

**HB**

**309**

<TARGET><BILL>HB 309</BILL><SUBJECT>HB  
309</SUBJECT><COMM>HHSS27</COMM></TARGET>

# Alaska State Legislature

**Chairman**  
State Affairs Committee

**Member**  
Judiciary Committee  
Energy Special Committee  
Joint Armed Services Special Committee  
Military and Veterans' Affairs Committee

**Finance Subcommittees**  
Administration  
Corrections  
Military and Veterans' Affairs



*A Communication From*

**REPRESENTATIVE BOB LYNN**  
**District 31 Anchorage**

**E-Mail:** [Representative\\_Bob\\_Lynn@legis.state.ak.us](mailto:Representative_Bob_Lynn@legis.state.ak.us)

**Session:**  
Alaska State Capitol #108  
Juneau, AK 99801-1182

Phone: (907) 465-4931  
Fax: (907) 465-4316  
Toll Free: (800) 870-4391

**Interim:**  
716 W. 4<sup>th</sup> Ave., #650  
Anchorage, AK 99501-2133

Phone: (907) 269-0205  
Fax: (907) 269-0207

March 8, 2012

To: Representative Wes Keller, Chair  
House Health and Social Services Committee

Fr: Representative Bob Lynn

Re: HB 309

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I am requesting a hearing for HB 309, "An Act relating to health care decisions, including do not resuscitate orders." I have attached a sponsor statement, a sectional analysis, the original version the bill, and some additional documentation.

HB 309 is a companion bill to Sen. Dyson's SB 172, which now has a new CS. I have ordered a new CS for HB 309 to mirror CSSB 172. I will forward you a copy of the new CS as soon as it arrives, along with updated material for the hearing.

Any questions or concerns can be directed to my staffer, Mike Sica, at 465-4965 or [mike\\_sica@legis.state.ak.us](mailto:mike_sica@legis.state.ak.us) .

Thank you in advance for your consideration.

Sincerely,

Representative Bob Lynn

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## **Sponsor Statement for CSHB 309**

*“An Act relating to health care decisions, including do not resuscitate orders.”*

The purpose of this bill is to protect a patient's right to prevent a physician from issuing a Do Not Resuscitate (DNR) order on the patient without the expressed consent of that patient, or if the patient lacks capacity, without the expressed consent of the authorized agent of the patient, or, if no one is available or known to be authorized to speak for the patient and the patient lacks capacity, without the concurrence of a second physician.

In 2004 the Alaska Legislature drafted the current AS 13.52 *Health Care Decisions Act*. The Legislature included language in AS 13.52.120(a) establishing a *presumption in favor of life*. Legislative Legal states the language of the Health Care Decision Act, when read in its entirety, supports interpreting the chapter to allow a patient (or the patient's authorized representative) to prevent a physician from issuing a DNR order, but that ambiguities in the chapter could result in other interpretations.

This ambiguity in statute allows unnecessary emotional and mental anguish to Alaskan residents faced with critical end of life decisions. HB 309 clarifies the authority of DNR decisions with respect to patients and physicians, and amends the Alaska Health Care Directive form to allow patients to accept or refuse life-sustaining procedures.

27-LS1115\B  
Bannister  
3/9/12

**CS FOR HOUSE BILL NO. 309( )**

**IN THE LEGISLATURE OF THE STATE OF ALASKA**

**TWENTY-SEVENTH LEGISLATURE - SECOND SESSION**

**BY**

**Offered:  
Referred:**

**Sponsor(s): REPRESENTATIVE LYNN**

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act relating to health care decisions, including do not resuscitate orders."**

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

3 **\* Section 1.** AS 13.52.045 is amended by adding a new subsection to read:

4 (b) A health care institution or health care facility may not interpret the  
5 issuance of a do not resuscitate order for a patient as preventing the health care  
6 institution or health care facility from providing life-sustaining procedures to the  
7 patient.

8 **\* Sec. 2.** AS 13.52.060(e) is amended to read:

9 (e) A health care provider may decline to comply with an individual  
10 instruction or a health care decision for reasons of conscience, except **that a health**  
11 **care provider may not decline to comply with** [FOR] a do not resuscitate order **that**  
12 **is consistent with this chapter for reasons of conscience.** A health care institution or  
13 health care facility may decline to comply with an individual instruction or health care  
14 decision if the instruction or decision is contrary to a policy of the institution or  
15 facility that is expressly based on reasons of conscience and if the policy was timely

1           communicated to the patient or to a person then authorized to make health care  
2           decisions for the patient. **Notwithstanding the other provisions of this subsection,**  
3           **this subsection does not, except as provided by AS 13.52.030(h), allow a health**  
4           **care provider, health care institution, or health care facility to decline to comply**  
5           **with an individual instruction or a health care decision that requests that a do not**  
6           **resuscitate order be made ineffective.**

7           \* **Sec. 3.** AS 13.52.060(f) is amended to read:

8                     (f) A health care provider, health care institution, or health care facility may  
9           decline to comply with an individual instruction or a health care decision that requires  
10          medically ineffective health care or health care contrary to generally accepted health  
11          care standards applicable to the provider, institution, or facility. **Notwithstanding the**  
12          **other provisions of this subsection, this subsection does not, except as provided by**  
13          **AS 13.52.030(h), allow a health care provider, health care institution, or health**  
14          **care facility to decline to comply with an individual instruction or a health care**  
15          **decision that requests that a do not resuscitate order be made ineffective.** In this  
16          subsection, "medically ineffective health care" means health care that according to  
17          reasonable medical judgment cannot cure the patient's illness, cannot diminish its  
18          progressive course, and cannot effectively alleviate severe discomfort and distress.

19          \* **Sec. 4.** AS 13.52.065(a) is amended to read:

20                     (a) A physician may issue a do not resuscitate order for a patient of the  
21          physician **only as provided in this section.** The physician shall document the grounds  
22          for the order in the patient's medical file.

23          \* **Sec. 5.** AS 13.52.065(b) is amended to read:

24                     (b) The department shall by regulation adopt a protocol, subject to the  
25          approval of the State Medical Board, for do not resuscitate orders that sets out a  
26          standardized method of procedure for the withholding of cardiopulmonary  
27          resuscitation by health care providers and health care institutions. **The protocol**  
28          **adopted by the department must comply with this section.**

29          \* **Sec. 6.** AS 13.52.065 is amended by adding new subsections to read:

30                     (g) Except as provided in (h) of this section, a physician may not issue a do  
31          not resuscitate order for a patient of the physician without the express consent of

1 (1) the patient, if the patient has capacity and is 18 years of age or  
2 older; under this paragraph, the consent may be provided by an advance health care  
3 directive; or

4 (2) a person authorized to make health care decisions for the patient.

5 (h) A physician may issue a do not resuscitate order for a patient of the  
6 physician without the express consent required by (g) of this section if the patient does  
7 not have capacity, no person is authorized to make health care decisions for the  
8 patient, and,

9 (1) if the patient has an advance health care directive, the directive  
10 indicates that the patient wants a do not resuscitate order;

11 (2) if the patient has an advance health care directive, the directive is  
12 silent about the issuance of a do not resuscitate order and another physician concurs in  
13 the decision to issue a do not resuscitate order; or

14 (3) if the patient does not have an advance health care directive,  
15 another physician concurs in the decision to issue a do not resuscitate order.

16 (i) A physician shall revoke a do not resuscitate order issued for a patient if

17 (1) the issuance of the do not resuscitate order violates (g) of this  
18 section;

19 (2) except as provided in (4) of this subsection, the patient has capacity  
20 and requests that the do not resuscitate order be revoked;

21 (3) the patient does not have capacity, the patient does not have an  
22 advance health care directive that indicates that the patient wants a do not resuscitate  
23 order, and a person authorized to make health care decisions for the patient requests  
24 the revocation of the do not resuscitate order; or

25 (4) the patient is under 18 years of age and the parent or guardian of  
26 the patient requests that the do not resuscitate order be revoked.

27 (j) A physician may revoke a do not resuscitate order issued by another  
28 physician for a patient, if the physician has a physician-patient relationship with the  
29 patient.

30 \* **Sec. 7.** AS 13.52.080(a) is amended to read:

31 (a) A health care provider or health care institution that acts in good faith and

1 in accordance with generally accepted health care standards applicable to the health  
2 care provider or institution is not subject to civil or criminal liability or to discipline  
3 for unprofessional conduct for

4 (1) providing health care information in good faith under  
5 AS 13.52.070;

6 (2) complying with a health care decision of a person based on a good  
7 faith belief that the person has authority to make a health care decision for a patient,  
8 including a decision to withhold or withdraw health care;

9 (3) declining to comply with a health care decision of a person based  
10 on a good faith belief that the person then lacked authority;

11 (4) complying with an advance health care directive and assuming in  
12 good faith that the directive was valid when made and has not been revoked or  
13 terminated;

14 (5) participating in the withholding or withdrawal of cardiopulmonary  
15 resuscitation under the direction or with the authorization of a physician or upon  
16 discovery of do not resuscitate identification upon an individual;

17 (6) causing or participating in providing cardiopulmonary resuscitation  
18 or other life-sustaining procedures

19 (A) under AS 13.52.065(e) when an individual has made an  
20 anatomical gift;

21 (B) because an individual has made a do not resuscitate order  
22 ineffective under AS 13.52.065 [AS 13.52.065(f)] or another provision of this  
23 chapter; or

24 (C) because the patient is a woman of childbearing age and  
25 AS 13.52.055 applies; or

26 (7) acting in good faith under the terms of this chapter or the law of  
27 another state relating to anatomical gifts.

28 \* **Sec. 8.** AS 13.52.300 is amended to read:

29 **Sec. 13.52.300. Optional form.** The following sample form may be used to  
30 create an advance health care directive. The other sections of this chapter govern the  
31 effect of this or any other writing used to create an advance health care directive. This

1 form may be duplicated. This form may be modified to suit the needs of the person, or  
2 a different form that complies with this chapter may be used, including the mandatory  
3 witnessing requirements:

4 ADVANCE HEALTH CARE DIRECTIVE

5 Explanation

6 You have the right to give instructions about your own health care to  
7 the extent allowed by law. You also have the right to name someone  
8 else to make health care decisions for you to the extent allowed by law.  
9 This form lets you do either or both of these things. It also lets you  
10 express your wishes regarding the designation of your health care  
11 provider. If you use this form, you may complete or modify all or any  
12 part of it. You are free to use a different form if the form complies with  
13 the requirements of AS 13.52.

14 Part 1 of this form is a durable power of attorney for health care. A  
15 "durable power of attorney for health care" means the designation of an  
16 agent to make health care decisions for you. Part 1 lets you name  
17 another individual as an agent to make health care decisions for you if  
18 you do not have the capacity to make your own decisions or if you  
19 want someone else to make those decisions for you now even though  
20 you still have the capacity to make those decisions. You may name an  
21 alternate agent to act for you if your first choice is not willing, able, or  
22 reasonably available to make decisions for you. Unless related to you,  
23 your agent may not be an owner, operator, or employee of a health care  
24 institution where you are receiving care.

