SB 172

<TARGET><BILL>SB 172</BILL><SUBJECT>SB 172</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/20/12

Date of 5-Day Notice: 1/24/12
(in accordance with Uniform Rule 23)

FURTHER: Judiciary

DATE TURNED IN TO OFFICE: 1/30/12

Health and Social Services Committee considered SENATE BILL NO. 172

SB 172-CARE DIRECTIVES/DO NOT RESUSCITATE ORDERS

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

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DHS			✓	

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Meyer	X			
	Egan	X			
	DYSON	X			
CHAIR:	Davis	X			

Senator Fred Dyson

SPONSOR STATEMENT

SB 172 – An Act Relating to Health Care Decisions, Including Do Not Resuscitate Orders

The purpose of this bill is to provide for the protection of 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 and 2005 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. SB 172 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.

Contact: Chuck Kopp, Staff to Senator Fred Dyson, (907)465-2199

SENATE BILL NO. 172

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY SENATORS DYSON, Davis, Coghill, McGuire, Olson

Introduced: 1/20/12
Referred:

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

(e) A health care provider may decline to comply with an individual instruction or a health care decision for reasons of conscience, except **that a health care provider may not decline to comply with** [FOR] a do not resuscitate order **that is consistent with this chapter for reasons of conscience**. A health care institution or health care facility 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 or facility 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. **Notwithstanding the other provisions of this subsection, this subsection does not allow a health care provider, health care institution, or health care facility to decline to comply with an individual instruction or a health care decision that requests that cardiopulmonary resuscitation or other resuscitative measures be provided.**

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

(f) A health care provider, health care institution, or health care facility may decline to comply with an individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the provider, institution, or facility**, except that this subsection does not allow a health care provider, health care institution, or health care facility to decline to comply with an advance health care directive or a health care decision that requests that cardiopulmonary resuscitation or other resuscitative measures be provided**. In this subsection, "medically ineffective health care" means health care that according to reasonable medical judgment cannot cure the patient's illness, cannot diminish its progressive course, and cannot effectively alleviate severe discomfort and distress.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) except as provided in (5) of this subsection, the patient has capacity and requests that the do not resuscitate order be revoked;

(3) the patient has an advance health care directive that indicates that the patient does not want a do not resuscitate order;

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

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

(j) A physician may revoke a do not resuscitate order issued by another physician for a patient, if the physician has a

(1) physician-patient relationship with the patient; 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.

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

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

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

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

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

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

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

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

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

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

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

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

*** Sec. 8.** AS 13.52.080(c) is amended to read:

(c) A health care provider, health care institution, or health care facility is not subject to civil or criminal liability, or to discipline for unprofessional conduct, if a do not resuscitate order prevents the health care provider, health care institution, or health care facility from attempting to resuscitate a patient who requires cardiopulmonary resuscitation or other resuscitative measures because of complications arising out of health care being administered to the patient by the health care provider, health care institution, or health care facility. This subsection does not apply if

(1) the complications suffered by the patient are caused by gross negligence or reckless or intentional actions on the part of the health care provider, health care institution, or health care facility**; or**

(2) the do not resuscitate order relied on by the health care provider, health care institution, or health care facility was issued in violation of AS 13.52.065.

*** Sec. 9.** AS 13.52.120(b) is amended to read:

(b) Notwithstanding any other provision of law **except (h) of this section**, death resulting from the withholding or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures does not, for any purpose, constitute a suicide or homicide if the withholding or withdrawal is

(1) consistent with this chapter**, except that a violation of AS 13.52.065(g) - (i), does not, for any purpose, constitute a homicide**; and

(2) from an individual

(A) for whom a do not resuscitate order has not been issued;

(B) for whom a do not resuscitate order has been issued under

(i) the protocol for do not resuscitate orders established under AS 13.52.065; or

(ii) a do not resuscitate identification found on the individual.

*** Sec. 10.** AS 13.52.120 is amended by adding a new subsection to read:

(h) The provisions of (b) of this section do not apply to a person who orders or causes the withholding or withdrawal of cardiopulmonary resuscitation or other life-

sustaining procedures if the person acts intentionally, recklessly, with criminal negligence, or with gross negligence. In this subsection, "intentionally," "recklessly," and "criminal negligence" have the meanings given in AS 11.81.900.

* **Sec. 11.** AS 13.52.300 is amended to read:

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

ADVANCE HEALTH CARE DIRECTIVE

Explanation

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

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

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

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

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

(c) approve or disapprove 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 named as your agent to make sure that the person understands your wishes and is willing to take the responsibility.

