

ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672

11137 SENATE HEALTH, EDUCATION & SOCIAL SERVICES

# REPRESENTATIVE KEVIN MEYER

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## HOUSE DISTRICT 30

### Sponsor Statement

#### CS HB 18(JUD)am

**“An Act relating to the liability of parents and legal guardians of minors who destroy property.”**

CS HB 18(JUD)am establishes the limit on recovery of damages caused by a minor at \$15,000. CS HB 18(JUD)am will allow for a person, municipal corporation, association, village, school district, or religious or charitable organization to recover up to \$15,000 in damages from parents or guardians of a minor who knowingly destroys property. Currently, under AS 34.50.020(a), the recovery limit is \$10,000. CS HB 18(JUD)am does provide for an exemption for the legal guardian of a child who has been adopted after being in state custody, including foster care.

Traditionally, Alaska has held that parents are accountable for their children's behavior, and that parents should pay restitution for damages caused by their children. In 1995, the limit for recovery was raised from \$2,000 to \$10,000. Often, cumulative damage to a facility exceeds the \$10,000 limit, thus leaving taxpayers or organizations to bear the cost of repairs and clean up.

The large discrepancy between the \$10,000 limit and the actual cost of damages incurred to property became apparent this past summer in Anchorage. The Anchorage School District reported that minors did nearly \$750,000 in damage over the summer to facilities and schools. By raising the limit, the Anchorage School District will be able to recover more in cases that involve serious damage to property, rather than expending money earmarked for technology enhancement, textbooks, and personnel.

By increasing the limit, children are deterred from making decisions to vandalize and destroy property. This will also impose an additional duty on parents and legal guardians to exercise reasonable care, supervision, protection, and control over their child.

Last Update - May 16, 2003

# FISCAL NOTE

**STATE OF ALASKA**  
**2003 LEGISLATIVE SESSION**

Fiscal Note Number: 1  
 Bill Version: CSHB 18 (STA)  
 (H) Publish Date: 3/10/2003

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: \_\_\_\_\_  
 Title: Parental Liability BRU: Alaska Court System  
 Component: Trial Courts  
 Sponsor: Representative Meyer  
 Requester: House State Affairs Component No.: 768

**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						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>						
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**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)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2003) cost: 0.0

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)

The court system does not anticipate any fiscal impact from the passage of CSHB 18 (STA).

Prepared by: Doug Wooliver, Administrative Attorney  
 Division: Alaska Court System  
 Approved by: Stephanie Cole, Administrative Director  
 Agency: Alaska Court System

Phone 463-4750  
 Date/Time 3/10/03 10:50 AM  
 Date 3/10/2003

# Alaska King Crab

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Anchorage Daily News

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## **fires set at site of new high school**

**ARSON: Ceiling tiles found burning at several spots in building.**

By NICOLE TSONG

Anchorage Daily News

(Published: May 12, 2003)

Anchorage police are investigating as arson several small fires set at the construction site of the new South Anchorage high school early Sunday, police said.

Sgt. Jeff Morton said a person living near the school on Elmore Road, just south of Huffman Road, reported smoke to 911 operators at 6:37 a.m. Firefighters discovered a small shed on the northwest side of the parking lot was set on fire, then saw smoke coming from the partially built building.

They found acoustic ceiling tiles burning inside the building at several spots, he said. Damage included scorched drywall and the burned construction material.

But there were no estimates Sunday on how much the damage would cost to fix, Morton said. The school is scheduled to open in fall 2004.

Morton said he had no leads on who might have set the fires and would not say how they were set.

Carol Comeau, superintendent of the Anchorage School District, said the damage could have been much worse. It wasn't nearly as bad as vandalism at the Dimond High School construction site in December 2001, which caused more than \$100,000 in damage. But she was frustrated that someone would try to destroy public property.

"This was clearly purposeful arson," she said.

The only security at the time was a locked fence around the site, though Anchorage police have had more patrols in the area, Comeau said. The district's facilities staff met just last week to talk about increasing security for all construction sites, including those of Wendler Middle School, Ptarmigan Elementary School and the high schools.

There are people "who are very mean spirited and don't care and vandalize public facilities," Comeau said. "They always seem to do it this time of year."

She said district officials today plan to discuss ways to bolster security.

Daily News reporter Nicole Tsong can be reached at [ntsong@adn.com](mailto:ntsong@adn.com) or 257-4450.

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**Subject: AASB RESOLUTION SUPPORTING INCREASED LIABILITY FOR DESTRUCTION OF PROPERTY BY MINORS**

**Date:** Thu, 20 Feb 2003 08:40:50 -0900

**From:** Greg Giles <ggiles@asb.org>

**To:** Kevin Meyer <Representative\_Kevin\_Meyer@legis.state.ak.us>

ASSOCIATION OF ALASKA SCHOOL BOARDS

2.21 INCREASE LIABILITY FOR DESTRUCTION OF PROPERTY BY MINORS  
(Adopted Nov. 2002)

AASB encourages the Legislature to increase the maximum that may be recovered from either parent, both parents, or the legal guardian of an unemancipated minor under the age of 18 years who, as a result of a knowing or intentional act, destroys real or personal property belonging to a school district from \$10,000 to the actual amount of damages.

Rationale. Vandalism damages a school district's physical plant, has a negative impact on student learning, and demoralizes hard-working staff and students. Every dollar spent on repairing vandalism is a dollar we cannot invest in textbooks, teachers or technology.

Currently, school districts can recover a maximum of \$10,000 from either parent, both parents, or the legal guardian of an unemancipated minor under the age of 18 years who, as the result of a knowing intentional act, destroys real or personal property belonging to a school district. The current law forces taxpayers to bear the cost of vandalism even when a parent's liability insurance is otherwise available to pay the full cost.



## Anchorage School District

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### SUPERINTENDENT

Carol Comeau

February 14, 2003

Representative Kevin Meyer  
State Capitol  
Juneau, AK 99801

Dear Representative Meyer:

On behalf of the Anchorage School Board and Administration, I want to commend you for sponsoring HB 18 which deletes the \$10,000 cap on vandalism caused by juveniles. This is one of our School Board's priorities and I believe it is essential to our collective efforts to protect schools and other public property from juvenile vandalism.

As I have stated many times since the Dimond High School incident in late December of 2001, I strongly believe that the offenders and their parents should be held fully accountable for restitution in recovering the \$158,000 damage done to the school under construction. The community, as well as the staff and students of Dimond High School were outraged at this completely needless and destructive act, as were the construction workers employed by Alcan General. Since the incident, Alcan General has had to not only repair all of the damage to the building and to the vehicles and equipment of the workforce, they have had to add the additional security staff in order to prevent other vandalism at the school site. These juveniles must be held fully accountable for their actions, and as a deterrent to other juveniles who might decide that there are minimum consequences for destroying public property.

The Anchorage community and taxpayers showed great faith and support for the District when the bonds were approved for the construction of this high school, the first one in over thirty years! These two juveniles were so uncaring and reckless that they decided to do all they could to destroy various parts of the building under construction. They had no concern for their own safety, or for the impact of their actions on the morale of the workforce and the community. The Anchorage Police Department devoted many hours to their investigation in developing their case which led to the successful apprehension of these juveniles; what a waste of their time and resources! It is time for the community to know that there are consequences for vandalism of public property, and that the court supports restitution for this act.

This was the first of a rash of major vandalism that occurred in the District last year. The other incidents seriously damaged Chugiak Elementary School and our Maintenance Department yard. Fortunately, the Anchorage Police Department's efforts paid off; all juveniles were apprehended. I have spent quite a bit of time in juvenile court in the past few months advocating for restitution and consequences. The parents of the Chugiak Elementary students have cooperated with the authorities

RECEIVED

FEB 24 2003

and their children have agreed to pay full restitution and perform community work service. Those students have clearly learned their lesson and I believe, are on the way to success in their lives. I cannot say that about the others who vandalized our property. Their advocates and parents have put up road block after road block in an effort to protect their clients from accepting their responsibility.

Currently the law restricts the ability of the court to impose full restitution in these cases; rather, the judge assesses how much a juvenile can pay in restitution while under the jurisdiction of the court. We feel this is intolerable and sends the wrong message to juveniles that they can get away from long-time consequences of crimes committed when they are under the age of 18, and that the records will be kept confidential. We believe that juveniles should have to sign a commitment to repay full restitution no matter how long it takes them to repay the costs of the vandalism. We believe this will reinforce the importance of parents knowing who their children are with when they are out of their parents' direct supervision.

Our community, the Anchorage Police Department, the Mayor, and our locally elected officials support this statutory change. We must do something to stop this type of juvenile crime! Please accept our thanks for your leadership on this issue. I applaud you and Senator Dyson for your efforts to change the statutes regarding juvenile crime and vandalism.

Please feel free to contact me if you would like me to testify at a hearing on this bill. I will be in Juneau during the AASB fly-in from February 22-25 and again in March and in April, and will try and meet with you to discuss this proposed legislation. I can also call in from the Legislative Information Office in Anchorage.

Sincerely yours,



Carol Comeau  
Superintendent

cc School Board members  
Senator Fred Dyson  
Mayor George Wuerch  
Assembly Chair Dick Traini  
Chief of Police Walt Monegan  
Lt. Gardner Cobb  
Larry Wiget

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Anchorage Daily News (AK)

June 25, 2002

Section: Nation

Page: A1

## Vandals cost schools \$500,000

**ARRESTS:** Two boys, ages 13 and 14, charged in maintenance facility rampage.

Katie Pesznecker  
Anchorage Daily News

Two teenage boys were arrested late Sunday in connection with a weekend vandalism spree at the Anchorage School District's maintenance facility that racked up more than \$500,000 in damages, Anchorage police said. During the two-day rampage, the boys, ages 13 and 14, allegedly climbed behind the wheel of a John Deere tractor to ram buildings and storage sheds, police said. They destroyed roofs and boilers, ripped away chunks of walls and smashed windows.

The teens are charged with first-degree criminal mischief and resisting arrest. Police did not identify the suspects, who were taken to McLaughlin Youth Center, because they are charged in juvenile court.

"It's just so frustrating," Superintendent Carol Comeau said. "There is nothing that makes me more angry in this job than reckless, malicious vandalism. It's a real sad commentary on these young people. If I had it my way, I'd put their names on the front page of the paper."

Police in the past several days have responded to minor break-ins or vandalism reported at Rabbit Creek, Scenic Park, Homestead and Huffman elementaries, Central Middle School and East and West high schools. Damage ranged from shattered windows and busted copy machines to lewd graffiti.

The maintenance facility, at 1201 Labor St. in South Anchorage, was by far the worst hit. The complex contains offices, storage space for the district's maintenance, facilities and operations departments. Equipment on site includes vehicles and machinery the district uses for snow removal and construction and renovation projects.

Anchorage police said the boys initially broke into the facility a little after 10 p.m. Friday. They wrenched doors off and smashed windows of a dump truck, three street sweepers, two road graders and a tractor.

The boys were apparently driving around the fenced property on lawnmowers when a district employee approached them. The teenagers fled. The employee reported the incident to police, but no suspects were found.

Police said the boys showed up again late Sunday. They apparently fired up a John Deere tractor by using a lever.

The teenagers used the tractor to plow into a double-wide trailer used for storing heavy equipment. The impact caused part of the roof to collapse and obliterated the ramp to the trailer's main door.

The boys also bulldozed storage sheds in the northwest corner of the property, chewing chunks out of building walls. When it was over, the tractor's front wheels were bent at 45-degree angles.

"I'm surprised they didn't get hurt," said Stan Syta, district operations director.

Houses border the property's north side. Comeau is baffled that no one called police.

"They had to have heard breaking glass," she said. "That tractor ramming buildings -- I can't believe no one heard what was going on."

Another employee happened upon the boys and called police shortly after 10 p.m. When officers arrived, the teens bolted. Police caught the 14-year-old hiding in a nearby wooded area. The 13-year-old was later arrested at his home.

The boys admitted to Friday's vandalism at the site, police said.