25 Unless the form you sign limits the authority of your agent, your  
26 agent may make all health care decisions for you that you could legally  
27 make for yourself. This form has a place for you to limit the authority  
28 of your agent. You do not have to limit the authority of your agent if  
29 you wish to rely on your agent for all health care decisions that may  
30 have to be made. If you choose not to limit the authority of your agent,  
31 your agent will have the right, to the extent allowed by law, to

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(a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including the administration or discontinuation of psychotropic medication;

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

(c) approve or disapprove proposed diagnostic tests, surgical procedures, and programs of medication;

(d) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care; and

(e) make an anatomical gift following your death.

Part 2 of this form lets you give specific instructions for any aspect of your health care to the extent allowed by law, except you may not authorize mercy killing, assisted suicide, or euthanasia. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to make an anatomical gift following your death.

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

Part 5 of this form lets you designate a physician to have primary responsibility for your health care.

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

1 named as your agent to make sure that the person understands your  
2 wishes and is willing to take the responsibility.

3 You have the right to revoke this advance health care directive or  
4 replace this form at any time, except that you may not revoke this  
5 declaration when you are determined not to be competent by a court, by  
6 two physicians, at least one of whom shall be a psychiatrist, or by both  
7 a physician and a professional mental health clinician. In this advance  
8 health care directive, "competent" means that you have the capacity

9 (1) to assimilate relevant facts and to appreciate and understand your  
10 situation with regard to those facts; and

11 (2) to participate in treatment decisions by means of a rational  
12 thought process.

13 PART 1

14 DURABLE POWER OF ATTORNEY FOR  
15 HEALTH CARE DECISIONS

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

18 \_\_\_\_\_  
19 (name of individual you choose as agent)

20 \_\_\_\_\_  
21 (address) (city) (state) (zip code)

22 \_\_\_\_\_  
23 (home telephone) (work telephone)

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

27 \_\_\_\_\_  
28 (name of individual you choose as first alternate agent)

29 \_\_\_\_\_  
30 (address) (city) (state) (zip code)

31 \_\_\_\_\_

1 (home telephone) (work telephone)

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

5 \_\_\_\_\_  
6 (name of individual you choose as second alternate agent)

7 \_\_\_\_\_  
8 (address) (city) (state) (zip code)

9 \_\_\_\_\_  
10 (home telephone) (work telephone)

11 (2) AGENT'S AUTHORITY. My agent is authorized and directed to  
12 follow my individual instructions and my other wishes to the extent  
13 known to the agent in making all health care decisions for me. If these  
14 are not known, my agent is authorized to make these decisions in  
15 accordance with my best interest, including decisions to provide,  
16 withhold, or withdraw artificial hydration and nutrition and other forms  
17 of health care to keep me alive, except as I state here:

18 \_\_\_\_\_  
19 \_\_\_\_\_  
20 \_\_\_\_\_  
21 (Add additional sheets if needed.)

22 Under this authority, "best interest" means that the benefits to you  
23 resulting from a treatment outweigh the burdens to you resulting from  
24 that treatment after assessing

25 (A) the effect of the treatment on your physical, emotional, and  
26 cognitive functions;

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

29 (C) the degree to which your medical condition, the treatment, or the  
30 withholding or withdrawal of treatment, results in a severe and  
31 continuing impairment;

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

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

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

(G) your religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE.

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

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

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

PART 2

INSTRUCTIONS FOR HEALTH CARE

1           If you are satisfied to allow your agent to determine what is best for  
2 you in making health care decisions, you do not need to fill out this part  
3 of the form. If you do fill out this part of the form, you may strike any  
4 wording you do not want. There is a state protocol that governs the use  
5 of do not resuscitate orders by physicians and other health care  
6 providers. You may obtain a copy of the protocol from the Alaska  
7 Department of Health and Social Services. A "do not resuscitate order"  
8 means a directive from a licensed physician that emergency  
9 cardiopulmonary resuscitation should not be administered to you.

10           (6) END-OF-LIFE DECISIONS. Except to the extent prohibited by  
11 law, I direct that my health care providers and others involved in my  
12 care provide, withhold, or withdraw treatment in accordance with the  
13 choice I have marked below: (Check only one box.)

14           (A)  Choice To Prolong Life

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

17           (B)  Choice Not To Prolong Life

18           I want comfort care only and I do not want my life to be prolonged  
19 with medical treatment if, in the judgment of my physician,

20           I have (check all choices that represent your wishes)

21            (i) a condition of permanent unconsciousness: a condition that,  
22 to a high degree of medical certainty, will last permanently without  
23 improvement; in which, to a high degree of medical certainty, thought,  
24 sensation, purposeful action, social interaction, and awareness of  
25 myself and the environment are absent; and for which, to a high degree  
26 of medical certainty, initiating or continuing life-sustaining procedures  
27 for me, in light of my medical outcome, will provide only minimal  
28 medical benefit for me; or

29            (ii) a terminal condition: an incurable or irreversible illness or  
30 injury that without the administration of life-sustaining procedures will  
31 result in my death in a short period of time, for which there is no

1 reasonable prospect of cure or recovery, that imposes severe pain or  
2 otherwise imposes an inhumane burden on me, and for which, in light  
3 of my medical condition, initiating or continuing life-sustaining  
4 procedures will provide only minimal medical benefit;

5 [ ] Additional instructions: \_\_\_\_\_  
6 \_\_\_\_\_

7 (C) Artificial Nutrition and Hydration. If I am unable to safely take  
8 nutrition, fluids, or nutrition and fluids (check your choices or write  
9 your instructions),

10 [ ] I wish to receive artificial nutrition and hydration indefinitely;

11 [ ] I wish to receive artificial nutrition and hydration indefinitely,  
12 unless it clearly increases my suffering and is no longer in my best  
13 interest;

14 [ ] I wish to receive artificial nutrition and hydration on a limited  
15 trial basis to see if I can improve;

16 [ ] In accordance with my choices in (6)(B) above, I do not wish to  
17 receive artificial nutrition and hydration.

18 [ ] Other instructions: \_\_\_\_\_  
19 \_\_\_\_\_

20 (D) Relief from Pain.

21 [ ] I direct that adequate treatment be provided at all times for the  
22 sole purpose of the alleviation of pain or discomfort; or

23 [ ] I give these instructions:  
24 \_\_\_\_\_  
25 \_\_\_\_\_

26 (E) **Life-Sustaining Procedures. "Life-sustaining procedures"**  
27 **means any medical treatment, procedure, or intervention that may**  
28 **keep you alive but will not remove your terminal condition or**  
29 **remove permanent unconsciousness; "life-sustaining procedures"**  
30 **includes assisted ventilation, renal dialysis, surgical procedures,**  
31 **blood transfusions, and the administration of drugs, including**

**antibiotics, or artificial nutrition and hydration.**

**I wish to receive all life-sustaining procedures.**

**I do not wish to receive any life-sustaining procedures.**

**I wish to receive the following life-sustaining procedures:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(F)** Should I become unconscious and I am pregnant, I direct that

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Conditions or limitations: \_\_\_\_\_

\_\_\_\_\_

(Add additional sheets if needed.)

PART 3

ANATOMICAL GIFT AT DEATH

(OPTIONAL)

If you are satisfied to allow your agent to determine whether to make an anatomical gift at your death, you do not need to fill out this part of the form.

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

(A)  I give any needed organs, tissues, or other body parts, OR

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

\_\_\_\_\_  
\_\_\_\_\_

(C)  My gift is for the following purposes (mark any of the

following you want):

[ ] (i) transplant;

[ ] (ii) therapy;

[ ] (iii) research;

[ ] (iv) education.

(D) [ ] I refuse to make an anatomical gift.

PART 4

MENTAL HEALTH TREATMENT

This part of the declaration allows you to make decisions in advance about mental health treatment. The instructions that you include in this declaration will be followed only if a court, two physicians that include a psychiatrist, or a physician and a professional mental health clinician believe that you are not competent and cannot make treatment decisions. Otherwise, you will be considered to be competent and to have the capacity to give or withhold consent for the treatments.

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

(9) PSYCHOTROPIC MEDICATIONS. If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

\_\_\_\_\_ I consent to the administration of the following medications:

\_\_\_\_\_ I do not consent to the administration of the following medications:

Conditions or limitations: \_\_\_\_\_

(10) ELECTROCONVULSIVE TREATMENT. If I do not have the capacity to give or withhold informed consent for mental health

1 treatment, my wishes regarding electroconvulsive treatment are as  
2 follows:

3 \_\_\_\_\_ I consent to the administration of electroconvulsive  
4 treatment.

5 \_\_\_\_\_ I do not consent to the administration of electroconvulsive  
6 treatment.

7 Conditions or limitations: \_\_\_\_\_

8  
9 (11) ADMISSION TO AND RETENTION IN FACILITY. If I do  
10 not have the capacity to give or withhold informed consent for mental  
11 health treatment, my wishes regarding admission to and retention in a  
12 mental health facility for mental health treatment are as follows:

13 \_\_\_\_\_ I consent to being admitted to a mental health facility for  
14 mental health treatment for up to \_\_\_\_\_ days. (The number of days  
15 not to exceed 17.)

16 \_\_\_\_\_ I do not consent to being admitted to a mental health  
17 facility for mental health treatment.

18 Conditions or limitations: \_\_\_\_\_

19  
20 OTHER WISHES OR INSTRUCTIONS

21 \_\_\_\_\_  
22 \_\_\_\_\_  
23 \_\_\_\_\_

24 Conditions or limitations: \_\_\_\_\_

25  
26 PART 5

27 PRIMARY PHYSICIAN

28 (OPTIONAL)

29 (12) I designate the following physician as my primary physician:

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(name of physician)

\_\_\_\_\_  
(address) (city) (state) (zip code)

\_\_\_\_\_  
(telephone)

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

\_\_\_\_\_  
(name of physician)

\_\_\_\_\_  
(address) (city) (state) (zip code)

\_\_\_\_\_  
(telephone)

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

(14) SIGNATURES. Sign and date the form here:

\_\_\_\_\_  
(date) (sign your name)

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(address) (city) (state) (zip code)

(15) WITNESSES. This advance care health directive will not be valid for making health care decisions unless it is

(A) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; the witnesses may not be a health care provider employed at the health care institution or health care facility where you are receiving health care, an employee of the health care provider who is providing health care to you, an employee of the health care institution or health

1 care facility where you are receiving health care, or the person  
 2 appointed as your agent by this document; at least one of the two  
 3 witnesses may not be related to you by blood, marriage, or adoption or  
 4 entitled to a portion of your estate upon your death under your will or  
 5 codicil; or

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

7 ALTERNATIVE NO. 1

8 Witness Who is Not Related to or a Devisee of the Principal

9 I swear under penalty of perjury under AS 11.56.200 that the  
 10 principal is personally known to me, that the principal signed or  
 11 acknowledged this durable power of attorney for health care in my  
 12 presence, that the principal appears to be of sound mind and under no  
 13 duress, fraud, or undue influence, and that I am not

14 (1) a health care provider employed at the health care institution or  
 15 health care facility where the principal is receiving health care;

16 (2) an employee of the health care provider providing health care to  
 17 the principal;

18 (3) an employee of the health care institution or health care facility  
 19 where the principal is receiving health care;

20 (4) the person appointed as agent by this document;

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

22 (6) entitled to a portion of the principal's estate upon the principal's  
 23 death under a will or codicil.