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

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

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

PART 1

DURABLE POWER OF ATTORNEY FOR
HEALTH CARE DECISIONS

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

_____

(name of individual you choose as agent)

_____

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

_____

(home telephone) (work telephone)

OPTIONAL: If I revoke my agent's authority or if my agent is not

willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent

_____

(name of individual you choose as first alternate agent)

_____

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

_____

(home telephone) (work telephone)

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

_____

(name of individual you choose as second alternate agent)

_____

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

_____

(home telephone) (work telephone)

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

_____

_____

_____

(Add additional sheets if needed.)

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

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

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

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

(D) the effect of the treatment on 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

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

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

(A) [ ] Choice To Prolong Life

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

(B) [ ] Choice Not To Prolong Life

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

I have (check all choices that represent your wishes)

[ ] (i) a condition of permanent unconsciousness: a condition that, to a high degree of medical certainty, will last permanently without improvement; in which, to a high degree of medical certainty, thought, sensation, purposeful action, social interaction, and awareness of

myself and the environment are absent; and for which, to a high degree of medical certainty, initiating or continuing life-sustaining procedures for me, in light of my medical outcome, will provide only minimal medical benefit for me; or

[ ] (ii) a terminal condition: an incurable or irreversible illness or injury that without the administration of life-sustaining procedures will result in my death in a short period of time, for which there is no reasonable prospect of cure or recovery, that imposes severe pain or otherwise imposes an inhumane burden on me, and for which, in light of my medical condition, initiating or continuing life-sustaining procedures will provide only minimal medical benefit;

[ ] Additional instructions:_____

_____

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

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

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

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

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

[ ] Other instructions: _____

_____

(D) Relief from Pain.

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

[ ] I give these instructions:

_____

_____

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

[ ] I wish to receive life-sustaining procedures.

[ ] I do not wish to receive 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 treatment, my wishes regarding electroconvulsive treatment are as follows:

_____ I consent to the administration of electroconvulsive treatment.

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

Conditions or limitations: _____

_____.

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

_____ I consent to being admitted to a mental health facility for mental health treatment for up to _____ days. (The number of days not to exceed 17.)

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

Conditions or limitations: _____

_____.

OTHER WISHES OR INSTRUCTIONS

_____

_____

_____

Conditions or limitations: _____

_____.

PART 5

PRIMARY PHYSICIAN

(OPTIONAL)

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

_____

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

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

ALTERNATIVE NO. 1

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

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 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;

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

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

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

_____

(date) (signature of witness)

_____

(printed name of witness)

_____

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

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

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. 12.** AS 13.52.390(17) is amended to read:

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

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

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

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

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

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

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

* **Sec. 13.** AS 13.52.065(f) is repealed.

* **Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to read:

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

LEGAL SERVICES

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

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

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

MEMORANDUM January 23, 2012

SUBJECT: Sectional summary of SB 172 relating to health care decisions, including do not resuscitate orders
(Work Order No. 27-LS0991\B)

TO: Senator Fred Dyson
Attn: Chuck Kopp

FROM: Terry Bannister
Legislative Counsel

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

Section 1. Amends AS 13.52.045 to prohibit a health care institution or health care facility from interpreting the issuance of a do not resuscitate order as preventing the providing of life-sustaining procedures to the patient.

Section 2. Amends 13.52.060(e) to prohibit a health care provider from declining, for reasons of conscience, to comply with a do not resuscitate order that is consistent with this chapter. Also states that the subsection does not allow a health care provider, health care institution, or health care facility to decline to comply with an individual instruction or a health care decision that requests that cardiopulmonary resuscitation or other resuscitative measures be provided.

Section 3. Amends AS 13.52.060(f) to state that the subsection does not allow a health care provider, health care institution, or health care facility to decline to comply with an advance health care directive or a health care decision that is consistent with the chapter and that requests that cardiopulmonary resuscitation or other resuscitative measures be provided. The subsection addresses declining to comply with an individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards.

Section 4. Amends AS 13.52.065(a) limits a physician's right to issue a DNR order. The order may be issued only as provided in AS 13.52.065.

Section 5. Amends AS 13.52.065(b) to require that the protocol (adopted by the department) for withholding cardiopulmonary resuscitation comply with AS 13.52.065.

Section 6. Adds new subsections to AS 13.52.065.

Sec. 13.52.065(g) prohibits a physician from issuing a do not resuscitate order for a patient of the physician without the express consent described in the subsection (except as provided by (h)).

