or intravenously if necessary.

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

_____ Other directives:

_____

_____

_____

ORGAN DONATION (OPTIONAL)

In the event of my death, I donate the following part(s) of my body for the purposes identified in AS 13.50.020:

Tissue:
_____ Eyes
_____ Bone and connective tissue
_____ Skin
_____ Heart
_____ Other: _____

Limitations: _____

Organ:
_____ Heart
_____ Kidney(s)
_____ Liver
_____ Lung(s)
_____ Pancreas
_____ Other: _____

Signed this _____ day of _____, _____.

_____
(Signature)

_____
(Address)

_____
(Date of Birth) (Social Security Number)

WITNESS SIGNATURES

(If another person is to sign for the declarant, the person signing for the declarant must sign in the presence of two persons or a person who is qualified to take acknowledgments under AS 09.63.010. The witness form below may be used for the two witnesses. The acknowledgment form below may be used for the person qualified to take acknowledgments.)

The Declarant is known to me and voluntarily signed or voluntarily directed another to sign this document in my presence. I am at least 18 years of age, and am not related to the Declarant by blood or marriage.

_____
(Witness)

_____
(Address)

_____
(Witness)

_____
(Address)

****

STATE OF ALASKA)
) ss.
_____ JUDICIAL DISTRICT)

The foregoing instrument was acknowledged before me this _____day

of_____, 20 _____ by

_____
(Name of Person Who Acknowledged)

_____
(Signature of Person Taking Acknowledgment)

_____
(Serial Number, if any)

_____
(Title or Rank)

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

PATIENT'S RIGHTS
BARTLETT REGIONAL HOSPITAL

Bartlett Regional Hospital will abide by the following Patient's rights (as set forth in 7 AAC 12.890, 42 CFR Part 482; AS 18.05.040; AS 18.20.10)

While you are a patient at Bartlett Regional Hospital, we will do our best to respect your personal rights. You or your representative may expect:

1. Considerate and respectful care, that recognizes your dignity and individuality.
2. Protection of your right to privacy and confidentiality of information related to your medical care; including access to a telephone to make and receive confidential calls; and the ability to send or receive unopened correspondence.
3. Clear explanations of your condition, proposed treatments or procedures, the benefits or drawbacks of the proposed treatment, expected recuperation and the likelihood of success of treatments or procedures.
4. Willingness to let you and your family take the lead in decision making regarding your care and treatment.
5. A safe and secure setting free from abuse/ harassment.
6. Compliance with your request to refuse treatment or to have medically necessary and appropriate treatment provided.
7. Our compliance with your advance directives, per Alaska Law.
8. Freedom from any type of discrimination on the basis of age, race, color, sex, creed, national origin, martial status, sexual orientation or disability.
9. Access to protective services, from counseling to guardianship, to help you reach your maximum level of independence.
10. Access to an interpreter, your own of the hospitals.
11. Services of the hospital chaplain when you request them.
12. Assistance in obtaining financial aid or counseling, if needed.
13. Attentive, courteous response to any concerns or complaints you and your family may have.
14. Freedom from seclusion or restraints that are not medically necessary.
15. Access to the information contained in your medical record within a reasonable timeframe.
16. Upon request, information regarding services that are available in the hospital and their cost, including any costs for services or personal care items not covered by the facility's basic per diem rate or not covered under title XVII or Title XIX of the Social Security Act.
17. To have the rights of minors assured by prompt and consistent interpretation of patient rights to a patient or legal guardian.

PATIENT AND FAMILY GRIEVANCE

Patients and their families have the right to file a grievance regarding events occurring during their stay at BRH when a complaint is not mutually resolved. The Patient and Family Grievance Policy will be followed in the event of a grievance. In addition, you have the right to lodge a compliant with the Office of Health Facilities Licensing & Certification, Department of Health and Social Services, 4730 Business Park Blvd, Suite 18, Anchorage, Alaska 99503-7137, 907 561-8081. Your presentation of a complaint will not impact the future availability of care or services at BRH.