24 \_\_\_\_\_  
 25 (date) (signature of witness)

26 \_\_\_\_\_  
 27 (printed name of witness)

28 \_\_\_\_\_  
 29 (address) (city) (state) (zip code)

30 Witness Who May be Related to or a Devisee of the Principal

31 I swear under penalty of perjury under AS 11.56.200 that the

principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider who is providing health care to the principal;

(3) an employee of the health care institution or health care facility where the principal is receiving health care; or

(4) the person appointed as agent by this document.

\_\_\_\_\_  
(date) (signature of witness)

\_\_\_\_\_  
(printed name of witness)

\_\_\_\_\_  
(address) (city) (state) (zip code)

ALTERNATIVE NO. 2

State of Alaska

\_\_\_\_\_ Judicial District

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

Notary Seal

\_\_\_\_\_  
(signature of notary public)

\* Sec. 9. AS 13.52.390(17) is amended to read:

(17) "health care decision" means a decision made by an individual or

1 the individual's agent, guardian, or surrogate regarding the individual's health care,  
2 including

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

5 (B) approval or disapproval of proposed diagnostic tests,  
6 surgical procedures, and programs of medication;

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

12 (D) the administration or withdrawal of psychotropic  
13 medications, the use of electroconvulsive treatment, and the admission to a  
14 mental health facility; [AND]

15 (E) making an anatomical gift at death; **and**

16 **(F) a direction relating to the provision of cardiopulmonary**  
17 **resuscitation or other resuscitative measures;**

18 \* **Sec. 10.** AS 13.52.065(f) is repealed.

19 \* **Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to  
20 read:

21 CONTINUING EFFECT OF DO NOT RESUSCITATE ORDERS. A do not  
22 resuscitate order made under AS 13.52 before the effective date of this Act continues in effect  
23 under AS 13.52, unless the do not resuscitate order is revoked under AS 13.52.065(i) or (j),  
24 added by sec. 6 of this Act, or made ineffective under another provision of AS 13.52, as  
25 amended by this Act.

## Sectional Analysis for CSHB 309

*“An Act relating to health care decisions, including do not resuscitate orders.”*

**Section 1.** Amends AS 13.52.045 *Withholding or withdrawing of life-sustaining procedures.*

A Do-Not-Resuscitate (DNR) order does not prevent a health care institution or facility from providing life-sustaining procedures (i.e. assisted ventilation and intubation, blood transfusions, antibiotics, dialysis, artificial nutrition and hydration) to the patient.

**Section 2.** Amends AS 13.52.060(e) *Obligations of health care providers, institutions, and facilities.*

A health care provider may not decline to comply with a DNR order for reasons of conscience if the order is consistent with the provisions of AS 13.52; nor can a health care provider, health care institution or facility decline to comply with an individual instruction or a health care decision that requests that a do not resuscitate order be made ineffective, except as provided by AS 13.52.030(h).

**Section 3.** Amends AS 13.52.060(f) *Obligations of health care providers, institutions, and facilities.*

A health care provider, health care institution or facility may not decline to comply with an individual instruction or health care decision that requests that a do not resuscitate order be made ineffective, except as provided by AS 13.52.030(h).

**Section 4.** Amends AS 13.52.065(a) *Do not resuscitate protocol and identification requirements.*

A physician may issue a DNR order for a patient of the physician only as provided in this section.

**Section 5.** Amends AS 13.52.065(b) to state that the protocol adopted by DHSS for withholding of CPR by health care providers and institutions must comply with this section.

**Section 6.** Amends AS 13.52.065 by adding new subsections-

(g) a physician may not issue a DNR order without the express consent of the patient, if the patient has capacity and is 18 years or older; consent may also be provided by an advance health care directive or by a person authorized to make health care decisions for the patient.

(h) a physician may issue a DNR without the express consent required in (g) if patient does not have capacity, no one is authorized to make health care decisions for patient, and,

(1) patient has advance health care directive which indicates patient wants a DNR order;

or,

(2) patient has advance health care directive which is silent about issuance of a DNR order and another physician concurs in the decision to issue a DNR order; or

(3) patient does not have an advance health care directive, and another physician concurs in the decision to issue a do not resuscitate order.

(i) a physician shall revoke a DNR order for a patient if

- (1) DNR order violates (g) of this section;
- (2) patient has capacity and requests DNR be revoked;
- (3) patient does not have capacity, patient does not have advance health care directive that indicates patient wants a DNR order, and a person authorized to make health care decisions for the patient requests the revocation of the DNR order; or
- (4) patient is under 18 years of age and parent or guardian of patient requests that the DNR order be revoked.

(j) a physician may revoke a DNR order issued by another physician for a patient, if the physician has a physician-patient relationship with the patient.

**Section 7.** Amends AS 13.52.080(a) *Immunities*

Amends AS 13.52.080(a) to replace a citation to a subsection that is repealed by this bill (AS 13.52.065(f) *Do not resuscitate protocol and identification requirements*).

**Section 8.** Amends AS 13.52.300 the *Optional form* used to create an advance health care directive. A new section, *Life-Sustaining Procedures*, is added under Part 2 – Instructions for Health Care, (6)End-of-Life Decisions, giving patients the opportunity to accept or decline life-sustaining procedures, or identify specific life-sustaining procedures they wish to receive.

**Section 9.** Amends AS 13.52.390(17) *Definitions*

The definition for “Health care decision” is expanded to include *a direction relating to the provision of cardiopulmonary resuscitation or other resuscitative measures*;

**Section 10.** Repeals AS 13.52.065(f), which currently addresses how DNR orders are made ineffective.

**Section 11.** Adds a provision to indicate how DNR orders made before the bill’s effective date are to be treated in light of the bill.

## EXPLANATION OF CHANGES

### CSHB 309 (from 27-LS1115\M to 27-LS1115\B)

The substantive changes in Committee Substitute for HB 309 from original version M are as follows:

1. Section 2, p. 2, line 3; and Section 3, p. 2, line 12 – INSERT - **except as provided in AS 13.52.030(h)** to clarify that health care providers may decline to comply with a decision of a surrogate who the health care provider observes is not abiding by the wishes, values and best interest of the patient.

2. Section 2, p. 2, lines 5 – 6, and Section 3, p. 2, lines 14 - 15 –

DELETE - [cardiopulmonary resuscitation or other resuscitative measures be provided]; INSERT - **a do not resuscitate order be made ineffective.**

This reflects the narrow focus of the bill to protect patients from being subject to DNR orders against their consent, and is consistent with current statutory language in AS 13.52.065(f).

3. Section 3, p.2, line 13 - DELETE [advance health care directive] and INSERT **individual instruction.**

This language change was the original draft intent of Legislative Legal, and is a correction to keep language internally consistent within AS 13.52.060, subsection (f), and with the purpose of the bill.

4. Section 6, p. 3, adds new subsection (h)(3) – when physicians may issue do not resuscitate orders without express consent of patient.

This particular situation was not previously addressed.

5. Section 6, p. 3, lines 19 and 20 – DELETE [subsection (i)(3)].

This change recognizes that in the case of a patient who does not have capacity, a dated advance health care directive may not reflect the current wishes, values and best interest of the patient.

6. Section 6, p. 3, lines 23 and 24 – DELETE [or does not oppose]

This change removes ambiguity.

7. Section 6, p.3, lines 29 – 31, and p.4, lines 1 and 2 - DELETE [; or (2) health care obligation to the patient arising out of the physician's (A) individual relationship with the patient; or (B) employment by the health care institution or health care facility where the patient is being treated.]

This language change keeps the relationship more narrowly defined to the physician-patient relationship. It provides less complication and is consistent with current chapter language in 13.52.065.

8. Section 8, p. 5, lines 11 - 14 - DELETE all amended language.

Current statutory language in AS 13.52.080 *Immunities*, and AS 13.52.090 *Statutory Damages* adequately covers health care provider, health care institution and health care facility immunity and liability considerations.

9. Section 9, p. 5, line 16, 20 & 21- DELETE all amended language.

See comment on #10 below.

10. Section 10, p. 5, lines 29 - 31 and p. 6, lines 1 - 3- DELETE all new subsection language.

Section 13.52.120(b) already states that withholding or withdrawing of CPR or other life sustaining procedures must be *consistent with this chapter*, and statutory language in AS 13.52.080 *Immunities*, and AS 13.52.090 *Statutory Damages* adequately covers health care provider, health care institution and health care facility immunity and liability considerations.

11. Section 11, p.13, lines 2 - 11 – *Life-Sustaining Procedures*. In addition to the options of receiving or not receiving life-sustaining procedures, an additional option is provided to allow for a patient to select specific life-sustaining procedures so that this is not an "all or none" proposition when electing to receive or not receive life-sustaining procedures.

## Health Care Decisions Act – AS 13.52

*Concerns and a legal review of the law with respect to DNR orders*

### Terms

*Individual instruction* – an individual's direction concerning health care decisions for the individual

*Health care* – any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition

*Health care decision* – a decision made by an individual or individual's agent, guardian or surrogate regarding the individual's health care

*Advance health care directive* – an individual instruction or a durable power of attorney for health care

### Concern

It appears that patient or surrogate consent is not required by Providence Alaska Medical Center for issuance of a Do Not Resuscitate (DNR) order. Providence Alaska is a partner in the WWAMI medical education program. The University of Washington Medical Center, Harborview Medical Center and Seattle VA Medical Centers all state with respect to disagreements about DNR orders – *At the UW, Harborview, and VA Medical Centers, the policy is to write a DNR order only with patient/family agreement. If there is disagreement, every reasonable effort should be made to communicate with the patient or family. In many cases, this will lead to resolution of the conflict. In difficult cases, an ethics consultation can prove helpful. Nevertheless, CPR should generally be provided to such patients, even if judged futile. (emphasis added) – Ethics in Medicine, Do Not Resuscitate Orders, University of Washington School of Medicine.*

### Question

Does current law protect the right of a patient, or the patient's designee, to make ineffective a physician's decision to issue a DNR order?

### Legal Opinion

State of Alaska, Legislative Legal opinion of October 28, 2011, states *AS 13.52 is fairly clear that a patient with capacity has the right to make a DNR order ineffective. However, the chapter is not as clear that an individual can prevent a doctor from placing the order or that an authorized agent of the patient may make a DNR order ineffective or prevent the doctor from placing the DNR order.*

### Review of current law (AS 13.52 Health Care Decisions Act)

- ✓ AS 13.52.065(a) allows a physician to issue a DNR order. However, this cannot be read in isolation from the rest of AS 13.52 (Health Care Decisions Act).
- ✓ AS 13.52 is fairly clear that a patient with capacity has the right to make a DNR order ineffective.
- ✓ The chapter is not as clear that an individual can prevent a doctor from placing the order or that an authorized agent of the patient may make a DNR order ineffective or prevent the doctor from placing the DNR order.
- ✓ Rights of health care providers and institutions - right to object for reasons of conscience (except a DNR); right not to comply with medically ineffective health care (13.52.060(e-f) and 13.52.120(e)); right of health care provider not to comply with a decision of a surrogate who provider observes is not

abiding by wishes, values and best interests of patient (13.52.030(g-h)); and right of judicial relief (13.52.140).