Sec. 13.52.065(h) states when a physician may issue a do not resuscitate order for a patient of the physician without the express consent required by (g) of this section.

Sec. 13.52.065(i) requires a physician to revoke a do not resuscitate order issued for a patient under certain listed circumstances.

Sec. 13.52.065(j) allows a physician to revoke a do not resuscitate order issued by another physician under certain described circumstances.

Section 7. Amends AS 13.52.080(a) to replace a citation to a subsection that is repealed by this bill.

Section 8. Amends AS 13.52.080(c) to provide that its immunity provisions do not apply if a do not resuscitate order relied on by the health care provider, health care institution, or health care facility was issued in violation of AS 13.52.065.

Section 9. Amends AS 13.52.120(b) to clarify that a violation of the new provisions (added by bill sec. 6) does not, in the context of the provision's required consistency with the chapter, constitute a homicide. Adds a cross reference to the new (h) as an exception for applying the subsection's approach to suicide or homicide.

Section 10. Adds AS 13.52.120(h) to state that the provisions in (b) about homicide and suicide do not apply to a person who orders or causes the withholding or withdrawal of life-sustaining procedures and acts intentionally, recklessly, with criminal negligence, or with gross negligence.

Section 11. Amends the optional form in AS 13.52.300 to add a wish regarding life-sustaining procedures.

Section 12. Amends AS 13.52.390 (the definition section) to change the definition of "health care decision" to state that the term includes a direction about receiving cardiopulmonary resuscitation or other resuscitative measures.

Section 13. Repeals AS 13.52.065(f), which currently addresses how DNR orders are made ineffective.

Section 14. Adds a provision to indicate how DNR orders made before the bill's effective date are to be treated in light of the bill.

If I may be of further assistance, please advise.

TLB:plm
12-040.plm

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB172**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB172-DHSS-EP-1-27-12
Title: Care Directives / Do Not Resuscitate Orders
Sponsor: Dyson
Requester: Senate Health and Social Services

Dept. Affected: Health and Social Services
Appropriation: Public Health
Allocation: Emergency Programs
OMB Component Number: 2877

Expenditures/Revenues (Thousands of Dollars)

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

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable. Initial version.

Prepared by: Ward B. Hurlburt, M.D. MPH / Chief Medical Officer, Director — Phone 269-6680
Division: Public Health — Date/Time 1/27/12 4:30 PM
Approved by: Nancy Rolfzen, Assistant Commissioner — Date 1/27/2012
DHSS Finance & Management Services

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB172

Analysis

This bill specifies that a health care provider may not decline to comply with a do not resuscitate order that is consistent with the chapter for reasons of conscience. The bill amends the statutes specifically as it relates to requests that cardiopulmonary resuscitation or other resuscitative measures be provided. It provides that the protocol adopted by the department must comply with the amended language provided section.

Implementation of the bill as written would require the Division of Public Health's Section of Emergency Programs, Emergency Medical Services (EMS) Unit to upgrade the statewide DNR protocol in the Comfort One program.

Implementation of the bill as written would require the Division of Public Health's Section of Emergency Programs, Emergency Medical Services (EMS) Unit to upgrade the statewide Do Not Resuscitate protocol materials. While the program already budgets on-going printing costs as part of the base budget, revising these materials will have one-time costs associated that are not considered part of the base. This involves modifying already printed administrative forms and procedures that support the Comfort One program. Also, the current inventory of forms already printed and distributed will need to be replaced with the updated forms. The cost to update the forms and replace the inventory can be absorbed without reducing services elsewhere.

The Division of Public Health provides about 4500 enrollment forms and a lesser number of each of two pamphlets each year. The Comfort One enrollment forms are distributed to the three main EMS Regions (Southern, Southeast, and Interior). Southern Region is the largest user of the forms and has had an increasing number of requests for the forms. The three regions send forms out to the other four regions upon request.

LEGAL SERVICES

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

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MEMORANDUM October 28, 2011

SUBJECT: Question regarding AS 13.52 (Work Order No. 27-LS0991)

TO: Senator Fred Dyson
Attn: Chuck Kopp

FROM: Terry Bannister
Legislative Counsel

You have asked whether AS 13.52 adequately protects the right of a patient, or the patient's designee, to overrule a physician's decision to issue a do not resuscitate (DNR) order. This question was prompted by a recent situation in which a physician at a hospital issued a DNR order against the express wishes and directions of both the patient and the patient's wife who held his durable power of attorney.[1] You have referred me to AS 13.52.065, which addresses DNR protocol and identification requirements, AS 13.52.100, which addresses the patient's right to make health care decisions while the patient has capacity, and AS 13.52.120, which addresses a presumption in favor of life.