The district budgets about \$250,000 a year for vandalism. Much of the damage occurs at empty schools during summer breaks. Property damaged Friday and Sunday will not be covered by the district's insurance policy, which in this case covers amounts exceeding \$1 million.

Comeau said the district will do everything in its power to see that the boys are held responsible for the damages, including a possible civil suit. State statute says that in a civil case, a school district can sue for up to \$10,000 and court costs from one or both of a minor's parents or legal guardians.

In the interim, Comeau is encouraging people who live near schools to watch out for strange activity. The district has recruited 15 volunteers this summer to live in motor homes and trailers at more than a dozen schools.

Syta said last summer the district invited a man to live in his trailer at Rabbit Creek Elementary. His presence basically erased vandalism there, Syta said.

But the family living there now didn't prevent Sunday night's window breaking. They were eating dinner when the vandalism took place on the back side of the school, Syta said.

Reporter Katie Pesznecker can be reached at [kpesznecker@adn.com](mailto:kpesznecker@adn.com) or 907 257-4589.

#### ILLUSTRATION SHOWS RECENT SCHOOL VANDALISM

Police have responded to the following Anchorage schools to investigate vandalism or possible break-ins.

\* Dimond High School - On Dec. 31, vandalism at the new school resulted in spilled paint, smashed piping and sheetrock and windows. Damage totaled \$177,000. Two boys were arrested.

\* Chugiak Elementary - On May 4 and 5, three boys reportedly broke windows, destroyed stereos, televisions and classroom globes and vandalized a car in the parking lot. Damage totalled about \$25,000. Three boys were arrested.

\* Rabbit Creek Elementary - On ??? someone pruned boards off windows on the back side of the school and broke glass. No arrests.

\* District maintenance facility - On June 21, two boys entered and damaged seven vehicles, smashed windows and drove around on lawn mowers. Police arrived after the boys fled. No arrests.

\* West High School - A passerby on June 22 called police to report fowl graffiti on the auditorium's exterior wall. No arrests.

\* Scenic Park Elementary - Security guards on June 23 found several doors propped open with rocks. There was no sign of vandalism or arrests.

\* Homestead Elementary - Police responding to the school's alarm on June 23 found kids playing behind the school. There was no sign of vandalism or arrests.

\* Huffman Elementary - Police responded to an alarm early June 23 and found a broken window and two people running through the building. The people got away. No arrests.

\* William Tyson Elementary - On June 23, an intrusion alarm sounded. No arrests.

\* District maintenance facility - Late June 23, an employee found two boys ramming vehicles and buildings with a tractor. The boys fled and were soon arrested. They admitted to Friday's vandalism also. Police estimate total damage at \$500,00.

\* East High School - At 5:50 a.m. on June 24, police caught and arrested one person who had broken in and sprayed a fire extinguisher around the school.

\* Central Middle School - At 6 a.m. on June 24, police arrested a student who had broken in through a window. Police found damage to an interior window, a clock and a copy machine. No damage estimate.

Source: Anchorage School District

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Anchorage Daily News (AK)  
September 24, 2002  
Section: Metro

Page: B1

## Schools want damage limits erased

VANDALISM: District can sue for \$10,000 under current law.

Katie Pesznecker  
Anchorage Daily News

Anchorage School District officials want to erase limits that dictate the amount of money they can sue for when students vandalize school property. Current state law says the district can sue an 18-year-old culprit or a minor's parents for up to \$10,000. Sometimes that doesn't cover actual damages, Superintendent Carol Comeau said.

Members of the School Board's legislative subcommittee plan to lobby state lawmakers to do away with the cap. They want the freedom to sue for actual costs.

On Monday, the board voted unanimously to ask the Alaska Association of School Boards to make this move one of its 2002 resolutions. They want the backing of that group when time comes to persuade politicians.

Students smash windows and computers and trash Anchorage schools often enough that the district budget includes about \$250,000 a year to clean up.

But financial retribution is hampered by the \$10,000 limit. There used to be a \$2,000 ceiling on lawsuits but the Legislature increased it in 1995.

"We need to be able to recover the full cost of vandalism," Comeau said. "The current law limits recovery, and we think it's wrong because it penalizes the taxpayer."

School Board member Rita Holthouse said the subcommittee will push to change the law, whether or not the state school board association signs on.

The \$10,000 limit wasn't as noticeable with the more frequent lower-cost incidents, said Howard Trickey, one of the district's attorneys. But when kids do more than \$100,000 in damage, \$10,000 hardly helps. And the district's insurance policy applies only to damage amounts of more than \$1 million.

The most recent big-ticket vandalism came last summer when two teenagers destroyed buildings and equipment at the school maintenance facility in South Anchorage. District officials and the public were outraged.

"It looked like a tornado had been there," said Ed Conyers, then the district's maintenance director.

Vandalism at schools results mostly in small losses that quickly add up -- broken windows, gouges in

desks, busted locks.

The maintenance facility vandalism spree packed a financial wallop originally estimated by police at \$500,000. Later district officials said the sum was closer to \$100,000. It was one of the more costly attacks in recent years but not an isolated incident.

The new Dimond High School, currently under construction, sustained \$177,000 in damage last year when teenagers trashed the inside, which was just taking shape. Students broke into the then new Mirror Lake Middle School in Eagle River about five years ago and chewed through property with a forklift.

The roughly 120 employees in the maintenance department spend up to 15 percent of their time cleaning up this vandalism, Conyers said.

The district has tried to reduce the problem. Crews boarded up windows at more than a dozen schools during summer. Last summer, the district recruited volunteers who lived in motor homes at various schools to keep an eye out for troublemakers. Comeau has asked people who live near schools to watch for suspicious activity.

And whenever possible, the district sues.

Their legal success is mixed, Comeau said. She or other employees attend hearings, give the judge important statements on damage, and work closely with police.

"We routinely get reimbursement just from kids breaking windows," Conyers said. "That may only be \$250, but we still get it."

Reporter Katie Pesznecker can be reached at [kpesznecker@adn.com](mailto:kpesznecker@adn.com) or 907 257-4589.

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Anchorage Daily News (AK)  
October 7, 2002  
Section: Metro

Page: 85

## VOICE OF THE TIMES

Commentary

School vandals should . . . Pay the price

THE ANCHORAGE School District is on the right track in seeking approval from state lawmakers to sue for actual costs when vandals damage the schools and property it manages for taxpayers.

As it stands now, the district can demand only up to \$10,000 from the parents of minors or from 18-year-olds involved in school vandalism.

That amount -- increased from \$2,000 only a few years ago -- sometimes does not begin to cover the actual damages, Superintendent Carol Comeau said. She points to last year's \$100,000 in damages at the district's school maintenance facility as an example.

The School Board has voted to ask the Alaska Association of School Boards to lobby politicians for the increase, and Comeau said she believes the effort will find favor.

"The legislators we've had contact with . . . they've been very supportive," she said. "I think this is something that will resonate with legislators."

Each year, the school district budgets \$250,000 to \$300,000 to clean up vandalism, and "that's just for maintenance and repair costs," Comeau said. "That doesn't include labor or down time." That also does not reflect repairs to items such as photocopy machines or computers, she said.

Comeau credits additional police patrols and a policy of allowing campers to stay on school grounds with helping to keep vandalism in check this summer. And keeping it in check can save taxpayers hundreds of thousands of dollars.

The district is self-insured to \$1 million, Comeau said, and then its insurance kicks in. In construction areas, such as Dimond High School -- where vandals did about \$170,000 in damage last year -- the contractor's insurance is in force and its lawyers can go after the full amount.

There is no valid reason to bar the district from seeking the amount of actual damages from vandals or their parents. In fact, such a policy could act as a deterrent and encourage parents to know where their children are and what they are doing.

"That's what it comes down to in my mind," Comeau said, "good parenting."

We agree. While 99.9 percent of the kids in Anchorage's schools are good citizens, there is no reason to allow the other .1 percent to have a free ride when they damage the district's property. They and their parents rightly should pay the full amount.

The district should have the right to collect -- in full -- on the taxpayers' behalf.

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# LEGISLATIVE RESEARCH REPORT

SEPTEMBER 12, 2002



REPORT NUMBER 03.009

## LIMITS OF PARENTAL LIABILITY FOR PROPERTY DAMAGE BY MINORS

PREPARED FOR REPRESENTATIVE KEVIN MEYER

BY ROGER WITHINGTON

You asked for information regarding the scope of parental liability if a minor child willfully destroys property. Specifically, you asked for information on the parental liability laws for five western states and wished to know whether any of these state laws contain graduated limits to liability.

As you know, Alaska Statute 34.50.020(a) allows for a person, municipal corporation, association, village, school district, or religious or charitable organization to recover up to \$10,000 in damages in a civil action from either parent, both parents, or the legal guardian of an unemancipated minor who intentionally destroys property belonging to the person, municipal corporation, association, village, school district, or religious or charitable organization.<sup>1</sup> We were unable to obtain a fifty-state summary of similar parental liability statutes that included the monetary limits to the parents of a delinquent minor. However, we believe the most current information to be a 1999 report compiled by the National Center for Juvenile Justice (NCJJ) that states that at the end of the 1998 legislative session, 34 states had statutes that made the parent of a minor liable for restitution to the victim of a delinquent act. We include NCJJ's report as Attachment A.

In addition, in 1995 this agency completed a report that addressed questions similar to yours as well as the constitutionality of parental liability laws. In Legislative Research Report 95.068, we found that 34 states (not exactly the same 34 states identified in the NCJJ report) had statutes that established parental liability for damages caused by minor children. The dollar amount of the parental liability ranged from \$1,000 to \$25,000, with some states not capping the liability amount. We include Legislative Research Report 95.068 as Attachment B.

In an effort to provide you with more current information, we reviewed the current laws of five western states and British Columbia and found that California, Hawaii, Nevada, Oregon, Washington, and British Columbia all had statutes similar to AS 34.50.020(a). Table 1 provides a summary of the statutes from each of these jurisdictions. Attachment C provides the complete statute from each state.

<sup>1</sup> A minor is defined as a person under the age of 18 years.

As you will see, the laws in Nevada, Oregon, and British Columbia limit liability at the same or lesser amount than does the law in Alaska. The laws in California, Hawaii, and Washington make a distinction in liability for the type of damage caused by the minor; one law in California caps liability at \$25,000, while laws in Hawaii and Washington provide for actual damages.

<b>Table 1: Limits of Parental Liability for Property Damage by Minors</b>			
<b>State / Province</b>	<b>Statutory Citation</b>	<b>Maximum Financial Liability</b>	<b>Comments</b>
California	Cal Civ Code § 1714.1	\$25,000	
	Cal Ed Code § 48904	\$10,000	Specifically addresses damage to school property.
Hawaii	HRS § 46-1.5	\$1,000 or actual cost to repair/replace damage.	Pertains to damage to county property.
	HRS § 577-3.5	Actual cost to repair/replace damage or community work service.	Pertains to damage caused by graffiti.
Nevada	Nev. Rev. Stat. Ann. § 41.470	\$10,000	
Oregon	ORS § 30.765	\$7,500	
Washington	Rev. Code Wash. § 4A.190	\$5,000	
	Rev. Code Wash. § 28A.635.060	Actual cost to repair/replace damage to school.	Specifically addresses damage to school property.
British Columbia	S.B.C. 2001, c. 45, s. 6	\$10,000 CND <sup>(a)</sup>	
<b>Notes:</b> (a) \$10,000 CND equals \$ 6,413.26 USD as of 9/6/2002 per XE.COM, an online currency conversion site. The URL for XE.COM is <a href="http://www.xe.com/ucc/">http://www.xe.com/ucc/</a> .			
<b>Sources:</b> LEXIS Law Publishing.			