- ✓ AS 13.52.060(d) requires a health care provider to comply with an individual instruction of the patient, and with a health care decision made by an authorized person. AS 13.52.060(d) *a health care provider, health care institution, or health care facility providing care to a patient shall comply with (1) an individual instruction of the patient...; and (2) a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.*
- ✓ The term “individual instruction” appears to cover a DNR order (approving or disapproving) because it covers a health care decision, see AS 13.52.390(17), which includes any care, treatment, service, or procedure that affects an individual’s physical or mental condition.
- ✓ Specific provisions regarding DNR orders - AS 13.52.065(f) *Do not resuscitate protocol and identification requirements*, and AS 13.52.100(c) *Capacity*, clearly allow DNR orders to be made ineffective if a patient who is able to make the decision requests it, but these sections do not expressly address authorized agents. A do not resuscitate order may not be made ineffective unless, 1.) a physician revokes the do not resuscitate order; 2.) a patient for whom the order is written and who has capacity requests that the do not resuscitate order be revoked; or 3.) the patient for whom the order is written is under 18 years of age and the parent or guardian of the patient requests that the DNR order be revoked.
- ✓ The DNR protocol established by Department of Health and Social Services states that a DNR patient may revoke the patient’s DNR status at any time and in any manner in accordance with AS 13.52, but does not address revocation by agents of the individual.
- ✓ AS 13.52.060(d), mentioned above, and AS 13.52.080(a)(6)(B) *Immunities*, both indicate that an authorized agent of the patient may make a DNR order ineffective. Also, AS 13.52.010 *Advance health care directives*, allows a patient to make advance health care directives and appoint agents regarding health care decisions. Under AS 13.52.010(b), an agent may be given the authority under a durable power of attorney for health to make any health care decision the principal could have made while having capacity.
- ✓ AS 13.52.300 - The Advance Health Care Directive form allows persons to state health care decisions and appoint agents which supports an interpretation that individuals may indicate their wishes and appoint agents regarding DNR orders.
- ✓ AS 13.52.120(a) *Effect of this chapter*, states the chapter establishes a presumption in favor of life, which would seem to support interpreting the chapter to allow a patient (or authorized representative) to prevent a physician from issuing a DNR order.

### **Conclusion of Legislative Legal**

*In AS 13.52 it seems clear that a patient with capacity has the right to make a DNR order ineffective. And while I would tend to conclude that the better interpretation of AS 13.52 is that a doctor’s right to issue a DNR order is limited by the decision of the patient or the patient’s authorized representative, and that an agent with that authority can revoke a DNR order, there are some ambiguities in the chapter that could result in other interpretations. – October 28, 2011 Legal Memo to Senator Dyson*

## Response to February 10, 2012 Letter Outlining Concerns with SB 172

This legislation is consistent with current law. The intent is to clarify ambiguities within the Health Care Decisions Act – AS 13.52. We appreciate the opportunity to review this legislation with you.

### Sectional Analysis & Health Care Decisions Act – AS 13.52

A legal review of the Sectional Analysis of Senate Bill 172 (SB172), and of the current law (Health Care Decisions Act) pertaining to end of life decisions in AS 13.52, are provided along with this response and will be helpful to understanding the specifics of the legislation.

1. Providence – *These bills attempt to mandate that aggressive potentially hazardous interventions be performed on every patient who requests it, no matter what the underlying disease, injury or illness (Sec. 2, pg 2, lines 2 -6; Sec. 3, pg 2, lines 11-15).*

Response – This is a broad overstatement. Sec. 2, pg 2, lines 2 -6; and Sec. 3, pg 2, lines 11-15, restates more clearly what AS 13.52 already states. See October 28, 2011, State of Alaska, Legislative Legal opinion attached.

Note: On p. 2, line 13, the term “advanced health care directive” will be amended to “individual instruction”, to be consistent with the more narrow focus of limiting the health care provider’s right to decline to comply with a patient request that cardiopulmonary resuscitation be provided.

2. Providence – *If the patient is not capable of decision making, a surrogate decision maker can mandate that potentially hazardous interventions be performed EVEN if the patient’s advance health care directive states otherwise (Sec. 3, pg 2, lines 11-15; Sec. 6, pg 2, lines 29-31 and pg 3, line 4; and Sec. 12, pg 19, lines 18-19).*

Response – This is not correct. An advanced health care directive indicating a patient’s choice for a DNR order or choice not to prolong life must be adhered to (see 13.52.030(g)) and this legislation does not change that. Rather, it reiterates the authority of patient advance health care directives in Sec. 6, pg 3, lines 2-3 which states in part, *under this paragraph, the consent (to a DNR order) may be provided by an advance health care directive.* Further, the rights of health care providers and institutions not to comply with a decision of a surrogate who the provider observes is not abiding by the wishes, values and best interests of a patient are protected under 13.52.030(g-h) *Surrogates*, and under 13.52.140 *Judicial relief*.

3. Providence – *It agrees that health care providers can identify medical futility (when procedures or interventions will not help a patient condition) but it further mandates that health care providers cannot refuse to apply potentially harmful interventions to patients if they or their*

*families demand it. This is true even when the procedures are deemed to be medically ineffective (Sec. 3, pg 2, lines 7-18).*

Response – Much of this section is current law, not new law. Only lines 11 – 15 contain new language, which clarifies that a health care provider, health care institution or facility may not decline to comply with an individual instruction or health care decision that requests CPR or other resuscitative measures be provided.

4. Providence – *In short, it mandates that providers batter patients, by performing painful and potentially harmful procedures that are in direct contrast to generally acceptable medical practice (Sec. 3, pg 2, lines 7-18).*

Response – See response to #3.

5. Providence – *It mandates that under certain circumstances health care providers may not adhere to their medical creed to “first do no harm”. It mandates that providers harm patients (Sec. 3, pg 2, lines 7-18).*

Response – See response to #3.

6. Providence – *It does not encourage or support the input of medical providers or collaborative efforts to determine the best course of care by weighing all of the care options with clear understanding and discussion of risks vs. benefits (Sec. 3, pg 2, lines 7-18).*

Response – See response to #3; also, the authority to issue or make ineffective DNR orders is, unfortunately, often viewed as a zero sum game. If the physician gains decision making authority, the patient loses. If the patient gains decision making authority, the physician loses. This legislation does nothing to discourage the dialogue surrounding these difficult decisions. Ideally, agreement will be reached. But in the end, if there is an impasse between the patient (or surrogate) and the physician with respect to a DNR order, the law says the presumption is in favor of life, and with that of patient consent to a DNR order being required.

With respect to parents of a child patient, sometimes they cannot accept, even after long and painful discussions that their child will not survive. They will not “give up”. May CPR be done long enough (not prolonged) for the parents looking on to demonstrate its futility? The health care provider is also treating the family, even though the child is beyond saving. Public safety and critical care personnel with substantial service in the profession know the relevancy of this argument.

7. Providence – *It encourages individuals to direct hospitals and health care providers to perform potentially harmful interventions on patients who will not benefit from these interventions (Sec. 3, pg 2, lines 7-18; Sec. 2, pg 2, lines 2-6). It negates individual freedom to choose.*

Response – see response to #3 and #6; also, with respect to DNR orders, this legislation most certainly supports the patient’s individual freedom to choose, and protects them from becoming subject to a DNR order against their will. Determinations of when to discontinue efforts at life-saving interventions fall to the purview of physicians, the policies of the health care institutions, and the accepted standards of medical practice.

8. Providence - *It allows surrogate decision makers to reverse decisions made by individuals who have completed advance health care directives (Sec. 2, pg 2, lines 2-6; Sec. 3, pg 2, lines 7-18; Sec. 6, pg 3, line 4; Sec. 13.52.300, pg 7, lines 6-11, and 15 and 16).*

Response – this is not correct. See response to #2; also, a real misunderstanding occurs here with respect to what is current law, and what is being proposed in the legislation. The reference to Sec. 13.52.300, pg 7, lines 6-11, and 15 and 16, is all current law as stated in the sample Advance Health Care Directive form. None of this is new or amended language that is being proposed. Rather, the language in question on the form is merely giving the explanation that Part 1 of the form is a durable power of attorney for health care and advising the reader that they may appoint an agent, limit or not limit the agent’s authority to make health care decisions for the patient, and if they choose not to limit the agent’s authority, a careful description of the specific actions an agent make take on their behalf is identified.

9. Providence – *It mandates that all previously established health care directives become null and void if they were established previously but not in accordance with the new bill directives (Sec. 6, pg 3, lines 14 – 26; Sec. 14, pg 19, lines 23-27).*

Response – this is an incorrect, overly broad statement. Rather, the bill language mentioned in Sec. 14, pg 19, lines 23 – 27 speaks only to indicate how DNR orders made before the bill’s effective date are to be treated in light of the bill.

Further, 13.52.150 *Do not resuscitate orders and identification of other jurisdictions* states that with respect to DNR orders or DNR identification executed, issued or authorized in another state or territory or possession of the United States - a health care provider or health care institution may presume, in the absence of actual notice to the contrary, that the DNR order or the DNR identification complies with the laws of this state, regardless of where or when it was executed, issued, or authorized, and that the patient is a qualified patient.

10. Providence – *It threatens litigation to providers who will not inflict harm on patients by refusing to perform medically ineffective harmful procedures and aggressive interventions when patients or their families request it (Sec. 8, pg 5, lines 12-14).*

Response – the language of this section is consistent with current law liability for gross negligence or reckless or intentional actions, and states that immunities from liability do not apply to health care providers, institutions and facilities if the DNR order relied on by these entities was issued in violation of AS 13.52.065.

The legislation protects health care providers from criminal liability by providing that a violation of 13.52.065 *Do not resuscitate protocol and identification requirements* does not, for any purpose, constitute a homicide (Sec. 9, pg 5, lines 20-21).

11. Providence – *It defaults automatically to doing aggressive painful potentially hazardous procedures on all patients who have not previously established written health care directives that specifically refuse to have CPR or other advanced aggressive interventions (Sec. 6, pg 3, lines 5-10; Sec. 4, pg 2, lines 19-22).*

Response – this is not correct. This legislation allows patients (or surrogates) to make health care decisions with respect to DNR orders. Most patients do not have advanced health care directives, but defer making end of life decisions until they must be made.

A misunderstanding occurs here in the sections of legislation identified. Sec. 6, pg 3, lines 5-10 speaks to when a physician may issue a DNR order without the express consent of the patient in various situations, one of which is when a patient has an advance health care directive which indicates the patient wants a DNR, and another situation in which a patient has an advance health care directive which is silent about the issuance of a DNR and another physician concurs in the decision to issue a DNR order.

12. Providence – *It mandates that a physician revoke DNR orders under any circumstance in which a patient, a family member or a surrogate decision maker demands it – even if the interventions demanded are medically ineffective (Sec. 2, pg 2, lines 2-6; Sec. 3, pg 2, lines 7-18).*

Response – this is an incorrect, overly broad statement. See responses to #2, #6 and #7. True, the legislation protects patients from becoming subject to DNR orders against their will. However, the law clearly lays out process for determining who has standing to act on behalf of the patient, and who does not (13.52.030 *Surrogates*).

13. Providence – *It states that a physician who has “an individual relationship with the patient” may revoke a DNR. It does not specify what that relationship might be (Sec. 6, pg 3, line 31). It states that a physician who is employed by the health care institution where the patient is being treated may revoke a DNR order without establishing a professional patient-physician relationship (Sec. 6, pg 4, lines 1 and 2).*

Response – we welcome proposed language from Providence. The central idea is to limit the number of uninvolved physicians who could raise objections to a DNR order. Sec. 6, pg 3, line 30 contains the key contextual language arising out of the physician’s “individual relationship with the patient”; or “employment by the health care institution or health care facility where the patient is being treated”. With respect to *individual relationship* – a patient could have close friends, who just happen to be physicians, who know much about the patient’s medical situation, and personal values and wishes, but who are not the patient’s primary care providers. With respect to *employment by the health care institution....where the patient is being treated* - the patient-physician relationship is implied, but not clearly stated.

14. Providence – *The advance health care directive form has been altered to indicate that any selection by an individual that does not ask for full resuscitation efforts must wish to die (Sec. 13.52.300, pg 11, lines 8-31, and pg 12, lines 1-11). It does not address or support an individual’s right to request that their care be focused upon relief of pain and suffering, maximizing comfort and avoiding the prolonging of the dying process.*

Response – a complete misunderstanding occurs here in the sections of legislation identified. The reference to Sec. 13.52.300, pg 11, lines 8-31, and pg 12, lines 1-11, is all current law as stated in the sample Advance Health Care Directive form. None of this is new or amended language that is being proposed. Further, the plain meaning of this form is clear - to enable patients to provide detailed instructions for health care concerning end-of-life decisions. The form covers the choice to prolong life, not to prolong life (and under what circumstances), additional instructions from patient, choices concerning artificial nutrition and hydration, and relief from pain.

15. Providence - *The new version of the advance health care directive form does not encourage graduated selection of interventions. It is an all or none proposition (13.52.300, pg 13, lines 2-10). Response – This legislation incorporates the entirety of the current form, with one amendment (pg 13, lines 2-10) to provide an additional choice in the Alaska Health Care Directive form to allow patients to accept or refuse life-sustaining procedures. The current form under Part 2 – Instructions for Health Care, on pages 11 – 13 of the bill, give ample opportunities for graduated selection of interventions as stated in response to #14.*



# LEGISLATIVE RESEARCH SERVICES

Alaska State Legislature  
Division of Legal and Research Services  
State Capitol, Juneau, AK 99801

(907) 465-3991 phone  
(907) 465-3908 fax  
research@legis.state.ak.us

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## Memorandum

TO: Senator Fred Dyson  
FROM: Chuck Burnham, Legislative Analyst  
DATE: January 19, 2012  
RE: State Laws: Assuring Healthcare Provider Compliance with Advance Health Directives  
*LRS Report 12.142*

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*You asked about states' laws on "do not resuscitate orders" (DNRs). Specifically, you asked how other states prevent healthcare providers from using their patient care management authority to issue DNRs against the will of patients who have terminal conditions.*

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## Background

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As you likely know, all states have laws codifying patients' control, to varying degrees, over the medical care they receive in their final days of life.<sup>1</sup> Such legal mechanisms are commonly known as "advanced health directives," and may include "do not resuscitate orders" (DNRs). Typically, DNRs are used by elderly individuals or those with terminal illnesses to direct healthcare providers to suspend treatment should the patient experience a medical event that, in the absence of intervention, is likely to bring about death. In the absence of a DNR, medical ethics and standards of practice generally compel physicians to attempt life-saving measures; however, this requirement is limited when, in the judgment of the attending physician, such care would not ultimately prove beneficial to the patient. This concept is embodied in the Code of Ethics of the American Medical Association (AMA), which includes the following language in AMA Opinion 2.035:

Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, as defined in Opinion 2.03, "Allocation of Limited Medical Resources," and Opinion 2.095, "The Provision of Adequate Health Care," not on the concept of "futility," which cannot be meaningfully defined.

Recognizing the emotional and trying atmosphere that surrounds end-of-life care, the AMA provides in Opinion 2.037 a framework of considerations and actions to be taken by healthcare providers in circumstances where their prescribed treatment differs from the wishes of terminal patients. That Opinion frames the issue as follows:

When further intervention to prolong the life of a patient becomes futile, physicians have an obligation to shift the intent of care toward comfort and closure. However, there are necessary value judgments involved in coming to the assessment of futility. These judgments must give consideration to patient or proxy assessments of worthwhile outcome. They should also take into account the physician or other provider's perception of intent in treatment, which should not be to prolong the dying process without benefit to the patient or to others with legitimate interests. They may also take into account community and institutional standards, which in turn may have used physiological or functional outcome measures. Nevertheless, conflicts between the parties may persist in determining what is futility in the particular instance.<sup>2</sup>

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<sup>1</sup> Alaska's laws on advanced healthcare directives are codified at AS 13.52. For the purposes of this report, the term "patient" generally includes individuals receiving care, their families, and other proxies that may be involved in end-of-life decisions should the patient become incapacitated.

<sup>2</sup> The AMA Code of Medical Ethics is available online at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page?>.

The AMA recommends that healthcare institutions adopt policies that use a due process approach in determining medical futility. Opinion 2.037 outlines a seven-step approach that emphasizes fostering understanding and cooperation between patient and physician, involvement of institutional bodies such as ethics committees where disagreements remain, and the swift and orderly transfer of patients to other institutions when agreement cannot be reached.

### Patient Protections in State Laws

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Although the policies of the AMA generally appear to strike a reasonable balance between the wishes of patients and the medical judgment of physicians, those policies do not carry the weight of law. The concern that you contemplate—that physicians may order a DNR over the wishes of the patient at a point too early in the end-of-life process—is clearly shared by policymakers in a number of other jurisdictions.

For example, the Uniform Law Commission (ULC) includes protection against physicians superseding the wishes of patients in its Uniform Healthcare Decisions Act.<sup>3</sup> Section 7 of the Act, “Obligations of Healthcare Provider,” includes the following:

- (d) Except as provided in subsections (e) and (f), a health-care provider or institution providing care to a patient shall:
- (1) comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient; and
  - (2) comply with a health-care decision for the patient made by a person then authorized to make health-care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

The Act then allows that should a healthcare provider decline to comply with the instructions of a patient for reasons of conscience, policy, or conflict with generally accepted healthcare standards, the patient should be promptly informed and treatment should continue until transfer to another facility can be arranged.<sup>4</sup> The Act, in part or in total, has been adopted by a number of states including Alaska and, for example, Mississippi and New Mexico.

Although the policies of the AMA and the Uniform Act have clearly influenced policymakers’ approaches to protecting patients’ wishes in end-of-life circumstances, states nonetheless vary considerably in their laws on the topic. For instance, in California and Hawaii, physicians may issue orders specifying withholding end-of-life treatment, but only with the signature of a patient or legally recognized proxy. Similar orders may be issued by physicians in Tennessee and Virginia only with the “consent” of the affected patient. Medical doctors in Ohio may issue a “DNR Identification” order, but state law makes clear that the legal “declaration” of a patient regarding treatment preferences supersedes the physician’s DNR.<sup>5</sup>

It is important to note that although the states we have mentioned, and others, have taken steps to protect patients from becoming subject to a DNR order against their will, determinations on when to discontinue efforts at life-saving interventions such as cardio pulmonary resuscitation (CPR) fall to the purview of physicians, the policies of the institutions in which they practice, and the accepted standards of medical practice. Therefore, patients’ authority under the laws we’ve discussed necessarily extend only to whether they desire or refuse medical intervention through an advanced directive at the end of life rather than to the duration or timing of the cessation of those measures.

We hope this is helpful. If you have questions or need additional information, please let us know.

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<sup>3</sup> Established in 1892, the ULC, also known as the National Conference of Commissioners on Uniform State Laws, seeks to provide states with “non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of state statutory law.” The ULC is comprised of lawyers, judges, legislators, and academics who have been appointed by state governments. More information is available on the Commission’s website at <http://www.nccusl.org/Default.aspx>.

<sup>4</sup> Full text of the Act is available online at <http://www.nccusl.org/Default.aspx>.

<sup>5</sup> We include, as attachments, examples of relevant statutes of California, Delaware, Florida, Georgia, Hawaii, Mississippi, New Mexico, Ohio, Tennessee, and Virginia.

## **Attachment A**

Cal Prob Code § 4780

16 Del. C. § 2508

Fla. Stat. §§ 765.110-1115

O.C.G.A. §§ 31-32-8 to 9

HRS § 327K-2

Miss. Code Ann. § 41-41-215

N.M. Stat. Ann. § 24-7A-7

ORC Ann. 2133.03

Tenn. Code Ann. § 68-11-224

Va. Code Ann. § 54.1-2987.1

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(All 2011 legislation)

PROBATE CODE  
Division 4.7. Health Care Decisions  
Part 4. Request Regarding Resuscitative Measures

**GO TO CALIFORNIA CODES ARCHIVE DIRECTORY**

*Cal Prob Code § 4780 (2012)*

**§ 4780. Execution of Physician Orders for Life Sustaining Treatment form; Revocation; Medallion**

(a) As used in this part:

(1) "Request regarding resuscitative measures" means a written document, signed by (A) an individual with capacity, or a legally recognized health care decisionmaker, and (B) the individual's physician, that directs a health care provider regarding resuscitative measures. A request regarding resuscitative measures is not an advance health care directive.

(2) "Request regarding resuscitative measures" includes one, or both of, the following:

(A) A prehospital "do not resuscitate" form as developed by the Emergency Medical Services Authority or other substantially similar form.

(B) A Physician Orders for Life Sustaining Treatment form, as approved by the Emergency Medical Services Authority.

(3) "Physician Orders for Life Sustaining Treatment form" means a request regarding resuscitative measures that directs a health care provider regarding resuscitative and life-sustaining measures.

(b) A legally recognized health care decisionmaker may execute the Physician Orders for Life Sustaining Treatment form only if the individual lacks capacity, or the individual has designated that the decisionmaker's authority is effective pursuant to Section 4682.

(c) The Physician Orders for Life Sustaining Treatment form and medical intervention and procedures offered by the form shall be explained by a health care provider, as defined in Section 4621. The form shall be completed by a health care provider based on patient preferences and medical indications, and signed by a physician and the patient or his or her legally recognized health care decisionmaker. The health care provider, during the process of completing the Physician Orders for Life Sustaining Treatment form, should inform the patient about the difference between an advance health care directive and the Physician Orders for Life Sustaining Treatment form.

(d) An individual having capacity may revoke a Physician Orders for Life Sustaining Treatment form at any time

and in any manner that communicates an intent to revoke, consistent with Section 4695.

(e) A request regarding resuscitative measures may also be evidenced by a medallion engraved with the words "do not resuscitate" or the letters "DNR," a patient identification number, and a 24-hour toll-free telephone number, issued by a person pursuant to an agreement with the Emergency Medical Services Authority.

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\*\*\* This document is current through 78 Del. Laws, Ch. 203 \*\*\*  
\*\*\* Annotations current through cases posted as of September 2, 2011 \*\*\*

TITLE 16. HEALTH AND SAFETY  
PART II. REGULATORY PROVISIONS CONCERNING PUBLIC HEALTH  
CHAPTER 25. HEALTH-CARE DECISIONS

**GO TO DELAWARE STATUTES ARCHIVE DIRECTORY**

*16 Del. C. § 2508 (2011)*

§ 2508. Obligations of health-care provider

(a) Before implementing a health-care decision made for a patient, a supervising health-care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision. The decision of an agent or surrogate does not apply if the patient objects to the decision to remove life-sustaining treatment, providing that the objection is (1) by a signed writing or (2) in any manner that communicates in the presence of 2 competent persons, 1 of whom is a physician.

(b) A supervising health-care provider who knows of the existence of an advance health-care directive or a revocation of an advance health-care directive shall promptly record its existence in the patient's health-care record and, if it is in writing, shall request a copy and, if it is not in writing, shall request a copy of the witness statement, and shall arrange for its maintenance in the health-care record.

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

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

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

(2) In the absence of an individual instruction, comply with a health-care decision for the patient made by a person then authorized to make health-care decisions for the patient to the extent the agent or surrogate is permitted by this chapter.

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

(f) A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective treatment or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.

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

(1) Promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;

(2) Provide continuing care, including continuing life sustaining care, to the patient until a transfer can be effected; and

(3) Not impede the transfer of the patient to another health-care provider or institution identified by the patient, the patient's agent or the patient's surrogate.

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\*\*\* Annotations current through October 17, 2011. \*\*\*

TITLE 44. CIVIL RIGHTS (Chs. 760-765)  
CHAPTER 765. HEALTH CARE ADVANCE DIRECTIVES  
PART I. GENERAL PROVISIONS

**GO TO FLORIDA STATUTES ARCHIVE DIRECTORY**

*Fla. Stat. § 765.110 (2011)*

§ 765.110. Health care facilities and providers; discipline

(1) A health care facility, pursuant to Pub. L. No. 101-508, ss. 4206 and 4751, shall provide to each patient written information concerning the individual's rights concerning advance directives and the health care facility's policies respecting the implementation of such rights, and shall document in the patient's medical records whether or not the individual has executed an advance directive.

(2) A health care provider or health care facility may not require a patient to execute an advance directive or to execute a new advance directive using the facility's or provider's forms. The patient's advance directives shall travel with the patient as part of the patient's medical record.

(3) A health care provider or health care facility shall be subject to professional discipline and revocation of license or certification, and a fine of not more than \$ 1,000 per incident, or both, if the health care provider or health care facility, as a condition of treatment or admission, requires an individual to execute or waive an advance directive.

(4) The Department of Elderly Affairs for hospices and, in consultation with the Department of Elderly Affairs, the Department of Health for health care providers; the Agency for Health Care Administration for hospitals, nursing homes, home health agencies, and health maintenance organizations; and the Department of Children and Family Services for facilities subject to part I of chapter 394 shall adopt rules to implement the provisions of the section.

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TITLE 44. CIVIL RIGHTS (Chs. 760-765)  
CHAPTER 765. HEALTH CARE ADVANCE DIRECTIVES

## PART I. GENERAL PROVISIONS

**GO TO FLORIDA STATUTES ARCHIVE DIRECTORY***Fla. Stat. § 765.1105 (2011)*

## § 765.1105. Transfer of a patient

(1) A health care provider or facility that refuses to comply with a patient's advance directive, or the treatment decision of his or her surrogate, shall make reasonable efforts to transfer the patient to another health care provider or facility that will comply with the directive or treatment decision. This chapter does not require a health care provider or facility to commit any act which is contrary to the provider's or facility's moral or ethical beliefs, if the patient:

(a) Is not in an emergency condition; and

(b) Has received written information upon admission informing the patient of the policies of the health care provider or facility regarding such moral or ethical beliefs.

(2) A health care provider or facility that is unwilling to carry out the wishes of the patient or the treatment decision of his or her surrogate because of moral or ethical beliefs must within 7 days either:

(a) Transfer the patient to another health care provider or facility. The health care provider or facility shall pay the costs for transporting the patient to another health care provider or facility; or

(b) If the patient has not been transferred, carry out the wishes of the patient or the patient's surrogate, unless the provisions of *s. 765.105* apply.

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TITLE 44. CIVIL RIGHTS (Chs. 760-765)  
CHAPTER 765. HEALTH CARE ADVANCE DIRECTIVES  
PART I. GENERAL PROVISIONS

**GO TO FLORIDA STATUTES ARCHIVE DIRECTORY***Fla. Stat. § 765.1115 (2011)*

§ 765.1115. Falsification, forgery, or willful concealment, cancellation, or destruction of directive or revocation or amendment; penalties

(1) Any person who willfully conceals, cancels, defaces, obliterates, or damages an advance directive without the

principal's consent or who falsifies or forges the revocation or amendment of an advance directive of another, and who thereby causes life-prolonging procedures to be utilized in contravention of the previously expressed intent of the principal, commits a felony of the third degree, punishable as provided in *s. 775.082*, *s. 775.083*, or *s. 775.084*.

(2) Any person who falsifies or forges the advance directive of another or who willfully conceals or withholds personal knowledge of the revocation of an advance directive, with the intent to cause a withholding or withdrawal of life-prolonging procedures contrary to the wishes of the principal, and who thereby because of such act directly causes life-prolonging procedures to be withheld or withdrawn and death to be hastened, commits a felony of the second degree, punishable as provided in *s. 775.082*, *s. 775.083*, or *s. 775.084*.

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\*\*\* Annotations Current Through October 14, 2011 \*\*\*

TITLE 31. HEALTH  
CHAPTER 32. ADVANCE DIRECTIVES FOR HEALTH CARE

**Go to the Georgia Code Archive Directory**

*O.C.G.A. § 31-32-8 (2011)*

§ 31-32-8. Duties and responsibilities of health care providers

Each health care provider and each other person with whom a health care agent interacts under an advance directive for health care shall be subject to the following duties and responsibilities:

(1) It is the responsibility of the health care agent or declarant to notify the health care provider of the existence of the advance directive for health care and any amendment or revocation thereof. A health care provider furnished with a copy of an advance directive for health care shall make such copy a part of the declarant's medical records and shall enter in the records any change in or termination of the advance directive for health care by the declarant that becomes known to the health care provider. A health care provider shall grant a health care agent adequate access to a declarant when a declarant is admitted to any health care facility. Whenever a health care provider believes a declarant is unable to understand the general nature of the health care procedure which the provider deems necessary, the health care provider shall consult with any available health care agent known to the health care provider who then has power to act for the declarant under an advance directive for health care;

(2) A health care decision made by a health care agent in accordance with the terms of an advance directive for health care shall be complied with by every health care provider to whom the decision is communicated, subject to the health care provider's right to administer treatment for the declarant's comfort or alleviation of pain; provided, however, that if the health care provider is unwilling to comply with the health care agent's decision, the health care provider shall promptly inform the health care agent who shall then be responsible for arranging for the declarant's transfer to another health care provider. A health care provider who is unwilling to comply with the health care agent's decision shall provide reasonably necessary consultation and care in connection with the pending transfer;

(3) At the declarant's expense and subject to reasonable rules of the health care provider to prevent disruption of the declarant's health care, each health care provider shall give a health care agent authorized to receive such information under an advance directive for health care the same right the declarant has to examine and copy any part or all of the declarant's medical records that the health care agent deems relevant to the exercise of the health care agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, health care facility, or other health care provider, notwithstanding the provisions of any statute or rule of law to the contrary; and

(4) If and to the extent an advance directive for health care empowers the health care agent to direct that an autopsy of the declarant's body be made; to make an anatomical gift of any part or all of the declarant's body pursuant to

Article 6 of Chapter 5 of Title 44, the "Georgia Revised Uniform Anatomical Gift Act"; or to direct the final disposition of the declarant's body, including funeral arrangements, burial, or cremation, the decisions of the health care agent on such matters shall be deemed the act of the declarant or of the person who has priority under law to make the necessary decisions, and each person to whom a direction by the health care agent in accordance with the terms of the agency is communicated shall comply with such direction to the extent it is in accord with reasonable medical standards or other relevant standards at the time of reference.

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TITLE 31. HEALTH  
CHAPTER 32. ADVANCE DIRECTIVES FOR HEALTH CARE

**Go to the Georgia Code Archive Directory**

*O.C.G.A. § 31-32-9 (2011)*

§ 31-32-9. Conditions precedent to carrying out health care treatment preferences; physician's failure to comply with treatment preferences

(a) Prior to effecting a withholding or withdrawal of life-sustaining procedures or the withholding or withdrawal of the provision of nourishment or hydration from a declarant pursuant to a declarant's directions in an advance directive for health care, the attending physician:

(1) Shall determine that, to the best of that attending physician's knowledge, the declarant is not pregnant, or if she is, that the fetus is not viable and that the declarant has specifically indicated in the advance directive for health care that the declarant's directions regarding the withholding or withdrawal of life-sustaining procedures or the withholding or withdrawal of the provision of nourishment or hydration are to be carried out;

(2) Shall, without delay after the diagnosis of a terminal condition or state of permanent unconsciousness of the declarant, take the necessary steps to provide for the written certification of the declarant's terminal condition or state of permanent unconsciousness in accordance with the procedure set forth in subsection (b) of this Code section;

(3) Shall make a reasonable effort to determine that the advance directive for health care complies with *Code Section 31-32-5*; and

(4) Shall make the advance directive for health care and the written certification of the terminal condition or state of permanent unconsciousness a part of the declarant patient's medical records.

(b) The procedure for establishing a terminal condition or state of permanent unconsciousness is as follows: two physicians, one of whom shall be the attending physician, who, after personally examining the declarant, shall certify in writing, based upon conditions found during the course of their examination and in accordance with currently accepted medical standards, that the declarant is in a terminal condition or state of permanent unconsciousness.

(c) The advance directive for health care shall be presumed, unless revoked, to be the directions of the declarant regarding the withholding or withdrawal of life-sustaining procedures or the withholding or withdrawal of the provision of nourishment or hydration.

(d) The attending physician who fails or refuses to comply with the declarant's directions regarding the withholding or withdrawal of life-sustaining procedures or the withholding or withdrawal of the provision of nourishment or hydration shall advise promptly the health care agent, if one is appointed, and, otherwise, next of kin or legal guardian of the declarant that such physician is unwilling to effectuate such directions. The attending physician shall thereafter at the election of the health care agent, if one is appointed, and, otherwise, next of kin or legal guardian of the declarant:

(1) Make a good faith attempt to effect the transfer of the declarant to another physician who will comply with the declarant's directions regarding the withholding or withdrawal of life-sustaining procedures or the withholding or withdrawal of the provision of nourishment or hydration; or

(2) Permit the health care agent, if one is appointed, and, otherwise, next of kin or legal guardian of the declarant to obtain another physician who will comply with the declarant's directions regarding the withholding or withdrawal of life-sustaining procedures or the withholding or withdrawal of the provision of nourishment or hydration.

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DIVISION 1. GOVERNMENT  
TITLE 19 Health  
[CHAPTER 327K] Physician Orders for Life-Sustaining Treatment

**Go to the Hawaii Code Archive Directory**

*HRS § 327K-2 (2011)*

**[§ 327K-2.] Physician orders for life-sustaining treatment form; execution; explanation; compliance; revocation.**

(a) The following may execute a form:

- (1) The patient;
- (2) The patient's physician; and
- (3) The surrogate, but only if the patient:
  - (A) Lacks capacity; or
  - (B) Has designated that the surrogate is authorized to execute the form.

The patient's physician may medically evaluate the patient and, based upon the evaluation, may recommend new orders consistent with the most current information available about the individual's health status and goals of care. The patient's physician shall consult with the patient or the patient's surrogate before issuing any new orders on a form. The patient or the patient's surrogate may choose to execute or not execute any new form. If a patient is incapacitated, the patient's surrogate shall consult with the patient's physician before requesting the patient's physician to modify treatment orders on the form. To be valid, a form shall be signed by the patient's physician and the patient, or the patient's physician and the patient's surrogate. At any time, a patient, or, if incapacitated, the patient's surrogate, may request alternative treatment that differs from the treatment indicated on the form.

(b) The patient's physician or a health care provider shall explain to the patient the nature and content of the form, including any medical intervention or procedures, and shall also explain the difference between an advance health-care directive and the form. The form shall be prepared by the patient's physician or a health care provider based on the patient's preferences and medical indications.

(c) Any health care provider, including the patient's physician, emergency medical services personnel, and emergency physicians shall comply with a properly executed and signed form and treat the patient according to the orders on the form; provided that compliance shall not be required if the orders on the form request medically ineffective health care or health care that is contrary to generally accepted health care standards.

(d) A patient having capacity, or, if the patient is incapacitated, the patient's surrogate, may revoke a form at any

time and in any manner that communicates intent to revoke.

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\*\*\* Current through the 2011 Regular Session and 1st Extraordinary Session \*\*\*

TITLE 41. PUBLIC HEALTH  
CHAPTER 41. SURGICAL OR MEDICAL PROCEDURES; CONSENTS  
UNIFORM HEALTH-CARE DECISIONS ACT

**GO TO MISSISSIPPI STATUTES ARCHIVE DIRECTORY**

*Miss. Code Ann. § 41-41-215 (2011)*

§ 41-41-215. Health-care provider or institution responsibilities

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

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

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

(4) Except as provided in subsections (5) and (6), a health-care provider or institution providing care to a patient shall:

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

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

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

(6) A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.

(7) A health-care provider or institution that declines to comply with an individual instruction or health-care decision shall:

(a) Promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;

(b) Provide continuing care to the patient until a transfer can be effected; and

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

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

(9) If the patient who is an adult or emancipated minor has been determined by the primary physician to lack capacity to make a health-care decision and an agent, guardian or surrogate is not reasonably available, consent may be given by an owner, operator or employee of a residential long-term health-care institution at which the patient is a resident if there is no advance health-care directive to the contrary and a licensed physician who is not an owner, operator or employee of the residential long-term health-care institution at which the patient is a resident has determined that the patient is in need of health care. This power to consent is limited to the terms of this subsection (9) and shall not be construed to repeal or otherwise affect the prohibition of Section 41-41-211(9) relating to owners, operators, or employees of long-term health-care institutions. The consent given pursuant to this subsection shall be limited to the health-care services determined necessary by the licensed physician and shall in no event include the power to consent to or direct withholding or discontinuing any life support, nutrition, hydration or other treatment, care or support. When consent is obtained under this subsection, compliance with these requirements shall be stated in the patient's health-care record.

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CHAPTER 24. HEALTH AND SAFETY  
ARTICLE 7A. UNIFORM HEALTH-CARE DECISIONS

**Go to the New Mexico Code Archive Directory**

*N.M. Stat. Ann. § 24-7A-7 (2011)*

§ 24-7A-7. Obligations of health-care provider

A. Before implementing a health-care decision made for a patient, a supervising health-care provider shall promptly communicate to the patient the decision made and the identity of the person making the decision.

B. A supervising health-care provider who knows of the existence of an advance health-care directive, a revocation of an advance health-care directive, a challenge to a determination of lack of capacity or a designation or disqualification of a surrogate shall promptly record its existence in the patient's health-care record and, if it is in writing, shall request a copy and, if one is furnished, shall arrange for its maintenance in the health-care record.

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

D. Except as provided in Subsections E and F of this section, a health-care provider or health-care institution providing care to a patient shall comply:

(1) before and after the patient is determined to lack capacity, with an individual instruction of the patient made while the patient had capacity;

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

(3) with a health-care decision for the patient that is not contrary to an individual instruction of the patient and is made by a person then authorized to make health-care decisions for the patient, to the same extent as if the decision had been made by the patient while having capacity.

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

F. A health-care provider or health-care institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or health-care institution. "Medically ineffective health care" means treatment that would not offer the patient any significant benefit, as determined by a physician.

G. A health-care provider or health-care institution that declines to comply with an individual instruction or health-care decision shall:

(1) promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;

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

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

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

I. The Uniform Health-Care Decisions Act [24-7A-17 NMSA 1978] does not require or permit a health-care institution or health-care provider to provide any type of health care for which the health-care institution or health-care provider is not licensed, certified or otherwise authorized or permitted by law to provide.

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Page's Ohio Revised Code Annotated:  
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Current through Legislation passed by the 129th Ohio General Assembly  
and filed with the Secretary of State through file 55  
\*\*\* Annotations current through December 5, 2011 \*\*\*

TITLE 21. COURTS -- PROBATE -- JUVENILE  
CHAPTER 2133. MODIFIED UNIFORM RIGHTS OF THE TERMINALLY ILL ACT AND THE DNR  
IDENTIFICATION AND DO-NOT-RESUSCITATE ORDER LAW

**Go to the Ohio Code Archive Directory**

*ORC Ann. 2133.03 (2011)*

§ 2133.03. When declaration becomes operative; declaration supersedes general consent to treatment, DNR identification or durable power of attorney for health care

(A) (1) A declaration becomes operative when it is communicated to the attending physician of the declarant, the attending physician and one other physician who examines the declarant determine that the declarant is in a terminal condition or in a permanently unconscious state, whichever is addressed in the declaration, the applicable requirements of divisions (A)(2) and (3) of this section are satisfied, and the attending physician determines that the declarant no longer is able to make informed decisions regarding the administration of life-sustaining treatment. When the declaration becomes operative, the attending physician and health care facilities shall act in accordance with its provisions or comply with the provisions of *section 2133.10 of the Revised Code*.

(2) In order for a declaration to become operative in connection with a declarant who is in a permanently unconscious state, the consulting physician associated with the determination that the declarant is in the permanently unconscious state shall be a physician who, by virtue of advanced education or training, of a practice limited to particular diseases, illnesses, injuries, therapies, or branches of medicine or surgery or osteopathic medicine and surgery, of certification as a specialist in a particular branch of medicine or surgery or osteopathic medicine and surgery, or of experience acquired in the practice of medicine or surgery or osteopathic medicine and surgery, is qualified to determine whether the declarant is in a permanently unconscious state.

(3) In order for a declaration to become operative in connection with a declarant who is in a terminal condition or in a permanently unconscious state, the attending physician of the declarant shall determine, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that there is no reasonable possibility that the declarant will regain the capacity to make informed decisions regarding the administration of life-sustaining treatment.

(B) (1) (a) A declaration supersedes any general consent to treatment form signed by or on behalf of the declarant prior to, upon, or after the declarant's admission to a health care facility to the extent there is a conflict between the declaration and the form, even if the form is signed after the execution of the declaration. To the extent that the provisions of a declaration and a general consent to treatment form do not conflict, both documents shall govern the use or continuation, or the withholding or withdrawal, of life-sustaining treatment and other medical or nursing procedures, treatments, interventions, or other measures in connection with the declarant. Division (B)(1)(a) of this section does not

apply if a declaration is revoked pursuant to *section 2133.04 of the Revised Code* after the signing of a general consent to treatment form.

(b) A declaration supersedes a DNR identification, as defined in *section 2133.21 of the Revised Code*, of the declarant that is based upon a prior inconsistent declaration of the declarant or that is based upon a do-not-resuscitate order, as defined in *section 2133.21 of the Revised Code*, that a physician has issued for the declarant and that is inconsistent with the declaration.

(2) If a declarant has both a valid durable power of attorney for health care and a valid declaration, the declaration supersedes the durable power of attorney for health care to the extent that the provisions of the documents would conflict if the declarant should be in a terminal condition or in a permanently unconscious state. Division (B)(2) of this section does not apply if the declarant revokes the declaration pursuant to *section 2133.04 of the Revised Code*.

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\*\*\* CURRENT THROUGH THE 2011 REGULAR SESSION \*\*\*  
\*\*\* ANNOTATIONS CURRENT THROUGH APRIL 29, 2011 \*\*\*

Title 68 Health, Safety and Environmental Protection  
Health  
Chapter 11 Health Facilities and Resources  
Part 2 Regulation of Health and Related Facilities

**GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY**

*Tenn. Code Ann. § 68-11-224 (2011)*

**68-11-224. Withholding of resuscitative services -- Regulations.**

(a) A universal do not resuscitate order may be issued by a physician for a patient with whom the physician has a bona fide physician/patient relationship, but only:

(1) With the consent of the patient;

(2) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act, compiled in part 18 of this chapter; or

(3) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act, compiled in part 18 of this chapter, is not reasonably available, the physician determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(b) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke a universal do not resuscitate order. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke a universal do not resuscitate order. Nothing in this section shall be construed to require cardiopulmonary resuscitation of a patient for whom the physician determines cardiopulmonary resuscitation is not medically appropriate.

(c) Universal do not resuscitate orders issued in accordance with this section shall remain valid and in effect until revoked. In accordance with this section and applicable regulations, qualified emergency medical services personnel, and licensed health care practitioners in any facility, program or organization operated or licensed by the board or by the department of mental health or the department of intellectual and developmental disabilities or operated, licensed, or owned by another state agency are authorized to follow universal do not resuscitate orders that are available to them in a form approved by the board.

(d) Nothing in this section shall authorize the withholding of other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain.

(e) For the purposes of this section:

(1) "Emergency responder" means a paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of such person's proper function under law or rendering emergency care at the scene of an emergency;

(2) "Health care provider" shall have the same meaning as ascribed to that term in § 68-11-1802, and shall include, but shall not be limited to, qualified emergency medical services personnel;

(3) "Person authorized to consent on the patient's behalf" means any person authorized by law to consent on behalf of the patient incapable of making an informed decision or, in the case of a minor child, the parent or parents having custody of the child or the child's legal guardian or as otherwise provided by law;

(4) "Qualified emergency medical service personnel" shall include, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders; and

(5) "Universal do not resuscitate order" means a written order that applies regardless of the treatment setting and that is signed by the patient's physician that states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted.

(f) If a person with a universal do not resuscitate order is transferred from one (1) health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the universal do not resuscitate order to the receiving facility prior to the transfer. The transferring facility shall assure that a copy of the universal do not resuscitate order accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the universal do not resuscitate order a part of the patient's record.

(g) This section shall not prevent, prohibit, or limit a physician from issuing a written order, other than a universal do not resuscitate order, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices. This section shall have no application to any do not resuscitate order that is not a universal do not resuscitate order as defined in this section.

(h) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to the then-current law, shall remain valid and shall be given effect as provided in this section.

(i) (1) The board shall promulgate rules and create forms regarding procedures for the withholding of resuscitative services from patients in accordance with this part and this section.

(2) The rules shall address:

(A) The mechanism or mechanisms for reaching decisions about the withholding of resuscitative services from individual patients;

(B) The mechanism or mechanisms for resolving conflicts in decision making, should they arise; and

(C) The roles of physicians and, when applicable, of nursing personnel, other appropriate staff, and family members in the decision to withhold resuscitative services.

(3) The rules shall include provisions designed to assure that patients' rights are respected when decisions are made to withhold resuscitative services and shall include the requirement that appropriate orders be written by the physician primarily responsible for the patient, and that documentation be made in the patient's current clinical record if resuscitative services are to be withheld.

(4) This section shall not be construed or implemented in any manner that restricts or impairs the decision-making authority of the agent, surrogate, or other person designated in the Tennessee Health Care Decisions Act, compiled in part 18 of this chapter. This section does not authorize a surrogate to give consent for or take any action on behalf of a patient on any matter governed by title 33.

(j) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability for:

(1) Complying with a universal do not resuscitate order;

(2) Declining to comply with a universal do not resuscitate order based on a reasonable belief that the order then lacked validity; or

(3) Complying with a universal do not resuscitate order and assuming that the order was valid when made and has not been revoked or terminated.

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CODE OF VIRGINIA  
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\*\*\* Current through the 2011 Regular Session, Acts 2011, cc. 1 to 890, and 2011 Special Session I, c. 1. \*\*\*  
\*\*\* Annotations Current Through September 27, 2011 \*\*\*

TITLE 54.1. PROFESSIONS AND OCCUPATIONS  
SUBTITLE III. PROFESSIONS AND OCCUPATIONS REGULATED BY BOARDS WITHIN THE DEPARTMENT  
OF HEALTH PROFESSIONS  
CHAPTER 29. MEDICINE AND OTHER HEALING ARTS  
ARTICLE 8. HEALTH CARE DECISIONS ACT

**GO TO CODE OF VIRGINIA ARCHIVE DIRECTORY**

*Va. Code Ann. § 54.1-2987.1 (2011)*

§ 54.1-2987.1. Durable Do Not Resuscitate Orders

A. A Durable Do Not Resuscitate Order may be issued by a physician for his patient with whom he has a bona fide physician/patient relationship as defined in the guidelines of the Board of Medicine, and only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf.

B. If a patient is able to, and does, express to a health care provider or practitioner the desire to be resuscitated in the event of cardiac or respiratory arrest, such expression shall revoke the provider's or practitioner's authority to follow a Durable Do Not Resuscitate Order. In no case shall any person other than the patient have authority to revoke a Durable Do Not Resuscitate Order executed upon the request of and with the consent of the patient himself.

If the patient is a minor or is otherwise incapable of making an informed decision and the Durable Do Not Resuscitate Order was issued upon the request of and with the consent of the person authorized to consent on the patient's behalf, then the expression by said authorized person to a health care provider or practitioner of the desire that the patient be resuscitated shall so revoke the provider's or practitioner's authority to follow a Durable Do Not Resuscitate Order.

When a Durable Do Not Resuscitate Order has been revoked as provided in this section, a new Order may be issued upon consent of the patient or the person authorized to consent on the patient's behalf.

C. Durable Do Not Resuscitate Orders issued in accordance with this section shall remain valid and in effect until revoked as provided in subsection B or until rescinded, in accordance with accepted medical practice, by the provider who issued the Durable Do Not Resuscitate Order. In accordance with this section and regulations promulgated by the Board of Health, (i) qualified emergency medical services personnel as defined in § 32.1-111.1; (ii) licensed health care practitioners in any facility, program or organization operated or licensed by the Board of Health, the Department of Social Services, or the Department of Behavioral Health and Developmental Services or operated, licensed or owned by another state agency; and (iii) licensed health care practitioners at any continuing care retirement community registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 are authorized to

follow Durable Do Not Resuscitate Orders that are available to them in a form approved by the Board of Health.

D. The provisions of this section shall not authorize any qualified emergency medical services personnel or licensed health care provider or practitioner who is attending the patient at the time of cardiac or respiratory arrest to provide, continue, withhold or withdraw health care if such provider or practitioner knows that taking such action is protested by the patient incapable of making an informed decision. No person shall authorize providing, continuing, withholding or withdrawing health care pursuant to this section that such person knows, or upon reasonable inquiry ought to know, is contrary to the religious beliefs or basic values of a patient incapable of making an informed decision or the wishes of such patient fairly expressed when the patient was capable of making an informed decision. Further, this section shall not authorize the withholding of other medical interventions, such as intravenous fluids, oxygen or other therapies deemed necessary to provide comfort care or to alleviate pain.

E. For the purposes of this section:

"Health care provider" includes, but is not limited to, qualified emergency medical services personnel.

"Person authorized to consent on the patient's behalf" means any person authorized by law to consent on behalf of the patient incapable of making an informed decision or, in the case of a minor child, the parent or parents having custody of the child or the child's legal guardian or as otherwise provided by law.

F. This section shall not prevent, prohibit or limit a physician from issuing a written order, other than a Durable Do Not Resuscitate Order, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practice.

G. Valid Do Not Resuscitate Orders or Emergency Medical Services Do Not Resuscitate Orders issued before July 1, 1999, pursuant to the then-current law, shall remain valid and shall be given effect as provided in this article.



4800 Cordova St., Suite 100  
Anchorage, Alaska 99503  
Phone: (907) 375-3355  
Fax: (907) 375-3351

March 5, 2012

The Honorable Fred Dyson  
State Capitol Room 121  
Juneau, AK 99801

Dear Mr. Dyson:

My name is Ryan McGhan. I am writing to oppose SB 172 and HB 0309A, which seek to amend present Alaska law that pertains to the care of critically ill and injured Alaskans (AS13.52). I hope to share with you my perspective on how the present law is put into practice, and the potential ramifications of the proposed changes.

I am a physician board certified in Internal Medicine, Pulmonary Diseases, and Critical Care Medicine. I am Medical Director of Adult Critical Care at Providence Alaska Medical Center, and Co-President of The Alaska Hospitalist Group. I was born and raised in Alaska, and returned in 2007 after completing my fellowship in pulmonary and critical care medicine. My group presently covers 28 critical care beds at Providence Alaska Medical Center and an additional 15 critical care beds at Alaska Regional Hospital. We provide critical care consultation at St. Elias Specialty Hospital. We also help care for patients in Kodiak and Juneau through the electronic ICU (eICU), and have provided coverage for critically ill patients at the Alaska Native Medical Center. We currently employ seven full time intensivists, physicians who are board certified in critical care medicine. We help care for a large proportion, if not the majority, of critically ill Alaskans.

From my perspective, current Alaska law is quite reasonable as it pertains to the care of critically ill patients. It has as its central concern the rights of patients. It clearly delineates who should speak for patients when they are unable to speak for themselves. It presumes that in the absence of prior knowledge, most people would favor life-sustaining care. It strikes a good balance between the several goals considered most central to ethical decision making in medicine, namely patient autonomy, non-maleficence (first do no harm), beneficence (the imperative to act in the patient's best interest), and justice (the appropriate distribution of scarce health care resources). While decision making at the end of life is often emotional and difficult, physicians, patients and families are almost always able to find a successful balance between these goals.



I disagree with the position cited in the letter from Senator Dyson to Senator Davis dated January 18 that orders regarding do-not-resuscitate (DNR) are issued at the sole discretion of the physician, and that the desires of patients and/or their surrogate decision makers “do not matter.” This does not accurately reflect clinical practice, and would not be in keeping with the principles of medical ethics outlined above. Such decisions should always be made with the concerns of the patient at the very center of the conversation. In the vast majority of instances, consensus can be achieved between physicians and patients and/or their surrogates.

Occasionally, there will be a substantial disagreement between what patients or family members want and what the treating providers believe will be helpful. In these circumstances, it is important for the physician to remain humble, and to acknowledge that different people will make different judgments about what outcomes are acceptable. If the proposed treatment has benefit in the eyes of the patient, the physician needs to reconsider the decision from that perspective. There will, however, be cases in which terminally ill patients or their loved ones will request that “everything” be done, not because of a reasonable expectation of benefit but because of emotional distress at the impending loss and an unrealistic expectation that modern medicine can prevent death. Even in the year 2012, life and death are controlled by a higher power, not by physicians.

In these cases, it is important not to run afoul of the notion of medical “futility,” which has been rightly criticized in the literature surrounding the end of life care for being too vague and nonspecific. Current Alaska law is helpful in defining medical care which is medically ineffective, namely health care “that according to reasonable medical judgment cannot cure the patient’s illness, cannot diminish its progressive course, and cannot alleviate severe discomfort and distress.” It further stipulates the high burden of proof that exists when we choose not to provide ineffective care. When we believe we are being asked to provide such care, we must confer with other physicians, offer to transfer care if others believe the requested care will in fact be effective, and to inform patients and families that we will not be providing such care.

Autonomy is the first and most important principle of medical ethics. It is not, however, the singular and absolute principle. Providers are not ethically compelled to provide care that offers no benefit, is harmful, and diverts resources away from members of the community who can benefit from care. They should not be legally compelled to do so.


While the memorandum from the Legislative Research Services dated January 19, 2012 (LRS report 12.142) outlines laws in other states that favor patient autonomy over ethical medical care, it appears that they were specifically directed to find such examples. Current Alaska law, and law in other jurisdictions, seeks to balance these concerns. It is also worth noting that Alaska law has not, to my knowledge, been applied to discontinuing life support against the will of patients or their surrogates, but only to decisions about whether or not to offer new or additional interventions.

Caring for critically ill and injured patients is physically and emotionally exhausting, but can be quite rewarding when offered to patients who have a reasonable expectation of benefit. There are both nationwide and local shortages of critical care providers. One of the main sources of “burnout” in critical care providers is the moral distress that accompanies providing invasive and

uncomfortable care to dying patients who will not benefit from such care. By legally mandating that we provide medically inappropriate care that goes against the principles of medical ethics and our conscience, the proposed legislation is likely to adversely impact the availability of critical care to Alaskans who actually need it.

In summary, I believe that current Alaska law serves the residents of the State of Alaska well. The proposed legislation will help no one, as it compels the provision of aggressive care to dying patients who cannot reasonably expect to benefit from such care. The proposed law will instead force physicians to provide care that offers only harm and will adversely impact the critical care environment which all exists for the benefit of all Alaskans. I urge you to vote against SB 172 ad HB 0309A.

Sincerely,



Ryan McGhan, MD, MSPH, FCCP

On Behalf of:

Shadi Battah, MD, Pulmonary Program Director, St. Elias Specialty Hospital

Matthew Berenson, MD

Alexis Delgado, MD, CCU Medical Director, Alaska Regional Hospital

Lior Dolgonos, MD

Julian Rojas Caballero, MD

Jose Luna Zelaya, MD

Javid Kamali, MD

cc:

Senator Hollis French

Senator Bettye Davis

Senator Donny Olson

Senator Lesil McGuire

✓ Representative Wes Keller

Representative Paul Seaton

Representative Bob Herron

Representative Beth Kerttula