AS 13.52.065(a) does allow a physician to issue a do not resuscitate order. However, that provision cannot be read in isolation from the rest of AS 13.52 (the "chapter"). 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.

With certain exemptions for conscience or where medically ineffective standards are involved,[2] AS 13.52.060(d) requires a health care provider,[3] to comply with an individual instruction[4] of the patient, and with a health care decision made by an authorized person. The term, "individual instruction," appears to cover a DNR order, because it covers a

[1] I am presuming this was a durable power of attorney for health care.

[2] AS 13.52.060(e) - (f).

[3] The term includes a physician.

[4] Defined in AS 13.52.390 as an individual's direction concerning a health care decision for the individual.

health care decision,[5] which in turn includes any care, treatment, service, or procedure that affects an individual's physical or mental condition.[6]

The chapter's specific provisions regarding DNR orders, AS 13.52.065(f) and AS 13.52.100(c), clearly allow DNR orders to be made ineffective if a patient who is able to make the decision requests this, but these sections do not expressly address authorized agents. However, with regard to patients without capacity, AS 13.52.100(c) states that if the individual is not able to make the decision, the DNR protocol authorized by AS 13.52.065(b) be used. The sample form in AS 13.52.300 for an advance care directive states that the protocol governs the use of DNR orders by health care providers; the exact meaning of "use" is not defined in the chapter or the protocol, so it is left up to interpretation. The DNR protocol established by the Department of Health and Social Services[7] 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,[8] but does not go into more detail or expressly address revocation by agents of the individual.

It can also be argued that in this chapter a reference to a "patient" also includes an authorized agent of an adult individual. This interpretation is supported by AS 13.52.060(d) mentioned above. It is also supported by AS 13.52.080(a)(6)(B), because that provision appears to indicate that AS 13.52.065(f) is not the only provision under which a DNR order can be made ineffective. This position is also supported by AS 13.52.010's allowing a patient to make advance health care directives and appoint agents regarding health care decisions. And, 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.[9]

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[5] See AS 13.52.390(17).

[6] See AS 13.52.390(16).

[7] The current protocol was adopted in 1996 under AS 18.12, a chapter that was repealed when AS 13.52 was enacted in 2004 (with an effective date of January 1, 2005). Under sec. 18, ch. 83, SLA 2004, the Department of Health and Social Services was given authority to adopt regulations to implement AS 13.52, and under sec. 19, ch. 83, SLA 2004, the Department of Law's regulations attorney was directed to make certain citation changes in 7 AAC 16 to reflect the new chapter (these do not appear in the regulations) until the new regulations were adopted. Under sec. 19, ch. 83, SLA 2004, the regulations in 7 AAC 16 were to continue in effect until the Department of Health and Social services adopted regulations for the 2004 act.

[8] See 7 AAC 16.010(g).

[9] See AS 13.52.010(b).

The fact that the chapter at AS 13.52.300 contains an advance care directive form to state health care decisions and to appoint agents also supports an interpretation that individuals may indicate their wishes, and appoint agents, regarding DNR orders. The form itself contains language that the individual has the right to give instructions about the individual's own health care, although this language is qualified by making the right "to the extent allowed by law." But the form states that the DNR protocol governs the use of DNR orders. Finally, AS 13.52.120(a) states that the chapter establishes a presumption in favor of life, which would seem to support interpreting the chapter to allow a patient (or the patient's authorized representative) to prevent a physician from issuing a DNR order.

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.

It would be helpful to know the exact basis for the positions taken by the physician and the hospital.

If I may be of further assistance, please advise.

TLB:ljw
11-419.ljw

LEGAL SERVICES

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MEMORANDUM December 30, 2011

SUBJECT: Bill relating to health care decisions, including do not resuscitate orders (Work Order No. 27-LS0991\M)

TO: Senator Fred Dyson
Attn: Chuck Kopp

FROM: Terry Bannister
Legislative Counsel

This memo accompanies the bill described above.

1. "Intervening care." After reviewing what you were requesting and the terms used in the chapter, it appears that you are referring to "life-sustaining procedures" (see the definition in AS 13.52.300). Please read the complete definition and make sure that this is what you had in mind. The new section uses that term instead of "intervening care." The provision has been moved to AS 13.52.045, which addresses the provision of life-sustaining procedures.