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

## **Attachment A**

Linda A. Szymanski, "Parental Responsibility for the Delinquent Acts of Their Children," *NCJJ Snapshot*, Volume 4, Number 7, July 1999

# NCJJ Snapshot

© National Center for Juvenile Justice  
 Research Division of the National Council of Juvenile and Family Court Judges

## Parental Responsibility for the Delinquent Acts of Their Children

Linda A. Szymanski, Esq., Director of Legal Research, NCJJ

### States that have a Parental Accountability Statement in their Juvenile Code Purpose Clause



<input type="checkbox"/> No Parental Responsibility Statement in Purpose Clause	(41)
<input checked="" type="checkbox"/> Parental Responsibility Statement in Purpose Clause	(10)

Over the last fifteen years, juvenile courts have gained increasing power and authority over the parents of children who commit delinquent acts. While all states have had statutes making it illegal for parents to contribute to the delinquency of their children, a handful of states now make parents criminally liable for failing to supervise their minor who commits delinquent acts. There is a wide variety of parental responsibility laws in juvenile codes throughout the states.

For example, as of the end of the 1998 legislative session, 10 states, Alabama, Alaska, Florida, Idaho, Maryland, Nevada, North Carolina, Oregon, Texas, and Virginia, have added a parental

accountability statement in their juvenile code purpose clause.

Arkansas, California, Colorado, the District of Columbia, Florida, Idaho, Indiana, Kansas, North Carolina, Ohio, Oregon, Texas, Wisconsin, and Wyoming allow the juvenile court to order parents to attend a court-approved parental responsibility training program/parent education program.

Alaska, Mississippi, New Hampshire, New Mexico, and Wisconsin have statutes in their juvenile code that allow for public disclosure of the parent's name if his or her child commits specified serious offenses.

Eleven states, Kansas, Louisiana, Michigan, Montana, New Hampshire, North Carolina, Ohio, Pennsylvania, Texas, Virginia, and Wyoming, require parents to aid in the enforcement of court orders concerning their delinquent's rehabilitation program. Failure to aid in the enforcement of court orders can result in contempt sanctions being filed against the parent.

As of the end of the 1998 legislative session, two-thirds of the states have statutes that make the parent of a delinquent liable for restitution to the victim of the delinquent act: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Kentucky, Maryland, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, West Virginia, Wisconsin, and Wyoming.

Thirty-nine jurisdictions currently have statutes that permit or require parents of delinquents to participate in family treatment/counseling/probation with their children: Alabama, Alaska, Arizona, Arkansas, California, Colorado, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland,

Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

In all states, the parents of a delinquent can be held liable for the costs of confinement and/or services provided to their children, such as: the child's support while in an institution, the costs of probation supervision, costs of transporting and/or treatment for delinquent minors, court costs and legal fees, and payment for alcohol and other drug abuse services.

It remains to be seen whether or not these parental accountability laws actually lead to a decrease in juvenile crime.

NCJJ Snapshot is a copyrighted publication of the National Center for Juvenile Justice. NCJJ is a non-profit organization that conducts research (statistical, legal, and applied) on a broad range of juvenile justice topics and provides technical assistance to the field.

For additional information or to request a custom analysis, contact NCJJ at 710 Fifth Avenue, Pittsburgh, PA 15219. Phone: (412) 227-8950.

ISSN 1083-9369  
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 Szymanski, L. (1999). Parental Responsibility for the Delinquent Acts of Their Children. NCJJ Snapshot, 9(7). Pittsburgh, PA: National Center for Juvenile Justice.

**Attachment B**

Patricia Young, "Parental Liability Laws for Damages Caused by Minor Children,"  
Legislative Research Request 95.068, February 16, 1995

# Legislative Research Agency

Alaska State Legislature



130 Seward Street, Suite 218  
Juneau, Alaska 99801-2196

Phone: (907) 465-3991  
Fax: (907) 463-3351

February 16, 1995

## MEMORANDUM

TO:

FROM: Patricia Young *Pat Young*  
Legislative Analyst

RE: **Parental Liability for Damages Caused by Minor Children**  
Research Request 95.068

You wished to know the history behind AS 34.50.020, the law that caps at \$2,000 parents' liability for damages caused by their minor children. You also wished to know if and to what extent other states hold parents financially accountable for damages caused by their children.

In 1957, Alaska passed a statute providing that parents could be held responsible for damages maliciously and willfully caused by their minor children. Liability was capped at \$500. The cap was raised in 1967 from \$500 to the current level of \$2,000.

**At least 34 states have laws addressing parental liability for damages caused by minor children.** Many states, like Alaska, have traditionally held that parents are accountable for their children's behavior and that parents should pay restitution for damages caused by their children. The attached table shows caps for each state identified. As you will see, of the 34 states, eleven cap liability at \$2,000 or less and ten cap liability at \$5,000 or more. Five states do not specify a limit to parental liability. California's cap is the highest at \$25,000. These laws have been held constitutional in at least the following six states: California, Georgia, Maryland, North Carolina, Texas, and Wyoming.

I have attached copies of "Constitutional Limitations on State Power to Hold Parents Criminally Liable for the Delinquent Acts of Their Children," 44 *Vand. Law Rev.* 441 (1991) and "Parental Liability Law Upheld in California," *Youth Law News*, September-October 1993. I hope the information is helpful. Please let me know if you have questions or need more information.

Attachments

### Parental Responsibility for Delinquent Acts of Children

State	Cap (\$)	Notes
Alabama	1,000	
Illinois	1,000	
Minnesota	1,000	
North Carolina	1,000	
Pennsylvania	1,000	
South Dakota	1,500	
Alaska	2,000	
Arkansas	2,000	
Missouri	2,000	
Utah	2,000	
Wyoming	2,000	
Florida	2,500	court may absolve parents of liability if it finds they have made good faith efforts
Michigan	2,500	
New York	2,500	
Wisconsin	2,500	
Indiana	3,000	
Ohio	3,000	
Colorado	3,500	court may absolve parents of liability if it finds they have made good faith efforts
New Mexico	4,000	
Connecticut	5,000	
Georgia	5,000	
Maryland	5,000	parents may be heard and present evidence on their own behalf
Massachusetts	5,000	
Washington	5,000	
Arizona	10,000	
Kentucky	10,000	
New Hampshire	10,000	
Texas	15,000	
California	25,000	cap to be adjusted every 2 years to reflect changes in cost of living
Hawaii	no cap	
Idaho	no cap	victims may be "made whole"
Montana	no cap	court may order parents to pay restitution
New Jersey	no cap	cap at \$1,000 for damage to a public transportation utility
Oklahoma	no cap	court may order parents to pay restitution

Source: NCJJ analysis of state juvenile codes in the Automated Juvenile Law Archive, current as of the end of the 1993 legislative session; NCSL annual state summaries of Children, Youth and Family Issues; and Legislative Research Unit Research Response, "Laws on Parental Responsibility for Child's Acts," File 10-419, September 9, 1992.

Prepared by the Legislative Research Agency, February 1995 (95.068)

# SENATE COMMITTEE REPORT

DATE: 5/16/03

FURTHER:

DATE TURNED IN TO OFFICE: 5.16.03

Health, Education & Social Services Committee considered CS FOR HOUSE BILL NO. 18(JUD) am

## HB 18 PARENTAL LIABILITY FOR CHILD'S DAMAGE

"An Act relating to the liability of parents and legal guardians of minors who destroy property."

and recommends:

- be replaced with S CS CS HB 18 (HES)
- adopt previous \_\_\_\_\_ CS \_\_\_\_\_ (\_\_\_\_\_)
- attached amendment(s)
- adopt Letter of Intent by \_\_\_\_\_ Committee
- further referral to \_\_\_\_\_ Committee

**Senate Bill:**

same title

new title

**House Bill:**

same title

technical title

new: SCR # \_\_\_\_\_

**NEW FISCAL NOTE(S):**

Department	Date	Fiscal	Zero	FN#

**PREVIOUS FISCAL NOTE(S):**

Department	Date	Fiscal	Zero	FN#
CRT	3/10		X	1

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:		DO PASS	DO NOT PASS	NO REC	AMEND
Green	<i>[Signature]</i>	✓			
Gyess	<i>[Signature]</i>	✓			
Davis	<i>[Signature]</i>	✓			
Dyson	CHAIR: <i>[Signature]</i>	✓			

**HB**

**25**

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## Proof of Enrollment

### Comfort One Identification Form

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

### Comfort One Wallet Card

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

### Comfort One Bracelet

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

#### Confirming the Patient's Identity



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

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

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

#### Do Not Resuscitate Protocols

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

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

#### Palliative Care

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

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# The Alaska Comfort One Program

## Information for Health Care Providers



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

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# The Alaska Comfort One Program

## Information for Health Care Providers

### Overview

Some individuals who are terminally ill do not wish to have life saving measures, such as cardiopulmonary resuscitation, performed when they go into respiratory or cardiac arrest.

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.

This brochure is intended to provide health care providers with information on the Comfort One Do Not Resuscitate (DNR) protocol found in Alaska regulations (7 AAC 16.010 - 7 AAC 16.090).

### Definition of Health Care Provider

*Health care provider* means a person who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession. For the purposes of this statute, an individual who is certified to administer cardiopulmonary resuscitation appears to fall within the definition of a "health care provider" as defined in AS 18.12.100(7) with respect to activities related to CPR. Consequently even those certified to administer only limited health care must, by statute, respect the Comfort One form, wallet card, or bracelet.

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. Patients and families are encouraged to keep them 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.

There are two steps to identifying the Do Not Resuscitate patient set out in the regulations, including confirming the identity of the patient and determining whether the patient has a valid DNR order.

It is important to ensure that both criteria are met prior to treating the patient as if he or she has a valid DNR order.

### Patients with Out of State DNR Orders

A Do Not Resuscitate order issued in another state or a territory or possession of the United States should be considered valid by the caregiver and the patient should be treated in accordance with the Alaska Comfort One Protocols (AS 18.12.090).

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### Revocation of DNR Orders

A Do Not Resuscitate order may be revoked by:

- ? the qualified DNR patient;
- ? the patient's attending physician;
- ? a third party to whom the patient conveyed an intent to revoke; or
- ? the parent or guardian of the person for whom the order has been written if the person enrolled in the Comfort One program is less than 18 years of age.

The health care provider should carefully document the revocation. In some cases, the patient may simply destroy copies of the Comfort One form and wallet card.

**The protocol (regulations) requires that the physician or other health care provider (EMT Paramedic, etc.) immediately proceed with patient assessment and care, including cardiopulmonary resuscitation, until the patient's identity is confirmed and the patient is determined to have a valid DNR order.**

### Establishing the Patient's DNR Status

The caregiver should establish the patient's DNR status through at least one of the following means:

- ? a Comfort One form or Comfort One card for the patient;
- ? a Comfort One bracelet worn or carried by the patient;
- ? a DNR identification for the patient that is from another state, a territory, or a possession of the United States;
- ? an attending physician's DNR order, when the order is in writing and a copy has been provided or seen by the physician or other health care provider; or
- ? a verbal order has been issued directly to the physician or health care provider by the attending physician.

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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

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# 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

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# 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

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## 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.

# ALASKA STATE LEGISLATURE

Representative Bruce Weyhrauch

HOUSE DISTRICT 4

ALASKA  
STATE CAPITOL  
JUNEAU, ALASKA  
99801-1182

(907) 465-3744  
FAX (907) 465-2273

## MEMORANDUM

DATE: May 7, 2003

TO: Senator Fred Dyson  
Chair, Senate Health & Social Services Committee

FROM: Rep. Bruce Weyhrauch

SUBJECT: HB 25 – Healthcare Directives, or “The 5 Wishes Bill”

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Attached are materials in support of HB 25. At this time I respectfully request a hearing before your committee on this very important piece of legislation. This bill passed the House on Tuesday and will be read across in the Senate today.

It is my desire to start to work on HB 25 as soon as practicable, as so many people are pushing hard for it.

If you have any questions or need further information, I invite you to contact myself, or my aide, Linda Sylvester.

Thank you for your kind attention to this matter.



MEMORANDUM

TO: Members of the Alaska Legislature  
SUBJ: AARP 2003 Legislative Agenda  
DATE: February 7, 2003

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Attached is a background piece we developed for Alaska AARP members so they would know what issues we will be advocating for in the 2003 Legislature. I hope it is helpful to you.

We welcome your suggestions for bills that you think AARP and our members should support.

Recognizing that you have a difficult challenge with many competing priorities, please know that we stand by to help in any way you think appropriate.

Marie Darlin, Coordinator  
AARP Alaska Capital City Task Force  
415 Willoughby Ave., Apt #506  
Juneau, AK 99801

563.3637 voice  
463.3580 fax

Juneau based Task Force Members:

Jim Carroll	586.6115
Gene Dau	586.3816
John Furuness	789.9720
Rosalee Walker	586.2873

# ALASKA STATE LEGISLATURE

REPRESENTATIVE BRUCE WEYHRAUCH  
HOUSE DISTRICT 4



ALASKA  
STATE CAPITOL  
JUNEAU, ALASKA  
99801-1182

(907) 465-3744  
FAX (907) 465-2273

## MEMORANDUM

DATE: April 9, 2003  
TO: House Members  
FROM: Rep. Bruce Weyhrauch  
SUBJECT: CS for HB 25 (JUD) - Advanced Healthcare Directives or  
*The Five Wishes Bill*

Attached are materials in support of HB 25. Inspired by the Five Wishes legislation that has been adopted in 37 other states, HB 25 expands the options for people who want to prepare for the time when they can no longer speak or act on their own behalf. In addition to the new concept of the Five Wishes, HB 25 takes all of the current provisions related to end-of-life healthcare decisions and places them in one chapter under Alaska law.

These provisions include:

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

My staff has worked closely with the representatives from each group to insure that existing statutes have been integrated into the new chapter of law. As such, HB 25 enjoys broad support from the stakeholders and from numerous community health activist groups such as Hospice and AARP.

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

I respectfully request your support.

# ALASKA STATE LEGISLATURE

REPRESENTATIVE BRUCE WEYHRAUCH  
HOUSE DISTRICT 4



ALASKA  
STATE CAPITOL  
JUNEAU, ALASKA  
99801-1182

(907) 465-3744  
FAX (907) 465-2273

## Sectional Analysis

### CS for HB 25 (JUD)

#### "The Five Wishes Bill"

Section 1. States a principal purpose of the bill.

Section 2. Makes technical changes to conform this section to other changes in the bill.

Section 3. Establishes a new chapter called the Health Care Decisions Act.

Sec. 13.52.010(a). Allows a person to give an oral or written individual instruction. The instruction may be limited.

Sec. 13.52.010(b). Allows a person to make written power of attorney for health care. Power of attorney remains effective notwithstanding later incapacity of maker. Power of attorney may include individual instructions. Establishes the technical requirements for the power of attorney.

Sec. 13.52.010(c). Prohibits certain health care institution persons from being agents under a power of attorney for health care, unless related to the principal.

Sec. 13.52.010(d). Prohibits certain persons from acting as witnesses for a power of attorney for health care.

Sec. 13.52.010(e). Requires that at least one witness for a power of attorney for health care meet certain described criteria.

Sec. 13.52.010(f). Establishes the general rule as to when an agent's authority under a power of attorney for health care becomes effective and when the agent's authority ceases.

Sec. 13.52.010(g). Requires that certain determinations be made by a person's primary physician, unless otherwise specified in a written advance health care directive or in the case of

of mental illness.

Sec. 13.52.010(h). Requires an agent to make health care decisions in accordance with the principal's individual instructions and other wishes to the extent known. Otherwise, directs the agent to make decisions in accordance with the agent's determination of the principal's best interest.

Sec. 13.52.010(i). Establishes that an agent's health care decision does not need judicial approval to be effective.

Sec. 13.52.010(j). Allows a written advance health care directive to nominate a guardian.

Sec. 13.52.010(k). Establishes when an advance health care directive is valid under this chapter.

Sec. 13.52.020(a). Except in the case of mental illness, allows an individual to revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

Sec. 13.52.020(b). Except in the case of mental illness an individual to revoke an advance health care directive, except for agent designation, at any time and in any manner that communicates the intent to revoke.

Sec. 13.52.020(c). In the case of mental illness, an advance health care directive may be revoked only when the principal has capacity and is not incompetent. A person is considered to be incompetent when determined by a court during a guardianship proceeding und AS 13.26, or determined by two physicians, one of which is a psychiatrist or mental health clinician.

Sec. 13.52.020(d). Requires health care providers, agents, guardians, and surrogates to promptly communicate a revocation to the supervising health care provider and the health care institution.

Sec. 13.52.020(e). Establishes that a decree of annulment, divorce, dissolution, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or power of attorney.

Sec. 13.52.020(f). Provides that a conflicting advance health care directive revokes an earlier directive to the extent of the conflict.

Sec. 13.52.025. Allows a person who has withdrawn as an agent to rescind the withdrawal.

Sec. 13.52.030(a). Except in the case of mental health treatment, allows a surrogate to make a health care decision for a patient who has been determined to lack capacity if an agent or guardian has not been appointed or is not reasonably available.

Sec. 13.52.030(b). Allows an individual to designate an individual as a surrogate by personally informing the supervising health care provider. If there is no designation, or the designation is not reasonably available, establishes the priority of persons who may act as a surrogate.

Sec. 13.52.030(c). Allows an adult who meets certain described criteria to act as a surrogate if no individual who is eligible under (b) is reasonably available to act as a surrogate.

Sec. 13.52.030(d). Requires a surrogate to communicate the surrogate's assumption of authority as promptly as practicable to the patient's family listed in (b).

Sec. 13.52.030(e). Establishes how to handle certain disagreements about health care decisions.

Sec. 13.52.030(f). Establishes guidelines for surrogates when making health care decisions.

Sec. 13.52.030(g). Establishes that a health care decision by a surrogate is effective without judicial approval.

Sec. 13.52.030(h). Allows an individual to disqualify another person from acting as the individual's surrogate by using a signed writing or by personally informing the supervising health care provider.

Sec. 13.52.030(i). Prohibits, except when related to the patient, a surrogate from being an owner, operator, or employer of the patient's residential long-term health care institution.

Sec. 13.52.030(j). Allows a supervising health care provider to require from an individual claiming to be a surrogate a written declaration to establish the claimed authority.

Sec. 13.52.040(a). Requires a guardian to comply with the ward's individual instructions, and prohibits a guardian from revoking a ward's advance health care directive executed before incapacity, unless a court authorizes it.

Sec. 13.52.040(b). Establishes that a health care decision of an agent takes precedence over that of a guardian, unless a court orders otherwise.

Sec. 13.52.040(c). Provides that a health care decision made by a guardian for the ward is effective without judicial approval, except as provided in (a).

Sec. 13.52.050(a). Requires a supervising health care provider, if possible and before implementing the order, to promptly communicate a health care decision to the patient and identify the person making the decision.

Sec. 13.52.050(b). Requires a supervising health care provider who knows of an advance health care directive, the revocation of a directive, or a surrogate designation or disqualification, to promptly record the item in the patient's record, request a copy if written, and arrange to keep any furnished copy in the record.

Sec. 13.52.050(c). Requires a supervising health care provider who makes or is informed of a determination of a patient's condition that affects an individual instruction or an agent's, a guardian's or a surrogate's authority to promptly record the determination in the patient's record and communicate the determination to the patient, if possible, and to any person then authorized to make the health care decisions for the patient.

Sec. 13.52.050(d). Requires, with certain exceptions, that a health care provider or institution comply with qualifying individual instructions, reasonable instruction interpretations, and health care decisions.

Sec. 13.52.050(e). Permits a health care provider to decline, for reasons of conscience, to comply with individual instructions or health care decisions. Permits a health care institution to decline to comply with individual instructions or health care decisions if contrary to a policy of the institution's that is based on reasons of conscience.

Sec. 13.52.050(f). Permits a health care provider or institution to decline to comply with individual instructions or health care decisions that require medically ineffective health care or care contrary to generally accepted health care standards.

Sec. 13.52.050(g). Establishes the steps that a health care provider or institution must take if declining to comply with an individual instruction or health care decision.

Sec. 13.52.050(h). Prohibits health care providers and institutions from requiring or prohibiting the execution or revocation of advance health care directives as a condition for providing care.

Sec. 13.52.060. Directs the Department of Health and Social Services to adopt a do not resuscitate protocol for health care providers and health care institutions.

Sec. 13.52.070. Provides that, unless otherwise provided in a directive, an authorized person has the same rights as the patient regarding access to and consent to the disclosure of health care information.

Sec. 13.52.080(a). States that a health care provider or institution acting in good faith and under generally accepted health care standards is not subject to civil or criminal liability or to disciplinary actions for complying with qualified health care decisions, declining to comply with what appears to be an unauthorized decision, and complying with a directive and assuming the directive was valid when made and has not been revoked or terminated.

Sec. 13.52.080(b). States that agents, guardians, and surrogates are not subject to civil or criminal liability or to discipline for health care decisions made in good faith.

Sec. 13.52.090(a). Makes health care provider or institution liable to an aggrieved individual or the individual's estate for damages if the provider or institution intentionally violates this chapter.

Sec. 13.52.090(b). Holds a person engaging in certain described acts relating to an existing directive, to the making of a directive, or to the revocation of a directive liable to the individual concerned for damages.

Sec. 13.52.100(a). Establishes that this chapter does not affect the right of an individual to make health care decisions while having the capacity to make the decisions.

Sec. 13.52.100(b). Establishes a rebuttable presumption that an individual has the capacity to make health care decisions, to give or revoke a directive, and to designate or disqualify a surrogate.

Sec. 13.52.100(c). Establishes that an individual who is a qualified patient can make a decision regarding CPR or other life-sustaining procedures as long as the individual is able to make the decision. If an individual is not able to make the decision, the protocol adopted under AS 16.52.060 for do not resuscitate orders govern.

Sec. 13.52.110. Provides that a copy of a directive, revocation of a directive, or a designation or disqualification of a surrogate is as effective as the original.

Sec. 13.52.120(a). States that this chapter does not create a presumption about the intention of an individual who has not made or who has revoked a directive.

Sec. 13.52.120(b). Provides that death resulting from the withholding or withdrawal of health care of health care under this chapter who does not constitute a suicide or homicide or impair or invalidate an insurance policy or certain annuities.

Sec. 13.52.120(c). States that this chapter does not modify the terms of an existing policy of life insurance.

Sec. 13.52.120(d). States that this chapter does not create a presumption concerning the intention or intended treatment of an individual who has not executed a health care directive.

Sec. 13.52.120(e). States that this chapter does not increase or decrease the right of an individual to make decisions regarding the use of CPR or other life sustaining procedures as long as the individual is able to do so and does not impair or supercede any right or responsibility has to affect the withholding or withdrawal of medical care in a lawful manner.

Sec. 13.52.120(f). States that this chapter does not authorize mercy killing, assisted suicide euthanasia, or the provision healthcare, to the extent prohibited by other statutes of this state.

Sec. 13.52.120(g). States that this chapter does not require a health care provider or institution to provide health care contrary to generally accepted health care standards.

Sec. 13.52.120(h). States that this chapter does not authorize an agent or surrogate to consent to the admission of an individual to a mental health facility unless the advance directive specifically provides, and the period of admission may not exceed 17 days.

Sec. 13.52.120(i). This chapter does not affect the other statutes dealing with an individual involuntarily committed to a mental health facility.

Sec. 13.52.130. States that a DNR may not be required as a condition of receiving insurance or health care services.

Sec. 13.52.140. Allows the superior court, on petition by certain listed persons, to enjoin or direct health care decision or to order other equitable relief.

Sec. 13.52.150. Provides a sample optional form for an advance health care directive. Provides that the form may be modified or a different form used that contains the substance of this sample form.

Sec. 13.52.160. States that a DNR order or DNR identification executed in another state is effective in this state.

Sec. 13.52.190. Defines terms for the new chapter.

Sec. 13.52.195. Calls the chapter the Health Care Decisions Act.

**Section 4.** Makes changes to conform the section to other parts of the bill and removes the references to living wills and former will chapters.

**Section 5.** Makes changes to conform the section to other parts of the bill and removes the references to living wills.

**Section 6.** Makes changes to conform the subsection to other parts of the bill and removes the references to living wills.

**Section 7.** Makes changes to conform the subsection to other parts of the bill and removes the references to living wills and to the former chapter on living wills.

**Section 8.** Makes changes to conform the subsection to other parts of the bill.

**Section 9.** Makes changes to conform the subsection to other parts of the bill.

**Section 10.** Makes changes to conform the section to other parts of the bill.

**Section 11.** Makes changes to conform the subsection to other parts of the bill.

**Section 12.** Adds advance health care directives to the list of items that must be documented when providing the court with information under the subsection.

**Section 13.** Adds advance health care directives to the list of items that an assisted living home is required to maintain in a patient's file.

**Section 14.** Repeals certain statutes.

**Section 15.** Provides that certain existing documents continue until they are revoked.

**Section 16.** Provides that AS 13.52.120(b) does not apply to certain existing insurance policies and annuities.

**Section 17.** Directs the Department of Health and Social Services to adopt implementing regulations.

**Section 18.** Gives bill Sec. 17 an immediate effective date.

**Section 19.** Gives the rest of the bill an effective date.

# ALASKA STATE LEGISLATURE

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## CS FOR HB 25 (JUD)

HB 25 offers a "comprehensive simplified" alternative to the power of attorney enacted in Alaska in 1996 relating to health care services and directives for the terminally ill patient. That was not an oxymoron. The legislation is comprehensive because it speaks to the details and instructions that patients put in place regarding their care should they become incapacitated. It is simple in that the directives speak simply to the patient's wishes (the legislation is known nationally as the Five-Wishes) as follows:

My Wish for:

1. The person I want to make care decisions for me when I can't
2. The kind of medical treatment I want or don't want
3. How comfortable I want to be
4. How I want other people to treat me
5. What I want my loved ones to know

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

Five Wishes is changing the way America talks about and plans for care at the end of life. Nearly one million copies of the document are circulating throughout the nation, and more than 1,400 organizations are distributing this revolutionary document, including churches, synagogues, hospices, hospitals, doctor and law offices, and social service agencies.

Five Wishes speaks to people in their own language, helping families talk with their physician about a subject that is often avoided as being too hard to face.

*Last updated: January 19, 2003*

## HB 25

### Health Care Decisions Act

#### Sectional Analysis

##### Section 1

###### Intent Language

###### Uncodified law of the State of Alaska.

The purpose of the Health Care Decisions Act is to provide Alaskans with a comprehensive and coordinated approach to making health care decisions including anatomical gifts. It is also the intent of the Act to establish the right of a patient to control their own health care decisions, and absent evidence to the contrary, it is presumed that the patients intend to be kept alive

##### Section 2

###### Unclaimed bodies:

Sec. 12.65.100. Unclaimed bodies. Makes technical changes to conform this section to numbering changes in the bill.

##### Section 3

#### CHAPTER 52. HEALTH CARE DECISIONS ACT.

###### Section 13.52.010 Advance health care directives.

Sec. 13.52.010(a). Establishes the right to make instructions in advance. Allows a person to give an oral or written individual instruction. The instruction may be limited to take effect only if a specified condition arises. Except for anatomical gift donations (AS 13.52.170(b), the instruction may be oral or written.

Sec. 13.52.101(b). Establishes the right to execute an advance instruction with a durable power of attorney. Allows a person to make written power of attorney for health care. Power of attorney remains effective notwithstanding later incapacity of maker. Power of attorney may include individual instructions. Establishes the technical requirements for the power of attorney.

Sec. 13.52.010(c). Restrictions for persons who may be agents. Prohibits an owner, operator, or employee of a health care institution where the principal is receiving care from being agents under a power of attorney for health care, unless related to the principal.

Sec. 13.52.010(d). Restrictions for persons who may be witnesses to a durable power of attorney. Prohibits a health care provider, or their employee from acting as witnesses for a power of attorney for health care.

Sec. 13.52.010(e). Additional restrictions for persons who may be witnesses to a durable power of attorney. Requires that at least one witness for a power of attorney for health care not be related to the principal by blood, marriage or adoption, or be a perspective heir to the principal's estate.

Sec. 13.52.010(f). Guideline for when the agent's authority begins and ends. Establishes the general rule that an agent's authority under a power of attorney for health care becomes effective when the principal lacks capacity and ceases when the principal recovers capacity.

**Sec. 13.52.010(g). Stipulations for the determination of capacity.** Unless otherwise specified in a written advance health care directive or in the case of mental illness, the primary physician makes the determination of capacity. In the case of mental illness, a court makes the determination of capacity unless the situation is an emergency. Where the situation is a mental illness emergency, a primary physician or another health care provider makes the determination.

**Sec. 13.52.010(h). Guidelines for the agent's decision-making.** Requires an agent to make health care decisions in accordance with the principal's individual instructions and other wishes to the extent known. Otherwise, directs the agent to make decisions in accordance with the agent's determination of the principal's best interest.

**Sec. 13.52.010(i).** Establishes that an agent's health care decision does not need judicial approval to be effective.

**Sec. 13.52.010(j).** Allows a written advance health care directive to nominate a guardian.

**Sec. 13.52.010(k). Portability of advance directives.** Establishes when an advance health care directive is valid under this chapter. If the directive was executed in another state, and it complies with the laws of that other state where it was executed it is also valid in Alaska. This does not authorize the administering, withholding or withdrawal of health care that is otherwise prohibited in Alaska.

**Section 13.52.020. Revocation of advance health care directive.**

**Sec. 13.52.020(a). Revocation of an agent.** Allows an individual to revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider. This provision does not apply to (c) of this section ~ the case of mental illness.

**Sec. 13.52.020(b). Revocation of all or part of the directive.** Allows a principal to revoke all or part of the advance directive in any manner that communicates the intent to revoke. This doesn't apply to the agent designation noted above in (a). This also does not apply in the case of mental illness, detailed in (c) of this section.

**Sec. 13.52.020(c). Revocation issues unique to the case of mental illness.** There are two scenarios:

1. an advance health care directive may be revoked in whole or in part at any time by the principal if the principal does not lack capacity and is not incompetent. The revocation is effective when a capable competent principal communicates the revocation to the attending physician or other health care provider;
2. in the case of mental illness, when the principal is incompetent, the authority of the agent continues in effect as long as the advance directive that named the agent remains in effect or until the agent has withdrawn.

The determination that a principal is incompetent is made by: either the court in a guardianship proceeding under AS 13.26; or a physician and a professional mental health clinician.

The determination that a principal is incompetent is made when: they determine that an individual's ability to receive and evaluate information effectively or communicate decisions is impaired to the extent that the individual lacks the capacity to make mental health treatment decision.

**Sec. 13.52.020(d). Notice of a revocation must be issued.** Once the revocation is made, the health care provider, agent, guardian or surrogate must communicate that information to the supervising health care provider and to the institution where the patient is receiving care.

**Sec. 13.52.020(e). Divorce or separation automatically revokes the spouse as an agent.** Establishes that a decree of annulment, divorce, dissolution, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or power of attorney.

Sec. 13.52.020(f). Provides that a conflicting advance health care directive revokes an earlier directive to the extent of the conflict.

**Section 13.52.025. Rescission of withdrawal by agent.**

Sec. 13.52.025. Procedure for an agent to rescind their prior withdrawal. A person who has withdrawn as an agent may reaffirm their agency with written notice to the principal or to the health care provider if the principal is incapable.

**Section 13.52.030. Decisions by surrogate.**

Sec. 13.52.030(a). When a surrogate may step into the role of decision-maker. Except in the case of mental health treatment this subsection allows a surrogate to make a health care decision for a patient who has been determined to lack capacity if an agent or guardian has not been appointed or is not reasonably available.

Sec. 13.52.030(b). Circumstances when a surrogate makes decisions regarding mental health treatment. A surrogate may make decisions for mental health treatment for a patient if there is not an agent or guardian appointed, or they are not reasonably available, the mental health treatment is needed on an emergency basis and either two physicians or one physician and one mental health clinician has determined that the patient lacks capacity.

Sec. 13.52.030(c). Criteria for surrogacy. Allows an individual to designate an individual as a surrogate by personally informing the supervising health care provider. If there is no designation, or the designation is not reasonably available, establishes the priority of persons who may act as a surrogate. Provides for an exclusion for anatomical gifts in AS 13.52.170(b). In descending order of priority, these people may act as surrogate: (1) the spouse, unless legally separated; (2) an adult child; (3) a parent; (4) an adult sibling.

Sec. 13.52.030(d). Additional surrogacy provisions. Allows an adult who meets certain described criteria to act as a surrogate if no individual who is eligible under (c) is reasonably available to act as a surrogate. The criteria for a surrogate under this section is that the person has exhibited special care and concern for the patient and they are familiar with the patient's personal values.

Sec. 13.52.030(e). Procedure for surrogate to assume authority. Requires a surrogate to communicate the surrogate's assumption of authority as promptly as practicable to the patient's family listed in (c).

Sec. 13.52.030(f). Guidelines for disagreements among surrogates.

- If more than one members of a class under (c)(2)-(4) assumes authority to act as surrogate, and the members of the class do not agree on a health care decision, and the supervising health care provider is informed of the disagreement then the provider shall comply with the majority of the members.
- If the class is evenly divided concerning the health care decision, then that class and all individuals having a lower priority under (c)(2)-(4) are disqualified from making the decision and the primary physician shall make the decision based on the best interest of the patient. Best interest is defined in this chapter at 13.52.390(5).

[Please note that this section must be considered in conjunction with another key component of HB 25: Sec. 13.52.140 – Judicial relief.

“On petition of a patient, the patient's agent, guardian, surrogate, health care provider or institution involved with the patient's care, the superior court may enjoin or direct a health care decision or order other equitable relief. A proceeding under this section is governed by AS 13.26.165-320.”

AS 13.26.165-350 is titled, “Protection of Property of Persons Under Disability and Minor.” within the Guardianship statutes.]

**Sec. 13.52.030(g).** Establishes guidelines for surrogates when making health care decisions.

- Decisions shall be made in accordance with the patient's individual instruction or advance health care directives, and other wishes to the extent known by the surrogate.
- Otherwise, the surrogate makes the decision in accordance with the surrogate's own determination of the patient's best interest. When determining "best interest," the surrogate shall consider the patient's personal values to the extent known by the surrogate.

**Sec. 13.52.030(h).** Establishes that a health care decision by a surrogate is effective without judicial approval.

**Sec. 13.52.030(i).** Procedure for patient's to disqualify a potential surrogate. Allows an individual to disqualify another person from acting as the individual's surrogate by using a signed writing or by personally informing the supervising health care provider.

**Sec. 13.52.030(j).** Certain individuals prohibited as surrogates. Prohibits, except when related to the patient, a surrogate from being an owner, operator, or employer of the patient's residential long-term health care institution.

**Sec. 13.52.030(k).** Health care provider may require signed declaration from surrogate. Allows a supervising health care provider to require from an individual claiming to be a surrogate a written declaration to establish the claimed authority.

**Section 13.52.040 Decisions by guardian.**

**Sec. 13.52.040(a).** Requires a guardian to comply with the ward's individual instructions, and prohibits a guardian from revoking a ward's advance health care directive executed before incapacity, unless a court authorizes it.

**Sec. 13.52.040(b).** Establishes that a health care decision of an agent takes precedence over that of a guardian, unless a court orders otherwise.

**Sec. 13.52.040(c).** Provides that a health care decision made by a guardian for the ward is effective without judicial approval, except as provided in (a).

**Section 13.52.045 Pregnancy.**

**Sec. 13.52.045(a).** Consideration for impacts upon a fetus. Requires a health care provider to take reasonable steps to determine if a woman of childbearing age is pregnant if execution of a health care decision would affect a fetus, should one be present.

**Sec. 13.52.045(b).** Criteria that makes an advance health care directive ineffective. A decision for a patient may not be given effect if:

- The patient is a woman who is pregnant and lacks capacity;
- The directive or decision is to withhold or withdraw health care;
- The withholding or withdrawal of the health care would likely result in the patient's death; and
- It is probable that the fetus could develop to the point of live birth if health care were continued.

Once the fetus is delivered, the health care directive is then given effect.

**Sec. 13.52.045(c).** Exception. This section does not apply to EMTs or ambulance drivers responding in the field.

**Section 13.52.050 Obligations of health care provider.**

**Sec. 13.52.050(a).** Health care provider shall attempt to communicate health care decision with the patient. Requires a supervising health care provider, if possible and before implementing the order, to promptly communicate a health care decision to the patient and identify the person making the decision.

**Sec. 13.52.050(b). Health care provider shall obtain & furnish a copy of advance directive for patient's record.** Requires supervising health care providers who knows of an advance health care directive, the revocation of a directive, or a surrogate designation or disqualification, to promptly record the item in the patient's record, request a copy if written, and arrange to keep any furnished copy in the patient's record.

**Sec. 13.52.050(c). Health care provider shall record that a patient's condition implicates the authority of a personal representative.** Except for the routine inquiry of an anatomical gift donation, this section requires a supervising health care provider who makes or is informed of a determination of a patient's condition that affects an individual instruction or an agent's, a guardian's or a surrogate's authority to promptly record the determination in the patient's record and communicate the determination to the patient, if possible, and to any person then authorized to make the health care decisions for the patient.

**Sec. 13.52.050(d). Health care provider shall comply with advance directive.** Requires, with certain exceptions stated in (e) and (f) of this subsection, that a health care provider or institution comply with qualifying individual instructions, reasonable instruction interpretations, and health care decisions.

**Sec. 13.52.050(e). Exceptions for health care provider's compliance to advance directive: conscience.** Permits a health care provider to decline, for reasons of conscience, to comply with individual instructions or health care decisions. Permits a health care institution to decline to comply with individual instructions or health care decisions if contrary to a policy of the institution's that is based on reasons of conscience.

**Sec. 13.52.050(f). Exceptions for health care provider's compliance to advance directive: ineffective treatment.** Permits a health care provider or institution to decline to comply with individual instructions or health care decisions that require medically ineffective health care or care contrary to generally accepted health care standards.

**Sec. 13.52.050(g). Duties of non-compliant health care providers.** Establishes the steps that a health care provider or institution must take if declining to comply with an individual instruction or health care decision:

- Promptly inform the patient or their decision-maker that the provider has declined to comply;
- Provide continuing care to the patient until transfer is effected
- Unless the patient or decision-maker refuses, the health care provider must take reasonable steps to assist in the transfer to another provider.

**Sec. 13.52.050(h). Advance health care directive cannot be leveraged as a condition for providing care.** Except in the case of civil commitments under AS 47.30.817, this subsection prohibits health care providers and institutions from requiring or prohibiting the execution or revocation of advance health care directives as a condition for providing care.

***Section 13.52.060 Do not resuscitate protocol and identification requirements.***

**Sec. 13.52.060(a). DNRs issued by attending physician.** The attending physician may issue an order to 'do not resuscitate' and the grounds for that shall be documented in the patient's medical file.

**Sec. 13.52.060(b). The Department shall adopt protocols for DNR.** Directs the Department of Health and Social Services to adopt a do not resuscitate protocol for health care providers and health care institutions. The protocol sets out the standard method of procedure for the withholding of cardiopulmonary resuscitation by health care providers and institutions.

**Sec. 13.52.060(c). The Department shall develop standardized forms of DNR identification.** This includes necklaces, bracelets to be worn by the individual for whom a physician has issued a do not resuscitate order.

**Sec. 13.52.060(d).** Health care providers required to comply with the DNR protocol. Health care providers other than the physician shall comply when presented with a DNR identification, an oral DNR order issued directly by a physician if the applicable hospital allows for oral DNR orders.

**Sec. 13.52.060(e).** Anatomical gift donations must be given time for evaluation before implementing a DNR. Notwithstanding (d) of this subsection, if an individual has made an anatomical gift to occur at death and they are in the hospital when a DNR is to be implemented, the DNR must wait until the subject of the gift can be evaluated to determine the suitability for donation.

**Sec. 13.52.060(f).** DNR's may not be revoked by anyone except for the person whom they are issued for, exceptions for parents of minor children. A physician may not revoke the DNR unless the person making the revocation request is the person for whom the order was issued. However, if the person with a DNR order is under 18 years of age, and they are not capable of expressing their opinion, latitude is given to the parent or guardian with regard to a DNR revocation.

**Section 13.52.070. Health care information.**

**Sec. 13.52.070.** Personal representative has rights to health care information. Provides that, unless otherwise provided in a directive, an authorized person has the same rights as the patient regarding access to and consent to the disclosure of health care information.

**Section 13.52.080. Immunities.**

**Sec. 13.52.080(a).** Health care providers acting in good faith to comply with an advance directive is not subject to civil or criminal liability or professional discipline. States that if a health care provider or institution makes reasonable efforts to ensure the validity of an advance health care directive or a person's assumption of authority to make decisions for a patient, the provider acting in good faith and under generally accepted health care standards is not subject to civil or criminal liability or to disciplinary actions for:

- complying with qualified health care decision;
- declining to comply with what appears to be an unauthorized decision;
- complying with a directive and assuming the directive was valid when made and has not been revoked or terminated;
- participating in withholding or withdrawal of CPR or other life-sustaining procedures under direction or authorization of a physician, or upon discovery of a DNR identification; or
- participating in providing CPR or other life-sustaining procedures under AS 13.52.060(e) –when the individual has made an anatomical gift or per AS 13.52.060(f) – when the individual has revoked his or her DNR order; or
- the health care provider has acted in good faith under the terms of this Act or the laws of another state relative to ant

**Sec. 13.52.080(b).** An individual acting in good faith is not subject to civil or criminal liability. States that agents, guardians, and surrogates are not subject to civil or criminal liability or to discipline for health care decisions made in good faith.

**Section 13.52.085. Discriminatory treatment prohibited.**

**Sec. 13.52.085.** Health care treatment may not be denied to a patient because of their disability. When determining the best interest of a patient, health care treatment may not be denied to a patient because the patient has or is expected to have a disability.

**Section 13.52.090. Statutory damages.**

**Sec. 13.52.090(a).** Health care provider liable for damages for intentional violation of this chapter. The provider or institution who violates this chapter is liable to the aggrieved for \$10,000, or for actual damages, whichever is greater.

**Sec. 13.52.090(b).** A person who intentionally falsifies, forges, conceals, defaces or obliterates an individual's advance health care directive or a revocation is liable for damages. Holds a person engaging in certain described acts relating to an existing directive, to the making of a directive, or to the revocation of a directive liable to the individual concerned for damages of \$10,000, or actual damages resulting from the action.

***Section 13.52.100 Capacity.***

**Sec. 13.52.100(a).** Individuals with capacity have the right to make decisions. Establishes that this chapter does not affect the right of an individual to make health care decisions while having the capacity to make the decisions.

**Sec. 13.52.100(b).** Individuals are presumed to have capacity. Establishes a rebuttable presumption that an individual has the capacity to make health care decisions, to give or revoke a directive, and to designate or disqualify a surrogate.

**Sec. 13.52.100(c).** Qualified patients have the right to make decisions about Do Not Resuscitate orders while having capacity. Once the individual with a DNR order lacks capacity, the protocol adopted under AS 13.52.060 governs that decision.

***Section 13.52.110. Status of copy.***

**Section 13.52.110.** Provides that a copy of a directive, revocation of a directive, or a designation or disqualification of a surrogate is as effective as the original.

***Section 13.52.120. Effect of this chapter.***

**Sec. 13.52.120(a).** No presumption about the individual's intent is made. States that this chapter does not create a presumption about the intention of an individual who has not made or who has revoked a directive.

**Sec. 13.52.120(b).** Circumstances resulting from this chapter do not constitute suicide or homicide. Provides that death resulting from the withholding or withdrawal of health care of health care under this chapter who does not constitute a suicide or homicide or impair or invalidate an insurance policy or certain annuities.

**Sec. 13.52.120(c).** DNRs or health care decisions made under this chapter do not affect insurance policies. A life insurance policy is not legally impaired or invalidated in any manner by the withholding or withdrawal of life sustaining measures from an insured individual. Similarly, DNR orders have no impact on insurance coverage notwithstanding any policy term to the contrary.

**Sec. 13.52.120(d).** No presumption is made with regard to individuals who have not executed a health care directive or DNR. States that this chapter does not intend for health care providers or others to make decisions rooted in speculation on reasons why the patient did not execute an advance directive or DNR.

**Sec. 13.52.120(e).** No other decision-making rights are created or impaired. This Act does not increase or decrease the right of an individual to make decisions regarding the use of CPR or other life-sustaining procedures, so long as the individual is able. Likewise, this Act does not impair or supercede any right or responsibility that a person has to effect the withholding or withdrawal of medical care in a lawful manner.

**Sec. 13.52.120(f).** Assisted suicide. This Act does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this state.

**Sec. 13.52.120(g). Health care providers or institutions not required to violate generally accepted health care standards.** This Act does not authorize or require actions that are contrary to generally accepted health care standards applicable to the provider or institution.

**Sec. 13.52.120(h). Surrogates or agents not authorized to make decisions regarding mental health treatment.** States that this chapter does not authorize an agent or a surrogate to consent to the admission of an individual to a mental health facility unless a written directive expressly allows it and the period of admission may not exceed 17 days.

**Sec. 13.52.120(i). The Health Care Decisions Act does not affect statutes that govern treatment for mental illness or involuntary commitment.**

***Section 13.52.130 Prohibited requirements.***

**Sec. 13.52.130.** A health care provider, institution or insurer issuing health care insurance cannot require an individual to execute an advance health care directive as a condition of receiving services or coverage.

***Section 13.52.140 Judicial relief.***

**Sec. 13.52.140.** Individuals listed in 13.52.030(c) may always appeal to superior court for intervention. Allows the superior court, on petition by certain listed persons, to enjoin or direct health care decision or to order other equitable relief. These appeal proceedings are governed under AS 13.26.165-320 under the laws of guardianship. The individuals who may petition:

- the patient;
- the patient's agent;
- the guardian or surrogate;
- a health care provider or institution involved with the patient's care.

***Section 13.52.150. Uniformity of application and construction.***

**Sec. 13.52.150.** Directs that this chapter is to be applied and construed to carry out the purpose of making the law uniform among states enacting this law.

***Section 13.52.160. Do not resuscitate orders and identification of other jurisdictions.***

**Sec. 13.52.160.** A DNR order or identification issued in another state or jurisdiction of the United States is effective in Alaska.

***Section 13.52.170. Making, amending, revoking, and refusing to make anatomical gifts by individual.***

**Sec. 13.52.170(a)** An individual who is at least 18 may make an anatomical gift for the purposes stated in AS 13.52.210(a); the individual may limit the gift to one or more of the purposes listed in 13.52.210(a); or the individual may refuse to make an anatomical gift.

**Sec. 13.52.170(b)** An anatomical gift may be made only by a document of gift, signed by the donor. If the donor can't sign, then another individual and two witnesses, in the presence of the donor and at their behest, shall sign the document of gift.

**Sec. 13.52.170(c)** If the document of gift is attached to or imprinted on a donor's motor vehicle driver's license, a later suspension, revocation, expiration or cancellation of the license does not invalidate the anatomical gift.

**Sec. 13.52.170(d)** The document of gift may designate a physician to carry out the procedure; however, if that physician is unavailable, the donee may authorize another to carry out the procedure.

**Sec. 13.52.170(e)** An anatomical gift by will takes effect at the death of the testator. If, after death, the will is declared invalid for testamentary purposes, the anatomical gift is unaffected.

**Sec. 13.52.170(f)** A donor may amend or revoke an anatomical gift, not made by will, by:

- a signed statement;
- an oral statement made in the presence of two individuals;
- any form of communication during a terminal illness or injury addressed to a physician;
- the delivery of a signed statement to a specified donee to whom a document of gift had been delivered.

**Sec. 13.52.170(g)** A donor of an anatomical gift made by will may be amended or revoked by subsequent actions in the will.

