SB 172

<TARGET><BILL>SB 172</BILL><SUBJECT>SB 172</SUBJECT><COMM>SJUD27</COMM></TARGET>

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 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

SENATOR FRED DYSON

CSSB 172 - Section Analysis

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.

SENATOR FRED DYSON

CSSB 172 (27-LS0991\D) – EXPLANATION OF CHANGES

The substantive changes in Committee Substitute for SB 172 as introduced on 01/20/12 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.

27-LS0991\D
Bannister
3/1/12

CS FOR SENATE BILL NO. 172( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DYSON, Davis, Coghill, McGuire, Olson

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, except as provided by AS 13.52.030(h), 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 a do not resuscitate order be made ineffective.**

*** 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. **Notwithstanding the other provisions of this subsection, this subsection does not, except as provided by AS 13.52.030(h), 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 a requests that do not resuscitate order be made ineffective.** 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;

(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; or

(3) if the patient does not have an advance health care directive, 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 (4) of this subsection, the patient has capacity and requests that the do not resuscitate order be revoked;

(3) 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 the revocation of the do not resuscitate order; or

(4) 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 physician-patient relationship with the patient.

* **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 13.52.300 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 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

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. 9.** 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. 10.** AS 13.52.065(f) is repealed.

*** Sec. 11.** 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.

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.

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)

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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Mail Stop 3101

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

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

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[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]

---

[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.

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PROVIDENCE
Health & Services
Alaska

February 14, 2012

Senator Fred Dyson
State Capitol, Room 121
Mailstop 3100
Juneau, AK 99801-1182

Dear Senator Dyson:

I recently became aware that in a letter dated January 18, 2012 from you to Senator Bettye Davis, and subsequently made part of the public record for Senate Bill 172, there are statements attributed to the "Chief Operating Officer" and the "Chief Medical Officer" of an area hospital in reference to a specific patient and family. For a number of reasons, I believe that the "chief operating officer" referenced in your letter may be me, and the "chief medical officer" would then be Roy Davis, MD. I wish to clarify a statement attributed to Providence executives in order to avert misunderstanding among interested parties who are neither familiar with the case referenced in your letter nor the mechanisms and laws for physician prescriptions, including "Do Not Resuscitate" ("DNR") orders.

While I presently serve as the chief executive officer of Providence Health & Services Alaska, at the time referenced in your letter, I served as the chief operating officer. You and I spoke on at least two occasions about the case in question. I explained that these cases are almost always highly complicated and emotionally demanding for all parties. Physicians do an outstanding job of considering each patient's needs and of determining the appropriateness for such orders under these challenging circumstances.

Roy Davis, MD, our chief medical officer, indicates that he never spoke with you about the patient matter. However, you did speak with Richard Mandsager, MD. Dr. Mandsager serves as chief executive officer for Providence Alaska Medical Center, and he recalls speaking with you about certain details of the case. We suspect that your reference to the "chief medical officer" was in fact to Dr. Mandsager in his role as chief executive officer.

The specific clarification we wish reflected in the public record is that neither Dr. Mandsager nor any other executive of Providence Health & Services represented to you that the DNR order would be removed from the referenced patient's medical record. Such an action is inconsistent with policy, bylaws and community practice. As such, removal of the DNR was never considered.

I respectfully request that you correct the official record on this important matter.

Sincerely,

Bruce Lamoureux

Bruce Lamoureux
Sr Vice President/Chief Executive Alaska Region

BL:lb

Cc: Senator Bettye Davis
Senator Hollis French
Representative Bob Lynn

Providence Health & Services Alaska
Review of Senate Bill 172 and House Bill 309
Prepared by Providence Physician Leadership - February 10, 2012 and Unanimously Endorsed by the Providence Alaska Medical Center's (PAMC) Medical Executive Committee, elected representatives of physicians who hold medical privileges at PAMC – February 13, 2012

At first glance, Senate bill # 172 and its partner bill #309 in the House, appear to empower patients to make decisions about their health care at the end of life (Sec. 1 pg 1 lines 3-7). However, on further review these bills contain language involving a very complex decision making process that normally occurs between a patient and his or her physician.

These bills attempt to legislate a complex decision making process and make a "one size fits all" model for end-of-life care. Specifically, these bills are concerned with advanced health care directives which may be made independently or may accompany a will or estate planning. The advanced health care directive is designed to give direction to your family, loved ones and health care providers about care choices if you become critically ill and cannot make decisions for yourself. Ideally, every individual would make this directive ahead of time, when they are clear of mind and not under stress or distracted in any way. In reality, fewer than 1 in 5 individuals arriving to a hospital have an advanced directive(Halpern NA, Pastores SM, Chou JF, Chawla S, Thaler HT, Palliat Med. 2011 Apr;14(4):483-9. Epub 2011 Mar 18; . Knott CI, Psirides AJ, Young PJ, Sim D., Crit Care Resusc. 2011 Sep;13(3):167-74).

These bills also address requests by patients or health care providers to use or not to use advanced medical procedures in an attempt to keep them alive. New terminology adopted by several states terms these issues as "Allow Natural Death," (AND). In Alaska, the terminology utilized is called DNR (do not resuscitate) orders and advanced resuscitative measures. A DNR order can be initiated with or without an advance health care directive. Historically, A DNR is a written agreement that is made between a physician and a patient after discussion about a patient's medical condition. A DNR can answer questions about whether a patient wants CPR (chest compressions or cardiopulmonary resuscitation), wants artificial breathing applied (also called intubation) or some assistance with breathing if an individual needs assistance on a temporary or long term basis. It addresses artificial nutrition if an individual is temporarily or permanently unable to swallow or eat. It addresses the use of antibiotics for infection and other medications to support blood pressure. It addresses the use of electricity/shocking of the heart to reset or restart the heart if the heart stops. .

The decisions made by an individual about how they want to spend their end days are complex and personal. Each person has their own set of circumstances that guide their decision making. The decision may be based on what types of illnesses an individual has or how long they have had these illnesses. It may have to do with their ability or inability to tolerate pain and suffering. It may be directly or indirectly related to religious or cultural beliefs. It may reflect a preference to allow all bodily processes to occur

naturally and not be artificially supported. It may have to do with a desire not to be a burden to family or loved ones if circumstances alter one's ability to care for themselves. It may reflect financial concerns.

The list of reasons why people make decisions is lengthy and unique to each individual. These decisions should be discussed at length with family and loved ones and preferably with a physician who can communicate the degree and prognosis of illnesses with the individual and their loved ones. Ideally, everyone knows and understands the choices and why they are made.

In reality, fewer than 1 in 5 patients admitted to the hospital have made these decisions even though they may have very complicated advanced illnesses or injuries (Halpern, et.al. and Knott et.al.). In general, the American culture tends to not discuss death and dying and is generally unprepared to address these issues until they are forced to do so when confronted by a life altering or life threatening injury or illness. The decisions must then be made under stress. The worst case scenario presents when a patient is not able to make decisions and family members must make decisions while hoping they know what a patient may want. Often families do not know, are unsure, or simply are not present or cannot be found. Whenever possible, these decisions are made in advance. When they have not been made in advance, the medical team caring for the patient is faced with making the decisions together with available family members. Decisions are based upon what is known about the illness(es) or injuries, progression of disease, and benefits vs. harm of interventions. These decisions are crafted with input from family regarding patient preferences. It is a complex process and made with due diligence, generally with the input of many care providers, in addition to family wishes. They are not made lightly.

It is important to note that advanced interventions including CPR, artificial breathing techniques, artificial nutrition, shocking of the heart, etc. are helpful only in very specific medical circumstances. They are not applicable to each and every end of life illness or injury no matter what is portrayed on TV (references: code of Ethics of the American Medical Association (AMA), Opinions 2.035, 2.095). In fact, many of these interventions are painful and are rarely successful (Ebell & Alfonsa; Family Practice 2011; 28:505-515) . They are often associated with severe painful and sometimes persistent complications that leave the few who survive the procedures permanently impaired. CPR for example, was designed to be utilized in only a specific subset of heart patients (Kouwenhouen JAMA 1960 173: 1064-7). It was not recommended for other situations because the likelihood of survival is so low and the risks of complications are so high. For example, advanced cancer patients have not been shown to benefit from CPR. The procedure frequently causes broken ribs and a broken breast bone and collapsed lungs, to mention only a few of the potential complications. The benefits of the procedures should clearly outweigh the potential risks of the complications associated with these procedures. In end stage cancer, the benefits rarely outweigh the risks. When they do outweigh the risks, then CPR and other advanced aggressive procedures are performed. However, medical standards do not recommend doing advanced aggressive interventions in every case (references: code of Ethics of the American Medical Association (AMA), Opinions 2.035, 2.095). In these situations, the

recommendation is to provide full support for patients, but not to provide procedures that have a higher risk of injury than to provide benefit, irrespective of a DNR that may be in effect.

The House and Senate bills do not reflect the complexity of this decision making process. This legislation is inappropriate for a large portion of individuals by mandating the following:

1. 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.

2. 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. Pg2, lines 29-31and pg 3, line 4, Sec 12, pg 19, lines 18,19).

3. 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) .

4. 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 s (Sec 3. pg 2, lines 7-18) .

5. 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).

6. 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) ..

7. 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.

8. 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.)

9. 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. Pt 19, lines 23-27).

10. 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).

11. 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).

12. 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)

13. 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 3)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).

14. 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.

15. The new version of the advance health care directive form does not encourage graduated selection of interventions. It is an all or none proposition (Sec 13.52.300, pg 13, lines 2-10).

Page 19 simply needs to be deleted altogether.

Why the medical community has grave concerns

- It does not allow those individuals with the most expert understanding of health and disease and prognosis to exercise their expertise.
- It implies that DNR orders are made flippantly and without deep compassionate concern for the welfare of patients.
- It makes an assumption that doing potentially harmful and painful interventions are always in the patients' best interests despite accepted medical standards that indicate otherwise.
- It ignores the Hippocratic Oath and that health care providers must first do no harm . It supports the battery of patients by mandating that harmful procedures be performed on patients without regard to the benefit vs. risk assessment of these interventions

- It does not support the time honored tradition of patient physician relationship in which these discussions should be made.
- It makes an assumption that every patient feels that the quantity of life trumps the quality of life
- It does not promote death with dignity
- It forces families and loved ones to reconsider the decisions of their loved ones and consider reversing decisions that may cause irreparable psychological and emotional damage in the long run.
- It assumes that physicians do not err on the side of over-utilizing CPR. It assumes that providers underutilize these aggressive procedures. This is untrue.

Considerations for Alaska citizens who do not want government intrusion into personal medical decision making

- It makes an assumption that each individual values the quantity of life over the quality of life without regard to the degree of suffering an individual may experience.
- It assumes that every individual wants artificial support even when it has been shown to not be helpful.
- It assumes that every person wants to have CPR and undergo potential pain and suffering from these procedures even when they have been shown not to be of any benefit.
- It allows other individuals to reverse your right to death with dignity because they are afraid to lose you. It implies that they may not value your life if they do not at least try the aggressive resuscitative measures.
- It forces others to ignore your choices and decide for themselves whether or not to honor your wishes.
- It mandates that every individual should be treated the same. It is a "cookie cutter approach" to medical care assuming that each person wants the same thing as proponents for the right to life.
- It has the potential to reverse a well thought out decision for end of life care that may have been made by you for reasons unknown to other individuals.
- It does not allow those who have not yet made advanced directives to have well thought out approaches to their medical care and instead defaults to the use of aggressive medical interventions

- It assumes that physicians do not make medical decisions incorporating acceptable medical standards of care.
- It assumes that a patient and their physician cannot tailor a unique care plan for each individual. Instead, a legislator with no medical experience whatsoever can mandate the procedures that will happen to you at the end of life.
- It mandates patients with extremely advanced medical conditions undergo these procedures simply because they do not have advance health care directives.
- It insists that all previously established advanced health directives and DNR orders be reconsidered and must be in compliance with the new standards established with this new bill.

SENATOR FRED DYSON

January 18, 2012

Senator Bettye Davis
State Capitol Room 30
Juneau, Alaska 99801

SB 172

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

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.

Cindy Smith

From: Paradise, Lisabeth <Lisabeth.Paradise@providence.org>
Sent: Friday, February 24, 2012 12:25 PM
To: Sen. Hollis French
Subject: HB 309!

Dear Senator French,

I am writing to encourage you to take a stand **AGAINST** HB 309 and SB 172.

These bills have the capacity to negate a person's advanced directive and take *medical* decision making out of the hands of the professionals who practice medicine, and place it in the hands of state government.

I do not believe that the people of Alaska would agree with government involvement in our personal health care decisions.

The central tenant of this amendment, which is flawed in an irreparable way, is that of a physician being compelled to provide medical procedures or therapies, which in his or her own judgment, ***inflict greater harm than good*** at the instruction of a patient or his surrogate decision maker.
Advanced directives are meant to allow a patient to approve or disapprove proposed medical procedures; not mandate a specific therapy or therapies.

As an advocate for patients living with chronic illness, and those nearing the end-of-life for most of my professional career, I am involved daily with difficult discussions regarding delivering appropriate, evidenced based, compassionate care to those facing their end days.
I strongly believe that health care providers do their best to promote and preserve life in a manner that is consistent with current standards of care; utilizing medical data that provides prognostic indication, similar case experiences, religious preferences and social norms.
Rarely, **if ever,** is a unilateral decision made about CPR, intubation or aggressive resuscitation.
These are difficult, moral and ethical decisions that weigh heavily upon a medical team with the full understanding that each individual is unique and no one solution applies to all of our society.

This pending legislation is alarming to those who work daily with patients and families who are navigating the complex waters of medical management of chronic and terminal illness.

Providing appropriate medical care is part of the ethical code that nurses and physicians must use to guide their care. Offering a medical intervention which has proven to be harmful, painful , ineffective or is associated with complications which may lead to death, is *inconsistent* with this ethical groundwork.

These bills do not allow open discussion between family members, spouses and loved ones to help make a determination about patient wishes, preferences, prognosis, outcomes and long term impact. In short, they legislate a belief that life, any type or quality of life, must be persevered or those not adhering to this directive will suffer the penalties of law.

Please take the time to examine the serious and harmful content of these bills.
HB 309 is not "fixable" by any edits of language within it. The current statute 13.52.065 is very clear and does not require any revision.

I look forward to hearing from you.

Lisabeth Paradise, MS, FNP, ACHPN
Palliative Care/Family Nurse Practitioner
Providence Palliative Care Service
Providence Alaska Medical Center
Anchorage, Alaska

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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

SENATOR FRED DYSON

CSSB 172 (27-LS0991\D) – EXPLANATION OF CHANGES

The substantive changes in Committee Substitute for SB 172 as introduced on 01/20/12 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.

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March 7, 2012

Stephen T. Rust, MD, FACP, FAAHPM
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Re: CSSB 172

Dear Dr. Rust:

This will respond to your request for a legal analysis of the most current version of the Committee Substitute for Senate Bill 172 (CSSB 172), which changes current law on Do Not Resuscitate orders.

We have analyzed the most recent version of Senate Bill 172, along with the 11 numbered changes in the most recent version of the committee substitute for that bill. While the changes in CSSB 172 eliminate the exposure to criminal penalties that were in the original bill, the fundamental change in the current law is still reflected in the committee substitute. CSSB 172 still requires a physician to perform procedures that may violate his or her conscience, violate recognized standards of medical care, or what could constitute medically ineffective health care, contrary to generally accepted health care standards. Sections 2, 3, 6 and 13 of the bill still require a physician to perform cardio-pulmonary resuscitation on a patient who has arrested even when such medical procedure is medically contra-indicated.

The current bill also directly contradicts provisions in three different places in the current Alaska Health Care Decisions Act. First, in AS 13.52.060(e), a health care provider may decline to comply with "an individual instruction," meaning the patient's instruction, "for reasons of conscience." Currently, the exception is that if there is a Do Not Resuscitate order, all health care providers must abide by it and cannot resuscitate a patient for which there is a DNR in place. AS 13.52.060(e) also permits a physician to decline complying with a patient's instruction if the instruction is "contrary to a policy of the institution or facility that is expressly based on reasons of conscience. . ." Consonant with the Ethical and Religious Directives for Catholic Health Care Services, Catholic hospitals do not require resuscitation when such is medically and clinically contra-indicated. Requiring a Catholic hospital to provide or allow the provision of such a procedure when not medically indicated may raise First Amendment, Freedom of Exercise implications.

Second, AS 13.52.060(f) permits a physician to decline a patient's instruction that "requires medically ineffective health care or health care contrary to generally accepted health care standards . . ."

Third, AS 13.52.120(e) states "this chapter does not authorize or require a health care provider or institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or institution."

Although CSSB 172 purports to leave all of that language in, it essentially eliminates those provisions when a patient instructs a physician to attempt to resuscitate the patient after the patient has arrested, meaning stopped breathing or the patient's heart has stopped beating or both; in other words, after the patient has died a natural death. In essence, the CSSB 172 still permits, as the original bill did, the patient to dictate what health care the physician must provide. This is contrary to the entire spirit of the Health Care Decisions Act when it was enacted in 2004, later when it was amended in 2006, and again when it was amended in 2008.

As you may know, Alaska's Health Care Decisions Act was patterned on and very closely follows the Uniform Health Care Decisions Act drafted by the National Conference of Commissioners on Uniform State Laws. The act represents a very comprehensive and cohesive treatment of health care decisions, including but not limited to end of life decisions. As is the case with all uniform laws, they are intended to be uniform so that when people travel from one state to another, they will have the benefit of the same or similar laws on similar subjects. In addition, uniformity assists courts when it is necessary for them to interpret the laws. The changes proposed in CSSB 172 would very significantly destroy that uniformity with the other acts that have been passed in other states. One of the Legislative Research Services memorandums to Senator Dyson dated January 19, 2012, acknowledges that Alaska's act came from the Uniform Health Care Decisions Act. The section from the Uniform Health Care Decisions Act cited in the Legislative Research Services memo is identical to the Alaska equivalent statute, AS 13.52.060(d). That uniformity would be destroyed by the proposed legislation.

Another fundamental point is that the proposed CSSB 172 is not needed. The existing statute already has a mechanism to deal with the situation that apparently provided the impetus for CSSB 172. In that situation, the physician's clinical judgment was that attempted resuscitation following arrest was not clinically indicated while the patient wanted such medical care to be provided anyway. The Alaska Health Care Decisions Act provides a mechanism that comes into play when there is such a dispute between physician and patient or surrogate decision maker. AS 13.52.060(g) provides that when the patient has requested care that the provider is unwilling to provide, care for the patient is transferred to other providers. Subsection (g) sets up a procedure under which the physician informs the patient of the physician's declining to carry out the patient's instructions. The physician then "provides continuing care to the patient until a transfer is affected." Assuming the patient or surrogate assists with the transfer, a physician also

then has the duty to "immediately cooperate and comply with the decision by the patient . . . to transfer . . . to another health care institution, to another health care facility, to the patient's home, or to another location chosen by the patient." This authority would include the ability to transfer to another physician.

Thus, the Health Care Decision Act already provides a mechanism for resolving disputes between patients and their physicians when the patient wants some procedure or medical care that the physician thinks is medically ineffective, unethical or is contra-indicated. When the opposite situation occurs, that is a physician recommending certain care but the patient refusing to consent to it, the result is already established: the patient will not receive the care. The only problem arises when the patient wants affirmative care to be provided that the physician thinks is clinically inappropriate. The statute already provides a way to resolve that situation.

CSSB 172, including the recent changes, appears to be based upon three fundamental mischaracterizations. First, the changes proposed in CSSB 172 confuse cardio-pulmonary resuscitation, a specific medical procedure brought to bear on a person who has died through the cessation of respiration or the cessation of cardio-activity or both with what are referred to as "life sustaining procedures." Cardio-pulmonary resuscitation becomes relevant only when there has been a cardiac or respiratory arrest. "Life-sustaining procedures," as generally understood and as used by AS 13.52, are "bridge" treatments that keep a person alive. "Life sustaining procedures" are defined in the Act at 13.52.390(26) and are defined to mean "any medical treatment, procedure or intervention that, in the judgment of the primary physician, when applied to a patient with a qualifying condition, [i.e., terminal or permanently unconscious] would not be effective to remove the qualifying condition and would serve only to prolong the dying process . . ." In other words, "life sustaining procedures" are treatments applied to people who are still living. They are further defined in the same section to include "assisted ventilation, renal dialysis, surgical procedures, blood transfusion, and the administration of drugs, including antibiotics, or artificial nutrition and hydration." All these treatments are applied to people who are still living. The changes proposed by CSSB 172 confuse CPR with life-sustaining procedures as if they were all the same thing. They are different procedures with different purposes and applied at different times to the patient.

The proposed changes also confuse resuscitation, a medical procedure which is done on a physician's order (like all other care) or medical staff (of physicians) policy with a decision to withhold or withdraw life-sustaining procedures which is a decision always left to the patient or his surrogates.

The Alaska Health Care Decisions Act distinguishes between cardio-pulmonary resuscitation and life sustaining procedures. The proposed changes will confuse or obliterate those distinctions and thus create ample grounds for disputes over correct statutory interpretation.

The second mischaracterization is that the proposed changes confuse the concept of "consent for treatment." The second numbered change proposed for CSSB 172 gives as the reason for that change that it "reflects the narrow focus of the bill to protect patients from being subject to DNR orders against their consent. . . ." The concept of "consent for treatment" applies to treatment that is proposed or recommended by a physician which cannot be administered unless and until a patient consents to the recommended treatment. Procedures performed on the patient to which there has been no informed consent, absent an emergency and presumed consent, are considered battery; and thus all medical treatment requires consent before it can be administered. "Consent for treatment," applies to treatment that is being recommended by the physician. The underlying assumption of the proposed changes for CSSB 172 is that a patient "consents" to a DNR. The DNR is the absence of a medical procedure, not a medical procedure. A patient does not and cannot logically "consent" to treatment that is not being proposed or recommended. This confusion with consent for treatment leads to a transformation of approval of treatment recommended by the physician to a direct order by the patient to the physician that the physician will perform a certain procedure.

It has always been the case, and continues to be the case, that a patient has the option of declining recommended treatment. Even if it is universally accepted that the proposed treatment is good for the patient, the patient can still decline that treatment. But there is a world of difference between a patient's right to decline recommended treatment and a patient's prerogative to demand medical procedures that the doctor thinks are medically ineffective or inappropriate.

The third fundamental confusion is the assumption that the Health Care Decisions Act is ambiguous on whether a physician has the authority to impose or revoke a DNR order. The statute is not ambiguous on that point. AS 13.52.065(f) states that a DNR order may not be revoked unless a physician revokes it. The first sentence in that subsection could be argued to be ambiguous because it also refers to a patient requesting that a DNR order be revoked. But the second and last sentence of subsection (f) makes it clear that it is only a physician who can revoke the DNR order. It states "any physician of a patient for whom a do not resuscitate order is written may revoke the Do Not Resuscitate order if the person for whom the order is written requests that the physician revoke the Do Not Resuscitate order." (Emphasis supplied.) A patient can request it, but a physician's order can be revoked only by a physician. There is really no ambiguity on that point.

If the legislature had intended that when a patient requested the DNR order to be revoked the physician was required to do so, the above underlined word would have been "shall."

The fact that the legislature used the word "may" unambiguously shows that it is the physician who makes the decision. In addition, the definition of "health care decision" found in AS 13.52.390(19) lists five areas upon which the patient can decide the health care that he wants. But requiring resuscitation in the face of a DNR is not among them. The statute thus excludes mandating resuscitation after the patient dies from the definition of "health care decision." Section 9 of CSSB 172 would change that.

Also, Section 10 of CSSB 172 expressly repeals outright A.S. 13.52.060(f) [the current DNR provision] in its entirety, which is a tacit admission that it unambiguously gives the ability to revoke a DNR solely to the physician.

As the Legislative Research Service memorandum dated January 19, 2012 to Senator Dyson sets out, the American Medical Association Code of Medical Ethics has opinions on these issues. E-2.035 provides "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. . . ." This is a standard of medical ethics applied across the country.

AMA Code of Ethics Opinion E-2.037 provides that "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."

The AMA has a specific medical ethic opinion on Do Not Resuscitate orders. E-2.22 states "when a patient suffers cardiac or respiratory arrest, attempts should be made to resuscitate the patient, except when cardio pulmonary resuscitation (CPR) is not in accord with the patient's expressed desires or is clinically inappropriate." As you know, many patients are inappropriate for resuscitation procedures because of their frailness or other conditions that make the traumatic resuscitation procedures contra-indicated.

In all of medical practice, only a physician has the authority to enter orders calling for the administration of health care to patients in a hospital. The proposed changes would reverse that universal practice when it came to Do Not Resuscitate orders and elevate the patient's desires and demands over the physician's best clinical judgment. Medical care in recent times is always subject to the consent of a patient. Even if the doctor recommends a certain procedure, the patient has the authority to decline to have it administered to him or her. The proposed changes turn this right to decline recommended medical care into a demand that the physician provide medical care regardless of the physician's best medical judgment.

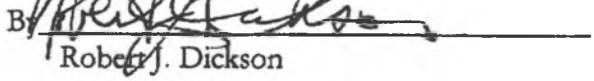
Finally, we note the Division of Legal and Research Services Memorandum dated December 30, 2011, to Senator Dyson, which apparently formed the basis for the CSSB 172, had a number of errors. That memo indicated that the selection of life-sustaining procedures was not sufficiently addressed in the statutory form. Although the term "life-sustaining procedures" is not set out in the form, the form provides for "choice to prolong life" which is understood by all concerned to include a request to use appropriate life-sustaining procedures "within the limits of generally accepted health care standards." The form goes on to address specifically artificial nutrition and hydration and relief from pain. But the initial choice would already call for the application of life-sustaining procedures. The memorandum also suggests that the term "individual instruction" appears to cover a DNR order. As indicated above, it does not. The same sentence misquotes the definition of "health care decision" and mis-cites to the wrong section of the statute. See text of that memorandum on p.2 at fn. 5 and 6. The correct cite is to AS 13.52.390(20). The memorandum then goes on to state that "AS 13.52.065(f) clearly allowed DNR orders to be made ineffective if a patient who is able to make the decision requests this. . . ." As explained above, that is not the case. Finally, in the final paragraph the memorandum states that "it seems that a patient with capacity has the right to make a DNR order ineffective." But that is inconsistent with the language of AS 13.52.062(f), as discussed above.

Consequently, CSSB 172 does not merely "clarify" what was the intent in the original enactment, it is diametrically opposed to the carefully crafted statutory scheme that complied with the uniform law on the subject and with national medical ethical codes. In the last analysis, the changes are unnecessary because the problem attempted to be solved is already addressed within the existing terms of the statute by permitting a patient to transfer to another physician or facility.

We hope the foregoing is helpful. Please let us know if there is further clarification or explanation needed.

Very truly yours,

ATKINSON, CONWAY & GAGNON

By 
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March 8, 2012

Stephen T. Rust, MD, FACP, FAAHPM
Director of Palliative Care
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Re: CSSB 172
Supplement to March 7 analysis

Dear Dr. Rust:

Mr. Jim Jordon, Executive Director of the Alaska State Medical Association has raised a very good point about the statutes governing physicians that require them to adhere to the AMA Code of Ethics. His point was passed on by Laurie Herman. The purpose of this is to follow-up on that point.

The bottom line is that the statutes and regulations governing physicians requires them to adhere to the nine AMA "Principles of Medical Ethics" appearing at the beginning of the book "Code of Medical Ethics" which includes both those principles as well as all of the opinions adopted by the AMA Counsel on Ethical and Judicial Affairs. None of those nine general principles specifically addresses end-of-life issues or Do Not Resuscitate orders. The closest one is principle VIII which states "a physician shall, while caring for a patient, regard responsibility to the patient as paramount." The nine "principles of medical ethics" do not include the specific ethics opinions referenced in our letter of March 7th.

The details are that Chapter 64 of Title 8 of the Alaska Statutes is the chapter that governs the Alaska State Medical Board, physician licensing, and physician discipline. A.S. 08.64.326(a)(11) states:

> The board may impose a sanction if the board finds after a hearing that a licensee . . .
>
> * * *
>
> (11) Has violated any code of ethics adopted by regulation by the board;

The State Medical Board has adopted regulations which include 12 AAC 40.955 entitled "Ethical Standards." 12 AAC 40.955(a) states:

> The Principles of Medical Ethics of The American Medical Association on p.xiv of the 2002 – 03 Edition of the Council on Ethical and Judicial Affairs, Code of Medical Ethics, published by the American Medical Association are adopted by reference as the ethical standards for physicians and applies to all physicians subject to this chapter.

The AMA publishes its Code of Medical Ethics which includes the nine "Principles of Medical Ethics" now appearing on p.xv of the 2006 – 07 Edition; but they are the same as those referenced in the 2002 – 03 Edition. The "Code of Medical Ethics" includes both these general principles and over 300 pages of ethics opinions on various matters which have been adopted by the Council on Ethical and Judicial Affairs. The State Medical Board's regulation does not explicitly incorporate all of these opinions. But from our conversation with Mr. Jordon, Executive Director of the Alaska State Medical Association, we understand that the State Medical Board interprets its own regulation to include not just simply the nine general principles, but also all of the opinions that are published as part of the "Code of Medical Ethics" by the AMA.

That being the case, requiring a physician to perform or authorize a resuscitation when he did not think it was medically effective or ethical would put him in the impossible position of either violating the new provisions of the Alaska Health Care Act as amended by CSSB 172 or violating the State Medical Board's disciplinary statutes.

Very truly yours,

ATKINSON, CONWAY & GAGNON

By _____
Robert J. Dickson

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February 14, 2012

PROVIDENCE
Health & Services
Alaska

Senator Fred Dyson
State Capitol, Room 121
Mailstop 3100
Juneau, AK 99801-1182

Dear Senator Dyson:

I recently became aware that in a letter dated January 18, 2012 from you to Senator Bettye Davis, and subsequently made part of the public record for Senate Bill 172, there are statements attributed to the "Chief Operating Officer" and the "Chief Medical Officer" of an area hospital in reference to a specific patient and family. For a number of reasons, I believe that the "chief operating officer" referenced in your letter may be me, and the "chief medical officer" would then be Roy Davis, MD. I wish to clarify a statement attributed to Providence executives in order to avert misunderstanding among interested parties who are neither familiar with the case referenced in your letter nor the mechanisms and laws for physician prescriptions, including "Do Not Resuscitate" ("DNR") orders.

While I presently serve as the chief executive officer of Providence Health & Services Alaska, at the time referenced in your letter, I served as the chief operating officer. You and I spoke on at least two occasions about the case in question. I explained that these cases are almost always highly complicated and emotionally demanding for all parties. Physicians do an outstanding job of considering each patient's needs and of determining the appropriateness for such orders under these challenging circumstances.

Roy Davis, MD, our chief medical officer, indicates that he never spoke with you about the patient matter. However, you did speak with Richard Mandsager, MD. Dr. Mandsager serves as chief executive officer for Providence Alaska Medical Center, and he recalls speaking with you about certain details of the case. We suspect that your reference to the "chief medical officer" was in fact to Dr. Mandsager in his role as chief executive officer.

The specific clarification we wish reflected in the public record is that neither Dr. Mandsager nor any other executive of Providence Health & Services represented to you that the DNR order would be removed from the referenced patient's medical record. Such an action is inconsistent with policy, bylaws and community practice. As such, removal of the DNR was never considered.

I respectfully request that you correct the official record on this important matter.

Sincerely,

Bruce Lamoureux

Bruce Lamoureux
Sr Vice President/Chief Executive Alaska Region

BL:lb

Cc: Senator Bettye Davis
Senator Hollis French
Representative Bob Lynn

ALASKA STATE SENATE

SENATOR FRED DYSON

May 23, 2012

Stephen T. Rust, MD
Director of Palliative Care
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Re: CSSB 172 & Response to Providence Alaska Medical Center's Legal Analysis Memo of March 7, 2012

Dear Dr. Stephen Rust,

I appreciate your patience and professionalism working with my office and the Legislature on our efforts to clarify the roles and responsibilities of physicians and patients with respect to do not resuscitate (DNR) orders as addressed in AS 13.52, the Alaska Health Care Decisions Act. It is my hope that we will find points of agreement on how the law is applied to the process of a physician issuing a DNR order, and a patient's right to make the order ineffective.

This letter is in response to the March 7, 2012 legal analysis memo of CSSB 172 (Version I) that was prepared by the Law Offices of Atkinson, Conway and Gagnon for Providence Alaska Medical Center. I will refer to this legal analysis as "the Memo". I would note that the current version of the bill is Version D, which I have included with this letter for your convenience.

My prime concern pertains to the process of physician issued DNR orders - that of a health care provider unilaterally disregarding the expressed wish of a fully informed patient, who has capacity to make their own health care decisions. The Alaska Health Care Decisions Act (AHCDA) in AS 13.52 makes it explicitly clear that the patient (or surrogate) and health care professional work together in end of life decisions, with neither party retaining absolute authority over the other. Nevertheless, AHCDA is heavily weighted with language protecting the self-determination and autonomy of the patient with respect to end of life care. Most importantly, SB 172 does nothing to change what the law already requires, it only states it more clearly.

In short, if the medical community would agree to follow the law *as it is written,* I would not be pursuing this legislation. The Memo identified three (3) points of law within AHCDA that protect physician rights with respect to provision of care: AS 13.52.060(e)- conscience rights of health care providers and health care facilities; AS 13.52.060(f)- right to decline 'medically ineffective' healthcare; and AS 13.52.120(e)- right not to

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provide healthcare contrary to generally accepted health care standards. I would also add AS 13.52.030(h), which protects a physician's right not to follow a surrogate's direction when the primary health care provider observes a surrogate to not be abiding by the wishes, values and best interest of the patient. Finally, the Memo rightly identifies the patient safeguard provided in AS 13.52.060(g) for when a health care facility or provider refuses to comply with an individual instruction or health care decision of a patient. I believe each of these protections is necessary, however, they must be considered in balance with the entirety of the AHCDA.

The Memo failed to recognize or identify the important patient protections of AHCDA, which provide counterbalance to the health care provider & facility protections. There is a healthy tension built into the AHCDA which encourages the patient and physician to work together. The relevant patient protections in existing law are as follows -

1. Sec. 13.52.060(d)(1)(2) Obligations of health care providers, institutions, and facilities. – notes the health care provider protections mentioned above, then states,

> *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 with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and*
>
> *(2) a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.(emphasis added)*

2. Sec. 13.52.065(f) Do not resuscitate protocol and identification requirements

> *(f) A do not resuscitate order may not be made ineffective unless a physician revokes the do not resuscitate order, a patient for whom the order is written and who has capacity requests that the do not resuscitate order be revoked, or 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 do not resuscitate order be revoked. Any physician of a patient for whom a do not resuscitate order is written may revoke the do not resuscitate order if the person for whom the order is written requests that the physician revoke the do not resuscitate order. (emphasis added)*

3. Sec. 13.52.080(a)(6)(B) Immunities

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

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

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

4. Sec. 13.52.100(a)(b)(c) Capacity

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

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

c) *An individual who is a qualified patient,* ***including an individual for whom a physician has issued a do not resuscitate order, has the right to make a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures as long as the individual is able to make the decision****. If an individual who is a qualified patient, including an individual for whom a physician has issued a do not resuscitate order, is not able to make the decision, the protocol adopted under AS 13.52.065 for do not resuscitate orders governs a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures. (emphasis added)*

5. Sec. 13.52.120(a) Effect of this chapter

   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. (emphasis added)*

6. Sec. 13.52.130. Prohibited requirements

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

These are clearly significant patient protections in the AHCDA that mitigate unilateral physician decision making with respect to DNR orders. Sections 13.52.080 and 13.52.100 mentioned above clearly refute the legal Memo's argument that only the physician may revoke a DNR order, or make an order for cardio-pulmonary resuscitation.

The Memo highlights the very ambiguity in the law which SB 172 seeks to address. It referenced the Ethical and Religious Directives for Catholic Health Care Services, and expressed a concern that SB 172 may bring about a Free Exercise of Religion complaint. In my reading of the Directives, I find that our legislation is entirely consistent with the declarations, and that the Directives never give unilateral authority on end of life decisions to a physician. SB 172 is no more likely to bring about a Free Exercise complaint than is current law. The Directives state in part,

> *"Neither the health care professional nor the patient acts independently of the other; both participate in the healing process. The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures. The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching."*

The Memo states that SB 172 is contrary to the spirit of the AHCDA. I was one of the prime sponsors of the AHCDA legislation in 2004 and Chair of the House HESS Committee. I have spoken with the legislators and staff members involved with the passage of AHCDA who affirm that SB 172 is entirely consistent with what was intended by the legislative body at that time.

The Memo takes some pains to explain the nuances of 'life-sustaining procedure' and 'cardiopulmonary resuscitation'. This was unnecessary, as SB 172 does not confuse CPR with life sustaining procedures. The language pertaining to life-sustaining procedures in Section 1 of the proposed bill simply says patients who are under a DNR order, do not forgo a right to receive other health care that would help sustain their life. It is straightforward. Further, the Section 8 amendment in CSSB172 concerning life-sustaining procedures to the Advanced Health Care Directives Form was made at Providence Alaska Medical Center request, not the bill sponsor.

The Memo argues that SB 172 destroys the uniformity between AHCDA and the Uniform Health Care Decisions Act. Legislative Legal advises my office that there was not an attempt at uniformity between the two Acts. Some sections were made uniform, but no legislative intent was directed toward cohesive uniformity between the Acts.

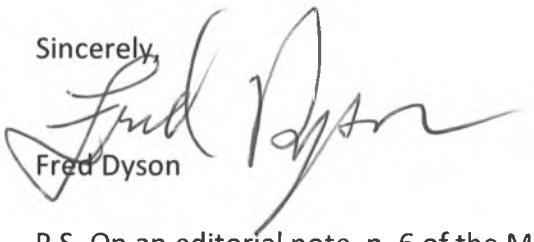
The Memo argues that a DNR order is not treatment as it is not a 'medical procedure'; therefore, "consent for treatment" from the patient for a DNR order is not required. This flawed logic fails to recognize that the default ethical standard/practice in medicine is that, in absence of a DNR order, physicians will attempt life-saving measures, and is properly the expectation of the patient. Further, this reasoning denies a DNR order to be 'health care'. A DNR order directly impacts *how* a patient is treated. Once a patient is under a DNR order, many other decisions about patient health care logically and procedurally follow. A DNR order is a health care decision, and we believe existing law in AHCDA clearly states this decision is not to be made unilaterally by the physician. Section 9 of CSSB 172 amends the current definition of 'health care decision' to include *a direction relating to the provision of cardiopulmonary resuscitation or other resuscitative measures* as identified in current law (see 13.52.100(c) above).

Finally, I do not wish to do away with the protections in statute against provision of 'clinically inappropriate' care. I do wish the decision making process surrounding DNR orders to recognize that a disease outcome model of understanding patient's wishes is not the only frame of reference for these decisions. A physician should be actively seeking to understand the deep values of his/her patient, and asking not only "what's the matter with you?", but "what matters to you?" We should never have a "surprise" at death's door with the patient expecting something entirely different than the physician. Sometimes, what matters to the patient is living to see a special moment or event, and then they can die in peace. The only way to know this is to spend time working through these issues with the patient and their families. It does not all fit well within a 15 minute appointment, and undoubtedly these discussions are very draining for physicians, but they must be done. Otherwise, we are left with a paternalistic approach to end of life decisions. Undoubtedly, it is easier and less expensive for health care

facilities and providers to make these decisions regardless of patient wishes. But I don't think that is what any of us truly desire.

In closing, I believe that our differing patient health care perspectives concerning DNR orders are not that far apart. I do appreciate Providence Alaska Medical Center's good work in many areas of health care. I and my family have directly benefited from Providence health care. Please don't consider this disagreement to mean disapproval of PAMC. This discussion has helped refine my thoughts on DNR orders and the process by which they are issued and made ineffective. I look forward to continuing the dialogue with hopes of achieving a common understanding and interpretation of what AHCDA requires of patients and physicians with respect to the issuance of DNR orders.

Sincerely,



Fred Dyson

P.S. On an editorial note, p. 6 of the Memo mis-cites the wrong section of the ACHDA by referring to AS 13.52.062(f), which does not exist. The correct cite is AS 13.52.065(f).

CC: Senator Hollis French, Senate Judiciary Chair
Senator Bettye Davis, Senate Health & Social Services Chair

Cindy Smith

From: Lewis, Jill (HSS) <jill.lewis@alaska.gov>
Sent: Saturday, March 24, 2012 9:21 AM
To: Cindy Smith
Cc: Hurlburt, Ward B (HSS); Laughlin, Wilda J (HSS); Chandler, Sierra B S (HSS); Robison, Elizabeth K (HSS)
Subject: Re: a question regarding regulations

I was able to find the original legislation passed in 2004, HB025. Page 51, lines 19-29, subsection (b) directs the Department of Law to change the citations in 7 AAC 16.10 from AS 18.12 to AS 13.52. Apparently that correction was not made, however, this confirms that the current regulations are the DNR protocols for AS 13.52.

Jill Lewis
Deputy Director
Alaska Division of Public Health
w: (907) 465-8617 c: (907) 209-6754

From: Lewis, Jill (HSS)
To: Smith, Cindy (LAA)
Cc: Hurlburt, Ward B (HSS); Laughlin, Wilda J (HSS); Chandler, Sierra B S (HSS); Robison, Elizabeth K (HSS); Lewis, Jill (HSS)
Sent: Fri Mar 23 18:32:20 2012
Subject: RE: a question regarding regulations

Cindy,

AS 18.12 was repealed in 2004 when AS 13.52.065 was enacted, and later amended in 2006. While I cannot say for sure, it appears that the department determined at least once, and perhaps additional times on review, that the existing protocol satisfied the requirement in AS 13.52. I cannot find another regulation with AS 13.52.065 as its statutory authority.

Jill
465-8617

From: Lewis, Jill (HSS)
Sent: Friday, March 23, 2012 5:55 PM
To: Smith, Cindy (LAA)
Cc: Hurlburt, Ward B (HSS); Laughlin, Wilda J (HSS); Chandler, Sierra B S (HSS); Robison, Elizabeth K (HSS)
Subject: RE: a question regarding regulations

Cindy, I have looked and haven't found a regulation that references AS 13.52 as its authority. I believe the regulations in 7 AAC 16.010 meet the requirements of AS 13.52.065 although that isn't the citation. I will need to check with the Department of Law for clarification.

Jill
465-8617

From: Cindy Smith [mailto:Cindy_Smith@legis.state.ak.us]
Sent: Friday, March 23, 2012 5:20 PM
To: Lewis, Jill (HSS)
Cc: Hurlburt, Ward B (HSS); Laughlin, Wilda J (HSS); Chandler, Sierra B S (HSS); Robison, Elizabeth K (HSS)
Subject: RE: a question regarding regulations

Thanks.

Cindy Smith
Office of Senator Hollis French
(907) 465-3892
www.senate.org

From: Lewis, Jill (HSS) [mailto:jill.lewis@alaska.gov]
Sent: Friday, March 23, 2012 5:12 PM
To: Cindy Smith
Cc: Hurlburt, Ward B (HSS); Laughlin, Wilda J (HSS); Chandler, Sierra B S (HSS); Robison, Elizabeth K (HSS)
Subject: RE: a question regarding regulations

Let me do more research. AS 13.52 is listed in our Comfort One materials as an authorizing statute but it isn't referenced in the regulations.

Jill
465-8617

From: Cindy Smith [mailto:Cindy_Smith@legis.state.ak.us]
Sent: Friday, March 23, 2012 5:06 PM
To: Lewis, Jill (HSS)
Cc: Hurlburt, Ward B (HSS); Laughlin, Wilda J (HSS); Chandler, Sierra B S (HSS); Robison, Elizabeth K (HSS)
Subject: RE: a question regarding regulations

The statute I am looking at was passed in 2005 – this DNR protocol was adopted some years prior to that and the regulations cited are for AS 18.12.035(B) and not 13.52.065(b)

Is there any regulation tying Comfort One to AS 13.52.065?

Cindy Smith
Office of Senator Hollis French
(907) 465-3892
www.senate.org

From: Lewis, Jill (HSS) [mailto:jill.lewis@alaska.gov]
Sent: Friday, March 23, 2012 4:57 PM
To: Cindy Smith
Cc: Hurlburt, Ward B (HSS); Laughlin, Wilda J (HSS); Chandler, Sierra B S (HSS); Robison, Elizabeth K (HSS)
Subject: RE: a question regarding regulations

Cindy,

The department's do not resuscitate protocol, Comfort One, and standards are set out in 7 AAC 16.010. The program is operated by the Division of Public Health's Emergency Medical Services Unit. Below is a link to the website which has copies of the brochures for patients and health care providers, enrollment forms, and an FAQ.

http://www.hss.state.ak.us/dph/emergency/ems/programs/Comfort_One.htm

JILL LEWIS ◊ DEPUTY DIRECTOR ◊ ALASKA DIVISION OF PUBLIC HEALTH ◊ DEPARTMENT OF HEALTH AND SOCIAL SERVICES
P.O. BOX 110610 ◊ JUNEAU, ALASKA 99811-0610 ◊ OFFICE: (907) 465-8617 ◊ MOBILE: (907) 209-6754 ◊ FAX: (907) 465-4632

From: Laughlin, Wilda J (HSS)
Sent: Friday, March 23, 2012 4:25 PM
To: Lewis, Jill (HSS); Hurlburt, Ward B (HSS)
Subject: FW: a question regarding regulations
Importance: High

Need ASAP

From: Cindy Smith [mailto:Cindy_Smith@legis.state.ak.us]
Sent: Friday, March 23, 2012 4:24 PM
To: Laughlin, Wilda J (HSS)
Subject: RE: a question regarding regulations

ASAP. It's in relation to a bill in the committee.

Cindy Smith
Office of Senator Hollis French
(907) 465-3892
www.senate.org

From: Laughlin, Wilda J (HSS) [mailto:wilda.laughlin@alaska.gov]
Sent: Friday, March 23, 2012 4:21 PM
To: Cindy Smith
Subject: RE: a question regarding regulations

When do you need it?

From: Cindy Smith [mailto:Cindy_Smith@legis.state.ak.us]
Sent: Friday, March 23, 2012 4:20 PM
To: Laughlin, Wilda J (HSS)
Subject: a question regarding regulations

In a recent bill hearing, the subject of do not resuscitate orders was discussed.

According to AS 13.52.065 (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".

Can you provide me those regs and that protocol?

Thanks --

Cindy Smith
Office of Senator Hollis French
(907) 465-3892
www.senate.org

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 19, 2012

Honorable Hollis French
State of Alaska
Senate
Chair, Senate Judiciary Committees
State Capitol Room 417
Juneau, AK 99801

RE: SB 172 – Health Care Decisions and Do Not Resuscitate Orders

Dear Senator French:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

Thank-you for the opportunity to testify on SB 172 which pertains to health care decisions and do not resuscitate orders.

ASMA urges you not to make any changes in the current law which has been termed Alaska's Health Care Decision Act until you have thoroughly explored all material aspects of this very complex subject. A bill of this complexity introduced in the second 90 day session of a two year Legislature cannot be properly addressed in the time allocated and available. SB 172 deals with death, dying and end of life care, all of which our society for the most part abhors discussing.

It is estimated that only 20% of us have adopted advance directives that document our decisions as to when and how our end of life care is provided. The other 80% of us, leave these decisions until we are gravely ill when decisions are made in an environment that is highly emotionally charged; and often are made by surrogates who may or may not know what care we desired. These decisions are as well guided by closely held personal beliefs, religious tenets, and cultures.

Physicians providing end of life care are an integral part of this decision making process and responsible, first and foremost to the patient. In providing their counsel they are guided by their medical expertise and by their code of ethics (The Principles of Medical Ethics of the American Medical Association which are adopted in AS 08.64, see AS 08.64.326(a)(11), and 12 AAC 40.955 (a)). A physician who violates this code of medical ethics is subject to disciplinary action.

SB 172 (and the work draft seen by ASMA for a committee substitute) provides for the impossible situation for physicians of either violating provisions of SB 172 or violating the AMA's Code of Medical Ethics and thus violating the Alaska State Medical Board's disciplinary statutes.

ASMA understands that Alaska's current Health Care Decision Act was patterned on and closely follows the Uniform Health Care Decision Act drafted by the National Conference of Commissioners on Uniform State Laws. The uniformity benefits the people when they travel from one state to another. It would appear that uniformity would be disrupted by SB 172.

SB 172 would provide a "one size fits all proscription for advance health care directives which is not appropriate for all medical situations that can present. Attached is a very recent article that provides an interesting discussion of the potential "default options". ("Time to Revise the Approach to Delivering Cardiopulmonary Resuscitation Status", Journal of the American Medical Association, March 7, 2012.) This article infers that much more discussion is needed. (Also please note that the 20% of those estimated to have enacted advance directives in Alaska, should SB 172 be enacted, would need to have their personal attorney examine their existing advance directives and modify them if required by this proposed bill.)

SB 172 will impact every Alaskan and every aspect of it needs to be thoroughly addressed by the Legislature. ASMA does not believe that the required and warranted attention can be given to the varied and complex issues in the less than 30 days remaining in this session. To do otherwise, can be a result fraught with unintended consequences most of which could be expected to adversely impact the patient/physician relationship and the care provided.

ASMA stands ready to assist you in forming a group representing various stakeholders to examine all of the pertinent issues in a manner that "first does no harm".

Sincerely,

Mary Ann Foland

By: Mary Ann Foland, MD, President
For: The Alaska State Medical Association

Donna Stephens
Testimony CSSB 172 – Health Care Decisions including Do Not Resuscitate Orders.
(907) 229-0721
donna@hospiceofanchorage.org

March 19, 2011

I. Introduction
   a. RN w a Master in Education Counseling
   b. Executive Director at Hospice of Anchorage for 3 years, volunteer for 28 years
   c. Teach adjunct at UAA – Psychology Department – Intro to Death and Dying
   d. I am testifying as an individual
   e. Thank you for your consideration of this important topic

II. First learned about death
   a. at 5 – uncle from car accident
   b. at 12 – a 3 yo cousin with cancer
   c. at 14 - a friend w muscular dystrophy
   d. at 20 – a 5 yo. cousin

III. In nursing school:
   I learned about how to help people recover from disease, but from my experiences as a child I've always been concerned about how we care for people who biologically can not recover and their families. My heart goes out to Mrs. Mullens in her pain and grief.

IV. What I've learned
   a. Most people fear what they don't know
   b. As a culture American's avoid learning about death and therefore when faced with a life-threatening crisis
      i. most of us do not have any knowledge of the choices we might face nor about what is legal or ethical. Most people are committed "to doing the right thing" – but they don't know what that is.
      ii. we are overwhelmed with emotional pain of fearing loss,
      iii. we ask that our doctors and hospitals - 'stop death'
      iv. when it's biologically impossible (and the doctor is brave enough and takes the time to have that conversation with the individual and family) people sometimes (actually quite often) react with anger as a way to avoid the pain.

V. The solution to the problem
   a. Isn't in this bill. In my opinion this bill creates many more problems for good end of life care than we already have (and we have plenty) and offers no workable solutions.
   b. Because there is no one right way to die, the solution is in each of us learning about the benefits and burdens of some of the common choices we are apt to face, and also the legal and ethical issues that guide care at end of life. And then very importantly talking, with all our loved ones,

about how each of us as individuals want to live until we die - what we want and don't want and why. Hospice of Anchorage hopes to be able to convene a coalition of stakeholders on this important topic.

c. This bill however is not addressing how to care for people at the end of life, which is where the real problem is, but what to do after they die.
    i. Resuscitation is done after someone dies.
    ii. It has a less than 1 % chance of bringing a person w an advanced chronic illness back to life and then only with a high likelihood that the individual's condition will be much worse. (http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center/cpr)
    iii. As Ira Byock, MD, a national expert in end of life care, currently practicing palliative medicine at Dartmouth- Hitchcock Medical Center, in his just published book: The Best Care Possible, pointed out, "The Presidential Commission for the study of Bioethical Issues, and court decision, have said the people have a right to refuse any medical treatments that are offered, and must be give a chance to decide among legitimate and available treatments for their conditions. But the Commission, and the courts have also said that people do not have a right to receive any treatments they desire. The responsibility for determining what treatment options are indicated rest with physicians." (p165) It is against the law to practice medicine without a medical license.

d. This bill in attempting to honor the choices of individual for care at end of life, is actually making it harder to honor choice in a number of ways but most concerning to me (besides the demand that physicians provide futile care):
    i. negates individual freedom to choose and allows surrogate decision makers to reverse decisions made by individuals? In doing so it places an undue burden on families. (Research shows that families whose loved ones die in the hospital suffer multiple negative effects, including higher rates of illness and PTSD, then persons who die at home.)
    ii. it calls into question previously established health care directives and Alaska's Comfort 1 system for expected home deaths.
    iii. it assumes that people who do not ask for full resuscitation efforts must wish to die. While in some circumstances I would not want CPR, I certainly do not want to die. It does not allow for a range of treatments.

VI. In conclusion

a. Physicians and hospitals are programmed to cure, to save lives. And despite advanced medical care, 100% of people still die. It is extremely difficult for physicians and hospitals to stop aggressive treatments, including trying to resuscitate people who have died. It is the rare physician that is willing to write a DNR order when the individual or family express a preference for that procedure, even knowing full well that

procedure is futile and may cause long lasting trauma to the survivors who may witness or demand a CPR attempt. The adherence to the ethics of good medical care should be applauded, not condemned, as this bill attempts to do.

b. Both healthcare professionals and individuals in Alaska need to learn to talk about dying and the choices to be made long before we are in crisis. I have testified as an individual as we do not have an agency statement on this bill. However, Hospice of Anchorage, a volunteer hospice, caring for Alaskans since 1982, is committed to making end of life easier and leading discussions. Please call us if you would like to learn more.

Testimony on SB172
before the Alaska Senate Judiciary Committee
3/19/2012

My name is Bryan Talbott-Clark. I'm a Master-level social worker with Hospice of Anchorage, testifying on my own behalf in opposition to SB 172. In my work here, and in a previous hospital internship, I've worked with numerous families on advance directives and the importance of making their wishes known.

What my experience tells me is that people don't like to talk or think about death until they have no choice. Physicians being people too, most of them don't like to talk about it, either. As I've read about the situations that prompted this bill, I do see a problem that should be addressed, but it's nothing to do with the subject of this bill. The real problem is very much one of understanding and communication around end-of-life issues.

I have to say, it appears to me that some of that very lack of understanding is reflected in the design of this legislation. A Do Not Resuscitate order is not the same as an Advance Directive; it's a statement of professional judgment that resuscitative measures are not medically indicated. A patient's judgment can't make something medically indicated when it isn't. This bill would amount to letting people require medical professionals to act unprofessionally, forcing them to give inappropriate treatments. If the patient or their power of attorney question their doctor's judgment, they can vote with their feet and get another doctor, who can readily revoke a DNR if his or her professional judgment says that's appropriate. But a patient should no more be able to revoke a DNR than they should be able to prescribe their own morphine.

I mentioned communication. If the general public were better educated about their options, if more doctors were more willing to discuss end-of-life issues with their patients sooner, there would be a lot fewer nasty surprises like the situation that prompted this bill. That's what we should be talking about – getting the word out about what kind of choices we may have at the end of our lives, and empowering people to talk about it with their families and their doctors before an illness forces their hand. But this bill won't do any of that.

As you know, the work of a legislator is very much like the work of a doctor. You must always be cautious in considering any intervention, because every intervention carries the risk of harmful consequences, some known, some unforeseen. These consequences must be weighed against the expected benefit of the intervention, whether it's a medical procedure or a legislative act.

The bill before you is clearly the wrong medicine. The predictable harm it will do is substantial, not even counting unforeseen consequences, while its intended effects entirely miss the mark. It will do nothing to improve communication between patients and doctors, while at the same time it stands to criminalize good medical practice and force good doctors to choose between following their ethics and obeying the law.

It's not a matter of tweaking or fixing the bill; SB 172 is the wrong approach entirely, and should not move forward. I urge that the committee act accordingly. Thank you.

Donna Stephens
Testimony CSSB 172 – Health Care Decisions including Do Not Resuscitate Orders.
(907) 229-0721
donna@hospiceofanchorage.org

March 19, 2011

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about how each of us as individuals want to live until we die - what we want and don't want and why. Hospice of Anchorage hopes to be able to convene a coalition of stakeholders on this important topic.

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procedure is futile and may cause long lasting trauma to the survivors who may witness or demand a CPR attempt. The adherence to the ethics of good medical care should be applauded, not condemned, as this bill attempts to do.

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Time to Revise the Approach to Determining Cardiopulmonary Resuscitation Status

Craig D. Blinderman, MD, MA
Eric L. Krakauer, MD, PhD
Mildred Z. Solomon, EdD

In US hospitals, cardiopulmonary resuscitation (CPR) is the de facto default option—patients must "opt out" by requesting or consenting to a do-not-attempt-resuscitation order. Despite its worthy intent, requiring all patients or their surrogates to consent to a do-not-attempt-resuscitation order to avoid CPR has resulted in an ethically unjustifiable practice that exposes many patients to substantial harms.

Whenever there is a plausible risk of cardiac arrest, the standard approach is to ask patients or their surrogates about their preferences regarding CPR. However, the very act of asking can suggest to the patient and family that CPR may be beneficial, even when the clinician believes otherwise. Additionally, research in cognitive psychology has revealed that default options are often interpreted as recommendations or guidelines, or as the path of least resistance, and that such default options significantly affect decision making.[1] For these reasons, patients or their surrogates may be biased toward choosing full resuscitation status, even when CPR likely would bring little or no benefit and would risk considerable harm. Therefore, the standard approach of neutrally seeking consent to withhold CPR may inadvertently diminish patients' and families' comprehension of the clinical situation and lead to decisions that are grounded neither in patients' values[2] nor in their best interest.

Instead of assuming that CPR must always be offered, we suggest 3 distinct approaches based on the likelihood and degree of potential benefits and harms of resuscitation. In all 3 approaches, physicians must take the time to fully explain the patient's prognosis and likely disease trajectory, clarify any misconceptions, and elicit the patient's values and goals, which should form the basis for all CPR discussions. However, the options offered by the physician should change as the likely proportion of burdens to benefits increases.

Approach 1: Consider CPR as a Plausible Option

Physicians should discuss CPR as a plausible option when the relative benefits and harms of CPR are uncertain, as is often the case in patients whose chronic illness has not reached end stage. Fried et al[3] have shown that patient preferences for treatment are determined by their attitudes toward the burden of treatment and the likelihood of those possible outcomes. Thus, physicians should explore the patient's or surrogate's understanding of the disease, clarify any misconceptions, and discuss the likelihood of successful CPR (approximately 16% of hospitalized patients survive to discharge following CPR)[4] and possible harms of attempting CPR (eg, injury related to resuscitation efforts, prolonged stay in an intensive care unit, disability, anoxic brain injury, or nursing home placement). Physicians should seek a nuanced understanding of the patient's values and expect that patients in medically similar circumstances may choose differently. The discussion, the resulting resuscitation preferences and status, and the patient's values and goals should be recorded in the medical record.

Approach 2: Recommend Against CPR

Physicians should recommend against CPR when there is a low likelihood of benefit from CPR and a high likelihood of harm, such as when patients have advanced incurable cancer, advanced dementia, or end-stage liver disease.[4] Patients in this category who survive resuscitation are likely to spend their last hours or days in an intensive care unit or have an anoxic brain injury. The physician should approach such patients or their surrogates with a presumption against providing CPR but also remain attentive when discussing the patient's values and goals for unique personal, familial, religious, or cultural factors that might make an attempt at CPR unusually beneficial.

For most of these high-risk patients, physicians should recommend against CPR and explain that they do not want to expose the patient to a procedure that is unlikely to be beneficial and will most likely cause significant harm. Assent to this recommendation by a patient or surrogate would then allow the physician to write a do-not-attempt-resuscitation order. Physicians must be careful not to give

See also p 915.

Author Affiliations: Department of Anesthesiology, Columbia University Medical Center, New York, New York (Dr Blinderman); Division of Medical Ethics (Dr Solomon), Departments of Medicine (Dr Krakauer) and Global Health and Social Medicine (Drs Krakauer and Solomon), Harvard Medical School, Boston, Massachusetts; Palliative Care Service and Optimum Care Committee, Massachusetts General Hospital, Boston (Dr Krakauer); and Department of Anesthesiology, Children's Hospital of Boston, Boston, Massachusetts (Dr Solomon).
Corresponding Author: Craig D. Blinderman, MD, MA, Columbia University Medical Center, 622 W 168th St, PH5-530B, New York, NY 10032 (cdb21@columbia.edu).

the impression that withholding CPR means giving up (ie, that other treatments will not be provided) or that the patient will be ignored or abandoned. On the contrary, physicians should explain that their intent is to protect the patient and ensure the best possible experience in the final phase of life.

Despite such a recommendation, some patients in this category or their surrogates may request that CPR be attempted for a variety of reasons, including religious or cultural beliefs. It is ethically acceptable for the physician to acquiesce to such a request as long as it is grounded in the patient's values and goals and there is a potential for a modicum of medical benefit.[5]

Approach 3: Do Not Offer CPR

Physicians should not offer CPR to the patient who will die imminently or has no chance of surviving CPR to the point of leaving the hospital. Once this determination is made, and absent extraordinary but reasonable patient values or goals that might make the harms of CPR in this situation worth risking, it is, in our opinion, not only ethical, but also imperative, that CPR not be offered. The physician's primary responsibility is to protect the patient from unnecessary harm. Indeed, CPR was not intended to be used in this clinical situation.[6]

Not offering CPR for imminently dying patients should be explicitly permitted by hospital policy. However, the decision not to offer CPR should be disclosed to the patient or surrogate. As in the previous approach, physicians should not give the impression that not attempting CPR means giving up or that the patient will be ignored or abandoned, but rather that the intent is to protect the patient from harm and maximize comfort.

If a patient or surrogate continues to insist that CPR be attempted, an ethics consultation should be requested if available. If the ethics consultants concur that the case falls within this clinical situation, and absent highly unusual patient values or goals, the consultants should gently and respectfully inform the patient or surrogate of their support for the decision to not attempt CPR and enter a note to this effect in the medical record. Support from a social worker, chaplain, or patient advocate should be made available to the patient and family as appropriate.

Conclusions

Whenever there is a reasonable chance that the benefits of CPR might outweigh its harms, CPR should be the default option. However, in imminently dying patients, a default status of full resuscitation is not justifiable. Not only is CPR in this situation likely to harm patients without compensatory benefit, the default framework likely influences patients and surrogates to request that full resuscitation is attempted even when the physician believes doing so may be inappropriate. The default option in this situation should be an order to not attempt CPR, perhaps coupled with consultation by a palliative care specialist. Similar reasoning may have motivated 15% of nursing homes in Wisconsin to develop policies that make withholding CPR the default option and to offer full-code status only on an opt-in basis.[7]

Physicians are responsible for recommending the medical means to honor their patients' values and for helping them to identify and achieve their health care goals. This responsibility becomes crucial in the setting of life-threatening illness, in which patients are especially vulnerable and may be exposed to potentially harmful life-sustaining interventions. While promotion of patient autonomy is a fundamental responsibility of physicians, protecting the patient from harm becomes increasingly important as the patient becomes more vulnerable. Sometimes, it should be preeminent.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Blinderman reported that he has served on speakers bureaus for Cephalon and has received travel accommodations and honorarium from the International Multidisciplinary Forum on Palliative Care for speaking at a conference in 2010 and from the Vietnam-Centers for Disease Control and Prevention-Harvard Medical School-AIDS Partnership for training and supporting Vietnamese clinicians in palliative care. Drs Krakauer and Solomon did not report any disclosures.

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Cindy Smith

From: Herman, Laurie <Laura.Herman@providence.org>
Sent: Saturday, March 17, 2012 2:04 PM
To: Cindy Smith
Subject: SB172

Hi Cindy,

Dr. Ryan McGhan, a critical care intensivist in Anchorage will be calling in via the 855 number to testify on SB172 on Monday in Senate Judiciary. He works nights so will sleep for a few hours and get up to call in so it would be very difficult for him to go to the LIO.

Thanks.

Laurie

AHCHA
Alaska Home Care & Hospice Association

April 24, 2012

Alaska State Senators,

We, members of the Alaska Home Care and Hospice Association (AHCHA), are writing to express the concerns of our membership related to a bill that was recently reviewed in the Alaska State Senate Judiciary Committee – SB 172. The bill was apparently introduced to address a perceived gap in the current Alaska Statute (Health Care Decisions Act AS 13.52, enacted in 2004), specifically the issue that a physician can issue a 'Do Not Resuscitate' (DNR) order without the expressed consent of a patient or surrogate decision maker. The current laws, and ethical health care processes, already allow a physician to decline to provide CPR while assisting the patient/family to find a physician willing to follow the patient/family wishes.

Our concerns relate to the impact that this proposed bill would have on our current DNR, 'Expected Home Death', and/or 'Comfort One' processes that occur outside of the acute care setting, and which are recognized state wide by healthcare, law enforcement and emergency response organizations. Home Health staff, Hospice staff and Physicians throughout the state, often care for the medically frail and dying members of our communities in the comfort of the dying persons home. The current law is reasonably clear on these types of situations, allowing Alaskan citizens to die peacefully at home when they have indicated that preference. Our position is that the current law has worked well for over 5 years. It allows Alaskans to express their desires related to end of life choices, and to die peacefully at home without the threat of their wishes being disregarded.

SB 172 appears to negate any Advance Directives currently in place, requiring that health care providers revisit the issue with patients and families, and to bow to the wishes of a surrogate decision maker who can now demand that CPR be provided, even when there is clearly no benefit to the patient, and/or the patient previously indicated that he or she does not desire resuscitation. While patients/surrogate decision makers may always decline any offered treatment, they have never had a right to demand a medical procedure that has not been offered. This bill would change that time honored dynamic. It will place community health care providers in the position of being required to provide a procedure that they know is futile and possibly traumatic for the family to witness.

The wording of SB 172 is ambiguous and may create increased confusion among health care providers and members of the community, resulting in increased strain on our Emergency Response System and more expensive, futile, and potentially distressing trips to the Emergency Room at the end of life.

We urge you to carefully consider the potential impact of any proposed changes to our current law in this session or future sessions of the legislature. The proposed SB 172 is trying to fix something that does not need to be fixed, and may create potential legal and medical problems, as well as unnecessary anguish for physicians, nurses, and Alaskan families in its wake.

Sincerely,

Jacob Malouf

Jacob Malouf, RN	President, Alaska Homecare and Hospice Association (907)729-5198
Pat Dooley, RN	Program Director, Providence Hospice (907) 212-4409
Shannon Updike, RN	Manager, PeaceHealth-Ketchikan Medical Center (907) 225-8914
Elizabeth Faulkner, RN	Manager, Sitka Comm Hospital Home Health Agency (907) 747-1750
Linda Wagner, RN	Clinical Coordinator, South Peninsula Home Health Care (907) 235-0348
Angela Klementson, RN	Clinical Coordinator, Southcentral Foundation Home Based Services (907) 729-5294

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Our View: First do no harm

Bill on CPR in terminal cases raises its own serious issues

(03/21/12 19:05:32)

Sen. Fred Dyson testified that his strong respect for life prompted his effort to rewrite part of the state's patients' rights law. Senate Bill 172 would not restrict a patient's right to refuse treatment to prolong life. But in cases where the patient's or a spouse or other family member's demands for treatment conflicted with a doctor's judgment or ethical standards, cardio pulomonary resuscitation might be required.

Medical professionals who testified were not in favor of the bill, pointing out that CPR is not a gentle procedure, especially for older terminal patients and that it may prolong life at a cost of much greater pain and misery for the patient.

That runs counter to the medical maxim, "First do no harm." Respect for life could make dying far more painful than it needs to be. Many who have been with a dying loved one have experienced that point where the patient waves off any more help, when they realize the fight for life is over. Hence the mercy in giving patients the right to refuse treatment, either at the time or in advance.

On the other side of that equation is testimony by one widow who said both she and her husband wanted life-sustaining treatment, no matter the pain, until the end, because of their faith -- faith that is often most precious at such times. What should doctors, who might argue that CPR in such cases could break ribs, cause more suffering or even hasten death, do in such cases? How would they reconcile the amended law and their own code?

The patients' rights law is good in letting patients decide when to simply let nature take its course. In one sense Dyson's bill keeps that decision with the patient and spouse or other surrogate. But the bill

creates a dilemma for doctors -- who already, with families, face hard calls about how far to go in prolonging a life.

There is no template answer for end of life decisions. In most cases, those final decisions are best made by patients and families. But in these most personal times, they're not the only ones involved. Lawmakers need to think this one over for awhile.

BOTTOM LINE: Patients' rights rewrite may solve one problem, create more.

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Providence Health & Services Alaska
Review of Senate Bill 172 and House Bill 309
Prepared by Providence Physician Leadership - February 10, 2012 and Unanimously Endorsed by the Providence Alaska Medical Center's (PAMC) Medical Executive Committee, elected representatives of physicians who hold medical privileges at PAMC – February 13, 2012

At first glance, Senate bill # 172 and its partner bill #309 in the House, appear to empower patients to make decisions about their health care at the end of life (Sec. 1 pg 1 lines 3-7). However, on further review these bills contain language involving a very complex decision making process that normally occurs between a patient and his or her physician.

These bills attempt to legislate a complex decision making process and make a "one size fits all" model for end-of-life care. Specifically, these bills are concerned with advanced health care directives which may be made independently or may accompany a will or estate planning. The advanced health care directive is designed to give direction to your family, loved ones and health care providers about care choices if you become critically ill and cannot make decisions for yourself. Ideally, every individual would make this directive ahead of time, when they are clear of mind and not under stress or distracted in any way. In reality, fewer than 1 in 5 individuals arriving to a hospital have an advanced directive(Halpern NA, Pastores SM, Chou JF, Chawla S, Thaler HT, Palliat Med. 2011 Apr;14(4):483-9. Epub 2011 Mar 18; . Knott CI, Psirides AJ, Young PJ, Sim D., Crit Care Resusc. 2011 Sep;13(3):167-74).

These bills also address requests by patients or health care providers to use or not to use advanced medical procedures in an attempt to keep them alive. New terminology adopted by several states terms these issues as "Allow Natural Death," (AND). In Alaska, the terminology utilized is called DNR (do not resuscitate) orders and advanced resuscitative measures. A DNR order can be initiated with or without an advance health care directive. Historically, A DNR is a written agreement that is made between a physician and a patient after discussion about a patient's medical condition. A DNR can answer questions about whether a patient wants CPR (chest compressions or cardiopulmonary resuscitation), wants artificial breathing applied (also called intubation) or some assistance with breathing if an individual needs assistance on a temporary or long term basis. It addresses artificial nutrition if an individual is temporarily or permanently unable to swallow or eat. It addresses the use of antibiotics for infection and other medications to support blood pressure. It addresses the use of electricity/shocking of the heart to reset or restart the heart if the heart stops. .

The decisions made by an individual about how they want to spend their end days are complex and personal. Each person has their own set of circumstances that guide their decision making. The decision may be based on what types of illnesses an individual has or how long they have had these illnesses. It may have to do with their ability or inability to tolerate pain and suffering. It may be directly or indirectly related to religious or cultural beliefs. It may reflect a preference to allow all bodily processes to occur

naturally and not be artificially supported. It may have to do with a desire not to be a burden to family or loved ones if circumstances alter one's ability to care for themselves. It may reflect financial concerns.

The list of reasons why people make decisions is lengthy and unique to each individual. These decisions should be discussed at length with family and loved ones and preferably with a physician who can communicate the degree and prognosis of illnesses with the individual and their loved ones. Ideally, everyone knows and understands the choices and why they are made.

In reality, fewer than 1 in 5 patients admitted to the hospital have made these decisions even though they may have very complicated advanced illnesses or injuries (Halpern, et.al. and Knott et.al.). In general, the American culture tends to not discuss death and dying and is generally unprepared to address these issues until they are forced to do so when confronted by a life altering or life threatening injury or illness. The decisions must then be made under stress. The worst case scenario presents when a patient is not able to make decisions and family members must make decisions while hoping they know what a patient may want. Often families do not know, are unsure, or simply are not present or cannot be found. Whenever possible, these decisions are made in advance. When they have not been made in advance, the medical team caring for the patient is faced with making the decisions together with available family members. Decisions are based upon what is known about the illness(es) or injuries, progression of disease, and benefits vs. harm of interventions. These decisions are crafted with input from family regarding patient preferences. It is a complex process and made with due diligence, generally with the input of many care providers, in addition to family wishes. They are not made lightly.

It is important to note that advanced interventions including CPR, artificial breathing techniques, artificial nutrition, shocking of the heart, etc. are helpful only in very specific medical circumstances. They are not applicable to each and every end of life illness or injury no matter what is portrayed on TV (references: code of Ethics of the American Medical Association (AMA), Opinions 2.035, 2.095). In fact, many of these interventions are painful and are rarely successful (Ebell & Alfonsa; Family Practice 2011; 28:505-515) . They are often associated with severe painful and sometimes persistent complications that leave the few who survive the procedures permanently impaired. CPR for example, was designed to be utilized in only a specific subset of heart patients (Kouwenhouen JAMA 1960 173: 1064-7). It was not recommended for other situations because the likelihood of survival is so low and the risks of complications are so high. For example, advanced cancer patients have not been shown to benefit from CPR. The procedure frequently causes broken ribs and a broken breast bone and collapsed lungs, to mention only a few of the potential complications. The benefits of the procedures should clearly outweigh the potential risks of the complications associated with these procedures. In end stage cancer, the benefits rarely outweigh the risks. When they do outweigh the risks, then CPR and other advanced aggressive procedures are performed. However, medical standards do not recommend doing advanced aggressive interventions in every case (references: code of Ethics of the American Medical Association (AMA), Opinions 2.035, 2.095). In these situations, the

recommendation is to provide full support for patients, but not to provide procedures that have a higher risk of injury than to provide benefit, irrespective of a DNR that may be in effect.

The House and Senate bills do not reflect the complexity of this decision making process. This legislation is inappropriate for a large portion of individuals by mandating the following:

1. 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.

2. 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. Pg2, lines 29-31and pg 3, line 4, Sec 12, pg 19, lines 18,19).

3. 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) .

4. 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 s (Sec 3. pg 2, lines 7-18) .

5. 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).

6. 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) ..

7. 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.

8. 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.)

9. 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. Pt 19, lines 23-27).

10. 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).

11. 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).

12. 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)

13. 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 3)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).

14. 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.

15. The new version of the advance health care directive form does not encourage graduated selection of interventions. It is an all or none proposition (Sec 13.52.300, pg 13, lines 2-10).

Page 19 simply needs to be deleted altogether.

Why the medical community has grave concerns

- It does not allow those individuals with the most expert understanding of health and disease and prognosis to exercise their expertise.
- It implies that DNR orders are made flippantly and without deep compassionate concern for the welfare of patients.
- It makes an assumption that doing potentially harmful and painful interventions are always in the patients' best interests despite accepted medical standards that indicate otherwise.
- It ignores the Hippocratic Oath and that health care providers must first do no harm . It supports the battery of patients by mandating that harmful procedures be performed on patients without regard to the benefit vs. risk assessment of these interventions

- It does not support the time honored tradition of patient physician relationship in which these discussions should be made.
- It makes an assumption that every patient feels that the quantity of life trumps the quality of life
- It does not promote death with dignity
- It forces families and loved ones to reconsider the decisions of their loved ones and consider reversing decisions that may cause irreparable psychological and emotional damage in the long run.
- It assumes that physicians do not err on the side of over-utilizing CPR. It assumes that providers underutilize these aggressive procedures. This is untrue.

Considerations for Alaska citizens who do not want government intrusion into personal medical decision making

- It makes an assumption that each individual values the quantity of life over the quality of life without regard to the degree of suffering an individual may experience.
- It assumes that every individual wants artificial support even when it has been shown to not be helpful.
- It assumes that every person wants to have CPR and undergo potential pain and suffering from these procedures even when they have been shown not to be of any benefit.
- It allows other individuals to reverse your right to death with dignity because they are afraid to lose you. It implies that they may not value your life if they do not at least try the aggressive resuscitative measures.
- It forces others to ignore your choices and decide for themselves whether or not to honor your wishes.
- It mandates that every individual should be treated the same. It is a "cookie cutter approach" to medical care assuming that each person wants the same thing as proponents for the right to life.
- It has the potential to reverse a well thought out decision for end of life care that may have been made by you for reasons unknown to other individuals.
- It does not allow those who have not yet made advanced directives to have well thought out approaches to their medical care and instead defaults to the use of aggressive medical interventions

- It assumes that physicians do not make medical decisions incorporating acceptable medical standards of care.
- It assumes that a patient and their physician cannot tailor a unique care plan for each individual. Instead, a legislator with no medical experience whatsoever can mandate the procedures that will happen to you at the end of life.
- It mandates patients with extremely advanced medical conditions undergo these procedures simply because they do not have advance health care directives.
- It insists that all previously established advanced health directives and DNR orders be reconsidered and must be in compliance with the new standards established with this new bill.

Hollis French- Senate Judiciary Chair

Hollis,

Thank you for hearing SB 172-I think you will hear why this is a very important clarification of the existing statues.

We would appreciate your allowing the hearing on SB-172 to proceed as follows:

Sponsor presentation- including explanation of the changes in the Sponsor substitute, (most of the sponsor changes are a result of meetings with Providence staff), and sectional analysis.

Testimony of Margery Mullins, the person whose experience with her husband (now deceased) brought the problems with ambiguities in the existing statues to light.

Testimony of Providence staff and supporters and Attorney(s)

Terry Banister to answer legal questions from committee

Testimony of Doctor's

-Dr. Ward Hurlburt-Chief Medical Officer of the State

-Dr. George Rhyneer- Former Chief Medical officer at Prov.

-Dr. Donald Olsen-Alaska State Senate

Final questions and debate.

ALASKA STATE SENATE

SENATOR FRED DYSON

Date: January 30, 2012

To: Senator Hollis French, Chair
Senate Judiciary

From: Senator Fred Dyson

Re: Committee Hearing Request for SB 172

I respectfully request a committee hearing be scheduled for SB 172, "An Act relating to health care decisions, including do not resuscitate orders."

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

During Session (January - May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 (fax)
During Interim (June-December): 10928 Eagle River Road, Suite 238 • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 (fax)
senator.fred.dyson@legis.state.ak.us • www.akrepublicans.org

Sec. 13.52.010. Advance health care directives.

(a) Except as provided in AS 13.52.173 , an adult may give an individual instruction. Except as provided in AS 13.52.177 , the instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

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

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

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

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

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

(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, or of the health care institution or health care facility where the principal is receiving health care; or

(3) the agent.

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

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

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

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

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

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

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

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

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

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

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

(k) Except as provided in AS 13.52.247 (a), an advance health care directive, including an advance health care directive that is made in compliance with the laws of another state, is valid for purposes of this chapter if it complies with this chapter, regardless of where or when it was executed or communicated.

(l) Notwithstanding the sample form provided under AS 13.52.300, an individual instruction that would be valid by itself under this chapter is valid even if the individual instruction is contained in a writing that also contains a durable power of attorney for health care and the durable power of attorney does not meet the witnessing or other requirements of this chapter.

Sec. 13.52.020. Revocation of advance health care directive.

(a) Except in the case of mental illness under (c) of this section, a principal may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

(b) Except in the case of mental illness under (c) of this section and except as provided by AS 13.52.183 , a principal may revoke all or part of an advance health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(c) In the case of mental illness, an advance health care directive may be revoked in whole or in part at any time by the principal if the principal does not lack capacity and is competent. A

revocation is effective when a competent principal with capacity communicates the revocation to a physician or other health care provider. The physician or other health care provider shall note the revocation on the principal's medical record. In the case of mental illness, the authority of a named agent and an alternative agent named in the advance health care directive continues in effect as long as the advance health care directive appointing the agent is in effect or until the agent has withdrawn. For the purposes of this subsection, a principal is not considered competent when

(1) it is the opinion of the court in a guardianship proceeding under AS 13.26, the opinion of two physicians, at least one of whom is a psychiatrist, or the opinion of a physician and a professional mental health clinician, that the principal is not competent; or

(2) a court in a hearing under AS 47.30.735 , 47.30.750, or 47.30.770 determines that the principal is gravely disabled; in this paragraph, "gravely disabled" has the meaning given in AS 47.30.915 (7)(B).

(d) A health care provider, agent, guardian, or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health care provider and to any health care institution at which the patient is receiving care.

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

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

Sec. 13.52.025. Rescission of withdrawal by agent.

A person who has withdrawn as an agent may rescind the withdrawal by executing an acceptance after the date of the withdrawal. A person who rescinds a withdrawal shall give notice to the principal if the principal has capacity or to the principal's health care provider if the principal does not have capacity.

Sec. 13.52.030. Surrogates.

(a) Except in the case of mental health treatment and except as provided by AS 13.52.173 and 13.52.193, a surrogate may make a health care decision for a patient who is an adult if an agent or guardian has not been appointed or the agent or guardian is not reasonably available, and if the patient has been determined by the primary physician to lack capacity.

(b) Subject to AS 13.52.055 (b), a surrogate may make a decision regarding mental health treatment for a patient who is an adult if

(1) an agent or guardian has not been appointed or the agent or guardian is not reasonably available;

(2) the mental health treatment is needed on an emergency basis; and

(3) the patient has been determined to lack capacity by

(A) two physicians, one of whom is a psychiatrist; or

(B) a physician and a professional mental health clinician.

(c) Except as provided for anatomical gifts in AS 13.52.173 , an adult may designate an individual to act as surrogate for that adult by personally informing the supervising health care provider. Except as provided by AS 13.52.173 or 13.52.193, in the absence of a designation, or if the designee is not reasonably available, a member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

(1) the spouse, unless legally separated;

(2) an adult child;

(3) a parent; or

(4) an adult sibling.

(d) Except as provided by (l) of this section or AS 13.52.173 or 13.52.193, if none of the individuals eligible to act as surrogate under (c) of this section is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate.

(e) A surrogate shall communicate the surrogate's assumption of authority as promptly as practicable to the health care provider, the health care institution, and the members of the patient's family specified in (c) of this section who can be readily contacted.

(f) If more than one member of a class under (c)(2) - (4) of this section assumes authority to act as surrogate, the members of that class do not agree on a health care decision, and the supervising health care provider is informed of the disagreement, the supervising health care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the class is evenly divided concerning the health care decision and the supervising health care provider is informed of the even division, that class and all individuals having a lower priority under (c)(2) - (4) of this section are disqualified from making the decision, and the primary physician, after consulting with all individuals in that evenly divided class who are reasonably available, shall make a decision based on the consultation and the primary physician's own determination of the best interest of the patient.

(g) A surrogate shall make a health care decision in accordance with the patient's individual instructions or other advance health care directives, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the

surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

(h) If a patient's primary health care provider observes that a surrogate is not abiding by the wishes, values, and best interest of the patient, the primary health care provider may decline to comply with a decision of the surrogate and shall notify the health care institution where the primary health care provider is providing health care to the patient.

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

(j) A patient who has capacity may, at any time, disqualify another person, including a member of the patient's family, from acting as the patient's surrogate by a signed writing or by personally informing the supervising health care provider of the disqualification.

(k) Unless related to the patient by blood, marriage, or adoption, a surrogate may not be an owner, operator, or employee of the health care facility where the patient is receiving care.

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

Sec. 13.52.040. Decisions by guardian.

(a) Subject to AS 13.52.183 , 13.52.193, and 13.52.203, a guardian shall comply with the ward's individual instructions and may not revoke a ward's advance health care directive executed before the ward's incapacity unless a court expressly authorizes the revocation.

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

(c) Except as provided in (a) of this section, a health care decision made by a guardian for the ward is effective without judicial approval.

Sec. 13.52.045. Withholding or withdrawing of life-sustaining procedures.

Notwithstanding any other provision of this chapter, an agent or a surrogate may determine that life-sustaining procedures may be withheld or withdrawn from a patient with a qualifying condition when there is

(1) a durable power of attorney for health care or other writing that clearly expresses the patient's intent that the procedures be withheld or withdrawn; or

(2) no durable power of attorney for health care or other writing that clearly expresses the patient's intent to the contrary, the patient has a qualifying condition as determined under AS

13.52.160 , and withholding or withdrawing the procedures would be consistent with the patient's best interest.

Sec. 13.52.050. Decisions for exceptional procedures.

Unless there is a durable power of attorney for health care or another writing clearly expressing an individual's intent to the contrary, an agent or surrogate may not consent on behalf of a patient to an abortion, sterilization, psychosurgery, or removal of bodily organs except when the abortion, sterilization, psychosurgery, or removal of bodily organs is necessary to preserve the life of the patient or to prevent serious impairment of the health of the patient.

Sec. 13.52.055. Pregnancy.

(a) Before implementing a health care decision for a woman of childbearing age that would affect a fetus if present, the supervising health care provider shall take reasonable steps to determine whether the woman is pregnant.

(b) Notwithstanding any other provision of this chapter to the contrary, an advance health care directive by a patient or a decision by the person then authorized to make health care decisions for a patient may not be given effect if

(1) the patient is a woman who is pregnant and lacks capacity;

(2) the directive or decision is to withhold or withdraw life-sustaining procedures;

(3) the withholding or withdrawal of the life-sustaining procedures would, in reasonable medical judgment, be likely to result in the death of the patient; and

(4) it is probable that the fetus could develop to the point of live birth if the life-sustaining procedures were provided.

(c) This section does not apply to emergency services in the field.

Sec. 13.52.060. Obligations of health care providers, institutions, and facilities.

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

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

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

(d) Except as provided in (e), (f), and (i) of this section and by AS 13.52.253 , 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 with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and

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

(e) A health care provider may decline to comply with an individual instruction or a health care decision for reasons of conscience, except for a do not resuscitate order. A health care institution 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.

(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. 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.

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

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

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

(3) unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately cooperate and comply with a decision by the patient or a person then authorized to make health care decisions for the patient to transfer the patient to another health care institution, to another health care facility, to the patient's home, or to another location

chosen by the patient or by the person then authorized to make health care decisions for the patient.

(h) Except as provided for civil commitments under AS 47.30.817 , a health care provider, health care institution, or health care facility may not require or prohibit the execution or revocation of an advance health care directive as a condition for providing health care.

(i) Notwithstanding the exception in (e) of this section for do not resuscitate orders, a health care provider may perform cardiopulmonary resuscitation or other resuscitative measures on a patient even if there is a do not resuscitate order for the patient if the condition requiring cardiopulmonary resuscitation or other resuscitative measures is precipitated by complications arising out of medical services being provided by the health care provider to the patient.

(j) The provisions of (i) of this section do not apply when a health care provider performs emergency medical services on a patient in the field, unless an online physician orders the health care provider to perform cardiopulmonary resuscitation or other resuscitative measures; in this subsection,

(1) "health care provider" does not include a physician;

(2) "in the field" does not include in a health care facility, health care institution, hospital, or mental health facility;

(3) "online physician" means a physician who is immediately available in person or by radio or telephone, when medically appropriate, for communication of medical direction to health care providers.

Sec. 13.52.065. Do not resuscitate protocol and identification requirements.

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

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

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

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

(e) Notwithstanding (d) of this section, if an individual has made an anatomical gift to occur at death and is in a hospital when a do not resuscitate order or an order to withdraw life-sustaining procedures is to be implemented for the individual, the order may not be implemented until the subject of the anatomical gift can be evaluated to determine if it is suitable for donation.

(f) A do not resuscitate order may not be made ineffective unless a physician revokes the do not resuscitate order, a patient for whom the order is written and who has capacity requests that the do not resuscitate order be revoked, or 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 do not resuscitate order be revoked. Any physician of a patient for whom a do not resuscitate order is written may revoke the do not resuscitate order if the person for whom the order is written requests that the physician revoke the do not resuscitate order.

Sec. 13.52.070. Health care information.

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

(b) Notwithstanding (a) of this section, if there is a question about the principal's capacity, an agent or a surrogate of the principal may immediately access the personal health care information necessary to determine the principal's capacity, even if the agency or surrogacy does not become effective until the principal lacks capacity.

Sec. 13.52.080. Immunities.

(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 (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.

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

(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 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.

Sec. 13.52.090. Statutory damages.

(a) A health care provider or institution that intentionally violates this chapter is liable to the aggrieved individual or the individual's estate for damages of $10,000 or actual damages resulting from the violation, whichever is greater, plus attorney fees as provided by court rule.

(b) A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health care directive or a revocation of an advance health care directive without the individual's consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health care directive, is liable to that individual for damages of $10,000 or actual damages resulting from the action, whichever is greater, plus attorney fees as provided by court rule.

Sec. 13.52.100. Capacity.

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

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

(c) An individual who is a qualified patient, including an individual for whom a physician has issued a do not resuscitate order, has the right to make a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures as long as the individual is able to make the decision. If an individual who is a qualified patient, including an individual for whom a physician has issued a do not resuscitate order, is not able to make the decision, the protocol adopted under AS 13.52.065 for do not resuscitate orders governs a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures.

Sec. 13.52.110. Status of copy.

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

Sec. 13.52.120. Effect of this chapter.

(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.

(b) Notwithstanding any other provision of law, 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; 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.

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

(d) This chapter does not authorize mercy killing, assisted suicide, or euthanasia.

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

(f) This chapter does not authorize an agent or a surrogate to consent to the admission of an individual to a mental health facility unless the individual's written advance health care directive expressly so provides, and the period of admission may not exceed 17 days.

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

Sec. 13.52.130. Prohibited requirements.

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

Sec. 13.52.135. Discriminatory treatment prohibited.

When determining the best interest of a patient under this chapter, health care treatment may not be denied to a patient because the patient has a disability or is expected to have a disability.

Sec. 13.52.140. Judicial relief.

On petition of a patient, the patient's agent, guardian, or surrogate, or a health care provider or institution involved with the patient's care, the superior court may enjoin or direct a health care decision or order other equitable relief. A proceeding under this section is governed by AS 13.26.090 - 13.26.320.

Sec. 13.52.150. Do not resuscitate orders and identification of other jurisdictions.

A do not resuscitate order or a do not resuscitate identification executed, issued, or authorized in another state or a territory or possession of the United States is valid for the purposes of this chapter if it complies with the laws of this state. A health care provider or health care institution may presume, in the absence of actual notice to the contrary, that the do not resuscitate order or the do not resuscitate 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.

THE ALASKA HEALTH CARE DECISIONS ACT, ANALYZED

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This Article reviews and examines the Alaska Health Care Decisions Act ("AHCDA"), found at section 13.52 of the Alaska Statutes and effective January 1, 2005. The AHCDA is examined functionally, historically, philosophically, and by hypothetical application to well-known cases. The Article identifies a number of errors and ambiguities in the AHCDA and concludes that while the AHCDA expresses itself as an attempt to balance the societal concerns of sanctity of life and the right to self-determination, in practice it is likely to promote termination of life support in circumstances supported by neither of those two philosophical imperatives.

I. INTRODUCTION

After four years of debate, the 2004 Alaska Legislature finally passed the Alaska Health Care Decisions Act ("AHCDA").[1] The AHCDA is an ambitious attempt to pull together a number of statutory schemes related to the end of life, including laws on advance directives (also known as "living wills"), termination of life support for those who are terminally ill or permanently unconscious, laws related to decision making for the mentally ill, and laws related to organ donation. The AHCDA also adds a section on surrogate decision making for those who have not filled out an advance medical directive and have no court-appointed guardian. The AHCDA includes an optional form called an advance healthcare directive, which can be used to appoint a decision maker for healthcare decisions in the event a person is incapacitated.[2] The advance healthcare directive also provides instructions for healthcare, including decisions to withdraw life

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1. ALASKA STAT. § 13.52 (2004).

2. § 13.52.300.

support (which includes feeding tubes); changes the system for making anatomical gifts at death; allows appointment of a surrogate decision maker for mental health treatment; and indicates the physician who will have the right, under certain circumstances, to make decisions on a patient's behalf.[3]

This Article will examine the AHCDA from several different perspectives. Part II reviews the AHCDA functionally, with an emphasis on what its various parts achieve and how well these parts fit together. Part III culls the legislative history to show how the bill evolved from a "Five Wishes" statement to its current form. Part IV examines the AHCDA from a philosophical perspective, showing how the various emphases on sanctity of life, right to self-determination, and quality of life have been factored, albeit somewhat unevenly, into the Act. Part V applies the AHCDA to the well-known cases involving Karen Ann Quinlan, Nancy Cruzan, Terri Schiavo, Sun Hudson, and Ora Mae Magouirk to see how those cases would likely have come out under the AHCDA. Finally, Part VI considers the likely practical effects of the AHCDA, analyzing whether the probable results are in fact consistent with the aims on which the AHCDA purports to be based.

II. FUNCTIONAL ANALYSIS

The Health Care Decisions Act is a hybrid enactment, covering a number of different areas relating to decision making on medical issues.

The AHCDA's most distinctive attribute is the new advance healthcare directive form, with the activating portion at the beginning of the statute,[4] and the optional form itself at the conclusion (except for the definitions).[5] Under the old living will statute,[6] a terminally ill individual could direct that his attending physician withhold or withdraw procedures that merely prolonged the dying process and were not necessary to keep him comfortable and to relieve pain.[7] The individual could also make an organ donation on the same document[8] or separately. Under the new form, in a single document, the individual can designate an agent to make healthcare decisions if he or she becomes incapacitated; can

3. *Id.*
4. § 13.52.010.
5. § 13.52.300.
6. ALASKA STAT. §§ 18.12.010–.100 (2002) (repealed 2004).
7. § 18.12.010(a) (repealed 2004).
8. § 13.50.030 (repealed 2004).

limit that agent's authority; can indicate, when the person has a "qualifying condition,"[9] whether life should be prolonged by artificial means, artificial nutrition or hydration, or whether pain relief should be provided; can direct an anatomical gift at death, and even what types of use to which the gift can be made; can delegate authority for mental health treatment; and can designate a primary physician for decision-making purposes.[10] The AHCDA provides details regarding how the form must be witnessed, when it is effective,[11] what the agent must consider in making decisions on the person's behalf, and how it may be revoked, among other limitations.

Noticeably, the statutes related to guardianship were not incorporated into the AHCDA, but were instead left in Title 13.[12] However, several portions of the AHCDA do relate to guardians. Under the guardianship statutes, a person nominated by the respondent has priority to be selected as guardian,[13] and under the AHCDA the form may include the individual's nomination of a guardian;[14] thus, the AHCDA provides a method for nominating the person who will be given priority under the guardianship statutes. The sample form, if left unaltered, simply nominates the person who is designated to make healthcare decisions as the guardian.[15] Note, however, that under the guardianship statutes, a general guardian has a great deal of authority with regard to finances (assuming a separate conservator has not been appointed), and a different person might be better able to handle those duties. As a result, patients are advised to consider carefully the decision to designate a healthcare agent that will also act as the preferred guardian. Separating the functions of healthcare agent and guardian would require writing a separate instruction on the form, as the appointment of a guardian is otherwise automatic in the last paragraph of Part One of the statutory form.

Interestingly, absent a court order to the contrary, a healthcare decision made by an agent[16] takes precedence over that of a

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9. Defined as either a condition of permanent unconsciousness or a terminal condition. ALASKA STAT. § 13.52.300 (2004).

10. *Id.*

11. § 13.52.010(f). The form is only effective during the time the principal lacks capacity. *Id.*

12. §§ 13.26.090–.155.

13. § 13.26.145(d)(1).

14. § 13.52.010(j).

15. § 13.52.300 pt. 1(5).

16. An "agent" refers to one appointed under an advance healthcare directive.

guardian,[17] and the guardian is required to comply with the ward's healthcare directive unless a court expressly authorizes the revocation. Attorneys who represent petitioners in guardianship cases have already noticed the potential malpractice trap; consequently, they now draft proposed orders for the court so that their guardians will be able to act according to their own perceptions of the ward's best interest and will not be overruled by an appointed agent. To understand the problem, imagine that you are the attorney for the petitioner in a guardianship case, and your client has asked you to secure guardianship over a relative with dementia, in part so that reasonable healthcare decisions can be made. In your proposed orders, which are ultimately adopted by the court, you neglect to state clearly that the guardian's decisions will overrule any decisions by an agent (probably because you are using the same forms you used in the past, when this was not an issue). On the eve of an important medical procedure, you discover that the ward has a pre-existing, valid healthcare directive, naming another individual as the agent. The agent will not consent to the medical procedure, so it cannot be performed. The malpractice risk in that scenario should be apparent.

In recognition of the fact that a significant portion of the population does not, and will not, have advance directives, the AHCDA includes a detailed provision allowing for the appointment of surrogates for individuals who do not have advance healthcare directives or guardians.[18] A patient can designate such a surrogate by personally informing the supervising healthcare providers of the identity of the desired surrogate.[19] If the patient fails to do so, a surrogate is appointed according to a priority list, beginning with the patient's spouse, then adult children, then parents, then adult siblings, and finally "an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available."[20] The surrogate is to act in accordance with the patient's individual instructions and wishes; otherwise, the surrogate may make the decision in accordance with his or her determination of the patient's best interest, considering the patient's personal values.[21] The patient's primary healthcare provider may overrule the

17. § 13.52.040(b).
18. § 13.52.030.
19. § 13.52.030(c).
20. § 13.52.030(d).
21. § 13.52.030(g).

surrogate's decision if it appears that he or she is not abiding by the wishes, values, and best interests of the patient.[22]

The AHCDA has specific restrictions on when life support (including the withholding of artificial nutrition and hydration) may be withheld or withdrawn. The patient must have a "qualifying condition," which means either a terminal condition or a state of permanent unconsciousness.[23] However, the standards for do-not-resuscitate orders (commonly called "DNR" or "Comfort One" orders) are different under the AHCDA. Specifically, the order must be entered by a physician and does not require the consent of the patient, agent, guardian, surrogate, or family.[24]

The rules on anatomical gifts (also known as "organ donation") primarily involve two different sections of the AHCDA. The first, section 13.52.170, allows the patient to make an anatomical gift in a variety of ways.[25] The second, section 13.52.180, allows other individuals (again, according to a priority list) to make anatomical gifts on the patient's behalf, unless the patient had previously and specifically objected.[26] The statute also provides a form for a third party to make the gift,[27] and other sections of the statute attempt to sort out the necessary details and prevent abuses.[28]

Finally, there are the mental health provisions.[29] Part Four of the optional form directive allows an individual to make a variety of decisions about mental health treatment, including whether he or she consents to administration of psychotropic medications, electroconvulsive treatment, or mental health commitment.[30] The remaining mental health provisions, for the most part, carve out

22. § 13.52.030(h).
23. § 13.52.390(36).
24. § 13.52.065.
25. § 13.52.170.
26. § 13.52.180.
27. § 13.52.190.
28. §§ 13.52.200–.270.
29. Whether mental health treatment even falls within the AHCDA depends on whether the AHCDA is viewed as primarily related to medical care or to end-of-life issues. If the AHCDA is aimed at medical care in general, including mental health treatment, this part of the statute makes sense. But, if one thinks of the AHCDA as related primarily to questions surrounding the end-of-life, the section on mental health treatment does not fit at all.
30. § 13.52.300, pt. 4.

exceptions to the general rules applicable to other medical treatments.[31]

Most of the laws related to mental health commitments are not in the AHCDA, but rather in section 47.30[32] of the Alaska Statutes, which covers involuntary mental health commitments. Under the involuntary commitment statute, an individual can be committed by a peace officer, a psychiatrist or other physician, or a psychologist;[33] the AHCDA adds the designated healthcare agent to the list of people who can initially order a commitment.[34] Additionally, under the AHCDA, the agent can commit the patient for up to seventeen days,[35] whereas the statute on involuntary commitments mandates a probable cause hearing within three days.[36]

The mental health portion of the advance directive itself is nothing new; indeed, it is lifted word-for-word from the old statute, which was titled "Personal Declaration of Preference for Mental Health Treatment"[37] and was repealed effective the same day the AHCDA took effect.[38] Both forms allow the agent to make the decisions on psychotropic medication, electroconvulsive treatment, and involuntary commitment for up to seventeen days.[39]

Curiously, under Part Four of the AHCDA's form, the default rule is that the healthcare agent can make mental health decisions on behalf of the patient.[40] Consequently, there is a risk that those who do not read the form carefully or check off the boxes indicating non-consent will inadvertently give the agent the authority to consent to highly invasive and controversial mental

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31. *E.g.*, § 13.52.020(a)–(c) (outlining exceptions to the general rules regarding revocation of a directive); § 13.52.030 (relating to surrogates); § 13.52.120(f) (regarding commitments to mental health facilities).

32. §§ 47.30.700–.815.

33. § 47.30.705.

34. § 13.52.300.

35. *Id.*

36. § 47.30.715.

37. ALASKA STAT. §§ 47.30.950–.980 (2002) (repealed 2004).

38. ALASKA STAT. § 13.52.300 (2004); ALASKA STAT. §§ 47.30.950–.980 (2002) (repealed 2004).

39. ALASKA STAT. § 13.52.300 (2004); ALASKA STAT. §§ 47.30.950–.980 (2002) (repealed 2004).

40. ALASKA STAT. § 13.52.300, pt. 4 (2004). The optional form directive reads as follows: "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." *Id.*

health treatments.[41] Under the repealed mental health declaration, there was no such default.[42] Rather, a patient who did not wish to give an agent those powers did not have to fill out the form in the first place.[43]

Moreover, the witnessing requirements were more stringent under the prior statute. Under that statute, neither witness could be related to the patient,[44] and the agent was expected to accept the appointment in writing.[45] Under the AHCDA, one witness may be a relative of the patient's.[46] As a result, it is easier to delegate important mental health decisions, and such delegation can even be done accidentally by leaving Part Four of the statutory form blank.

This puzzling default in the mental health section underscores a problem that surfaces throughout the AHCDA: people are encouraged to fill out these forms as part of estate planning or general good stewardship, even if they do not have current medical problems; however, many parts of the statutory form seem designed for those with an existing major medical issue.

III. HISTORICAL ANALYSIS

The AHCDA's history is unusual in that it took a full four years of work in various committees in order for the bill to become law. The bill was introduced in 2001, in the first session of the 22nd legislature, as House Bill 197.[47] After the House Health, Education and Social Services ("HESS") Committee and the Judiciary Committee made amendments, the bill passed the House during the second session of that legislature in 2002.[48] It did not pass the Senate (it was never even scheduled for a Senate hearing), and so, technically speaking, it died. However, in the following legislature,

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41. Although some individuals with current psychological disorders may wish to give a trusted agent the authority to make these decisions on his or her behalf, it is unlikely that a person who has no current mental disorder would want to appoint someone to override his or her express wishes in this regard. After all, mental health treatment is generally recommended only for conscious patients. If the patient is conscious and agrees to the treatment, there is no need for the agent to be involved. So, presumably if the agent is acting, it is because the patient is not in agreement, at the time the decision must be made, with the proposed treatment.

42. *See* ALASKA STAT. §§ 47.30.950–.980 (2002) (repealed 2004).

43. *Id.*

44. § 47.30.954 (repealed 2004).

45. § 47.30.970 (repealed 2004).

46. ALASKA STAT. § 13.52.010(e) (2004).

47. H.B. 197, 22d Leg., 1st Sess. (Alaska 2001).

48. H.B. 197, 22d Leg., 2d Sess. (Alaska 2002).

the bill was reintroduced in exactly the same form.[49] Finally, in 2004, after being amended numerous times by both the House and Senate committees, the bill received near-unanimous legislative approval and became law.[50]

From the beginning, the bill was touted as being based on the "Five Wishes."[51] The Five Wishes is a document developed by the Aging With Dignity organization,[52] which prompts the declarant to make choices regarding the following:

1. Comfort care (such as how much medicine should be provided, whether warm baths should be given, and whether religious readings or "well-loved poems" should be read aloud to the declarant when near death);
2. How people should treat the declarant (such as whether people should be around when death is near, whether members of a church or synagogue should be asked to pray for the declarant, and whether there is a preference to die in the home);
3. What loved ones should be told (including, for example, whether the declarant wishes forgiveness from family or friends, how the declarant wishes to be remembered, and instructions for memorial services);
4. Desired medical treatment (including especially the question of withdrawal of life support); and,
5. Which person should be named to make healthcare decisions if the declarant is no longer able to do so.

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49. *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 6 (Alaska Feb. 13, 2003), *available at* http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507. pdf.

50. H.B. 25, 23d Leg., 2d Sess. (Alaska 2004).

51. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 6 (Alaska Mar. 8, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-081333.pdf; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 11–13 (Alaska Feb. 13, 2003), *available at* http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507.pdf; *Minutes, H. Judiciary Comm.*, 22d Leg., 2d Sess. 36–39 (Alaska Mar. 20, 2002), *available at* http://www.legis.state.ak.us/PDF/22/M/HJUD2002-03-201315.pdf; *Minutes, H. Health, Educ. and Soc. Serv. Comm.* 22d Leg., 1st Sess. 8–13 (Alaska Apr. 17, 2001), *available at* http://www.legis.state.ak.us/PDF/22/M/HHES2001-04-171502. pdf.

52. The Dying Process: Five Wishes Document, http://www.learningplaceonline.com/stages/together/wishes/wishes-1.htm (last visited Sept. 26, 2005) [hereinafter Five Wishes Document].

The 2001 version of the bill closely resembled the Five Wishes document, including the many details of comfort care.[53] However, by 2002, legislative committees had substantially rewritten the bill;[54] eventually, the finished product was merely "inspired by" the Five Wishes.[55]

The Five Wishes document is a personal document not a legal document, and, as such, is written in lay language. By contrast, the AHCDA is more comforting to lawyers, as it is drafted in the style of a legal document and employs language and stylistic trends familiar to lawyers.[56]

The legislature's desire to provide something similar to the Five Wishes explains those portions of the AHCDA related to the healthcare directive, but those portions account for less than half of the total Act. The rest of the bill was explained as an attempt to bring together, under a single chapter, a variety of laws which previously had been scattered throughout the statutes.[57] The bill can be said to have accomplished this.[58]

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53. *Compare* H.B. 197, 22d Leg. 13, 1st Sess. (Alaska 2001) *with* Five Wishes Document, *supra* note 52, Part B, Wish 3.

54. *Compare* H.B. 197, 22d Leg., 1st Sess. (Alaska 2001) *with* H.B. 197, 22d Leg., 2d Sess. (Alaska 2002).

55. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 6 (Alaska May 16, 2003), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2003-05-161351. pdf.

56. *Compare* ALASKA STAT. § 13.52.300, pt. 2(6)(B)(i)–(ii) (2004) (defining "a condition of permanent unconsciousness" as "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") *with* Five Wishes Document, *supra* note 52 (using terms such as being "close to death," "in a coma and not expected to wake up or recover," or "have permanent and severe brain damage and are not expected to recover").

57. *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 8 (Alaska Feb. 13, 2003), *available at* http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507.pdf; *Minutes, H. Judiciary. Comm.*, 22d Leg., 2d Sess. 9–10 (Alaska Apr. 10, 2002), *available at* http://www.legis.state.ak.us/PDF/22/M/HJUD2002-04-101318.pdf; *Minutes, H. Judiciary Comm.*, 22d Leg., 2d Sess. 37 (Alaska Mar. 20, 2002), *available at* http://www.legis.state.ak.us/PDF/22/M/HJUD2002-03-201315.pdf.

58. *See, e.g.*, ALASKA STAT. §§ 18.12.010–.100 (2002) (repealed 2004) (living wills and "Do Not Resuscitate" protocols), 13.50.010–.070 (repealed 2004) (organ donation), 47.30.950–.980 (mental health powers of attorney). Current versions at ALASKA STAT. § 13.52 (2004).

For the most part, philosophical discussions about end-of-life issues did not occur in the legislature until 2004, when the bill reached the Senate HESS Committee. The chairman, Senator Fred Dyson (R-Eagle River), raised a number of questions about life support termination, as did the Alaska Catholic Conference.[59] In addition to numerous committee meetings, a meeting was held off record and included the Alaska Catholic Conference's representative, the Lieutenant Governor's chief of staff, and a staff member of a legislator who advocated passage of the bill.[60] As a result of this meeting, a number of changes were made to the bill, including the addition of a broad statement that, in the absence of evidence to the contrary of the patient's intent, the AHCDA established a presumption in favor of life,[61] and a clarification that the AHCDA does not authorize mercy killing, assisted suicide, or euthanasia.[62] The changes did not entirely satisfy the Catholic Conference[63] but seemed to assuage the concerns of Senator Dyson, for when the bill moved to the Senate Judiciary Committee, Senator Dyson advocated its passage.[64]

One of the more interesting exchanges in the Senate HESS Committee centered on the issue of pregnancy. Senator Dyson, who described himself as "irrevocably pro-life regarding the abortion issue" took the position that if a pregnant woman was in an unconscious state, efforts should be made to keep the child alive, even if that meant continuing life support past a point of physical benefit for the woman.[65] Senator Gretchen Guess (D-Anchorage) took the position that the statute should not overturn a healthcare directive and that the healthcare directive ought to have an option for a pregnant woman to determine whether she would want to be kept alive so that the child might be

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59. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 6, 18 (Alaska Mar. 8, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-081333.pdf.

60. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 24 (Alaska Mar. 24, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-241344.pdf.

61. ALASKA STAT. § 13.52.120(a) (2004).

62. § 13.52.120(d).

63. *Minutes, S. Judiciary Comm.*, 23d Leg., 2d Sess. 16 (Alaska Apr. 29, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SJUD2004-04-290808.pdf.

64. *Id.*

65. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 11–12 (Alaska Mar. 8, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-081333.pdf.

born.[66] This seems to have led to an odd compromise under which the statute and the sample form say two different things. In the sample form[67] the declarant is to answer the question "should I become unconscious and I am pregnant, I direct that" (followed by several blank lines). However, a section of the AHCDA says that, if a pregnant woman lacks capacity, a directive or decision to withhold or withdraw life-sustaining procedures may not be given effect if it is probable that the fetus could develop to the point of live birth with the provision of such life-sustaining procedures.[68] In other words, if life support will enable the baby to be born alive, then life support must be continued, regardless of what the mother might have said in her directive. So the AHCDA itself would overrule a directive to discontinue life support. The resolution of any tension between a directive and the AHCDA may hinge on whether the doctor has actually read the statute or only the approved statutory form.

After four years of testimony, committee hearings, committee substitutes, and debate, the final version of House Bill 25 passed the Senate unanimously, and was then adopted by the House with only one dissenting House vote.[69] The governor signed the Act the following month, and it took effect on January 1, 2005.[70]

IV. PHILOSOPHICAL ANALYSIS

A central premise of this article posits that people approach end-of-life issues from three different philosophical positions. This section of the Article will analyze how each of these positions ultimately influenced the adoption of the AHCDA.

A. Self-Determination

The first of these positions is an emphasis on self-determination, that is, the ability to make one's own decisions about one's own life. This is usually referenced as a "constitutional right" to self-determination. In *Cruzan v. Missouri Department of Health,*[71] a case involving a woman in a vegetative state whose

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66. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 12, 29 (Alaska Apr. 14, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-141341.pdf (testimony of Sen. Gretchen Guess).

67. ALASKA STAT. 13.52.300, pt. 2(6)(E) (2004).

68. § 13.52.055(b).

69. H.J. 23, 2d Sess., at 4026 (Alaska 2004); S.J. 23, 2d Sess., at 3248 (Alaska 2004).

70. H.J. 23, 2d Sess., at 4508 (Alaska 2004).

71. 497 U.S. 261 (1990).

family wanted to remove her feeding tube, the United States Supreme Court held that the early common law rule that individuals are to be free from the restraint or interference of others[72] and the requirement for informed consent to medical treatment[73] suggested that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.[74] The Court noted in *Cruzan* that this right to self-determination may also extend to allowing others to exercise what it called a substituted judgment.[75] Substituted judgment involves informing the medical providers of what the patient, presumably unable to express his or her own wishes, would have wanted regarding cessation of medical treatment. Interestingly, Chief Justice Rehnquist's majority opinion does not actually find that there is a constitutional right to refuse medical treatment, but rather notes that such a right could be inferred from the Court's previous decisions.[76] In the subsequent case of *Washington v. Glucksberg*,[77] the Court, again in an opinion written by Chief Justice Rehnquist, noted that while that right could be inferred (since it had been "strongly suggested" by previous opinions), it had not actually been pronounced by the Court.[78]

B. Sanctity of Life

The second significant philosophical position represents an emphasis on the sanctity of life. The Supreme Court has recognized this position, not as a constitutional right, but as a legitimate state interest,[79] which a state can consider in establishing laws. In *Cruzan*, it was this interest, among others, that justified allowing Missouri to require clear and convincing evidence that the individual would want life support terminated.[80] In *Glucksberg*, the state's interest in the preservation of life was a factor in upholding the state of Washington's prohibition of assisted suicide.[81]

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72. *Id.* at 267 (citing Union Pac. R.R. Co. v. Botsford, 141 U.S. 250, 251 (1891)).

73. *Id.* at 269 (citing Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914)).

74. *Id.* at 278.

75. *Id.* at 284.

76. *See id.* at 278–79.

77. 521 U.S. 702 (1997).

78. *See id.* at 720.

79. *Id.* at 728–29; *Cruzan*, 497 U.S. at 280.

80. *Cruzan*, 497 U.S. at 281.

81. *Glucksberg*, 521 U.S. at 728–29.

C. Quality of Life

A patient's quality of life has never been specifically recognized as either a legitimate interest or a right by the Supreme Court. Nonetheless, concern for a patient's quality of life influenced the debate over the AHCDA.

A moderate quality of life position may be defined as concern for the pain and misery that accompany the end of life. An extreme position suggests that once one is no longer able to do anything useful, productive, or interesting, one ought to die. Various courts and professional groups have taken diverging positions on this philosophical question.

In *In re Quinlan*,[82] the New Jersey Supreme Court factored into its decision-making calculus the likelihood of the patient ever returning to "cognitive life," thus taking a position somewhere between the moderate and the extreme positions outlined above.[83]

In one survey of doctors and medical administrators, a remarkable 89% believed it was ethical to withdraw nutrition and hydration from patients in a vegetative state, with a majority endorsing the view that patients in a vegetative state would be "better off dead."[84] One version of this philosophy was expressed in the legislative hearings on the AHCDA by Dr. Maria Wallington, a medical ethicist.[85] She testified that the decision to terminate life support should hinge on whether "what is needed to keep the person alive actually allows him/her to go on with life" or the chance the person will become healthy again and not depend on medical care.[86]

Remarkably, throughout the lengthy history of committee hearings and floor debates in 2001, 2002, and 2003, there was hardly any examination of the philosophical underpinnings of the law, which initially appeared to be strongly influenced by the right to self-determination. Throughout the committee minutes, legislators appeared to assume that people should be able to make their own choices regarding end-of-life decisions.[87] Examples, both

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82. 355 A.2d 647 (N.J. 1976).

83. *Id.* at 664.

84. Kirk Payne et al., *Physicians' Attitudes about the Care of Patients in the Persistent Vegetative State: A National Survey*, 125 ANNALS OF INTERNAL MED. 104, 105 (1996).

85. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 12-14 (Alaska Apr. 7, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES 2004-04-071745.pdf.

86. *Id.*

87. *See, e.g.*, *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 17 (Alaska Feb. 27, 2003), *available at* http://www.legis.state.ak.us/PDF/23/

good and bad, were given from the personal experiences of witnesses and legislators.[88] However, no one raised much concern for the sanctity of life, until the bill reached the Senate HESS Committee in March 2004.[89] At that point, intertwined with the debate over the pregnancy provisions of the bill and the hammering out of various details, the concern for the sanctity of life finally surfaced.[90] Senator Dyson and the Alaska Catholic Conference raised the issue, and a few witnesses took opposing positions.[91]

Notably, a significant portion of the debate centered on the issue of withdrawal of artificial nutrition and hydration.[92] Senator Dyson raised this as a main question about the bill in the opening

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M/HHES2003-02-271504.pdf; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 4 (Alaska Feb. 13, 2003), *available at* http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507.pdf; *Minutes, H. Judiciary Comm.*, 22d Leg., 2d Sess. 12 (Alaska Apr. 10, 2002), *available at* http://www.legis.state.ak.us/PDF/22/M/HJUD2002-04-101318.pdf; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 22d Leg., 1st Sess. 27 (Alaska Apr. 24, 2001), *available at* http://www.legis.state.ak.us/PDF/22/M/HHES2001-04-241508.pdf; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 22d Leg., 1st Sess. 8 (Alaska Apr. 17, 2001), *available at* http://www.legis.state.ak.us/PDF/22/M/HHES2001-04-171502.pdf.

88. *See, e.g.*, *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 6 (Alaska May 16, 2003), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2003-05-161351.pdf; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 20–21 (Alaska Feb. 27, 2003), *available at* http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-271504.pdf; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 3-4 (Alaska Feb. 13, 2003), *available at* http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507.pdf; *Minutes, H. Judiciary Comm.*, 22d Leg., 2d Sess. 11 (Alaska Apr. 10, 2002), *available at* http://www.legis.state.ak.us/PDF/22/M/HJUD2002-04-101318.pdf; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 22d Leg., 1st Sess. 11 (Alaska Apr. 17, 2001), *available at* http://www.legis.state.ak.us/PDF/ 22/M/HHES2001-04-171502.pdf.

89. *See Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 18-19 (Alaska Mar. 8, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-081333.pdf.

90. *See id.*

91. Including, curiously, Dr. Maria Wallington, who purported to represent Providence Health Systems, which is owned by Sisters of Providence, a branch of the Roman Catholic Church. With the Alaska Catholic Conference (representing the Catholic bishops in Alaska) on one side of several issues, and Dr. Wallington of Providence Health Systems on the other, two different agencies of the Roman Catholic Church (sometimes thought to be "monolithic") weighed in on opposite sides of the debate. *See id.* at 8.

92. *Id.* at 14–19.

of his committee's hearing.[93] A representative of the Alaska Nurses' Association argued that withholding fluid and nutrition actually allows a patient to die naturally.[94] Dr. Wallington argued that the law should safeguard the choices made in a person's advance directive.[95] On the other hand, the Alaska Catholic Conference representative argued that the law should have a strong presumption in favor of life, quoting the statement of then-Pope John Paul II that administration of water and food always represents a natural means of preserving life, not a medical act, even when provided by artificial means.[96]

Ultimately, for the most part, the resulting bill is based on the right to self-determination, with a few specific overlays based on concern for the sanctity of life. Life support, including artificial nutrition and hydration, can be withdrawn only if the person is in a state of permanent unconsciousness (meaning a coma or a permanent vegetative state, depending on how one interprets the definitions) or has a terminal illness.[97] A surrogate, whether appointed by the patient or selected according to the statutory procedure, can make decisions for the patient; but in doing so, the surrogate must consider the patient's personal values, including any religious beliefs.[98] Life support may not be withdrawn for a pregnant woman if her child could survive to birth with the procedures in place.[99] Further, a healthcare provider may decline to provide "medically ineffective health care or healthcare contrary to generally accepted health care standards," but only after providing the family an opportunity to transfer the patient to another institution.[100] Finally, the AHCDA explicitly states that, in the absence of evidence of the patient's intent to the contrary, the law establishes a presumption in favor of life, consistent with the patient's best interest.[101]

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93. *Id.* at 7.

94. *Id.* at 9.

95. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 12 (Alaska Apr. 7, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-071745.pdf.

96. *Id.* at 20.

97. ALASKA STAT. §§ 13.52.045, .390 (2004).

98. §§ 13.52.030(g), .390(6)(G).

99. § 13.52.055.

100. § 13.52.060(f)–(g).

101. § 13.52.120.

D. Distrust of Lawyers

A distrust for lawyers seems, if only speculatively, to have influenced the bill. Such distrust is evidenced by the fact that the AHCDA vests final decision-making authority in patients, their agents, or their surrogates, with some limited rights-of-refusal or review by their doctors.[102] Further, doctors, not courts, decide whether a person lacks capacity.[103] A doctor may decline to comply with a surrogate's decisions if he or she believes that the surrogate is not abiding by the wishes, values, and best interest of the patient.[104] The doctor can otherwise refuse to comply with the individual instruction or decision for a variety of reasons, such as "reasons of conscience,"[105] or a belief that the proposed treatment would be ineffective or contrary to generally accepted healthcare standards.[106] It is the doctor who ultimately decides whether to issue a "Do Not Resuscitate" order.[107] The AHCDA grants healthcare providers fairly broad immunity in making these decisions.[108] The role of the judiciary receives only the briefest mention,[109] and an agent's healthcare decision can even overrule the decision of a court-appointed guardian (unless a court order specifically provides otherwise).[110]

In his book *Strangers at the Bedside*,[111] historian David Rothman chronicles how, beginning in the 1960s, the United States evolved from a society of unwavering acceptance of the decisions of doctors to a society in which lawyers, bioethicists, politicians, judges, and ethics committees are involved in the decision-making. He credits the shift in part to the fact that most Americans no longer have a trusted family doctor whom they know well enough to trust with end-of-life decisions.[112] Nonetheless, the AHCDA places some of the decision-making authority directly into the physician's hands.[113] Thus, the AHCDA assumes that patients want

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102. *See* §§ 13.52.010-.395.
103. § 13.52.010(g).
104. § 13.52.030(h).
105. § 13.52.060(e).
106. § 13.52.060 (f).
107. § 13.52.065.
108. § 13.52.080.
109. § 13.52.140.
110. § 13.52.040(b).
111. DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING (Walter de Gruyter 2003) (1991).
112. *See id.* at 128–31.
113. ALASKA STAT. § 13.52.300, pt. 5 (2004); *see also* § 13.52.030(h).

their primary physicians to make such decisions. This is a questionable assumption in an age when many people go to a clinic, family practice group, or emergency room for primary care. At no point did legislators discuss this issue in the many committee hearings on the bill. Therefore, whether the AHCDA reflects an atavistic view of primary physicians or merely a general hesitancy to let lawyers make these decisions is uncertain.[114]

An emphasis on decision making by physicians may have also resulted from the drafters' focus on patients with pre-existing medical conditions, rather than on those who fill out the advance directive form as part of general estate planning.[115] For instance, the designation of a primary physician will typically pose little problem for someone with cancer, who would likely designate his or her oncologist. Regardless, under the AHCDA, nearly all end-of-life decisions will be made by doctors in consultation with family members, and very few decisions will be made by judges.

V. APPLICATION TO CASES

One rarely appreciates the implications of a statute until one applies the statute to a set of facts. This part of the Article will examine some of the best-known cases from recent memory to determine how they might have turned out under the AHCDA.

A. Karen Ann Quinlan

In April of 1975, Karen Ann Quinlan, a twenty-one year old New Jersey woman, stopped breathing.[116] She was revived, but suffered anoxia, or a loss of oxygen in the blood stream going to the brain.[117] Quinlan ended up in a "chronic persistent vegetative state," which was explained as a "primitive reflex level" of neurological function, with the brain stem working, but other parts of the brain nonfunctional.[118] She was sustained by a respirator and feeding tube, and it was assumed by the doctors (incorrectly, as it

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114. The Alaska Legislature has invariably had fewer attorney members than most legislatures. In the current 24th Alaska Legislature, only eleven of sixty legislators hold law degrees, according to their legislative web sites. *See* Alaska Leg. State Senate, http://w3.legis.state.ak.us/senate/24/senate.htm (last visited Oct. 19, 2005); Alaska Leg. H. R., http://w3.legis.state.ak.us/house/24/house.htm (last visited Oct. 19, 2005).

115. *See, e.g.*, *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 11–22 (Alaska Apr. 7, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-071745.pdf.

116. *In re* Quinlan, 355 A.2d 647, 653–54 (N.J. 1976).

117. *Id.* at 654.

118. *Id.* at 654–55.

turned out) that her primitive level of brain stem function would be insufficient for her to breathe on her own.[119]

Karen's father filed a petition, asking that he be appointed guardian and that the letters of guardianship contain an express power to authorize the discontinuance of all extraordinary medical procedures.[120] The hospital opposed the discontinuance, and the judge denied the father's request.[121] On appeal, the Supreme Court of New Jersey found that if Karen were able to do so, she could decide to discontinue the life support apparatus.[122] Addressing the question of substitution of judgment, the court determined that her guardian could "assert her right to privacy" on her behalf.[123] The court did not assert a broad right of guardians to make such decisions, but rather found such a right to be reasonable within the context of these particular facts.[124] In doing so, the court balanced the individual's right to privacy against the State's interest in the preservation and sanctity of human life and a physician's right to administer medical treatment according to his best judgment.[125] The court applied a sliding scale, finding that the State's interest weakened, and the individual's right to privacy grew, "as the degree of bodily invasion increase[d] and the prognosis dim[med]."[126] The court incorporated consideration of Karen's quality of life into the analysis.[127] It said that the "focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which Karen seems to be doomed."[128] As the court's words indicate, the quality of life philosophical position is implicated whenever the focus is on the possibility of returning to a sapient or more productive level of life.[129]

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119. *See id.* at 655.
120. *Id.* at 651.
121. *Id.*
122. *Id.* at 663.
123. *Id.* at 664.
124. *Id.*
125. *Id.* at 663–64. The doctors in this case were opposed to the removal of life support. *Id.* at 663.
126. *Id.* at 664.
127. *Id.*
128. *Id.* at 669.
129. Conversely, the sanctity of life position would tend to consider any life as being valuable, even if it were sub-cognitive. The self-determination position would be neutral unless the patient had expressed her wishes in some way.

The court announced a rather curious requirement for termination of life support: although the father was appointed guardian, in order to terminate life support he had to obtain the concurrence of the rest of the family.[130] Furthermore, the attending physicians, in consultation with the hospital ethics committee, had to determine that there was no reasonable possibility of Karen ever emerging from her vegetative state.[131]

How would the Quinlan case be analyzed under the AHCDA? Because Karen did not have an advance healthcare directive,[132] her father would have turned to the surrogacy statute,[133] and because she had no spouse or adult child, her father would be next in line to be Karen's surrogate under the AHCDA.[134] Therefore, he would have the authority to act, assuming Karen's mother did not object.[135]

As surrogate, Mr. Quinlan would inform the attending physician that he wanted life support removed. The doctor would turn to section 13.52.045 and see that, because Karen did not sign a directive to the contrary, he would not be prohibited from removing the life support.[136]

Next, the same section would direct him over to section 13.52.160 to see whether Karen had a "qualifying condition."[137] That section does not actually define "qualifying condition," but rather requires that the determination be made by the patient's primary physician and at least one other physician.[138] A "qualifying condition" is defined in section 13.52.390(36) as either a terminal condition or permanent unconsciousness.[139]

The definition of "terminal condition" is "an incurable or irreversible illness or injury" that will result in imminent death, for which there is no reasonable prospect of cure or recovery, that imposes severe pain or an inhumane burden on the patient, and for which continuing life sustaining procedures will provide only

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130. *See In re Quinlan*, 355 A.2d at 671–72.

131. *Id.*

132. *See id.* at 664.

133. ALASKA STAT. § 13.52.030 (2004).

134. § 13.52.030(c).

135. Karen's mother would have the same right as Karen's father to declare herself a surrogate. *See id.*

136. § 13.52.045.

137. *Id.*

138. § 13.52.160. In the case of permanent unconsciousness, the doctors must also consult with a neurologist. *Id.*

139. § 13.52.390(36).

minimal medical benefit.[140] The definition of "terminal condition" would be problematic here, because there was no guarantee that Karen would die within a "short period of time" if life-sustaining procedures were discontinued.[141] Additionally, Karen's family members did not request removal of the feeding tube, further casting doubt on whether removal of the respirator would result in death.[142]

The doctor would next turn to the definition of "permanent unconsciousness": a condition that will last "permanently without improvement," in which thought, sensation, purposeful action, social interaction, and awareness of self and the environment are absent, and for which initiating or continuing life sustaining procedures provide only minimal medical benefit.[143] This definition is also problematic for a person in a vegetative state because it requires that sensation be absent.[144] Doctors seem to be in some disagreement as to whether a patient in a persistent vegetative state feels pain.[145] If Karen felt pain, one would assume sensation was not absent, and the definition of permanent unconsciousness could not legitimately be met.[146] There is no general consensus in neurology on this issue, probably due to the fact that although patients in a vegetative state react to painful stimuli,[147] they lack a connection to the "higher" parts of the brain that understand what pain is.[148] According to one survey of doctors, about 30% of the respondents believe that vegetative state patients experience pain,

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140. § 13.52.390(42).

141. In fact, to everyone's surprise, after the respirator was eventually removed, Karen Quinlan lived for another ten years. Ascension Health, Healthcare Ethics Cases: Quinlan, Karen Ann, http://www.ascensionhealth.org/ethics/public/cases/case21.asp (last visited Oct. 25, 2005).

142. The Quinlan family was strict Roman Catholic and made the decision to remove her from the respirator only after consultation with, and approval by, the church, which would not have approved removal of the feeding tube. *In re* Quinlan, 355 A.2d 647, 657–60 (N.J. 1976).

143. § 13.52.390(31).

144. *Id.*

145. Payne et al., *supra* note 84, at 105 tbl. 2.

146. For instance, the *Cruzan* decisions made several references to her responses to painful stimuli. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 266–67 n.1 (1990) (quoting Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1989)).

147. Jan Kassubek et al., *Activation of a Residual Cortical Network During Painful Stimulation in Long-term Postanoxic Vegetative State*, 212 J. NEUROLOGICAL SCI. 85, 88 (2003).

148. *See generally* S. Laureys et al., *Cortical Processing of Noxious Somatosensory Stimuli in the Persistent Vegetative State*, 17 NEUROIMAGE 732 (2002).

and about 13% believe they experience hunger and thirst.[149] Given that the majority of doctors believe there is no sensation, combined with the possibility of "doctor shopping" by the family,[150] it is probably safe to assume that the Quinlans could, today, find a doctor who agrees that Karen meets the criteria for "permanent unconsciousness." This is even further evident when considering that 88% of the doctors responding to the survey believed it was ethical to withdraw artificial nutrition and hydration from a patient in a vegetative state.[151]

The legislative history also yields some guidance. The definition of "permanent unconsciousness" was based on an Illinois statute,[152] which includes the mandate that sensation be absent.[153] While the Illinois courts have not specifically addressed the question of whether reaction to painful stimuli constitutes sensation, several Illinois Supreme Court decisions have concluded that the condition of permanent unconsciousness covers the patient in a vegetative state.[154] Also, during legislative hearings in 2004, the Alaska legislative aide who had been shepherding the bill through the legislature specifically referenced "vegetative state" among the circumstances that would constitute a qualifying condition for purposes of removal of life support.[155]

Let us assume that the primary physician and one other doctor, after consulting with the neurologist,[156] have informed the attending physician that at least one of the qualifying conditions has been met, either because they assume Karen will die within a short period of time without life support or because they believe she does not have sensation. The matter would then be back in the hands of the attending physician, who would return to section

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149. *See* Payne et al., *supra* note 84, at 105.

150. Nothing in the AHCDA, or other Alaska laws, prohibit the surrogate from looking for another doctor who agrees with him or her. *See* ALASKA STAT. § 13.52 (2004).

151. Payne et al., *supra* note 84, at 107.

152. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 25 (Alaska Mar. 24, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-241344.pdf (testimony of Linda Sylvester).

153. 755 ILL. COMP. STAT. 40/10 (2005).

154. *See, e.g., In re* Estate of Greenspan, 558 N.E.2d 1194, 1197 (Ill. 1990); *In re* Estate of Longeway, 549 N.E.2d 292, 298 (Ill. 1989).

155. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 24 (Alaska Apr. 14, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-141341.pdf (testimony of Linda Sylvester).

156. The neurologist does not have to agree with the primary physician; he or she only needs to be consulted. ALASKA STAT. § 13.52.160 (2004).

13.52.045 and see that there must be an additional determination that withdrawing the life support would be consistent with the patient's best interest.[157] However, this decision is initially made by the surrogate.[158] The doctor would thus direct Mr. Quinlan to make the determination and, to the extent known to him, to consider Karen's wishes and personal values.[159] He would explain that "best interest" means that the benefits to the individual outweigh the burdens on the individual. In this decision, several factors should be considered: "the effect of treatment on the physical, emotional, and cognitive functions of the patient"; "the degree of pain or discomfort caused by either treatment or withdrawal of treatment"; the degree to which Karen's medical condition results in a severe and continuing impairment; the effect of treatment on her life expectancy; the prognosis for recovery; the risks, side effects, and benefits of treating or not treating; and Karen's religious beliefs and basic values.[160] Presumably, Mr. Quinlan would report back that he has considered all of those factors and still believes it to be in Karen's best interest to withdraw life support.

The decision would now go back to the medical professionals for several possible vetoes. First, the patient's primary healthcare provider may determine that the surrogate is not abiding by the wishes, values, and best interest of the patient, and may therefore decline to comply with the surrogate's decision.[161] Alternatively, the healthcare provider may decline to comply for reasons of conscience.[162] It is hard to say whether Karen's physicians would veto the surrogate's decision; they testified that "removal from the respirator would not conform to medical practices, standards and traditions,"[163] but that standard is not recognizably close to the standard under the AHCDA.[164] Under the AHCDA, a healthcare provider can refuse to provide healthcare contrary to generally accepted healthcare standards.[165] But here it would not be a question of providing healthcare, but rather of withdrawing it. As best as can be determined from the case law, the doctors never asserted an objection of conscience.[166] However, they might have

157. § 13.52.045.
158. *Id.*
159. § 13.52.030(g).
160. § 13.52.390(6).
161. § 13.52.030(h).
162. § 13.52.060(e).
163. *In re* Quinlan, 355 A.2d 647, 655 (N.J. 1976).
164. *See* § 13.52.060(f).
165. *Id.*
166. *See Quinlan*, 355 A.2d at 647–72.

argued that removal was not in Karen's best interest, especially in 1976.

If either side chose to go to court, they could do so under section 13.52.140, which provides that a court, through a guardianship proceeding, may enjoin or direct a healthcare decision.[167] A probate court judge adjudicating Karen's case would need to know what legal standard to apply, and immediately he or she would encounter a problem: there is an apparent error in the section on judicial relief. Section 13.52.140 says that a proceeding to enjoin or direct a healthcare decision is governed by sections 13.26.165–.320.[168] However, these statutory sections do not cover adult guardianships, but rather conservatorships.[169] In Alaska, conservators deal only with financial matters, not with medical decisions,[170] and the procedural protections are less than those for appointment of a guardian.[171] The statute should have referenced sections 13.26.090–.155, for guardians of incapacitated adults. There is, within those sections, a specific provision as to what a guardian is or is not allowed to do:

> A guardian may not . . . consent on behalf of the ward to the withholding of lifesaving medical procedures; however, a guardian is not required to oppose the cessation or withholding of lifesaving medical procedures when those procedures will serve only to prolong the dying process and offer no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated unless the ward has clearly stated that lifesaving medical procedures not be withheld . . . .[172]

Is the probate court to look only to this section of the guardianship statutes and determine whether a guardian is fulfilling that duty, or is the probate court to look at the AHCDA and review all of its decision-making requirements (including whether the patient has a qualifying condition, and whether it is in the patient's best interest to withdraw life support)? That question will undoubtedly have to be answered in future litigation.

At any rate, the likely end result is that Karen Quinlan would still have her respirator removed, as she would be found to have met the standards of both the guardianship and healthcare decision laws related to removal of life support. In fact, Karen continued to

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167. § 13.52.140.
168. *Id.*
169. §§ 13.26.165-.320.
170. § 13.26.280.
171. *See* §§ 13.26.165-.320.
172. § 13.26.150(e)(3).

breathe after removal of the respirator[173] and could survive for as long as she had the feeding tube inserted.[174] Under the AHCDA, she could have the tube removed only upon her father's consent or if the doctors concluded that it was "medically ineffective health care,"[175] a problematic standard that will be examined in more detail in the Sun Hudson case below.

B. Nancy Beth Cruzan

In January 1983, a Missouri woman, Nancy Cruzan, was in a serious automobile accident.[176] Paramedics were able to restore her breathing and heart beat.[177] After three weeks in a coma, she progressed to a vegetative state.[178] She was able to take some food orally, but in order to ease the feeding and ensure that she had sufficient nutrition, a "gastrostomy feeding and hydration tube" was surgically inserted.[179] However, after several years with no improvement, Nancy's parents, who had already been appointed as co-guardians, petitioned in Missouri state court for authority to remove the feeding tube.[180]

Initially, the only evidence as to Nancy's own wishes was testimony by a former roommate that Nancy once said that she would not wish to continue her life unless she could live at least halfway normally.[181] The trial court authorized the withdrawal of life support, but the state appealed.[182] The Missouri Supreme Court reversed, based on Missouri's living will statute, which had a policy strongly favoring preservation of life.[183] Specifically, Missouri required clear and convincing evidence of the patient's wishes for removal of life support when there was not a specific advance directive.[184] The Supreme Court affirmed, holding that Missouri had a legitimate interest in the protection and preservation of

173. Ascension Health, Healthcare Ethics Cases: Quinlan, Karen Ann, http://www.ascensionhealth.org/ethics/public/cases/case21.asp (last visited Sept. 21, 2005).
174. *Id.*
175. § 13.52.060 (f).
176. Cruzan v. Mo. Dep't of Health, 497 U.S. 261, 266 (1990).
177. *Id.*
178. *Id.*
179. *Id.*
180. *Id.* at 267–68.
181. *Id.* at 268.
182. *See id.*
183. *Id.*
184. *See id.* at 265.

human life, which it was entitled to safeguard with a statute designed to guard against potential abuses.[185]

There, the case law ends, but not the case. The publicity surrounding *Cruzan* brought forward two new witnesses who had known Nancy before her accident and who learned about the case through the news coverage surrounding the appeal.[186] They both related conversations with Nancy, which supported the idea that she would not want to live in a vegetative state.[187] Aided by friendlier medical testimony the second time around, Mr. and Mrs. Cruzan prevailed in a new trial; third-party attempts to intervene and appeal were refused, and the feeding tube was removed, resulting in Nancy Cruzan's death twelve days later.[188]

In many respects, Nancy Cruzan's situation was similar to that of Karen Quinlan. However, a significant difference is that Nancy Cruzan did not need a respirator.[189] However, she did need a feeding tube, and unlike the Quinlans, the Cruzan family wanted the feeding tube removed.[190] The AHCDA makes no distinction between respirators and feeding tubes; they are all considered "life sustaining procedures" that may be withheld if the qualifying conditions are met.[191] This distinction may make a big difference to the Roman Catholic Church and, judging by the number of protestors in both the Cruzan and Schiavo cases,[192] to quite a lot of other people as well. However, it makes no legal difference in Alaska. It should be noted that defining artificial hydration and nutrition as medical care constitutes a significant philosophical choice on the legislature's part; the Catholic Church, among others,

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185. *Id.* at 282.

186. WILLIAM H. COLBY, LONG GOODBYE: THE DEATHS OF NANCY CRUZAN 333–36 (2002).

187. *Id.*

188. *Id.* at 341–89.

189. Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988). Another potentially significant difference is that Cruzan was married at the time of her accident. However, Cruzan's husband agreed to dissolution of their marriage before the case reached the point of contested litigation. COLBY, *supra* note 187, at 29. Hence, Cruzan's marriage does not affect the outcome of the analysis.

190. *Cruzan*, 760 S.W.2d. at 410–11.

191. *See* ALASKA STAT. § 13.52.390(26) (2004).

192. COLBY, *supra* note 18, at 371–77; *All Things Considered: Protesters at Schiavo Hospice Grow Agitated* (NPR broadcast Mar. 27, 2005); Larry Copeland and Laura Parker, *Terri Schiavo's Case Doesn't End With Her Passing*, USA Today, Apr. 1, 2005, at A1.

would define it not as medical care but as feeding, and thus a basic responsibility which must not be withdrawn.[193]

The next difference looks like a complication, but it actually leads to a simplification: Nancy Cruzan's parents were already her guardians when they decided to withhold artificial nutrition and hydration.[194] As her guardians, they would be surprised to discover that the AHCDA does not grant them any authority: it only allows an *agent or surrogate* to withhold or withdraw life sustaining procedures.[195] A guardian is not an agent or a surrogate. The definition of an agent requires that the declarant have executed a durable power of attorney for healthcare.[196] Furthermore, the definition of surrogate specifically excludes guardians.[197]

The operation of these definitions, as they apply to the AHCDA, might be cause for consternation. However, not all of the laws related to end-of-life decision-making were included in Chapter 13.52. For example, under section 13.26.150(e)(3), which is part of the guardianship statutes, a guardian can oppose cessation of "life saving medical procedures" under a set of conditions similar to those in the AHCDA.[198] The guardian may consent to the withholding of such procedures when "[the procedures] will only serve to prolong the dying process, and offer no reasonable expectation of effecting a cure of or relief from the condition being treated if the ward has not clearly stated that the life sustaining medical procedures not be withheld . . . ."[199] While Nancy never prohibited such procedures from being withheld,[200] another portion of that set of conditions is problematic. It refers to prolonging the dying process. Prior to the removal of the feeding tube, Nancy was not dying; the consensus was that she could possibly live for

193. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 20 (Alaska Apr. 7, 2004), *available at* http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-071745.pdf (testimony of Chip Wagoner, representing the Alaska Catholic Conference).

194. *See Cruzan*, 760 S.W.2d at 410.

195. The AHCDA states "an agent or a surrogate may determine that life-sustaining procedures may be withheld or withdrawn . . . ." § 13.52.045.

196. § 13.52.390(2).

197. § 13.52.390(40).

198. § 13.26.150(e)(3).

199. *Id.*

200. Ms. Cruzan had only made general statements to a roommate that she would not want to continue her life unless she could live "halfway normally." *See* Cruzan v. Harmon, 760 S.W.2d 408, 411, 424 (Mo. 1988).

another thirty years.[201] Unfortunately, this requirement in section 13.26.150(e)(3) seems to have been written for terminally ill patients, not patients in a coma or a vegetative state. However, technically speaking, the feeding tube prolongs the dying process.[202] Furthermore, the feeding tube appears to meet the other requirements of section 13.26.150(e) because it would offer no reasonable expectation of a cure or relief for Cruzan.[203] Under these circumstances, the guardian would undoubtedly be legally justified in taking action.[204] Nothing in the adult Guardianship Statutes or the AHCDA requires a guardian to seek specific court approval to withhold or withdraw life support.[205] Under section 13.52.140, the superior court may enjoin or direct a healthcare decision, but an application to the superior court is not required.[206] A healthcare decision made by a guardian is effective without judicial approval.[207]

A question remains as to the conscience clause in section 13.52.060(e), which allows a healthcare provider to decline to comply with an instruction for reasons of conscience.[208] The state-run institution in which Nancy lived out her final years strongly opposed, on moral grounds, the removal of the feeding tube.[209] However, the AHCDA's conscience clause has different standards for healthcare providers and healthcare institutions or facilities. The provider may decline to comply for reasons of conscience,[210] but another provider can easily be brought in to remove the tube. Under the statute, the healthcare facility can object to an instruction only if it is contrary to a written policy of the facility that is expressly based on reasons of conscience.[211] Nothing in the case law or background materials suggests that the Missouri Rehabilitation Center had any such written policy. Therefore the facility would not have had the right to object.

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201. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 266 n.1 (1990) (citing *Harmon,* 760 S.W.2d at 411).

202. Nancy Valko, *Of Living Wills and Butterfly Ballots*, LIFEISSUES.NET, http://www.lifeissues.net/writers/val/val_11_livingwills.html (last visited Oct. 19, 2005).

203. *See* § 13.26.150(e)(3).

204. *See id.*

205. §§ 13.26.090-.155; §§ 13.52.010-.395.

206. § 13.52.040(c).

207. *Id.*

208. § 13.52.060.

209. COLBY, *supra* note 18, at 188–96.

210. § 13.52.060(e).

211. *Id.*

The AHCDA's section on judicial relief allows the healthcare provider to petition the superior court for an injunction.[212] In *Cruzan*, the facility may have sought this relief because the appeals featured the State of Missouri, representing its healthcare institution as a party, and the Cruzans as the opposing party.[213] After the appeals, the State of Missouri was dismissed from the guardianship case.[214] Even if the State of Missouri had continued to be involved with the guardianship case, the guardianship statute would have formed the substantive basis for the decision to withdraw life support, and the conditions of that statute appear to be easily met.[215]

Analyzing Cruzan's case under the AHCDA demonstrates that when a patient is in a terminal, comatose, or vegetative state, and has not executed an advance directive, a close family member who wants to remove life support should not claim the status of surrogate. Rather, the family member should petition to be appointed guardian first and then act under the guardianship statute. Because the guardianship statutes were not updated to be consistent with the AHCDA, it is easier for a guardian to find sufficient legal justification to terminate life support.

C. Teresa Marie Schindler-Schiavo

In February of 1990, Terri Schiavo suffered a heart attack at the age of twenty-seven.[216] The heart attack caused her to enter into a vegetative state.[217] Her husband, Michael Schiavo, was appointed guardian without objection.[218] By 1993, however, serious disagreements between Terri's parents and Michael ensued.[219] The parents petitioned to have Michael removed as guardian,[220] and Michael eventually petitioned the court to allow him to remove the feeding tube that kept Terri alive.[221] The trial court found clear and

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212. § 13.52.140.

213. *See* Cruzan v. Harmon, 760 S.W.2d 408, 410 (Mo. 1988).

214. COLBY, *supra* note 18, at 330–31, 341.

215. § 13.26.150(e)(3).

216. Schindler v. Schiavo, 780 So.2d 176, 177 (Fla. Dist. Ct. App. 2001) [hereinafter Schiavo I].

217. *Id.*

218. *Id.*; *see also* Jay Wolfson, Guardian ad Litem, A Report to Governor Jeb Bush and the 6th Judicial Circuit in the Matter of Theresa Marie Schiavo 8 (Dec. 1, 2003), *available at* http://www.miami.edu/ethics/schiavo/wolfson%27s%20report.pdf [hereinafter Wolfson Report].

219. *Schiavo I*, 780 So.2d at 178; *see also* Wolfson Report, *supra* note 218, at 8.

220. *Schiavo I*, 780 So.2d at 177–78.

221. *Id.* at 177.

convincing evidence to support removal of the feeding tube.[222] Despite interventions by Terri's parents, the Florida governor and legislature, and the United States Congress and President, the courts sided with Michael Schiavo and allowed the feeding tube to be removed.[223] Terri Schiavo died on March 31, 2005.[224]

The first court action in the Schiavo case was the uncontested petition by Michael Schiavo to be appointed guardian.[225] Under Alaska law, a spouse has priority for appointment as guardian, unless the incapacitated person nominated someone else at a time when she had sufficient mental capacity to make an informed choice.[226] A court may decline to appoint a person who has priority when it is in the best interest of the incapacitated person.[227]

In the Schiavo case, there was initially no reason for the court to consider that it might not be in Terri's best interest to appoint her husband as her guardian.[228] When Terri's parents petitioned to remove Michael as the guardian, an Alaska court would have turned to section 13.26.125 and found that, while the court was clearly empowered to remove and replace a guardian, the statutes do not dictate the substantive standard for taking such action. Subsection (e) of that section states that a guardian may be removed if there is "probable cause to believe [he] is not performing [his] responsibilities effectively and there is an imminent danger that the physical health or safety of the ward will be seriously impaired . . . ."[229] However, it is clear from the context of that subsection that there may be other bases.[230] The Alaska

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222. *Id.* at 179.

223. Schindler v. Schiavo, 403 F.3d 1223, 1226 (Fla. 11th Cir. 2005) [hereinafter Schiavo II].

224. Abby Goodnough, *Schiavo Dies, Ending Bitter Case over Feeding Tube*, N.Y. TIMES, Apr. 1, 2005, *available at* http://www.nytimes.com.

225. *Schiavo I*, 780 So. 2d at 177.

226. ALASKA STAT. § 13.26.145(d)(1)-(2) (2004).

227. § 13.26.145(f).

228. Later issues arose largely for two reasons. First, Michael Schiavo took the position that his wife should be allowed to die. Even before applying to the court for an order to terminate life support, he had entered a DNR order for her. Diana Lynne, *The Whole Terri Schiavo Story*, WORLD NET DAILY, Mar. 25, 2005, http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=43463; *see also* Wolfson Report, *supra* note 218, at 10. Second, Michael began to live with a woman he referred to as his fiancé and with whom he had two children. Jamie Thompson, *She's the Other Woman in Michael Schiavo's Heart*, ST. PETERSBURG TIMES, Mar. 26, 2005, *available at* http://www.sptimes.com/2005/03/26/Tampabay/She_s_the_other_woman.shtml.

229. § 13.26.125(e).

230. *See id.*

Supreme Court addressed this question recently in *H.C.S. v. Community Advocacy Project of Alaska, Inc.*[231] The court concluded that before removing or replacing a guardian, the trial court should first determine whether there has been a material change in circumstances since the guardian was originally appointed, and if there has been, whether the existing appointment is in the ward's best interest.[232] Terri's parents alleged abuse by Michael, but the judge found inadequate evidence of abuse.[233] In all likelihood, the same judge who would later order removal of Terri's feeding tube would not have removed Michael from his position as guardian for proposing a DNR order.

This leaves the question of whether a conflict existed due to Michael's romantic interest in another woman. Nothing in the Alaska statutes or case law indicates whether such a conflict would have been sufficient, in and of itself, to justify removal. The priority section of the guardianship statutes states that the court may not appoint a person who has "interests that may conflict with those of the incapacitated person."[234] However, this provision is included among several other bases for disqualification that relate to financial, not personal, interests.[235] If the person is providing substantial services in a business or professional capacity,[236] is a creditor of the incapacitated person,[237] or is employed by someone else who would be disqualified,[238] the person may not be appointed. Because the definition of a conflict of interest is unclear under this statute, Terri's parents could have argued that Michael's personal relationship warranted his removal. It is this very ambiguity, however, that makes it impossible to say how the judge might have ruled.

Note that the three cases examined thus far involved guardians rather than agents, and so the surrogacy section of the AHCDA did not apply.[239] Given that all three of these women were relatively young and healthy before a sudden trauma placed them in a vegetative state, it is hardly surprising that they did not have

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231. 42 P.3d 1093 (Alaska 2002); *see also* Wolfson Report, *supra* note 218, at 11, 34 n.1.

232. *H.C.S.*, 42 P.3d at 1099.

233. *See* Schiavo I, 780 So. 2d 176, 177 (Fla. Dist. Ct. App. 2001).

234. ALASKA STAT. § 13.26.145(b)(3) (2004).

235. § 13.26.145.

236. § 13.26.145(b)(1).

237. § 13.26.145(b)(2).

238. § 13.26.145(b)(4).

239. *In re* Quinlan, 355 A.2d 647, 653–54 (N.J. 1976); Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988); Schiavo I, 780 So. 2d 176, 177 (Fla. Dist. Ct. App. 2001).

appointed healthcare agents. It should also not be surprising that at least two of them already had guardians,[240] for the simple reason that in the *Cruzan* and *Schiavo* cases, the family members in question waited for a number of years before petitioning the court to remove life support.[241] In the meantime, a myriad of medical and other decisions had to be made, so that guardianship would have been a normal and expected action, even if the thought of removing life support was on no one's mind at the time. For instance, approximately 50% of patients who are diagnosed as being in a vegetative state one month after the injury will recover consciousness within a year.[242] Therefore, if the patient is in a vegetative or minimally conscious state, as opposed to being comatose, there will almost certainly be significant delays before the issue of removing life support comes to the fore.

There can be no surrogate under Alaska law if a guardian is already appointed and available.[243] Thus, surrogates are unlikely to make life-support decisions for patients in a vegetative state because, by the time life support decisions are being made, the patient will likely have a guardian. A variety of non-medical decisions need to be made for someone in a vegetative or minimally conscious state, so a guardian would be appointed to make those decisions. A guardianship petition may be dismissed if there are feasible alternatives to guardianship,[244] and a surrogate would be a feasible alternative to guardianship if only medical decisions need to be made.

Another potential problem with the AHCDA exists. Assume hypothetically that no one, including Michael Schiavo, had been appointed Terri's guardian. Suppose instead he argued for surrogate status under the AHCDA. In the absence of a designation by the patient as to whom she wanted as her surrogate, the first priority for appointment goes to the spouse, "unless legally separated."[245] One might naturally assume that because he had moved in with another woman, fathered two children by her, and began referring to her as his fiancée, Michael Schiavo would be considered legally separated from his wife. That would be an incorrect assumption. Legal separation has a specific meaning in

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240. In the *Quinlan* case, the issue of termination of life support came up in the initial litigation over the appointment of a guardian. *Quinlan*, 355 A.2d at 651.

241. *Cruzan*, 760 S.W.2d at 411, 413; *Schiavo I*, 780 So.2d at 177–78.

242. The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State*, 330 NEW ENG. J. MED. 1572, 1572 (1994).

243. § 13.52.030(a).

244. § 13.26.113(d).

245. § 13.52.030(c)(1).

Alaska, and it is not based on the general facts of the case, but rather on whether a decree of legal separation has been entered under section 25.24.450.[246] Because there was no legal separation decree between Michael and Terri Schiavo, Michael would still have been entitled to priority to be the surrogate, despite his conflicted circumstances. The primary healthcare provider could decline to comply with specific decisions made by Michael,[247] but not with his right to be the surrogate. Of course the hospital, the parents, or any other interested person could petition for judicial relief under section 13.52.140 or guardianship under section 13.26.105.

Assuming Michael was able to maintain his position as guardian, we would again return to the statutes to determine his authority to consent to withdrawal of life-saving medical procedures. As in the *Cruzan* case, the question would be whether the procedures in question serve only to prolong the dying process and offer no reasonable expectation of effecting a temporary or permanent cure or relief from the illness or condition being treated.[248] Suppose for the sake of argument no one had been appointed guardian, and Michael was seeking to act under surrogacy authority. He would have to establish, among other things, that his wife was in a state of permanent unconsciousness,[249] and again there is the question of whether she experienced sensation.[250] Terri's autopsy report indicated that, toward the end of her life, she was given acetaminophen,[251] but it is unclear whether this was for pain, fever, or inflammation. If the definition of permanent unconsciousness in the AHCDA is interpreted literally, surrogates will not be able to terminate life support for patients such as Nancy Cruzan and Terri Schiavo. The statute states that thought, sensation, purposeful action, social interaction, *and* awareness of self and the environment must be absent for the person to be found permanently unconscious.[252] A literal interpretation means that each of those five prongs must be absent, so that if the patient still experiences sensation, they are not

246. § 25.24.450.
247. § 13.52.030(h).
248. § 13.26.150(e)(3).
249. This state is known as a "qualifying condition." § 13.52.390(36).
250. *See* AUTOPSY REPORT OF THERESA SCHIAVO, CASE # 5050439 1 (June 13, 2005), http://news.findlaw.com/hdocs/docs/schiavo/61305autopsyrpt.pdf.
251. *Id.*
252. § 13.52.390(31)(b).

permanently unconscious.[253] However, under Illinois law, sensation is interpreted as consciousness, and under this interpretation, a surrogate would be able to direct removal of a feeding tube for a person in a vegetative state.[254] Furthermore, given that the majority of doctors believe it is appropriate to remove feeding tubes for patients in vegetative states[255] and the possibility of "doctor shopping" by the guardian, there is little doubt that Terri Schiavo's fate would not have changed under the AHCDA.

D. Sun Hudson

If the Quinlan, Cruzan, and Schiavo cases look remarkably similar from a factual viewpoint, the sad case of Sun Hudson is quite different.[256] Sun was born with a genetic condition called thanatophoric dysplasia, a form of dwarfism, which includes a narrow chest, small ribs, and underdeveloped lungs.[257] Infants born with this condition, if they are not stillborn, usually die shortly after birth from respiratory failure.[258] This condition normally restricts the growth of the rib cage so that the baby slowly suffocates.[259] Texas Children's Hospital, where Sun was born, placed him on a ventilator, but informed his mother that further treatment would be futile, merely prolonging the inevitable, and that in their view he should be removed from the ventilator.[260] His mother refused, and the matter ended up in probate court, where the judge eventually ruled that five-month old Sun could be taken off life support,

253. Sensation is defined as the activity of the sensors, or the immediate result of this activity before the combination with other data. THE NEW LEXICON WEBSTER'S DICTIONARY OF THE ENGLISH LANGUAGE, ENCYCLOPEDIC EDITION 907 (1989).

254. *See* Keiner v. Cmty. Convalescent Ctr., 549 N.E.2d 292, 298 (Ill. 1998) (stating in part that a patient in a persistent vegetative state is unable to purposely interact with stimulation from his environment).

255. Payne, *supra* note 84, at 107, Table 4.

256. Associated Press, *Infant Born with Fatal Defect Dies After Being Taken Off Life Support*, ABC13.NET, Mar. 15, 2005, http://abclocal.go.com/ktrk/news/031405_local_baby1.html; Associated Press, *Houston Mother Loses Fight to Keep Baby on Life Support*, NBC5.COM, Mar. 15, 2005, http://www.nbc5.com/health/428633/detail.html; Rick Casey, *No Villains in This Sad Story*, HOUSTONCHRONICLE.COM, Feb. 23, 2005, http://www.chron.com/cs/CDA/ssistory.mpl/metropolitan/casey/3047420.

257. *Infant Born with Fatal Defect Dies After Being Taken Off Life Support*, *supra* note 257.

258. Rick Casey, *supra* note 256.

259. *Id.*

260. *Houston Mother Loses Fight to Keep Baby on Life Support*, *supra* note 256.

despite his mother's objections.[261] Under Texas law, the mother was allowed ten days to find another hospital willing to take over care.[262] When the mother was unable to find another hospital, Sun was removed from the ventilator, and he died a few breaths later, on March 15, 2005.[263]

The AHCDA applies only to adults,[264] so under Alaska law, Sun's mother would act on her baby's behalf under general parental rights rather than as a surrogate.[265] Nonetheless, the hospital could have determined that keeping Sun on a respirator would constitute "medically ineffective health care," which is care that "cannot cure the illness, cannot diminish its progressive course, and cannot effectively alleviate severe discomfort and distress."[266] This would have been a questionable determination, however, because the respirator diminished the progressive course of the malady by prolonging Sun's life.

Another way in which the Alaska and Texas procedures diverge is that under Alaska law, if the mother chose to seek a transfer, the hospital would have had to provide continuing care until the transfer was effected.[267] By contrast, there is a ten-day time limit under Texas law.[268] In Alaska, the search for a hospital willing to take the child could go on indefinitely.

Alternatively, the hospital could have turned to section 13.52.140, under which it could have requested the superior court to direct a healthcare decision. At that point, the court has the dilemma noted earlier: should it review the surrogate's decision under the standards provided in the AHCDA or under the standards provided in the guardianship act? The judicial relief section of the AHCDA appears to direct the court to the guardianship act.[269] However, another question arises as to whether to consult the section on guardians of minors or guardians of incapacitated persons. The statute does not provide guidance

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261. Casey, *supra* note 256.

262. *Id.*

263. *Infant Born with Fatal Defect Dies After Being Taken Off Life Support*, *supra* note 256.

264. *See, e.g.*, Troxel v. Granville, 530 U.S. 57 (2000); Stanley v. Illinois, 405 U.S. 645 (1972); Evans v. Taggart, 88 P.3d 1078 (Alaska 2004).

265. ALASKA STAT. § 13.52.030(a) (2004).

266. § 13.52.060(f).

267. § 13.52.060(g)(2).

268. TEX. HEALTH & SAFETY CODE ANN. § 166.046(e) (Vernon 2002).

269. The AHCDA states that "[a] proceeding under this section is governed by AS 13.26.165–13.26.320." § 13.52.140. These sections are a part of the guardianship statutes.

because it mistakenly directs that the statute on conservatorships be used.[270] Understandably, the statute on minor guardianships does not address termination of life support beyond generally authorizing the guardian to facilitate medical care and treatment.[271] The article regarding incapacitated persons, which does address termination issues, is not limited to adults and can apply to any incapacitated person.[272] If the court turns to this article, it may hold that a guardian can consent to withholding life-saving medical procedures, as long as those procedures serve only to prolong the dying process, under section 13.26.150(e)(3). However, nothing in the guardianship statutes suggests that the judge may order the withholding of life-sustaining procedures if the guardian does not want them withheld.

On the other hand, if the judge interprets the section of the AHCDA which states that "[a] proceeding under this section is governed by" the guardianship statutes as merely referring to the procedure, then it would look to the AHCDA for the standards to be applied in determining whether life support should be terminated. However this is a stretch, not only because section 13.52.140 does not refer to *procedure*, but rather a *proceeding*, and the AHCDA does not appear to contemplate that the decisions be made by a judge.[273] If a judge heard a case similar to that of baby Sun's, the judge would have to determine whether the condition is "incurable or irreversible," whether "without administration of life-sustaining procedures death would result in a short period of time," whether "there is no reasonable prospect of cure or recovery," and whether "the condition imposes severe pain or an inhumane burden on the patient."[274] Assuming the other conditions were met, the court might nonetheless have a difficult time finding that there would be an "inhumane burden" on the baby, who was apparently not in any particular pain and breathing reasonably well on the ventilator.

Assuming the judge would not find an inhumane burden, this would have left the hospital with one remaining alternative: it could petition the court to appoint someone other than the mother as the

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270. Section 13.52.140 points to sections 13.26.165-.320, part of the guardianship statutes covering conservatorships.

271. § 13.26.070(3).

272. § 13.26.090.

273. *See* § 13.52.030(a).

274. This is the definition of a "terminal condition" under section 13.52.390(42). Life-sustaining procedures may be withheld or withdrawn from a patient with a "qualifying condition." § 13.52.045. The definition of "qualifying condition" includes a "terminal condition." § 13.52.390(36).

child's guardian, hoping that the appointee would be more likely to agree with its position. However, section 13.26.045 allows appointment of a guardian for a minor only if all parental rights of custody have been terminated or suspended by circumstances or a prior court order. None of those conditions occurred in this case. Therefore, regardless of the hospital's position, it is likely Sun Hudson would have lived a little while longer under the AHCDA.

E. Ora Mae Magouirk

In April 2005, at the height of the Schiavo controversy, one of the hot topics of discussion on the Internet was the unusual case of a widow who was allegedly being starved to death in a hospice. Unlike the previous cases, it is not possible to conclusively state the facts of this case.[275] However, for purposes of this Article, ascertaining the precise facts from among the multiple versions is unnecessary. Therefore, the following version has been pieced together by combining the various sources, with no representation of accuracy.

Ora Mae Magouirk was an eighty-one year old woman living in Alabama. Because she was a widow without any surviving children, her granddaughter helped take care of her by running errands and bringing her food. The granddaughter also had a general power of attorney. Magouirk had a living will, which said

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275. Only a few articles appeared in the mainstream press, none of which were able to determine which side of the controversy gave the most accurate facts. Most of the information available on the case comes from Internet news sources that have a particular philosophical perspective and whose information, therefore, is necessarily suspect. *See, e.g.*, Sarah Foster, *Closest Kin Prevented from Visiting 'Grandma,'* WORLDNETDAILY.COM, Apr. 12, 2005, http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=43763; Sarah Foster, *Granddaughter Yanks Grandma's Feeding Tube*, WORLDNETDAILY.COM, Apr. 7, 2005, http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=43688; Mark A. R. Kleiman, *Mae Magouirk: Is There a Reporter in the House?*, MARK A. R. KLEINMAN: A WEBLOG FOR THE REALITY-BASED COMMUNITY, Apr. 8, 2005, http://www.markarkleiman.com/archives/_/2005/04/mae_magouirk_is_there_a_reporter_in_the_house.php; Mark A. R. Kleiman, *Magouirk Update*, MARK A. R. KLEINMAN: A WEBLOG FOR THE REALITY-BASED COMMUNITY, Apr. 11, 2005, http://www.markarkleiman.com/archives/schiavo_/2005/04/magouirk_update.php; Denis O'Hayer, *Georgia Case Mirrors Schiavo Battle*, 11 ALIVE.COM, Apr. 8, 2005, http://www.11alive.com/help/search/search_article.aspx?storyid=61478; Charles Yoo, *Illness Splits Woman's Kin*, THE ATLANTA JOURNAL-CONSTITUTION, Apr. 12, 2005, http://www.ajc.com/hp/content/metro/0405/12illness.html; Maria Vitale Gallagher, *Woman's Starvation Stopped in a Terri Schiavo-Like Situation*, LIFENEWS.COM, Apr. 11, 2005, http://www.lifenews.com/bio905.html.

that nutrition and hydration were to be withheld only if she were either comatose or in a vegetative state. In March 2005, Magouirk was hospitalized for an aortic problem, reportedly lucid at the time. The granddaughter had her transferred to a hospice, telling other relatives they should let her pass away, and apparently not telling the hospice about the living will. Magouirk was only able to eat foods such as Jell-O and chips of ice. On learning of this, Magouirk's sister and brother insisted on placement of a feeding tube, and made arrangements for Magouirk to be transported to the hospital at the University of Alabama at Birmingham to begin the procedure. However, while they were at the hospice awaiting her transport to the hospital, the granddaughter went to court and obtained an emergency order appointing herself as guardian; she again refused to have the feeding tube inserted. A few days later, after hearing from Magouirk's siblings, the probate judge ordered that she be "adequately fed" pending a determination of her condition, which was to be based on the opinion of three mutually agreed-upon neurologists. There is no available record of the final decision. Magouirk reportedly died a few months later at a relative's home.

Perhaps the first and foremost lesson one can learn from the Magouirk case is that having an advance directive is useless if one's medical providers are unaware of it. In Alaska, most of the major hospitals have now set up directories that will store copies of advance directives for those who provide one.[276] In addition, declarants should provide a copy to any physician they see on a regular basis and any surgeon or specialist who may be treating them for a particular problem (and to the declarant's lawyer, of course).

In the Magouirk case, the granddaughter's power of attorney did not include medical decision-making, and the living will apparently did not include appointment of an agent for health-care decisions. Therefore, under the AHCDA, the hospice would have referred to section 13.52.030, the section on surrogates. The sources reflect conflicting information on Magouirk's ability to express herself at the time she arrived at the hospice. However, if she had been able to express an opinion, she could have designated a surrogate and informed her healthcare providers of her choice. Assuming that she could not express an opinion, the healthcare providers would have looked to the priority list to see who should

276. Confirmed by phone calls by author's staff to major hospitals in Alaska. Telephone interviews by author's staff with Providence Hospital, Alaska Regional Hospital, and Alaska Native Medical (July 19-22, 2005).

make decisions on her behalf.[277] Magouirk did not have a surviving spouse, adult child, or parent, but the fourth priority is an adult sibling. Magouirk had two adult siblings. Either her sister or brother could have stepped forward and claimed the position of surrogate, or they could have both done so and would have had to reach consensus.[278] Had they both stepped forward and not been able to agree on decisions, the doctor would have broken the tie.[279] Either way, the sister and brother were both inclined to have a feeding tube inserted, and there is no reason to think that doing so would have been so far outside generally accepted healthcare standards that the provider would have been entitled to refuse. Presumably, the tube would have been inserted.

Could the granddaughter nonetheless have gone to probate court and received an emergency guardianship order? After all, a surrogate may make decisions only if a guardian has not been appointed,[280] and while an *agent* may, in certain circumstances, be able to overrule a guardian,[281] there is nothing in the AHCDA that suggests that a *surrogate* can overrule a guardian. The granddaughter could have applied for temporary guardianship under section 13.26.140, and if she convinced the court that an emergency order was necessary to protect the respondent from serious injury, illness, or disease, she could have obtained it.[282] The maneuver may or may not have worked. The granddaughter would have had to file a petition that provides the names and addresses of "the individuals most closely related to the respondent by blood or marriage."[283] This would have required her to provide the names of the brother and sister and take the risk that the court would contact them and learn that they were opposed to her guardianship.

The guardianship statutes also have a priority list, which is similar to, but not identical to, the list in the AHCDA.[284] One of the differences between the two lists could be absolutely critical in this case: the surrogate list begins with a spouse, then an adult child, then a parent, then an adult sibling, and finally an adult who has exhibited special care and concern for the patient.[285] The

277. § 13.52.030(c).
278. *See* § 13.52.030(f).
279. *See id.*
280. *See* § 13.52.030(a).
281. § 13.52.040(b).
282. *See* § 13.26.140(d).
283. *See* § 13.26.105(b)(6).
284. The guardianship priority list is at section 13.26.145(d); the surrogate preference list is at section 13.52.030(c).
285. § 13.52.030(c).

guardianship list begins with the spouse, then an adult child or parent, then a relative with whom the incapacitated person has resided for more than six months, then a relative or friend who has demonstrated a sincere longstanding interest in the welfare of the incapacitated person.[286] As adult siblings, the brother and sister would have had priority over the granddaughter for appointment as surrogates, but for guardianship appointment, the siblings would have been on the same priority level as relatives who had demonstrated a sincere, longstanding interest in the welfare of the incapacitated person. In fact, the granddaughter might have been considered higher on the list than the siblings, because while she was not actually living with Magouirk, she had apparently been helping to provide for her for some time.

Regardless of who was appointed as guardian (if the probate court even found a necessity for guardianship given the availability of a surrogate), the court would have still had the authority to review and amend a decision of the guardian[287] and, therefore, could have directed the insertion or withholding of the feeding tube. The court would have considered whether the procedures in question would "serve only to prolong the dying process and offer no reasonable expectation of effecting a temporary or permanent cure of, or relief from, the illness or condition being treated . . . ."[288] While Magouirk was elderly and had a potentially dangerous aortic condition, the information at hand suggests that she was not terminal, and, therefore, would probably not have qualified for cessation of life-sustaining treatment. She was also not in a vegetative state, so she would have experienced severe discomfort from being given inadequate nutrition and hydration, which would have unquestionably factored into a judge's decision.

VI. CONCLUSION

In the spring of 2005, the news of the moment was the death of Terri Schiavo by dehydration. Congress passed legislation to stop this action in a late-night session,[289] and numerous writs, cases, and appeals were filed. In the end, judicial authority won out over congressional dissent. Ms. Schiavo's feeding tube was disconnected and she slowly died. In the meantime, the media and the internet buzzed with stories about a deformed baby in Houston and an

286. § 13.26.145(d).
287. *See* § 13.26.125(a)(1).
288. *See* § 13.26.150(e)(3).
289. Terry Schiavo Law, Pub. L. No. 109-3, 119 Stat. 15 (2005).

elderly woman in a hospice in Georgia. End-of-life decisions were the water-cooler topic of the season.

The majority public sentiment seems to have been that Ms. Schiavo should not have been "starved to death,"[290] an observation supported by the legislative response. In the U.S. House of Representatives, where the vote was recorded, 203 representatives voted in favor of the bill to provide her with specific relief and only 58 representatives voted against the bill.[291] The U.S. Senate passed the same bill on a voice vote, and the President promptly signed it. Based on the overwhelming legislative response, one could assume that the majority of Americans seem to be opposed to removal of a feeding tube from a patient in a minimally conscious or vegetative state.

Nonetheless, in Alaska,[292] the recently passed AHCDA would, in all likelihood, have resulted in Terri Schiavo's death by dehydration, just as it actually happened in Florida. Despite the fact that the AHCDA says that it establishes a presumption in favor of life,[293] the specifics and the legislative history allow plenty of leeway to terminate life support, including removal of a feeding tube in circumstances in which most people believe it would be wrong to do so.[294]

The AHCDA needs to be revisited, regardless of the philosophical position from which one approaches these issues. For example, the misdirection in section 13.52.140, in which the reader is referred to the conservatorship statutes instead of the guardianship statutes; the dichotomy between what the form suggests about the right to direct that life support be terminated even if one is pregnant[295] and the statute that does not allow it;[296]

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290. Ninette Sosa, et al., *Schiavo's Feeding Tube Removed*, CNN.com, Mar. 18, 2005, http://www.cnn.com/2005/LAW/03/18/schiavo.brain-damaged/.

291. 151 CONG. REC. H1728 (daily ed. Mar. 20, 2005). One hundred seventy-four representatives did not vote. *Id.*

292. At present, the Senate is Republican-controlled by a margin of twelve to eight, and the House of Representatives by twenty-six to fourteen. Committee/Member Information of the Alaska State Legislature, http://www.legis.state.ak.us/basis/commbr_info.asp? session=24 (last visited Sept. 26, 2005). The Governor is Republican as well. Republican Governors Association, http://www.rga.org/ (last visited Sept. 26, 2005).

293. *See* ALASKA STAT. § 13.52.120(a) (2004).

294. *See supra* notes 152–55 and accompanying text.

295. The sample Advance Health Directive given in the statutes has a section that seems to allow a person to enter end-of-life directives in case that person is unconscious and pregnant. § 13.52.300, pt. 2, item (6)(E).

296. § 13.52.055(b).

and the possible misconception as to what "legally separated" means in the context of a spouse taking control as a surrogate,[297] all need to be clarified.

When it addresses these technical concerns, the legislature should also consider whether the actual effect of the AHCDA will accomplish its purpose. The AHCDA purports to be based on the right to self-determination, combined with a concern for the sanctity of life.[298] Instead, it has been infused with enough loopholes such that doctors and surrogates can terminate lives, even of the unwilling, based on their own philosophical convictions. Although many people espouse the philosophy that those who cannot lead a productive life are "better off dead," this is not the philosophy the legislature appears to have endorsed, at least explicitly, when it passed the AHCDA.[299] If the legislature did not intend this result, it should consider a number of changes to the AHCDA, including a re-examination of whether the definition of "permanent unconsciousness" should include those in a vegetative state.

297. § 13.52.030(c)(1).
298. *See* § 13.52.010.
299. *See id.*