Contrary to what I indicated on the phone, it appears that the selection of life-sustaining procedures is not sufficiently addressed in the form provided under AS 13.52.300, so it is necessary to change the form. Unfortunately, this requires that the entire form be laid out in your bill even though the actual changes are small.

2. Use of "advance health care directive." After reviewing your question about the substitution of "advance health care directive" for "individual instruction" in AS 13.52.060(e), I decided to return to "individual instruction" because it is narrower than "advance health care directive," and a narrower term is consistent with the goal of the changes to AS 13.52.060(e) (to limit the health care provider's right to decline to comply for reasons of conscience).

3. Authorization by another physician to revoke a DNR order. Language has been added to proposed sec. 13.52.065(j) to identify which physicians may revoke another physician's DNR. Please examine sec. 13.52.065(j)(2)(B): is employment of the physician by the health care facility or institution the relationship that you had in mind?

If I may be of further assistance, please advise.

TLB:ljw
11-476.ljw
Enclosure

LEGISLATIVE RESEARCH SERVICES

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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

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.

Background

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.[1] 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.[2]

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[1] 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.

[2] 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

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.[3] 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.[4] 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.[5]

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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[3] 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*.

[4] Full text of the Act is available online at *http://www.nccusl.org/Default.aspx*.

[5] We include, as attachments, examples of relevant statutes of California, Delaware, Florida, Georgia, Hawaii, Mississippi, New Mexico, Ohio, Tennessee, and Virginia.

SENATOR FRED DYSON

January 18, 2012

Senator Bettye Davis
State Capitol Room 30
Juneau, Alaska 99801

Re: AS 13.52 Alaska Health Care Decisions Act – Do Not Resuscitate (DNR) Orders & End of Life Decisions

Dear Senator Davis,

Thank you for your valuable support as a co-sponsor of the attached bill amending AS 13.52 *Alaska Health Care Decisions Act.* Ambiguities in the current law concerning the rights of patients and their surrogates to refuse or invalidate a DNR order have resulted in unnecessary distress of Alaskan residents facing critical end of life decisions.

In August 2011 my office was contacted by a recently discharged Anchorage area hospital patient and his wife, Mervin and Margery Mullins. The couple stated that a physician at the hospital put a Do-Not-Resuscitate order on Mervin, who has brain cancer, but doing much better than the prognosis. The DNR order was issued against the expressed wishes of both Mervin and Margery. When they protested, the physician told them that a DNR order is issued at the sole direction of a physician for his/her patient. Margery met with the hospital Chief Ethicist who confirmed their attending physician was correct. According to the Mullins, they were also told that the Durable Power of Attorney held by Margery "did not matter" because the decision was the physician's to make.

I had several conversations with the hospital Chief Operating Officer and Chief Medical Officer. They stated there is ambiguity in the law as to what a hospital (health care facility) can do with respect to overruling a DNR order placed on a patient by a physician. I explained my view - that the presumption of the law is in favor of life and of the patient's rights on end of life decisions, stated as such in AS.13.52.120(a) *In the absence of evidence to the contrary of the patient's intent, this chapter establishes a presumption in favor of life, consistent with the best interest of the patient.* The Chief Medical Officer agreed and directed that the DNR order be removed from Mr. Mervin Mullins.

I asked Legislative Legal to advise me on what the law actually says in AS 13.52 with respect to DNR orders and end of life decisions, and their opinion on whether the law adequately protects the patient (or his/her agent) right to overrule a physician's decision to issue a DNR order. I have attached to this correspondence the memos from Legal, dated October 28, 2011, and December 30, 2011.

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senator.fred.dyson@legis.state.ak.us • www.akrepublicans.org

In part, Legal 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. (emphasis added)*
>
> *Finally, AS 13.52.120(a) states that the chapter establishes a presumption in favor of life, which would seem to support interpreting the chapter to allow a patient (or the patient's authorized representative) to prevent a physician from a issuing a DNR order. 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. (emphasis added)*

Based on this review by Legal, the stated confusion in the law by an Anchorage area hospital facility, and the experience of the Mullins couple, I asked Legal to draft an amendment to AS 13.52 clarifying the ambiguities. Specifically, that a physician may not issue a DNR order without the expressed consent of the 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, without the concurrence of a second physician.

The Advance Health Care Directive sample form provided in AS 13.52.300 is also amended to allow the patient the option of accepting or decline life-sustaining procedures (treatments that will keep you alive, but not remove your terminal condition).

If you agree with me that this is an important matter and find the amendments to AS 13.52 to be acceptable, I would very much welcome your support as a co-sponsor.

Best regards,

Fred Dyson