**Sec. 13.52.170(h)** An anatomical gift that has never been revoked by the donor is irrevocable by any other person after the donor's death.

**Sec. 13.52.170(i)** An individual may refuse to make an anatomical gift by a writing signed in the same manner as a gift; or by a statement attached to their driver's license; or any other writing. During a terminal illness, an oral statement or communication is an effective refusal.

***Section 13.52.180. Making, amending, revoking, and objecting to anatomical gifts by others.***

**Sec. 13.52.180(a).** Persons authorized to make an anatomical gift, in priority order. Any member of the following classes may donate all or part of a decedent's body for an authorized purpose, unless the decedent has revoked or refused to make an anatomical gift:

- the spouse of the decedent
- an adult son or daughter of the decedent;
- either parent of the decedent;
- an adult brother or sister of the decedent;
- a grandparent of the decedent; and
- a guardian of the person of the decedent at the time of death.

**Sec. 13.52.180(b).** Effects of the priority list. An anatomical gift may not be made by a person listed in (a) if:

- a person in a prior class is available at the time of death to make an anatomical gift;
- the person proposing the gift knows of refusal or contrary indication by the decedent; or
- the person proposing the gift knows of a refusal or contrary indication by a member of the person's class or a prior class.

**Sec. 13.52.180(c).** Method of making an anatomical gift by authorized person. An anatomical gift made by a person under (a) shall be made by a document of gift signed by the person; or by recorded telephonic or reproduced writing and signed by the recipient.

**Sec. 13.52.180(d).** Restrictions set on revocation. An anatomical gift by a person authorized in (a) may be revoked by a member of the same or prior class, if before procedures have begun for removal, the physician knows of the revocation.

**Sec. 13.52.180(e).** Absence of a donation does not indicate intent. Failure to make an anatomical gift under (a) of this section is not an objection to the making of a gift.

***Section 13.52.190 Optional form for anatomical gift by next of kin or guardian of the person.***

The following form is provided in statute as a suggested format for making an anatomical gift:

ANATOMICAL GIFT BY NEXT OF KIN OR  
GUARDIAN OF THE PERSON  
Under AS 13.52.170 - 13.52.280, I make this anatomical gift from the body of

---

(name of decedent)  
who died on \_\_\_\_\_  
(date)  
at \_\_\_\_\_  
(place) (city)  
in \_\_\_\_\_  
(state)

The marks in the appropriate squares and the words filled into the blanks below indicate my relationship to the decedent and my wishes respecting the gift.

I survive the decedent as  spouse;  adult son or daughter;  parent;  adult brother or sister;  grandparent;  guardian of the person.

I hereby give (check boxes applicable):

any needed organs, tissues, or parts;

the following organs, tissues, or parts only:

\_\_\_\_\_  
 the following purposes only:

\_\_\_\_\_  
(date) (signature of survivor)

\_\_\_\_\_  
(address of survivor)

**Section 13.52.200. Routine inquiry and required request; search and notification.**

**Sec. 13.52.200(a). Inquiries at the hospital.** On or before admission to the hospital, a designated staff person shall ask each patient, who is 18 years or older, "are you an organ or tissue donor?" If the answer is yes, staff shall request a copy of the document of gift. If the answer is no, and the attending physician consents, the designated staff shall discuss with the patient the option to make or refuse to make an anatomical gift. All the relevant information shall be noted in the patient's record.

**Sec. 13.52.200(b). Inquiries at or near the time of death.** At that time, if there is not indication of a gift or of a refusal to make a gift, a designated hospital staff member shall discuss the option with the family of the patient. The request must be made with reasonable discretion and sensitivity to the circumstances of the family. A request is not required if the gift is not suitable. The commissioner of health and social services shall adopt regulations to implement this subsection.

**Sec. 13.52.200(c). Document of gift search.** Certain individuals are required under this chapter to make a reasonable search for a document of gift if they come upon an individual who the searcher believes is dead or near death: A law enforcement officer, fire fighter, paramedic or other emergency rescuer, and upon admission, the hospital.

**Sec. 13.52.200(d). Required hospital notification.** If a document of gift or evidence of refusal is located during this search, the hospital must be notified.

**Sec. 13.52.200(e). Required notification of procurement organization.** If the hospital knows that an anatomical gift has been made by a person under their care, or by a person en route to the hospital, the hospital shall notify an appropriate procurement organization and cooperated in the implementation of the procurement.

**Sec. 13.52.200(f). Failure to discharge duties.** Notwithstanding AS 13.52.090, a person who fails to discharge the duties imposed by this section is subject to appropriate administrative sanctions but not civil or criminal fines.

**Section 13.52.210. Persons who may become donees; purposes for which anatomical gifts may be made.**

Sec. 13.52.210(a) Who can become a donee (receive a gift)? A hospital, physician, or procurement organization for transplantation or therapy, medical or dental education, research, or advancement of science; an accredited medical or dental school, college or university; or a designated individual for transplantation or therapy needed by that individual.

Sec. 13.52.210(b) An anatomical gift may be made to a designated donee or without designating a donee. If the donee is not designated, or the donee is not available, the gift may be accepted by any hospital.

Sec. 13.52.210(c) Effects of refusal or contrary indications. If the donee knows of the decedent's or the a surrogate decision maker's refusal or contrary indications to making a gift, the donee may not accept the gift.

**Section 13.52.220. Delivery of document of gift.**

Sec. 13.52.220(a) Delivery during the donor's lifetime is not required.

Sec. 13.52.220(b) Safekeeping of document of gift. A copy of the gift delivered to the donee will expedite the appropriate procedures after death; therefore, the document may be deposited at any hospital, procurement organization, or registry office for safekeeping.

**Section 13.52.230. Rights and duties at death.**

Sec. 13.52.230(a) Rights of a donee. Rights of a donee created by an anatomical gift are superior to rights of others, except in terms of autopsies. A donee may accept or reject an anatomical gift. If the donee accepts the anatomical gift, they must follow prescribed methods.

Sec. 13.52.230(b) Directions for physicians regarding time of death & removal. A physician who attends the donor at death or who certifies the death must determine the time of death. The physician who attends the donor at death or who determines the time of death may not participate in removal procedures unless the document of gift designates a particular physician.

Sec. 13.52.230(c) Eucleators & technicians. After the time of death has been noted, a technician or enucleator may remove any donated parts.

**Section 13.52.240. Coordination of procurement and use.**

Sec. 13.52.240 Coordination. Each hospital in Alaska shall coordinate with other hospitals and procurement organizations to establish affiliations for coordination of procurement.

**Section 13.52.250. Sale or purchase of parts prohibited.**

Sec. 13.52.250(a) Prohibited use of donation. A person may not knowingly purchase or sell a part for transplantation if removal of the part is intended to occur after the death of the decedent.

Sec. 13.52.250(b) Exception. Valuable consideration for sale does not include reasonable payment for the removal, processing, disposal, preservation, quality control, storage, transportation, or implantation of a part.

**Section 13.52.260. Examination, autopsy, liability.**

Sec. 13.52.260(a) Examination. An anatomical gift authorizes any reasonable examination necessary to assure medical acceptability of the gift.

Sec. 13.52.260(b) Autopsy. The autopsy provisions found in AS 13.52.170-280 are subject to the autopsy provisions of AS 12.65.

Sec. 13.52.260(c) Liability. A hospital, physician, coroner, ME, local public health officer, enucleator, technician or other person who acts in good faith under applicable anatomical gift laws of Alaska or another state is not liable for that act in civil or criminal proceedings.

**Sec. 13.52.260(d) Liability.** An individual who makes an anatomical gift under the gift laws of Alaska or another state is not liable for any injury or damage that may result from making or the use of the anatomical gift.

**Section 13.52.270. Applicability provisions.**

AS 13.52.170-280 apply to a document of gift, revocation, or refusal to make an anatomical gift signed by the donor or the person so authorized.

**Section 13.52.280. Uniformity of application and construction.**

AS 13.52.170-280 shall be applied and construed to carry out the purpose of uniform law with respect to anatomical gifts among the states.

**Section 13.52.300. Optional form.**

The following form is a sample and it may be used to create an advance directive. This form may be duplicated or 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 to the extent allowed by law. You also have the right to name someone else to make health care decisions for you to the extent allowed by law. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form if the form contains the substance of this form or otherwise complies with the requirements of AS 13.52.

Part 1 of this form is a durable 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 that you could legally make for yourself. This form has a place for you to limit the authority of your agent. You do not have to limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right, to the extent allowed by law, to

- (a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including the administration or discontinuation of psychotropic medication;
- (b) select or discharge health care providers and institutions;
- (c) approve or disapprove proposed diagnostic tests, surgical procedures, programs of medication, and do not resuscitate orders; and
- (d) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care; and
- (e) make an anatomical gift following your death.

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

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

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

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

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

You have the right to revoke this advance health care directive or replace this form at any time, except that you may not revoke this declaration when you are determined 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 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.)

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

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

PART 2

INSTRUCTIONS FOR HEALTH CARE

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

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

(A) Choice To Prolong Life

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

(B) Choice Not To Prolong Life

I want comfort care only and I do not want my life to be prolonged with medical treatment if (check all choices that represent your wishes)

(i) I have an incurable and irreversible condition that, in the judgment of my physician, will result in my death within a relatively short period of time despite appropriate medical care;

(ii) the use of life-sustaining procedures would serve only to artificially prolong my dying process without hope of recovery;

(iii) I become unconscious and, to a reasonable degree of medical certainty, I will not ever regain consciousness;

(iv) the likely risks and burdens of treatment would outweigh the expected benefits.

Additional instructions: \_\_\_\_\_

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

I wish to receive artificial nutrition and hydration indefinitely;

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

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

Other instructions: \_\_\_\_\_

(D) Relief from Pain. If I mark this box , I direct that sufficient treatment should be provided to me to alleviate my pain or discomfort.

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

\_\_\_\_\_

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

(Add additional sheets if needed.)

PART 3  
ANATOMICAL GIFT AT DEATH  
(OPTIONAL)

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

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

- (A) I give any needed organs, tissues, or other body parts, OR  
 (B) I give the following organs, tissues, or other body parts

only \_\_\_\_\_

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

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

(D) I refuse to make an anatomical gift.

PART 4  
MENTAL HEALTH TREATMENT

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

(9) 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: \_\_\_\_\_

(10) ELECTROCONVULSIVE TREATMENT. If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

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

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

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

(11) ADMISSION TO AND RETENTION IN FACILITY. If I 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. (The number of days not to exceed 17.)

\_\_\_\_\_ 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)

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

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

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

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

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

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

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

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

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

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

ALTERNATIVE NO. 1

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 durable 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.

\_\_\_\_\_  
(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 durable 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.

(date) (signature of witness)

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

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

ALTERNATIVE NO. 2

State of Alaska

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

On this \_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_, before me,

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

Notary Seal

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

***Section 13.52.330. Definitions.***

**Section 4.** Makes changes to conform the section to other parts of the bill and removes the references to living wills and former will chapters.

**Section 5.** Makes changes to conform the section to other parts of the bill and removes the references to living wills.

**Section 6.** Makes changes to conform the subsection to other parts of the bill and removes the references to living wills.

**Section 7.** Makes changes to conform the subsection to other parts of the bill and removes the references to living wills and to the former chapter on living wills.

**Section 8.** Makes changes to conform the subsection to other parts of the bill.

**Section 9.** Makes changes to conform the subsection to other parts of the bill.

**Section 10.** Makes changes to conform the section to other parts of the bill.

**Section 11.** Makes changes to conform the subsection to other parts of the bill and adds advance health care directives to the list of items that may specify when psychotropic drugs may be administered in a non-emergency.

**Section 12.** Makes changes to conform the subsection to other parts of the bill and adds advance health care directives to the list of items that may specify when psychotropic drugs may be administered without the patient's informed consent.

**Section 13.** Adds advance health care directives to the list of items that must be documented when providing the court with information under the subsection.

**Section 14.** Adds advance health care directives to the list of items that an assisted living home is required to maintain in a patient's file.

**Section 15.** Repeals certain statutes which are then re-implemented into the bill including:

- AS 13.26.332 (L), 13.26.335(1) and 13.26.344(l) – Within Article 5. Powers of Attorney statutes, HB 25 repeals the health care services option where it is currently included with banking, bonds, and chattel among many, many other material concerns.
  - *The Power of Attorney for health care is re enacted in a much expanded form in the bill.*
- AS 13.50.010 through 13.50.090 - Chapter 50. Uniform Anatomical Gift Act is repealed in its entirety.
  - HB 25 repeals the 1984 version of the Uniform Anatomical Gift Act and re enacts the provision with the 1987 Uniform Anatomical Gift Act, excluding only Section 4 of the uniform language.
- AS 18.12.010 – 18.12.100 – Chapter 12. Living Wills and Do Not Resuscitate Orders is repealed in its entirety.
  - HB 25 repeals the existing statute and re enacts the provisions in the bill.
- AS 47.30.950 – 47.30.980 Article 12. Personal Declaration of Preferences for Mental Health Treatment is repealed in its entirety.
  - HB 25 repeals the 1996 Act and re enacts the provisions in the bill.

**Section 15.** Provides that a power of attorney or a declaration lawfully under Alaska statute repealed by this Act continue to be effective until the power or declaration is revoked.

**Section 17.** Provides that AS 13.52.120(b) does not apply to certain existing insurance policies and annuities.

**Section 18.** Directs the Department of Health and Social Services to adopt implementing regulations.

**Section 19.** Provides that current regulations found at 7 AAC 16, as modified by this Act, continue in effect until the Department of Health and Social Services adopts new regulations.

**Section 20.** Gives bill Sec. 18 an immediate effective date.

**Section 21.** Gives the rest of the bill an effective date of January 1, 2005.

*Updated: February 19, 2004*

# LEGAL SERVICES

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

(907) 465-3867 or 465-2450  
FAX (907) 465-2029  
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State Capitol  
Juneau, Alaska 99801-1182  
Deliveries to: 129 6th St., Rm. 329

## MEMORANDUM

March 3, 2004

**SUBJECT:** Summary of statutes repealed by draft CSHB 25( ) relating to health care decisions (Work Order No. 23-LS0137U)

**TO:** Representative Bruce Weyhrauch  
Attn: Linda

**FROM:** Theresa L. Bannister  
Legislative Counsel

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

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

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

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

AS 13.26.344(1). In the statutory form power of attorney, this provision indicates what the language conferring general authority with respect to health care services will be construed to mean.

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

AS 13.50.010. Describes who may make an anatomical gift and when they may make the gift. Prohibits a donee from accepting a gift, if the donee has actual notice of contrary indications by the decedent or if the gift is opposed by certain persons. However, provides that an anatomical gift that is not revoked by the donor before death is

Representative Bruce Weyhrauch

March 3, 2004

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irrevocable and does not require the consent or concurrence of any person after the donor's death. States that a gift authorizes any examination necessary to assure medical acceptability of the gift for the purposes intended. States that the rights of the donee are superior to others' rights but are subject to the state's autopsy laws.

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

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

AS 13.50.020. Lists approved potential donors and purposes.

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

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

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

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

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

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

AS 13.50.070. Defines the terms for the chapter.

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

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

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

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

Provides an optional form for a declaration.

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

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

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

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

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

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

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

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

AS 18.12.080. States that if death results from the withholding or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures under a DNR order or protocol, under a declaration, or upon discovery of DNR identification and in accordance with this chapter, the death does not constitute a suicide or homicide. States that a DNR

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

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

AS 18.12.100. Defines terms for the chapter.

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

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

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

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

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

Representative Bruce Weyhrauch

March 3, 2004

Page 6

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

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

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

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

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

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

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

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

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

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

If I may be of further assistance, please advise.

TLB:lmb  
04-060.lmb

# 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      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						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**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)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2003) cost: \_\_\_\_\_  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

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

Prepared by: Karen E. Pearson, M.S., Director      Phone 465-3090  
 Division: Public Health      Date/Time 02/13/2003  
 Approved by: Joel S. Gilbertson, Commissioner      Date 02/13/2003  
 Agency: Department of Health and Social Services

**Subject: Five wishes legislation**

**Date: Wed, 16 Apr 2003 04:07:53 -0700 (PDT)**

**From: mike alter <waltalter7@yahoo.com>**

**To: linda\_sylvester@legis.state.ak.us**

To whom it may concern,

Thank you for your recent letter concerning legislation on end of life issues. As an Emergency Physician I am often faced with these issues. I believe very strongly that a person has the right to make decisions about the end of their life. I am often put in difficult situations because people have not been given easy access to a system that lets them make their desires known. I believe a person has the right to die with dignity and without pain and to make clear what he or she wants or doesn't want done. Any legislation which can make it easier for people to convey these wishes and for health providers to have access to these wishes is a worthy cause and has my full support

Thank you for your efforts on this regard, this is the type of legislation that can really make a difference.

Sincerely,

Michael Alter MD  
Chairman of Emergency Medicine, Valley Hospital,  
Palmer  
Chief of Medical Staff, Valley Hospital, Palmer

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BETHANN BOUDAH CHAPMAN

One Sealaska Plaza, Suite 202

Juneau, Alaska 99801

Bchapman@faulknerbanfield.com

March 31, 2003

Via Fax 465-2273

Representative Bruce Weyhrauch

Alaska State Legislature

State Capitol Room 102

Juneau, AK 99801-1182

Re: CSHB 25

Dear Representative Weyhrauch:

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

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

Furthermore, proposed Section 13.52.030, regarding health care decisions by a surrogate, is a vast improvement over current law and will allow family members to participate in health care decisions even if the incapacitated individual failed to sign a health care power of attorney. This law will ease the burden on family members when

faced with difficult health care decisions. The family will no longer be required to commence a guardianship proceeding and may actively participate in another family member's health care decisions.

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

Thank you for your consideration of my comments.

Sincerely,



BethAnn Boudah Chapman

c: Representative Beth Kerttula (via fax)

3

**Life Alaska**  
Tissue and Organ Donation  
P.O. Box 231809  
Anchorage, AK 99523-1809  
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Fax 1-907-562-5333



February 27, 2003

The Honorable Bruce Weyhrauch  
Alaska State Legislature  
Alaska State Capitol  
Juneau, AK 99801-1152

Dear Mr. Weyhrauch:

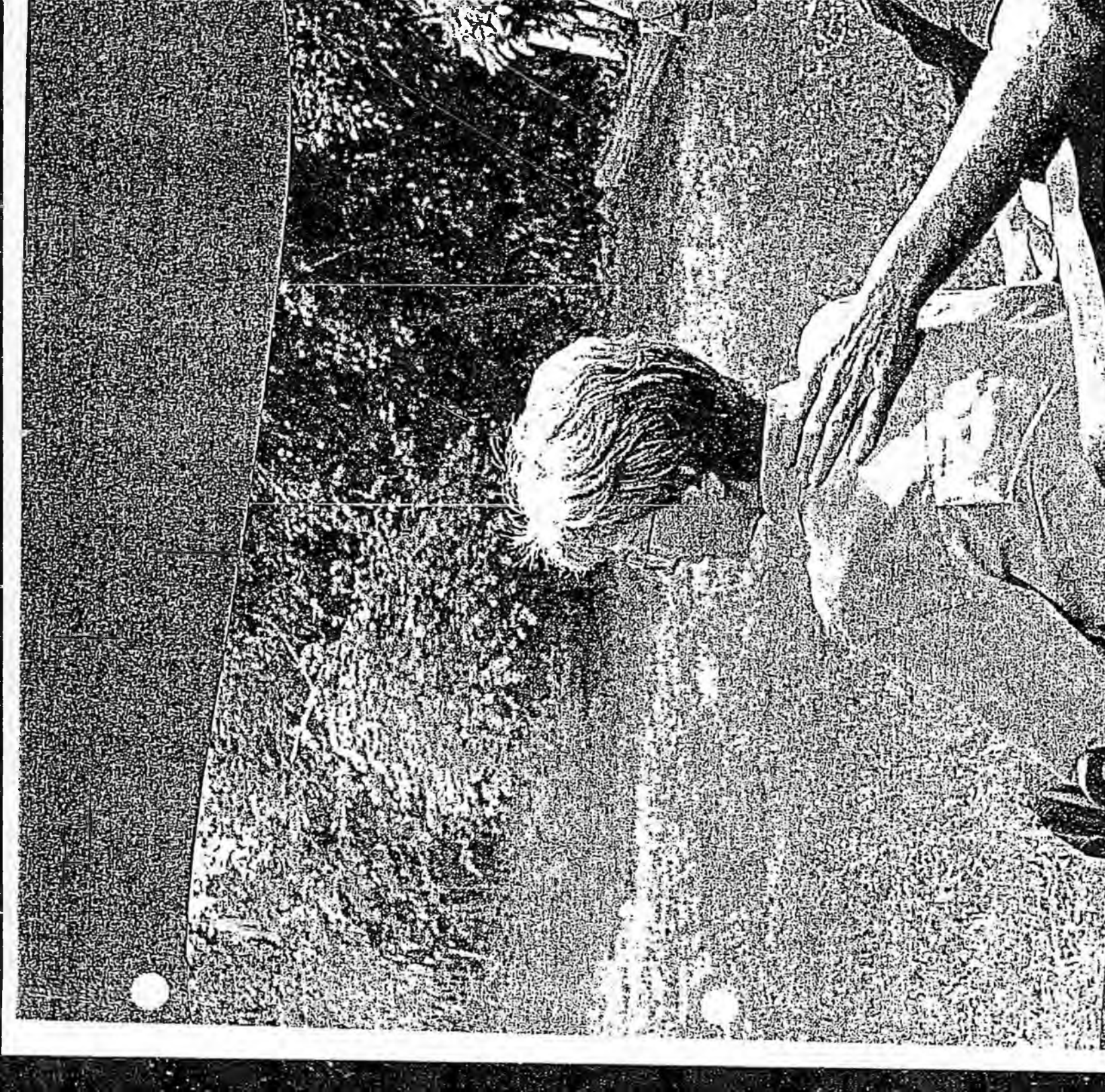
Thank you and your committee for your dedication and interest in simplifying patient directives through HB 25. As the Director of Life Alaska, the agency responsible for donation and transplant in Alaska, I want to share some facts. We work in partnership with LifeCenterNorthWest Organ Donor Network 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

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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 15)

## 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](http://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](http://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](http://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

The popular document that helps you get the care you want - when you need it.

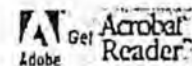
five wishes Order Five Wishes!



### 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.

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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.



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**Valid States**

Legally valid in:

**Five Wishes States**



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1-888-5-WISHES e-mail: [fivewishes@agingwithdignity.org](mailto: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 your 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 POTEMPA  
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 way 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."

Anch. Daily News  
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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](mailto: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.

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## Alaska Commission on Aging

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### 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 23<sup>rd</sup> Alaska Legislature to pass HB 25.

Adopted this 21<sup>st</sup> day of February, 2003.

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

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Marjorie J. Hays, Chair



Honorable Fred Dyson, Chair  
Senate Health, Education and Social Services Committee  
Alaska Capitol, Room 121  
Juneau, AK 99801-1182

March 6, 2004

RE: HB 25 (Weyhrauch) – Support

Dear Chair Dyson:

On behalf of the members of AARP in Alaska, we urge you and your colleagues on the Senate Health, Education and Social Services Committee to support HB 25, authored by Representative Bruce Weyhrauch, and co-sponsored by eight of his colleagues in the House (four Republicans and four Democrats).

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.

A handwritten signature in cursive script that reads "Marguerite Stetson".

Marguerite Stetson  
AARP State Coordinator for Advocacy

CC: Vice-Chair Lyda Green  
Senator Gary Wilken  
Senator Bettye Davis

Senator Gretchen Guess  
Representative Bruce Weyhrauch  
Marie Darlin  
Patrick Luby