

ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672

11138 SENATE HEALTH, EDUCATION & SOCIAL SERVICES

Subject: HB 25

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From: Richard Block <akcompub@sinbad.net>

Organization: Committee on Publication

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

Representative Weyhrauch and
Linda Sylvester

This office is pleased to see that you are continuing the effort of Representative Hudson from last Legislature to adopt in Alaska the Model Advance Health Care Directive Act.

We support the adoption of the model bill, which HB 25 currently follows.

It is our view that it is good public policy to give individuals the freedom to make their own choices concerning their health care and to be able to have the confidence that their wishes will be followed even when they may be unable to express those wishes. HB 25 confirms that individual freedom whether it is based on making choices among medical alternatives, conscientiously seeking to rely on non-meical modalities or to rely exclusively on prayer, as with those for whom I speak.

We will be watching your progress with this bill with great interest and hope that you will call upon me if you have questions about our interest in this bill or if we can be helpful in obtaining its adoption.

Dick Block

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HB 25

SENIOR VOICE

The Monthly Publication for Alaskans 50+

Publication of Older Persons Action Group, Inc. 325 E. Third Ave., Suite 300, Anchorage, Alaska 99501

Vol. 25 No.12 December, 2002

State flunks on end-of-life care

National group gives system low marks

By DAVID WASHBURN
Senior Voice

A national survey gives the country low marks for its care of people who are dying, and gives Alaska a particularly bad report.

Last Acts, a national coalition advocating for better end-of-life care, issued a state-by-state "report card" in November and graded Alaska "poor" in most categories. The state received the lowest possible grade in some key areas such as management of pain, numbers of health care professionals trained in end-of-life care, and state policies governing pain management and advance care planning.

Last Acts is made up of more than 1,000 different organizations, including the American Medical Association, the American Hospital Association, AARP and NAACP. The report card,

entitled "Means to a Better End: A Report on Dying in America Today," was developed mainly through analysis of what end-of-life-care services are available in each state and how they are used, according to a Nov. 18 press statement released by Last Acts. Experts, funded by a grant through the Robert Wood Johnson Foundation, spent a year putting together the report, according to the statement.

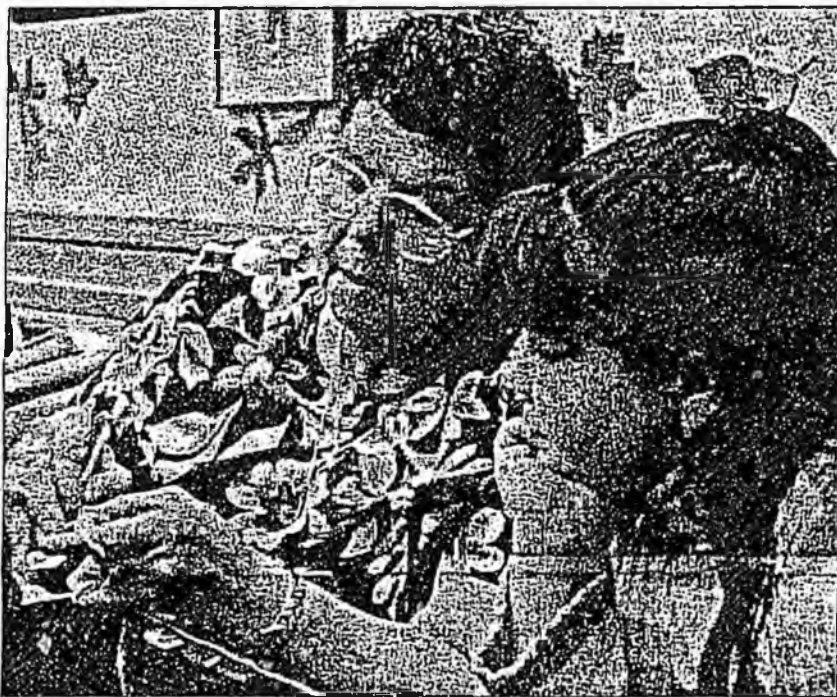
Care providers in Alaska said they were not surprised by the report's general message, but took issue with some of the findings.

"I figured we would score low," said Paula McCarron, who coordinates end-of-life care services for Providence Hospital's Interfaith Caregiver Program in Anchorage. "Alaska is still such a young state. Where other states have been dealing with health care issues for years and are in the realm of more sophisticated systems, Alaska's not there."

However, McCarron argued that some of the report's findings are misleading because they fail to take into account the many volunteer-run programs that the state relies on heavily.

page 30 please

Threading together generations



Amy Hartley/Senior Voice

Patsy "Grandma" Bascom demonstrates a crochet technique to Gladys Wood Elementary School student Alisha Graham, 10. Fifth and sixth graders from the school's student council visited the Anchorage Senior Center in November for some hands-on crochet instruction. The students plan to crochet scarves to donate to Covenant Home, a local charity.

Anchorage Senior Center ready to grow by 9,000 square feet

Big expansion project was years in the making

By AMY HARTLEY
Senior Voice

After securing financial backing and nearly a decade of planning, the first stage of the Anchorage Senior Center's expansion is complete. The new wing is an aesthetic addition to the building, but the extra room also boosts the probability of more activities for area seniors.

The construction of the new wing adds 9,000 square feet to the already-sizeable building, located off East 19th Avenue in Anchorage. Billie Lewis, the senior center's executive director, says this is the first expansion the center has seen since it opened in 1982.

"Now we're going to have a new fitness area, a new art room, a new craft room, a 12-person computer lab, a new three-room library, and lots and lots of storage," Lewis said.

The Anchorage Senior Center's new wing has widened hall ways to make access easier for those with disabilities and for heavy traffic when the center is operating at peak hours. The newly constructed education rooms are spacious, providing plenty of room for large groups to make arts and crafts. Celeste Benson, program coordinator at the center, says the staff is eager to utilize the additional classrooms and she foresees an expanded activities roster.

"I can see a lot of educational experiences to take place in that wing, which is very exciting for the seniors," Benson said.

One of the center's most anticipated additions is the computer lab. Administrators say this new space will eliminate the crunch for computer use and may spur a heightened interest in computer activities.

"Our new computer area, it can hold 12 computers. (Before), we had a hall with seven computers in it for people to use," Benson said. "It was like"

page 23 please

Inside

Editorials and Letters	2
Around the State	5
Calendar of Events	9
Health and Medicine	11
Alaska Senior News	23
Tech Talk	27
Going Places	28
Washington Watch	29



Report card: End-of-life care gets poor scores . . .

continued from page 1

Lowest possible grade

In its report card, Last Acts gave the state the lowest possible grade for each of the following areas:

• **Palliative care and certified nurses.** "Very few primary care physicians and registered nurses are certified to provide palliative care, considered the 'gold standard' in end-of-life care," the report stated. "Palliative care controls pain and symptoms while also offering emotional and spiritual support for patients and families, respecting their cultural traditions."

• **Hospice use.** "Only 5 percent of people over 65 who died in Alaska used Hospice in the last year of life," the report stated. "Hospice is the most widely-available form of palliative care. This means that too few patients and families were able to benefit from this approach, which emphasizes caring over curing in the face of terminal illness."

• **State pain policies.** Researchers concluded Alaska statutes and laws "may create barriers to good pain management."

• **State advance directive policies.** "Alaska's laws do not support good advance care planning in the form of living wills and medical powers of attorney, which designate a health care decision-maker, should the patient become unable to communicate," the report stated. Such legal documents that explain the extent to which a patient wants life-sustaining treatments "are considered critical to end-of-life care," the report said.

• **Hospital end-of-life care services.** The report found that the level of pain and palliative care services provided by hospitals is too low. Just 38 percent of hospitals reported offering pain management programs, and only 19 percent reported offering palliative care programs, according to the report. An even lower number, 6 percent, of hospitals reported that they offered Hospice programs, the report stated.

A better picture

McCarron agreed with several of the conclusions, but

said the grading system used for the report was somewhat stacked against Alaska.

For instance, in tallying programs, researchers didn't take into account those not certified by Medicare or Medicaid — which make up the bulk of the state's programs, McCarron said.

"The kinds of programs we have for care are very informal, they work out of hospitals, churches or senior centers. They're very often volunteered and they may not be a sustained program. They may be very active and then dissolve, but then start back up in four months," McCarron said.

She continued, "Our Hospice programs, I don't even know if they showed up on the map because so many of the programs are volunteer-based and not Medicare certified."

Hospice of Anchorage Executive Director Julia Thorsness agreed.

"(The researchers) didn't include organizations like mine, or the Hospice in Fairbanks. There's only one Medicare-certified Hospice in the state, and that's in Mat-Su."

The report also seemed to focus on Hospice programs that operated out of hospitals, which is common in the Lower-48, but not in Alaska. Maria Wallington, medical ethicist for Providence Hospital in Anchorage, said she was familiar with the content of the report. She has led forums on end-of-life issues and is preparing an educational course on palliative care for the hospital's nurses.

"I think the report card will be great because it will stimulate discussion and support people trying to do a better job with palliative care by raising questions and increasing consciousness of the issue," Wallington said.

The poor grade the report gave the state's policies on advance care directives, for instance, will hopefully lead to action, she said. Last year, a lot of work went into a bill that would have addressed many of the problems, but the bill stalled in the legislature, she said. "If it would have passed, we would have gotten a much better score."

Wallington said she was not surprised that the report researchers found such an extremely low number of Alaskan doctors and nurses with special certifications for palliative care. "Most of the people who have been doing the geriatrics work here got into it because of the need."

McCarron agreed. "Part of the reason that we don't have a lot of palliative care-certified nurses and physicians is that the practice of that is still fairly new, and the percentage of people in the state who require that sort of care is small."

Room for improvement

Despite their questions about the report, all of the commentators agreed the state has a long way to go, and not just in end-of-life care.

"We come up pretty crummy across the board," McCarron said. "Look at the hospital in Seward—they don't even deliver babies there." The areas on the report card where Alaska scored well don't even necessarily make a good impression,

McCarron said. The report card gave the state a "C" grade for its relatively high percentage of residents who died at home, rather than in an institution.

"More than one third of state residents died at home, where most Americans say they prefer to be, in comfortable surroundings with their loved ones," the report stated.

McCarron argued that the percentage is more likely a result of the lack of access to hospitals in rural areas.

Hospice of Anchorage's Thorsness agreed. "I think it's a reflection of us being more rural, and the lack of road systems and access to hospitals."

However, she said she does believe it's a positive thing for families to take care of relatives in their homes.

One of the biggest problems in the current system, Thorsness said, is the recent changes to Medicaid regulations involving pain medication. "They made a change in the last six months about when a prescription can be refilled." Under the new rules, people can't get a refill until their medi-

cine is 95 percent used up. This doesn't leave enough time for seniors dealing with limited transportation or other problems, so they run out of their medicine, