

ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672

10775 HOUSE JUDICIARY

1 individual may revoke the designation of an agent only by a signed writing or by
2 personally informing the supervising health care provider.

3 (b) An individual may revoke all or part of an advance health care directive,
4 other than the designation of an agent, at any time and in any manner that
5 communicates an intent to revoke.

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

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

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

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16 withdrawn as an agent may rescind the withdrawal by executing an acceptance after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

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

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

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

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

30 (b) Except as provided for anatomical gifts in AS 13.52.170(b), an adult or
31 emancipated minor may designate an individual to act as surrogate by personally

1 informing the supervising health care provider. In the absence of a designation, or if
2 the designee is not reasonably available, a member of the following classes of the
3 patient's family who is reasonably available, in descending order of priority, may act
4 as surrogate:

- 5 (1) the spouse, unless legally separated;
- 6 (2) an adult child;
- 7 (3) a parent; or
- 8 (4) an adult sibling.

9 (c) If none of the individuals eligible to act as surrogate under (b) of this
10 section is reasonably available, an adult who has exhibited special care and concern
11 for the patient, who is familiar with the patient's personal values, and who is
12 reasonably available may act as surrogate.

13 (d) A surrogate shall communicate the surrogate's assumption of authority as
14 promptly as practicable to the members of the patient's family specified in (b) of this
15 section who can be readily contacted.

16 (e) If more than one member of a class under (b)(2) - (4) of this section
17 assumes authority to act as surrogate, the members of that class do not agree on a
18 health care decision, and the supervising health care provider is informed of the
19 disagreement, the supervising health care provider shall comply with the decision of a
20 majority of the members of that class who have communicated their views to the
21 provider. If the class is evenly divided concerning the health care decision and the
22 supervising health care provider is informed of the even division, that class and all
23 individuals having a lower priority under (b)(2) - (4) of this section are disqualified
24 from making the decision, and the primary physician shall make the decision based on
25 the best interests of the patient.

26 (f) A surrogate shall make a health care decision in accordance with the
27 patient's individual instructions, if any, and other wishes to the extent known to the
28 surrogate. Otherwise, the surrogate shall make the decision in accordance with the
29 surrogate's determination of the patient's best interest. In determining the patient's best
30 interest, the surrogate shall consider the patient's personal values to the extent known
31 to the surrogate.

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

3 (h) An individual may, at any time, disqualify another person, including a
4 member of the individual's family, from acting as the individual's surrogate by a
5 signed writing or by personally informing the supervising health care provider of the
6 disqualification.

7 (i) Unless related to the patient by blood, marriage, or adoption, a surrogate
8 may not be an owner, operator, or employee of a residential long-term health care
9 institution at which the patient is receiving care.

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

14 **Sec. 13.52.040. Decisions by guardian.** (a) A guardian shall comply with
15 the ward's individual instructions and may not revoke a ward's advance health care
16 directive executed before the ward's incapacity.

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

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

21 **Sec. 13.52.050. Obligations of health care provider.** (a) Before
22 implementing a health care decision made for a patient, a supervising health care
23 provider, if possible, shall promptly communicate to the patient the decision made and
24 the identity of the person making the decision.

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

30 (c) A supervising health care provider who makes or is informed of a
31 determination that a patient lacks or has recovered capacity, or that another condition

1 exists that affects an individual instruction or the authority of an agent, a guardian, or a
2 surrogate, shall promptly record the determination in the patient's health care record
3 and communicate the determination to the patient, if possible, and to any person then
4 authorized to make health care decisions for the patient.

5 (d) Except as provided in (e) and (f) of this section, a health care provider or
6 institution providing care to a patient shall comply with

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

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

13 (e) A health care provider may decline to comply with an individual
14 instruction or a health care decision for reasons of conscience, except for a do not
15 resuscitate order. A health care institution may decline to comply with an individual
16 instruction or health care decision if the instruction or decision is contrary to a policy
17 of the institution that is expressly based on reasons of conscience and if the policy was
18 timely communicated to the patient or to a person then authorized to make health care
19 decisions for the patient.

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

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

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

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

31 (3) unless the patient or person then authorized to make health care

1 decisions for the patient refuses assistance, immediately make all reasonable efforts to
2 assist in the transfer of the patient to another health care provider or institution that is
3 willing to comply with the instruction or decision.

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

7 **Sec. 13.52.060. Do not resuscitate protocol and identification**
8 **requirements.** (a) An attending physician may issue a do not resuscitate order for a
9 patient of the physician. The physician shall document the grounds for the order in the
10 patient's medical file.

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

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

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

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

29 (f) A physician may not revoke a do not resuscitate order at the request of a
30 person, and a person may not make a do not resuscitate order ineffective, unless the
31 person making the request or proposing to make the order ineffective is the person for

1 whom the order has been issued. However, if the person for whom the order has been
2 issued is not capable of expressing an opinion on the subject, the request or proposal
3 may be made by the parent or guardian of the person for whom the order has been
4 issued if the person for whom the order has been issued is under 18 years of age.

5 **Sec. 13.52.070. Health care information.** Unless otherwise specified in an
6 advance health care directive, a person then authorized to make health care decisions
7 for a patient has the same rights as the patient to request, receive, examine, copy, and
8 consent to the disclosure of medical or other health care information.

9 **Sec. 13.52.080. Immunities.** (a) A health care provider or institution acting
10 in good faith and in accordance with generally accepted health care standards
11 applicable to the health care provider or institution is not subject to civil or criminal
12 liability or to discipline for unprofessional conduct for

13 (1) complying with a health care decision of a person apparently
14 having authority to make a health care decision for a patient, including a decision to
15 withhold or withdraw health care;

16 (2) declining to comply with a health care decision of a person based
17 on a reasonable belief that the person then lacked authority;

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

21 (4) participating in the withholding or withdrawal of cardiopulmonary
22 resuscitation or other life-sustaining procedures under the direction or with the
23 authorization of a physician or upon discovery of do not resuscitate identification upon
24 an individual;

25 (5) causing or participating in providing cardiopulmonary resuscitation
26 or other life-sustaining procedures

27 (A) under AS 13.52.060(e) when an individual has made an
28 anatomical gift; or

29 (B) because an individual has made a do not resuscitate order
30 ineffective under AS 13.52.060(f) or another provision of this chapter; or

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

1 another state relating to anatomical gifts.

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

5 **Sec. 13.52.090. Statutory damages.** (a) A health care provider or institution
6 that intentionally violates this chapter is liable to the aggrieved individual or the
7 individual's estate for damages of \$500 or actual damages resulting from the violation,
8 whichever is greater, plus attorney fees as provided by court rule.

9 (b) A person who intentionally falsifies, forges, conceals, defaces, or
10 obliterates an individual's advance health care directive or a revocation of an advance
11 health care directive without the individual's consent, or who coerces or fraudulently
12 induces an individual to give, revoke, or not to give an advance health care directive,
13 is liable to that individual for damages of \$2,500 or actual damages resulting from the
14 action, whichever is greater, plus attorney fees as provided by court rule.

15 **Sec. 13.52.100. Capacity.** (a) This chapter does not affect the right of an
16 individual to make health care decisions while having capacity to make health care
17 decisions.

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

21 (c) An individual who is a qualified patient, including an individual for whom
22 a physician has issued a do not resuscitate order, has the right to make a decision
23 regarding the use of cardiopulmonary resuscitation and other life-sustaining
24 procedures as long as the individual is able to make the decision. If an individual who
25 is a qualified patient, including an individual for whom a physician has issued a do not
26 resuscitate order, is not able to make the decision, the protocol adopted under
27 AS 13.52.060 for do not resuscitate orders governs a decision regarding the use of
28 cardiopulmonary resuscitation and other life-sustaining procedures.

29 **Sec. 13.52.110. Status of copy.** A copy of a written advance health care
30 directive, revocation of an advance health care directive, or designation or
31 disqualification of a surrogate has the same effect as the original.

1 **Sec. 13.52.120. Effect of this chapter.** (a) This chapter does not create a
2 presumption concerning the intention of an individual who has not made or who has
3 revoked an advance health care directive.

4 (b) Notwithstanding any other provision of law, if the withholding or
5 withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures is
6 consistent with this chapter, death resulting from the withholding or withdrawal of
7 cardiopulmonary resuscitation or other life-sustaining procedures under a do not
8 resuscitate order, under the protocol for do not resuscitate orders established under
9 AS 13.52.060, or under a do not resuscitate identification found on an individual does
10 not, for any purpose, constitute a suicide or homicide.

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

21 (d) This chapter does not create a presumption concerning the intention or
22 intended treatment of an individual who does not have do not resuscitate
23 identification, has not executed a health care directive, or for whom a do not
24 resuscitate order has not been issued with respect to the use, withholding, or
25 withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures.

26 (e) This chapter does not increase or decrease the right of an individual to
27 make decisions regarding the use of cardiopulmonary resuscitation or other life-
28 sustaining procedures as long as the individual is able to do so, and does not impair or
29 supersede any right or responsibility that a person has to effect the withholding or
30 withdrawal of medical care in a lawful manner.

31 (f) This chapter does not authorize mercy killing, assisted suicide, euthanasia,

1 or the provision, withholding, or withdrawal of health care, to the extent prohibited by
2 other statutes of this state.

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

6 (h) This chapter does not authorize an agent or a surrogate to consent to the
7 admission of an individual to a mental health facility unless the individual's written
8 advance health care directive expressly so provides.

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

11 **Sec. 13.52.130. Prohibited requirements.** As a condition of receiving or
12 being insured for health care services, a health care provider, a health care institution,
13 a health care service plan, an insurer issuing health insurance, a self-insured employee
14 welfare benefit plan, or a nonprofit hospital plan may not require an individual to
15 execute a health care directive, obtain a do not resuscitate order from a physician, or
16 possess do not resuscitate identification.

17 **Sec. 13.52.140. Judicial relief.** On petition of a patient, the patient's agent,
18 guardian, or surrogate, or a health care provider or institution involved with the
19 patient's care, the superior court may enjoin or direct a health care decision or order
20 other equitable relief. A proceeding under this section is governed by AS 13.26.165 -
21 13.26.320.

22 **Sec. 13.52.150. Uniformity of application and construction.** This chapter
23 shall be applied and construed to carry out its general purpose to make uniform the
24 law with respect to the subject of this chapter among states enacting it.

25 **Sec. 13.52.160. Do not resuscitate orders and identification of other**
26 **jurisdictions.** A do not resuscitate order or a do not resuscitate identification
27 executed, issued, or authorized in another state or a territory or possession of the
28 United States in compliance with the law of that jurisdiction is effective for the
29 purposes of this chapter.

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

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

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

8 (1) the spouse;

9 (2) an adult son or daughter;

10 (3) a parent;

11 (4) an adult brother or sister;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 **Sec. 13.52.280. State autopsy laws.** The provisions of AS 13.52.170 -
31 13.52.260 are subject to the autopsy provisions of AS 12.65.

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

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

ADVANCE HEALTH CARE DIRECTIVE

Explanation

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

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

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a

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1 place for you to limit the authority of your agent. You do not have to
2 limit the authority of your agent if you wish to rely on your agent for all
3 health care decisions that may have to be made. If you choose not to
4 limit the authority of your agent, your agent will have the right to

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

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

10 (c) approve or disapprove diagnostic tests, surgical procedures,
11 programs of medication, and do not resuscitate orders; and

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

14 (e) make an anatomical gift following your death.

15 Part 2 of this form lets you give specific instructions for your
16 end-of-life health care. Choices are provided for you to express your
17 wishes regarding the provision, withholding, or withdrawal of
18 treatment to keep you alive, including the provision of artificial
19 nutrition and hydration, as well as the provision of pain relief
20 medication. Space is provided for you to add to the choices you have
21 made or for you to write out any additional wishes.

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

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

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

28 After completing this form, sign and date the form at the end
29 and have the form witnessed by one of the two alternative methods
30 listed below. Give a copy of the signed and completed form to your
31 physician, to any other health care providers you may have, to any

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health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as your agent to make sure that the person understands your wishes and is willing to take the responsibility.

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

PART 1

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

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

(name of individual you choose as agent)

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

(home phone) (work phone)

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

(name of individual you choose as first alternate agent)

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

(home phone) (work phone)

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

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agent

(name of individual you choose as second alternate agent)

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

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

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

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in

1 accordance with what my agent determines to be in my best interest. In
2 determining my best interest, my agent shall consider my personal
3 values to the extent known to my agent.

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

9 PART 2

10 INSTRUCTIONS FOR HEALTH CARE

11 If you are satisfied to allow your agent to determine what is best
12 for you in making health care decisions, you do not need to fill out this
13 part of the form. If you do fill out this part of the form, you may strike
14 any wording you do not want. There is a state protocol that governs the
15 use of do not resuscitate orders by physicians and other health care
16 providers. You may obtain a copy of the protocol from the state
17 Department of Health and Social Services.

18 (6) END-OF-LIFE DECISIONS: I direct that my health
19 care providers and others involved in my care provide, withhold, or
20 withdraw treatment in accordance with the choice I have marked
21 below: (Check only one box.)

22 (A) Choice To Prolong Life

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

26 (B) Choice Not To Prolong Life

27 I do not want my life to be prolonged if (i) I have
28 an incurable and irreversible condition that will result in my
29 death within a relatively short time; (ii) I become unconscious
30 and, to a reasonable degree of medical certainty, I will not
31 regain consciousness; or (iii) the likely risks and burdens of

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treatment would outweigh the expected benefits.

(7) ARTIFICIAL NUTRITION AND HYDRATION:

Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: If I mark this box [], I

direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of

the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that

Conditions or limitations: _____

(Add additional sheets if needed.)

PART 3

ANATOMICAL GIFT AT DEATH

(OPTIONAL)

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

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

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

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

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[] (C) My gift is for the following purposes
(strike any of the following you do not want):

- (i) transplant;
- (ii) therapy;
- (iii) research;
- (iv) education;

PART 4

MENTAL HEALTH TREATMENT

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

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

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

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

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

Conditions or limitations: _____

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

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

_____ I consent to the administration of electroconvulsive treatment.

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

Conditions or limitations: _____

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

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

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

Conditions or limitations: _____

OTHER WISHES OR INSTRUCTIONS

Conditions or limitations: _____

PART 5

PRIMARY PHYSICIAN

(OPTIONAL)

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

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(name of physician)

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

(phone)

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

(name of physician)

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

(phone)

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

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

(date)(sign your name)

(print your name)

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

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

(A) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or

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

ALTERNATIVE NO. 1

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Witness

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider or an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

(date)(signature of witness)

(printed name of witness)

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

Witness

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, or an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

(date)(signature of witness)

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(printed name of witness)

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

ALTERNATIVE NO. 2

State of Alaska

_____ Judicial District

On this ____ day of _____, in the year _____, before me, _____

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

Notary Seal

(Signature of Notary Public)

Sec. 13.52.390. Definitions. In this chapter, unless the context otherwise requires,

(1) "advance health care directive" means an individual instruction or a power of attorney for health care;

(2) "agent" means an individual designated in a power of attorney for health care to make a health care decision for the individual granting the power;

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

(4) "best interest" means that the benefits to the individual resulting from a treatment outweigh the burdens to the individual resulting from that treatment and includes

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

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

- 1 (C) the degree to which the individual's medical condition, the
2 treatment, or the withholding or withdrawal of treatment, results in a severe
3 and continuing impairment;
- 4 (D) the effect of the treatment on the life expectancy of the
5 patient;
- 6 (E) the prognosis of the patient for recovery, with and without
7 the treatment;
- 8 (F) the risks, side effects, and benefits of the treatment or the
9 withholding of treatment; and
- 10 (G) the religious beliefs and basic values of the individual
11 receiving treatment, to the extent that these may assist in determining benefits
12 and burdens;
- 13 (5) "capacity" means an individual's ability to understand the
14 significant benefits, risks, and alternatives to proposed health care and to make and
15 communicate a health care decision;
- 16 (6) "cardiopulmonary resuscitation" means cardiopulmonary
17 resuscitation or a component of cardiopulmonary resuscitation;
- 18 (7) "decedent" means a deceased individual, stillborn infant, or fetus;
- 19 (8) "department" means the Department of Health and Social Services;
- 20 (9) "donor" means an individual who makes an anatomical gift;
- 21 (10) "do not resuscitate identification" means an identification card,
22 form, necklace, or bracelet that carries the standardized design or symbol developed
23 by the department under AS 13.52.060 to signify, when carried or worn, that the
24 carrier or wearer is an individual for whom a physician has issued a do not resuscitate
25 order;
- 26 (11) "do not resuscitate order" means a directive from a licensed
27 physician that emergency cardiopulmonary resuscitation should not be administered to
28 a qualified patient;
- 29 (12) "emancipated minor" means a minor whose disabilities have been
30 removed under AS 09.55.590 or who has arrived at the age of majority as determined
31 under AS 25.20.020;

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

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

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

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

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

12 (B) approval or disapproval of diagnostic tests, surgical
13 procedures, programs of medication, and do not resuscitate orders;

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

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

22 (E) making an anatomical gift at death;

23 (17) "health care institution" means an institution, facility, or agency
24 licensed, certified, or otherwise authorized or permitted by law to provide health care
25 in the ordinary course of business;

26 (18) "health care provider" means an individual licensed, certified, or
27 otherwise authorized or permitted by law to provide health care in the ordinary course
28 of business or practice of a profession;

29 (19) "hospital" means

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

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

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

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

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

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

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

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

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

19 (27) "primary physician" means a physician designated by an
20 individual, or by the individual's agent, guardian, or surrogate, to have primary
21 responsibility for the individual's health care or, in the absence of a designation or if
22 the designated physician is not reasonably available, a physician who undertakes the
23 responsibility;

24 (28) "qualified patient" means a patient who has been determined by
25 the attending physician to be in a terminal condition; in this paragraph, "terminal
26 condition" means a progressive incurable or irreversible condition that, without the
27 administration of life-sustaining procedures, will, in the opinion of two physicians,
28 when available, who have personally examined the patient, one of whom must be the
29 attending physician, result in death within a relatively short time;

30 (29) "reasonably available" means able to be contacted with a level of
31 diligence appropriate to the seriousness and urgency of a patient's health care needs,

1 and willing and able to act in a timely manner considering the urgency of the patient's
2 health care needs;

3 (30) "state" means a state of the United States, the District of
4 Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession
5 subject to the jurisdiction of the United States;

6 (31) "supervising health care provider" means the primary physician or
7 the physician's designee, or the health care provider or the provider's designee who has
8 undertaken primary responsibility for an individual's health care;

9 (32) "surrogate" means an individual, other than a patient's agent or
10 guardian, authorized under this chapter to make a health care decision for the patient.

11 **Sec. 13.52.195. Short title.** This chapter may be cited as the Health Care
12 Decisions Act.

13 * **Sec. 4.** AS 18.65.311 is amended to read:

14 **Sec. 18.65.311. Anatomical gift [OR LIVING WILL DOCUMENT].** (a)
15 The department shall provide, at the time that an identification card is issued, a form
16 for a document by which the card holder may make an anatomical gift under AS 13.52
17 [AS 13.50 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER
18 AS 18.12 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)]. The
19 document (1) may not be larger than an identification card, (2) must contain sufficient
20 space for the signature of two witnesses [OR A PERSON WHO IS QUALIFIED TO
21 TAKE ACKNOWLEDGMENTS UNDER AS 09.63.010], and (3) [MUST USE THE
22 FORMS AND DESIGNS DEVELOPED UNDER AS 18.12.037, AND (4)] must
23 provide a means by which the card holder may cancel the gift [OR THE LIVING
24 WILL]. If the document is executed by the applicant, it shall be sealed in plastic and
25 attached to the identification card. [A SYMBOL DEVELOPED UNDER
26 AS 18.12.037 INDICATING THE EXISTENCE OF THE ANATOMICAL GIFT OR
27 LIVING WILL DOCUMENT MUST BE DISPLAYED IN THE LOWER RIGHT-
28 HAND CORNER ON THE FACE OF THE IDENTIFICATION CARD.]

29 (b) An employee of the department who processes an identification card
30 application, other than an application received by mail, shall ask the applicant orally
31 whether the applicant wishes to execute an anatomical gift [OR A LIVING WILL].

1 The department shall, by placement of posters and brochures in the office where the
2 application is taken, and by oral advice, if requested, make known to the applicant the
3 procedure necessary to execute an anatomical [A] gift under AS 13.52 [AS 13.50 OR
4 A LIVING WILL UNDER AS 18.12].

5 * Sec. 5. AS 28.10.021(c) is amended to read:

6 (c) An employee of the department who processes an application for
7 registration or renewal of registration, other than an application received by mail or an
8 application for registration under AS 28.10.152, shall ask the applicant orally whether
9 the applicant wishes to execute an anatomical gift [OR A LIVING WILL]. The
10 department shall make known to all applicants the procedure for executing an
11 anatomical [A] gift under AS 13.52 (Health Care Decisions Act) [AS 13.50
12 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER AS 18.12
13 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)] by displaying posters
14 in the offices in which applications are taken, by providing a brochure or other written
15 information to each person who applies in person or by mail, and, if requested, by
16 providing oral advice.

17 * Sec. 6. AS 28.15.061(d) is amended to read:

18 (d) An employee of the department who processes a driver's license
19 application, other than an application received by mail, shall ask the applicant orally
20 whether the applicant wishes to execute an anatomical gift [OR A LIVING WILL].
21 The department shall make known to all applicants the procedure for executing an
22 anatomical [A] gift under AS 13.52 (Health Care Decisions Act) [AS 13.50
23 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER AS 18.12
24 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)] by displaying posters
25 in the offices in which applications are taken, by providing a brochure or other written
26 information to each person who applies in person or by mail, and, if requested, by
27 providing oral advice.

28 * Sec. 7. AS 28.15.111(b) is amended to read:

29 (b) The department shall provide, at the time that an operator's license is
30 issued, a form for a document by which the owner of a license may make an
31 anatomical gift under AS 13.52 [AS 13.50 OR A LIVING WILL UNDER AS 18.12].

1 The document (1) may not be larger than an operator's license, (2) must contain
2 sufficient space for the signature of two witnesses [OR A PERSON WHO IS
3 QUALIFIED TO TAKE ACKNOWLEDGMENTS UNDER AS 09.63.010], and (3)
4 [MUST USE THE FORMS AND DESIGNS DEVELOPED UNDER AS 18.12.037,
5 AND (4)] must provide a means by which the owner may cancel the anatomical gift
6 [OR THE LIVING WILL]. If the document is executed by the applicant, it shall be
7 sealed in plastic and attached to the license. [A SYMBOL DEVELOPED UNDER
8 AS 18.12.037 INDICATING THE EXISTENCE OF THE ANATOMICAL GIFT OR
9 LIVING WILL DOCUMENT MUST BE DISPLAYED IN THE LOWER RIGHT-
10 HAND CORNER ON THE FACE OF THE DRIVER'S LICENSE.]

11 * Sec. 8. AS 47.30 is amended by adding a new section to article 9 to read:

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

17 * Sec. 9. AS 47.30.825(b) is amended to read:

18 (b) The patient and the following persons, at the request of the patient, are
19 entitled to participate in formulating the patient's individualized treatment plan and to
20 participate in the evaluation process as much as possible, at minimum to the extent of
21 requesting specific forms of therapy, inquiring why specific therapies are or are not
22 included in the treatment program, and being informed as to the patient's present
23 medical and psychological condition and prognosis: (1) the patient's counsel, (2) the
24 patient's guardian, (3) a mental health professional previously engaged in the patient's
25 care outside of the evaluation facility or designated treatment facility, (4) a
26 representative of the patient's choice, (5) a person designated as the patient's agent or
27 surrogate [ATTORNEY-IN-FACT] with regard to mental health treatment decisions
28 under AS 13.52 [AS 13.26.332 - 13.26.358, AS 47.30.950 - 47.30.980, OR OTHER
29 POWER-OF-ATTORNEY], and (6) the adult designated under AS 47.30.725. The
30 mental health care professionals may not withhold any of the information described in
31 this subsection from the patient or from others if the patient has signed a waiver of

1 confidentiality or has designated the person who would receive the information as an
2 agent or surrogate under AS 13.52 [ATTORNEY-IN-FACT] with regard to mental
3 health treatment.

4 * Sec. 10. AS 47.30.825(f) is amended to read:

5 (f) A patient capable of giving informed consent has the absolute right to
6 accept or refuse electroconvulsive therapy or aversive conditioning. A patient who
7 lacks substantial capacity to make this decision may not be given this therapy or
8 conditioning without a court order unless the patient expressly authorized that
9 particular form of treatment in an advance health care directive [A
10 DECLARATION] properly executed under AS 13.52 [AS 47.30.950 - 47.30.980] or
11 has authorized an agent or surrogate under AS 13.52 [ATTORNEY-IN-FACT] to
12 make this decision and the agent or surrogate [ATTORNEY-IN-FACT] consents to
13 the treatment on behalf of the patient.

14 * Sec. 11. AS 47.30.836 is amended to read:

15 **Sec. 47.30.836. Psychotropic medication in nonemergencies.** An evaluation
16 facility or designated treatment facility may not administer psychotropic medication to
17 a patient in a situation that does not involve a crisis under AS 47.30.838(a)(1) unless
18 the patient

19 (1) has the capacity to give informed consent to the medication, as
20 described in AS 47.30.837, and gives that consent; the facility shall document the
21 consent in the patient's medical chart;

22 (2) authorized the use of psychotropic medication in an advance
23 health care directive [A DECLARATION] properly executed under AS 13.52
24 [AS 47.30.950 - 47.30.980] or authorized an agent or surrogate under AS 13.52
25 [ATTORNEY-IN-FACT] to consent to the use of psychotropic medication for the
26 patient and the agent or surrogate [ATTORNEY-IN-FACT] does consent; or

27 (3) is determined by a court to lack the capacity to give informed
28 consent to the medication and the court approves use of the medication under
29 AS 47.30.839.

30 * Sec. 12. AS 47.30.838(d) is amended to read:

31 (d) An evaluation facility or designated treatment facility may administer

1 psychotropic medication to a patient without the patient's informed consent if the
2 patient is unable to give informed consent but has authorized the use of psychotropic
3 medication in an advance health care directive [A DECLARATION] properly
4 executed under AS 13.52 [AS 47.30.950 - 47.30.980] or has authorized an agent or
5 surrogate under AS 13.52 [ATTORNEY-IN-FACT] to consent to this form of
6 treatment for the patient and the agent or surrogate [ATTORNEY-IN-FACT] does
7 consent.

8 * Sec. 13. AS 47.30.839(d) is amended to read:

9 (d) Upon the filing of a petition under (b) of this section, the court shall direct
10 the office of public advocacy to provide a visitor to assist the court in investigating the
11 issue of whether the patient has the capacity to give or withhold informed consent to
12 the administration of psychotropic medication. The visitor shall gather pertinent
13 information and present it to the court in written or oral form at the hearing. The
14 information must include documentation of the following:

15 (1) the patient's responses to a capacity assessment instrument
16 administered at the request of the visitor;

17 (2) any expressed wishes of the patient regarding medication,
18 including wishes that may have been expressed in a power of attorney, a living will,
19 an advance health care directive under AS 13.52, or oral statements of the patient,
20 including conversations with relatives and friends that are significant persons in the
21 patient's life as those conversations are remembered by the relatives and friends; oral
22 statements of the patient should be accompanied by a description of the circumstances
23 under which the patient made the statements, when possible.

24 * Sec. 14. AS 47.33.070(a) is amended to read:

25 (a) An assisted living home shall maintain, for each resident of the home, a
26 file that includes

27 (1) the name and birth date, and, if provided by the resident, the social
28 security number of the resident;

29 (2) the name, address, and telephone number of the resident's closest
30 relative, service coordinator, if any, and representative, if any;

31 (3) a statement of what actions, if any, the resident's representative is

- 1 authorized to take on the resident's behalf;
- 2 (4) a copy of the resident's assisted living plan;
- 3 (5) a copy of the residential services contract between the home and
- 4 the resident;
- 5 (6) a notice, as required under AS 47.33.030, regarding the depository
- 6 in which the resident's advance payment money is being held;
- 7 (7) written acknowledgment [ACKNOWLEDGEMENT] by the
- 8 resident or the resident's representative that the resident has received a copy of and has
- 9 read, or has been read the
- 10 (A) resident's rights under AS 47.33.300;
- 11 (B) resident's right to pursue a grievance under AS 47.33.340;
- 12 (C) resident's right to protection from retaliation under
- 13 AS 47.33.350;
- 14 (D) provisions of AS 47.33.510, regarding immunity; and
- 15 (E) home's house rules;
- 16 (8) an acknowledgment [ACKNOWLEDGEMENT] and agreement
- 17 relating to home safekeeping and management of the resident's money, as required by
- 18 AS 47.33.040;
- 19 (9) a copy of the resident's living will, if any, or an advance health
- 20 care directive made under AS 13.52, if any; and
- 21 (10) a copy of a power of attorney or other written designation,
- 22 including an advance health care directive made under AS 13.52, of an agent,
- 23 representative, or surrogate by the resident.

24 * **Sec. 15.** AS 13.26.332(L), 13.26.335(1), 13.26.344(l); AS 13.50.010, 13.50.014,

25 13.50.016, 13.50.020, 13.50.030, 13.50.040, 13.50.050, 13.50.060, 13.50.065, 13.50.068,

26 13.50.070, 13.50.080, 13.50.090; AS 18.12.010, 18.12.020, 18.12.030, 18.12.035, 18.12.037,

27 18.12.040, 18.12.050, 18.12.060, 18.12.070, 18.12.080, 18.12.090, 18.12.100; AS 47.30.950,

28 47.30.952, 47.30.954, 47.30.956, 47.30.958, 47.30.960, 47.30.962, 47.30.964, 47.30.966,

29 47.30.968, 47.30.970, 47.30.972, and 47.30.980 are repealed.

30 * **Sec. 16.** The uncodified law of the State of Alaska is amended by adding a new section to

31 read:

1 CONTINUING EFFECT OF EXISTING DOCUMENTS. (a) An anatomical gift
2 made under AS 13.50 or AS 18.12, repealed by sec. 15 of this Act, before the effective date
3 of secs. 1 - 15 of this Act continues in effect under AS 13.50 or AS 18.12, as those chapters
4 exist before the effective date of secs. 1 - 15 of this Act, until the donation is revoked.

5 (b) A power of attorney that is made under AS 13.26.332(L), 13.26.335(1), or
6 13.26.344(l), repealed by sec. 15 of this Act, before the effective date of secs. 1 - 15 of this
7 Act and that contains authority for health care services under AS 13.26.332(L),
8 AS 13.26.335(1), or 13.26.344(l), repealed by sec. 15 of this Act, continues in effect under
9 AS 13.26.332(L), 13.26.335(1), and 13.26.344(l), as those provisions exist before the
10 effective date of secs. 1 - 15 of this Act, until the power of attorney is revoked.

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

14 (d) A declaration made under AS 47.30.950 - 47.30.980, repealed by sec. 15 of this
15 Act, before the effective date of secs. 1 - 15 of this Act continues in effect under
16 AS 47.30.950 - 47.30.980, as those sections exist before the effective date of secs. 1 - 15 of
17 this Act, until the declaration is revoked.

18 * Sec. 17. The uncodified law of the State of Alaska is amended by adding a new section to
19 read:

20 EFFECT ON EXISTING INSURANCE POLICIES AND ANNUITIES.
21 AS 13.52.120(c), added by sec. 3 of this Act, does not apply to a policy of insurance or an
22 annuity that was entered into before the effective date of secs. 1 - 15 of this Act.

23 * Sec. 18. The uncodified law of the State of Alaska is amended by adding a new section to
24 read:

25 TRANSITION: REGULATIONS. The Department of Health and Social Services
26 may proceed to adopt regulations necessary to implement the changes made by secs. 1 - 15 of
27 this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not
28 before January 1, 2004.

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

31 CONTINUING EFFECT OF CURRENT REGULATIONS. (a) The regulations

1 found at 7 AAC 16, as modified by (b) of this section, continue in effect on and after
2 January 1, 2004, until the Department of Health and Social Services adopts the regulations
3 authorized under sec. 18 of this Act.

4 (b) The regulations attorney in the Department of Law shall

5 (1) in 7 AAC 16.010(a), replace the reference to "AS 18.12.035(b)" with
6 "AS 13.52.060(b)";

7 (2) in 7 AAC 16.010(d)(4), replace the reference to "AS 18.12.090" with
8 "AS 13.52.160";

9 (3) in 7 AAC 16.010(f), replace the reference to "AS 18.12" with "AS 13.52";

10 (4) in 7 AAC 16.090(1), replace the reference to "AS 18.12.100" with
11 "AS 13.52.390";

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

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

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

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

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

Revision Date/Time (Note if correction):

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

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

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES (0)						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2003) cost: _____

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

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

Prepared by: Karen E. Pearson, M.S., Director
 Division: Public Health
 Approved by: Joel S. Gilbertson, Commissioner
 Agency: Department of Health and Social Services

Phone 465-3090
 Date/Time 02/13/2003
 Date 02/13/2003

THE LAW FIRM OF

Faulkner Banfield

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One Sealaska Plaza, Suite 202 + Juneau, Alaska 99801-1245
(907) 586-2210 + Fax (907) 586-8090

www.faulknerbanfield.com

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

March 31, 2003

Via Fax 465-2273

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

Re: CSHB 25

Dear Representative Weyhrauch:

I am writing in support of CSHB 25 regarding health care decisions and advance directives. I am an attorney and practice extensively in the area of estate planning and long-term care planning. In my practice, more than 95% of my clients sign durable powers of attorney and living wills. While current Alaska law authorizes an individual to execute a power of attorney and living will, I believe CSHB 25 will clarify the agent's power under a health care power of attorney, will allow an individual more freedom to set forth his or her wishes for health care treatment, and will minimize conflicts regarding an individual's medical treatment.

Under current law, an individual who wishes to appoint an agent to make his or her health care decisions must sign a durable power of attorney. This power of attorney may authorize a person to make both financial and health care decisions. In addition, an individual who wishes to express his or her wishes regarding life-sustaining measures must sign a living will. Signing one document and not the other may lead to confusion. For example, an agent under a durable power of attorney cannot make decisions regarding life-sustaining measures unless the incapacitated person also signed a living will. Conversely, if an individual signs a living will, but not a durable power of attorney, then the individual has not appointed any person to represent his or her interests to assure that the living will is, in fact, implemented, or to make other health care decisions. Merging these equally important documents into one document will assure that individuals consider all issues involved with medical treatment and end-of-life decisions.

Furthermore, proposed Section 13.52.030, regarding health care decisions by a surrogate, is a vast improvement over current law and will allow family members to participate in health care decisions even if the incapacitated individual failed to sign a

Page 2

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

I commend the Legislature for considering changes to Alaska law that will provide Alaskans more freedom in making known their wishes for health care and that will allow family members to participate in health care decisions without the need for a guardianship. By adopting this law, Alaska will be taking a positive step for the benefit all Alaskans.

Thank you for your consideration of my comments.

Sincerely,



BethAnn Boudah Chapman

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



Alaska Commission on Aging

Resolution 2003-04

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

Whereas HB 25 will assist Alaskans to thoughtfully state their intent regarding the kind of medical, personal, emotional, and spiritual care they wish to receive in the last stages of their lives if they are no longer able to express their wishes, and

Whereas HB 25 provides a clear and helpful format to guide an individual in defining their wishes in this regard, and sharing that information with their loved ones, and

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

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

Adopted this 21st day of February, 2003.

A handwritten signature in cursive script that reads "Marjorie J. Hays".

Marjorie J. Hays, Chair



Honorable Lesli McGulre, Chair
House Judiciary Committee
Alaska Capitol, Room 118
Juneau, AK 99801-1182

March 24, 2003

RE: HB 25 (Weyhrauch) – Support

Dear Chair McGuire:

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

AARP believes that states should provide a comprehensive approach to health care decision making, such as that contained in the Uniform Health Care Decisions Act designed by the National Conference of Commissioners on Uniformed State Laws. Competent adults should be allowed and encouraged to communicate their medical treatment wishes and/or appoint a surrogate to make the treatment decisions for them in the event of their incapacity.

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

AARP recommends an "AYE" vote on HB 25.

Should you have any questions about our position, please feel free to contact Marie Darlin (586-3637), Coordinator of the AARP Capital City Task Force; Patrick Luby (907-762-3314), AARP Legislative Representative; or me (907-245-5259).

Thank you for your consideration.

Sincerely,

Marguerite Stetson
Executive Council Member for Advocacy

CC: Vice Chair Tom Anderson
Representative Dan Ogg
Representative Jim Holm
Representative Ralph Samuels
Representative Les Gara
Representative Max Gruenberg

Representative Bruce Weyhrauch

Marie Darlin
Patrick Luby

Subject: HB 25 appeal2

Date: Wed, 26 Feb 2003 16:09:56 -0900

From: "Wallington, Maria Dr." <MWalling@provak.org>

To: "'linda_sylvester@legis.state.ak.us'" <linda_sylvester@legis.state.ak.us>

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

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

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

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

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

decision-making.)

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

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

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

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

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

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

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

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

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

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Life Alaska

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



February 27, 2003

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

Dear Mr. Weyhrauch:

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

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

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

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

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



On Our Own Terms: Moyers on Dying

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



Discussion Guide

How to Talk About End-Of-Life Concerns

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

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

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

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

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

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

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

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

What to Talk About...

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

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

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

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

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

The DNR ("do-not-resuscitate") MedicAlert® bracelet is imprinted with the MedicAlert® emblem on one side and DNR wording on the other. It is backed by a fully staffed 24-hour Emergency Call Center and recognized as a valid pre-hospital DNR order by emergency medical services in eight states: Arkansas, California, Indiana, Kansas, Maryland, Nevada, New Mexico, and Wisconsin. "DNR-EMS ON FILE" or similar wording is engraved for residents of other states.

For more information about DNR and advance directives repository services contact MedicAlert® Foundation at 1-800-432-5378 or on the Web at www.medicalert.org.

photo © Geraldine Rubio



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

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

Writing It Down

Advance Directives

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

Talking About the Future

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

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

Issues for Further Consideration

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



[Projects](#) [News](#) [5 Wishes™](#) [Get Involved](#) [Resources](#) [Links](#)

Five Wishes

Five Wishes is a document that helps you express how you want to be treated if you are seriously ill and unable to speak for yourself. It is unique among all other living will and health agent forms because it looks to all of a person's needs: medical, personal, emotional and spiritual. Five Wishes also encourages discussing your wishes with your family and physician.

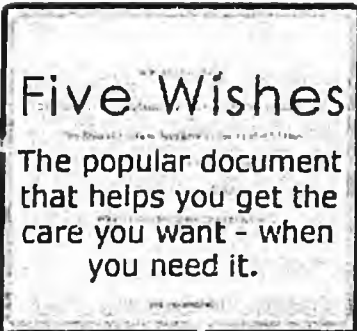
Five Wishes lets your family and doctors know:

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

Five Wishes is changing the way America talks about and plans for care at the end of life. More than 1.5 MILLION copies of the document are circulating throughout the nation, and more than 3,500 organizations are distributing this revolutionary document, including churches, synagogues, hospices, hospitals, doctor and law offices, and social service agencies. Many employers are providing the document to their employees, to help them plan for themselves and have those delicate discussions with their aging parents.

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

The 15 states that Five Wishes is not legally valid in, either require a specific state form or that the person completing an advance directive be read a mandatory notice or "warning." Residents of these states can still use Five Wishes to put their wishes in writing and communicate their wishes with their family and physician. Most health care professionals understand they



Five Wishes Order Five Wishes!



Preview Five Wishes

View a non-printable example of Five Wishes.

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



Five Wishes At Work

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

Five Wishes Video

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

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

Order now!

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

888-594-74

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

Five Wishes Q&A

Answers to the most commonly asked questions about Five Wishes.

Five Wishes States

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



Five Wishes Feedback

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



five Order Five wishes Wishes!

Projects News 5 Wishes™ Get Involved Resources Links

Five Wishes States



Valid States
Legally valid in:

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

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

Alaska IS NOT a Five Wishes State
— — =

Five Wishes

What is Five Wishes?

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

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

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

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

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

Why should I fill out Five Wishes?

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

When do I need to use Five Wishes?

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

When does Five Wishes take effect?

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

Is Five Wishes a legal document?

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

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

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

How do I use Five Wishes?

Take the following steps to use Five Wishes:

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

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

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

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

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

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

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

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

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

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

Do I have to have my Five Wishes notarized?

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

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

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

Who developed Five Wishes?

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

What if I have more questions?

You may talk with a lawyer or health care professional for advice. If you want more information, visit our web site at:

<http://www.agingwithdignity.org/5wishes.pdf>

or

<http://www.agingwithdignity.org/order.html>

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

By ANN POTEPA
Anchorage Daily News

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

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

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

- A low percentage of Alaskans 65 and older died with the help of hospice programs. Hospice emphasizes comfort care for people with terminal illness.

- The state lacks physicians and nurses trained in palliative care, which controls pain and other symptoms and improves quality of life for dying patients.

- The state's hospitals don't have enough pain and palliative care services.

- Alaska laws don't support good care planning, such as living wills and powers of attorney. A medical power of attorney makes health care decisions for patients when they

can no longer communicate for themselves.

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

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

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

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

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

"It's a wonderful resource

for the community to have," Thorsness said.

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

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

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

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

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

Thorsness and Daddino stressed the importance of continuing education for professionals providing end-of-life care and for the community so residents understand what options they have. In May, Dr. Ira

Byock, author of "Dying Well: The Prospect for Growth at the End of Life," will spend two days in Alaska visiting hospitals and consulting with Providence Alaska Medical Center about its palliative care team. Byock also will speak at a free public session in Providence's auditorium on May 8.

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



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Anchorage Daily News

ALASKANS want more of a say over their final days
Legislation in House would change state's law to allow simpler approach

By Lisa Demer

Anchorage Daily News

(Published: January 25, 2002)

If you knew you were going to die soon, what would your last wishes be?

Maybe you'd like your old dog by your side. Or ice cream for lunch every day. Or your children to know you're sorry for a long-ago wrong.

If you're like most people, you want to die at home with family members and friends. But people usually end up in a hospital or nursing home cared for by strangers, according to Aging with Dignity, a national organization that advocates for the elderly.

Alaska is among 15 states where narrow laws crimp efforts by people to spell out their last wishes, said Jim Towey, the Washington, D.C., based-president and founder of Aging with Dignity.

That would change under a bill before the Legislature. House Bill 197, sponsored by Rep. Bill Hudson, R-Juneau, would retool Alaska law on health care decision-making and other matters that arise at the end of life.

The idea is to help people spell out their wishes now so that later, if they can't walk to the fridge or even speak, their family, friends and medical providers know what they want.

Alaska already has laws for setting up living wills and appointing someone to make health care decisions through a power of attorney. When the bill was aired last year, some legislators questioned whether Alaska needs a new law.

Advocates say it does. Existing laws include legal forms that people feel bound to use even when there are good alternatives, including an approach known as Five Wishes, which is gaining popularity.

"People are concerned if they go beyond the statutory form, it would cause problems if there was any dispute," said Beth Chapman, a Juneau attorney who works in estate planning. "They want to be more detailed about their wishes."

Under the legislation, people could more easily write their own tailored last wishes, advocates said. Their wishes would, in effect, get a state stamp of validity whether a lawyer wrote the document or the person scrawled something himself or herself on the back of a paper bag, Towey said.

In Alaska, hospice organizations, AARP, the Juneau End of Life Task Force, the state Commission on Aging, and the statewide Senior Advocacy Coalition have supported changing the law to allow the Five Wishes approach. That trademark system, designed by Aging with Dignity, uses simple language and covers emotional and spiritual needs as well as health care.

"People in America treat dying like a medical moment. The discussion is all about feeding tubes and respirators. It leaves family members guessing and feeling guilty," said Towey, who once worked in a Mother Teresa home for the dying and was her lawyer for a dozen years.

An American Bar Association analysis found that Five Wishes is valid in 35 states. But the rest, including Alaska, either direct people to use specific forms or require that someone preparing a health care directive

be read a warning first.

Besides living wills, people should delegate a trusted health care agent to make decisions, said Charles Sabatino of Washington, D.C., assistant director of the American Bar Association Commission on Legal Problems of the Elderly. There are too many medical scenarios to anticipate them all, he said.

But Alaska law governing how to do that through a health care power of attorney is rigid, he said.

The latest version of the Alaska bill doesn't mention Five Wishes specifically but would allow it under an "other wishes" section for people who write their own instructions from scratch or just want to add a few extra thoughts, said Melanie Lesh, a legislative aide to Hudson.

States that allow Five Wishes typically don't name it. Their laws let people choose what form to use or write their own if they want, Sabatino said.

"Five Wishes is a great form. It ought to be clearly valid in every state. It isn't the end all and be all for everybody," Sabatino said.

The Five Wishes approach includes:

Whom you want to make medical decisions for you.

The type of medical treatment you want, or don't want, through a living will.

How comfortable you want to be in terms of pain medicine, bathing and comfort measures like oil massages.

How you want people to treat you, including who should be around.

Your last thoughts for your family and friends.

Sabatino said he found Five Wishes valuable in unexpected ways when his mother died about six months ago. At her eulogy, he read aloud her fifth wish, in which she asked for forgiveness and said she forgave the hurts against her.

"It's kind of a closure wish and a blessing on her friends," he said.

The effort to change Alaska law began after a Bill Moyers public television series on dying that aired in fall 2000. Afterward, some Juneau residents formed an End of Life Task Force that decided to push for Five Wishes in Alaska, said Sioux Plummer, its chairwoman. She was a former aide to Hudson, and he agreed to carry the bill.

"They can be pretty much in control of their lives at the end," if the details are spelled out ahead of time, said Plummer, whose husband died of lung cancer three years ago.

Some Alaska advocates have been using Five Wishes for years, even though they are unsure whether it would hold up if tested.

Brenda Brown, a retired nurse who volunteers with families through an interfaith program, stumbled on the approach in Florida when her father-in-law became ill with a brain tumor in 1998. She used it to help him talk about whom he wanted to visit him at the end.

She takes a copy or two of Five Wishes when she gives workshops on living wills.

"The desire, I have heard from man after man after man, is I got to die at home because I've got a dog there, my big old dog," Brown said.

Others say they want "spiritual privacy." They may be religious but still not want their priest or pastor or rabbi to come by.

One woman wanted to die on her sofa, where she had a view of her hanging baskets, Brown said.

The conversations are so moving, she said, they should be taped to preserve as special treasures.

Reporter Lisa Demer can be reached at ldemer@adn.com and 907 257-4390.

Brenda Brown, A Retired Nurse, Helps People Address End-of-life Issues And Plan Living Wills. She Advocates For Legislation Allowing More Detailed Documents.

Close Window

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Emergency Medical Care

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

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

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

Other Related Programs

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

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

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

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

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

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

◆

◆

The Alaska Comfort One Program

Information for Patients and Families



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

◆

The Alaska Comfort One Program

Information for Patients and Families

Overview

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

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

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

A Do Not Resuscitate order is different from a "living will." Living wills are designed to allow the patient to express his or her wishes regarding life sustaining treatments and other medical care when unable to make treatment decisions. However, they do not go into effect until the patient is determined to be in a terminal condition and is unable to make treatment decisions. The Alaska Comfort One program removes the uncertainty

of whether the person has a terminal condition and wishes to have CPR performed or not. By preventing unwanted resuscitation efforts, the program provides benefit to patients and their families, as well as to health care providers, during the time surrounding the patient's death.

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

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



Optional Bracelet

Enrolling in the Comfort One Program

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

Proof of Enrollment

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

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

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

HB

29

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SSHB 29
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: DCED
 Title Real Property Transactions/Licensees RDU Occupational Licensing (117)
 Component Occupational Licensing
 Sponsor Representative Rokeberg
 Requester House Labor and Commerce Component No. 2360

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 0.0
 Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SSHB 29 makes changes to practices conducted by real estate licensees. New funds are not required to implement these changes.

Prepared by: Jennifer Strickler, Administrative Manager Phone (907) 465-2144
 Division Occupational Licensing Date/Time 2/2/04 1:42 PM
 Approved by: Edgar Blatchford, Commissioner Date 2/2/2004
 Agency Department of Community & Economic Development

ALASKA STATE LEGISLATURE

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



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

House Judiciary Committee

Memorandum

To: Terri Bannister, Leg. Legal
From: Vanessa Tondini, Committee Aide
House Judiciary Committee
Date: February 25, 2004
Re: CS Request

Please create a final draft House Judiciary Committee Substitute for work order # 23-LS0189AB, HB 29. All the amendments you incorporated look great and now we're ready to get the bill moving along. If possible, we'd like to hand the bill in to the Clerk by floor session tomorrow (Thurs.) at 10 a.m., but if you can't get the final out by then it okay.

If you have any questions, please call me at 4990. Thank you so much as always!

The information attached to this memo is **CONFIDENTIAL** an/or privileged. It is intended to be reviewed initially by only the individual named above. If the reader of this Memorandum is not the intended recipient or a representative of the intended recipient, you are hereby notified that any review, dissemination, or copying of the information contained herein is prohibited. If you have received this in error, please immediately notify the sender by telephone and return this to the sender at the above address.

ALASKA STATE LEGISLATURE

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



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

House Judiciary Committee

Memorandum

To: Leg. Legal

From: Vanessa Tondini, Committee Aide
House Judiciary Committee

Date: February 20, 2004

Re: CS Request

Please create a final draft House Judiciary Committee Substitute for work order # 23-LS0189X, CSSSHB 29, incorporating the attached amendments (A's # 1, 2, 3, 6, and 9). Amendment # 6 is conceptual for the purpose of ensuring that the inability to waive duties, as stated in AS 08.88.625 applies to AS 08.88.600(b)(4) (see attached amendment). Amendment 9 is conceptual for the purposes of making it grammatically and logically correct. The bill was passed out of committee today.

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

The information attached to this memo is **CONFIDENTIAL** an/or privileged. It is intended to be reviewed initially by only the individual named above. If the reader of this Memorandum is not the intended recipient or a representative of the intended recipient, you are hereby notified that any review, dissemination, or copying of the information contained herein is prohibited. If you have received this in error, please immediately notify the sender by telephone and return this to the sender at the above address.

23-LS0189X.1
Bannister
2/18/04

AMENDMENT #1 - PASSED

OFFERED IN THE HOUSE

BY REPRESENTATIVE ROKEBERG

TO: CSSSHB 29(L&C)

1 Page 4, line 19:

2 Delete "a pamphlet issued by the commission"

3 Insert "a copy of the pamphlet established under AS 08.88.685(b)(2) and
4 produced under AS 08.88.685(c)"

5

6 Page 11, line 23, following "contents":

7 Insert "and format"

8

9 Page 11, lines 23 - 24:

10 Delete "issued by the commissioner and provided"

11 Insert "provided by a licensee"

12

13 Page 11, following line 26:

14 Insert a new subsection to read:

15 "(c) Based on the content and format for the pamphlets established under
16 (b)(2) of this section, a real estate broker shall produce and pay the costs to
17 produce the actual pamphlets to be provided by licensees in the broker's business
18 under AS 08.88.615(a)(6)."

HB 29

Amendment 2 - PASSED

Gara

Insert at P. 3 line 24 after "person."

"The written consent must be provided on a separate form, not contained as part of another writing, titled "Waiver of Right To Be Represented."

HB 29

Amendment 3 - PASSED

Gara

Insert at page 3 line 3 after "also", the following language: ",with written consent of the parties,"

HB 29

Gara

Conceptual Amendment ~~HB 29~~ #6 - PASSED

Page 3, Line 4

After "writing"

Insert ", except that a real estate licensee or a person to whom a licensee provides specific assistance may not waive the duties identified under AS 08.88.615 and 08.88.620, except as otherwise allowed under AS*08.88.620(5) and (6)."

The purpose of this amendment is to ensure that ~~that~~ if the parties choose to "agree otherwise" under AS 08.88.600 (b) (4), they still can not waive the duties, with exceptions, as stated in 08.88.625.

conceptual AMENDMENT NO. 9 TO HB 29

By Representative Gruenberg

Page 7, line 13: Amend subsection (f) as follows:

(f) A real estate licensee who discloses confidential information to the licensee's broker for the purpose of seeking advice or assistance for the benefit of the person to whom the licensee is providing specific assistance does not breach the licensee's duty of confidentiality to the person[.] if the confidentiality of the information is retained by the licensee's broker.

HB 29

Amendment 4 - FAILED

Gara

Insert at page 3 line 4 after "writing", the following language: "except that a licensee cannot engage in dual agency, or dual representation."

(Note: Dual agency or dual representation to be defined per sponsors).

Gara

Amendment 5 - WITHDRAWN

P.3., L.5 Insert:

- (5) if ^{a licensee} ~~an agent~~ ~~is~~ represents ~~more than~~
 a person with potentially adverse interests
 to the represented person, the licensee must
 obtain the represented person's consent,
 on ~~with~~ a signed form that is not part of
 another writing, titled:

"Consent to allow representation of
 other parties ~~with~~ with Potentially Conflicting Interests"

Concept. - PASSED

A #6 by Gara
P.3, L.4

~~P.2, L.25~~
after writing,

Insert must be
"except as otherwise stated in
of 4/10/20"

P.6. 2.5-8

can not be
"allowed in" written.

HB 29

Amendment 7 - FAILED

Gara

At page 11 line 6 - 7, delete everything after "transactions", insert after "transactions" the following language: "is not abrogated except to the extent inconsistent with AS 08.88.600 - 08.88.695."

HB 29

Amendment 8 - FAILED

Gara

Insert at p. 5 line 16, and renumber remaining sections accordingly:

“(2) diligent performance in the represented person’s best interests and, when applicable, to act with reasonable care in a transaction to achieve the person’s best interests.”

TESTIMONY OF

**KIRK WICKERSHAM
351-3726**

**SSHB 29
HOUSE LABOR AND COMMERCE COMMITTEE**

FEBRUARY 4, 2004

This bill deals with the legal and practical relationship between real estate licensees and the consuming public, between real estate licensees and their clients, and between each other. It abolishes the common law of agency as applied to real estate licensees and their clients, and replaces it with a term called "representation." If the bill is adopted, it will improve relationships between the licensed professionals and the public in what is normally the largest and most significant transaction in their life -- the purchase of a home.

I have been a lawyer for over 34 years and a member of the Executive Committee of the ABA Real Estate Law Section for over 18 years. I have also been a real estate broker for over 25 years, and I served as both Vice Chairman and Chairman of the Alaska Real Estate Commission. I am a member of the Board of Realtors and served on the task force that developed this legislation.

I am a real estate licensee, but not an agent. For the last nine years I have owned and operated the For Sale By Owner Assistance Program, a real estate company that provides counseling services to people selling on their own. Thus, I and the other Realtors in my company are not affected by this bill, and I am testifying solely as an interested citizen. As people in Juneau say, I have no dog in this fight.

As a measure of my commitment, however, I would just like to say that I've been on sabbatical, attending screenwriting school at UCLA, and I've flown in from Los Angeles for this hearing.

I would like to provide some background and history. In the early 1980s, a series of state supreme court cases held that a real estate agent owed his or her client fiduciary duties similar to the duties a lawyer owed a client in a litigation situation -- or similar to the duties an attorney in fact owes to his or her principal. The legal structure of a real estate transaction was adversarial.

At that time, all agents, including those working with the buyer, were legally working for the seller. This created a huge clash between perception and reality, and

Alaska, along with the rest of the country, discovered that the consuming public expected and demanded that the agent working WITH the buyer be working FOR the buyer. This gave rise to exclusive buyers' agents, and as a result there are buyer agents operating today in all the major markets in the state.

Large firms, however, with many agents, had many listings and represented many buyers. These firms quickly ran into conflicts. The concept of dual agency, in which the company, and sometimes the individual agent, represented both the buyer and the seller, took hold. Today, 40 or 50 per cent of agent transactions involve dual agency.

I was a lawyer long before I was a Realtor, and the notion of dual agency is alien to me. However, the consuming public is apparently used to this arrangement, and relatively few problems have actually come up over the years, considered in the light of billions of dollars of transactions each year. In fact, the amount of litigation by consumers against real estate licensees is a fraction of what it was 15 years ago. And this is good.

Dual agency is specifically provided for in Alaska statutes. But it has inherent problems under Alaska court decisions. Under Alaska case law, an agent has duties to his client (among other things) to divulge to his client confidential information about his bargaining adversary, and to try to get the best possible price and terms for his client. These two duties are impossible when one is a dual agent, working for both parties.

Most licensees are probably dual agents. Despite the fact that transactions seem to go smoothly, agency disclosures are made and consumers seem to understand how dual agents operate, these conflicting legal duties and loyalties have given the industry significant heartburn over the years.

Recently, a lawsuit was settled after the court held that a dual agent had violated these duties -- the duty to divulge the other party's secrets and the duty to try to get the best price and terms -- to her buyer client.

The suit had several other issues, and the breach of agent duties was not as significant as the fact that she stole the buyer from another agent, and the fact that she did not properly or timely disclose her dual agency status to either of her clients as required by law.

Nevertheless, the suit has boiled this dual agency issue to a head. The Realtor task force began by considering reforms to the legal concept and duties involved with dual agency, but soon came to the conclusion that the entire legal notion of agency -- the

notion of the licensee as a hired combatant for his or her client in an adversarial conflict - simply does not reflect the way real estate is bought and sold.

It never has. Real estate transactions are not like lawsuits, where the parties are adversarial from start to finish. They are basically cooperative ventures in which conflicts can arise. In other words, in a real estate transaction, unlike a lawsuit, each party needs what the other offers, so both can "win" at the conclusion.

This proposal, at its simplest, brings the law into conformance with this actual practice. The Realtor who helps a family find a house is not a predator, looking to exploit an advantage; he or she is a helper. The concept of the agent's bargaining adversary is replaced with the concept of the consuming public.

Likewise, the concept of agency -- trying to discover weaknesses on the other side and exploit them, is replaced with the concept of representation -- being a good solid advocate for the client.

Instead of dual agency, the bill creates the role of a neutral middleman, a professional who just helps the parties come together and close the transaction without advocating for either side. This, too, is just common sense.

The bill acknowledges, for the first time, that within the same firm, one Realtor can adequately represent the buyer and another can adequately represent the seller.

The bill clarifies and strengthens the licensee's requirement to disclose his or her relationship to the parties.

What's in it for the real estate industry? They can exhale for the first time in about 15 years, because the law will reflect the practice.

What's in it for the consumer? Greater clarity, a better level of service, and common sense. Likewise, the law will reflect the public's expectations. Also, the law eliminates a strange and harsh element of agency law: the client's vicarious liability for his Realtor's transgressions.

What's in it for trial lawyers? Frankly, I hope that the increased clarity and common sense reflected in this bill will mean less litigation based solely on the difference between form and substance. This is often litigation where the only winners are the lawyers. I do not mean to sound critical of lawyers because again, this really has not been a significant problem so far. This is perhaps a reflection of the fact that, although practice has not always conformed to the law, the public has rarely been harmed.

What's in it for the legislature? It's the right thing to do. Alaska will join a growing list of states that have developed alternatives to the traditional notion of real estate agency. We studied other state's approaches, and came up with our own. It is partly a reflection of our unique market, and partly an improvement over other states' attempts to resolve this problem. I think -- I hope -- that the approach we've proposed will in turn be a model for other states as they resolve this issue for themselves.

There is one final point I would like to raise. This bill does not define the only possible relationships between the Realtor and his/her client. For instance, my company would not fit into the bill's concept of conventional representation. Other real estate firms also offer a nontraditional mix of services. All this enhances consumer choice.

This bill ensures that innovation and consumer choice, as represented by my company and others, will be preserved. The Realtor task force has been clear from the very start that it wants to preserve consumer choice. Please ensure that this remains in the bill as it moves forward to adoption.

THE
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DOCUMENT(S)
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POOR
ORIGINAL
COPIES



Gene Duval
REALTOR®

February 17, 2004

Dear Representative Lesil McGuire,

I have carefully reviewed the Sponsor Substitute for House Bill Number 29, "an Act relating to real estate transactions," sponsored by Representative Rokeberg.

I am a member of the Alaska Association of Realtors, and an Associate Broker real estate licensee in Alaska. I believe this Bill would offer needed protection to the public since it clearly defines and determines when and in what manner licensees must disclose agency to clients/customers. It also significantly simplifies the process of explaining and documenting agency representation to the public.

I urge you to support it. Feel free to contact me via phone, fax, or e-mail for comments or inquiries.

Best wishes,



Gene DuVal

RE/MAX Associates of Fairbanks

529 5th Avenue, Suite #200
Fairbanks, Alaska 99701
Office: (907) 452-4363
Fax: (907) 452-1499
e-mail: duval@gci.net
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FAX MEMORANDUM

DATE: 2-18-2004

TO: Judiciary Committee
269-0240

COMPANY: _____

FAX: _____

FROM: LINDA S. GARRISON, Broker

RE: SSHB 29-Sponsor-Rokeberg

OF PAGES TO FOLLOW _____

TITLE C. DUTIES OF LOYALTY

§ 387. General Principle

Unless otherwise agreed, an agent is subject to a duty to his principal to act solely for the benefit of the principal in all matters connected with his agency.

Comment:

a. Sections 388-398 are applications of the rule stated in this Section. In situations in which the rule makes improper the doing of acts which would be authorized if done with a proper purpose, the rule is an aspect of the duty of the agent to perform for the principal only acts which he should know are intended by the principal. The rule is broader, however, since it forbids the doing of acts in competition with the principal and the acquisition of interests adverse to him, under the circumstances stated in those Sections.

An agent is one who acts on behalf of the principal and only for his benefit. See § 39. The purposes which the principal has manifested to the agent as the object of the agency constitute the benefit which the principal is entitled to have the agent seek.

If a relation is created for any other purpose, it is not agency as herein defined; if an agent acts properly for any other purpose, he is not, as to such action, an agent. A power of attorney which, although created in the form of an agency power, is to be exercised solely on account of a person other than the one giving it, does not create an agency relation. See §§ 14 H and 138. To the extent to which he is privileged to act in the protection of his own interests as when he acts in the protection of a lien, he does not act as an agent.

Illustrations:

1. A, the manager of P, a stockbroker, promises T that he will reveal to T for T's benefit the transactions of one of P's customers. A is not authorized to make such a promise and if he thereafter performs it, he has committed a breach of duty to P.

2. P gives to A, his selling agent, a general power of attorney to sell to anyone in the world. Acting under this

See Appendix for Reporter's Notes, Court Citations, and Cross References

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power, A makes a conveyance to himself. The conveyance is ineffective at P's election.

Comment:

b. Scope of duty. The agent's duty is not only to act solely for the benefit of the principal in matters entrusted to him (see §§ 388-392), but also to take no unfair advantage of his position in the use of information or things acquired by him because of his position as agent or because of the opportunities which his position affords. See §§ 393-398. The agent is also under a duty not to act or speak disloyally in matters which are connected with his employment except in the protection of his own interests or those of others. He is not, however, necessarily prevented from acting in good faith outside his employment in a manner which injuriously affects his principal's business. His duties of loyalty to the interests of his principal are the same as those of a trustee to his beneficiaries. See the Restatement of Trusts, § 170.

Illustration:

3. A, employed by P, a life insurance company, in good faith advocates legislation which would require a change in the policies issued by the company. A has violated no duty to P.

Comment:

c. Gratuitous agents. A gratuitous agent is subject to the rule stated in this Section as fully as is an agent who is paid for his services.

Illustrations:

4. A gratuitously promises P to record a mortgage held by P on land of T. He fails to do so and in place thereof enters a judgment lien of his own against the same land. A's lien is subject to P's unrecorded mortgage.

5. A promises to act gratuitously for P in ascertaining the existence of oil in land in a certain area and to secure options for P upon land found to contain oil. A investigates the land in such area and obtains options upon his own account instead of for P. A holds such options as constructive trustee for P.

Comment:

d. The liabilities of an agent for a violation of the duty of loyalty and the defenses he can make are stated in Sections 399-421 A. The Restatement of Restitution, Sections 190-215, states the rules applicable to situations in which a fiduciary, whether or not an agent, acquires or retains property in violation of his duties of loyalty.

§ 388. Duty to Account for Profits Arising out of Employment

Unless otherwise agreed, an agent who makes a profit in connection with transactions conducted by him on behalf of the principal is under a duty to give such profit to the principal.

Comment:

a. Ordinarily, the agent's primary function is to make profits for the principal, and his duty to account includes accounting for any unexpected and incidental accretions whether or not received in violation of duty. Thus, an agent who, without the knowledge of the principal, receives something in connection with, or because of, a transaction conducted for the principal, has a duty to pay this to the principal even though otherwise he has acted with perfect fairness to the principal and violates no duty of loyalty in receiving the amount. See § 203 of the Restatement of Trusts.

Illustrations:

1. A, a real estate broker acting for P, the seller, in order to assure himself of his commission, makes a contract with T, a purchaser, by which, if T cancels the contract with P, as he is given the right to do, T is to pay A the amount of A's commission. T repudiates the contract with P but pays A. A holds his commission as a constructive trustee for P.

2. P authorizes A to sell land held in A's name for a fixed sum. A makes a contract to sell the land to T, who makes a deposit which is to be forfeited if the transaction is not carried out. T forfeits the amount. A sells the land to another person at the price fixed by P. A is under a duty to account to P for the amount received from T.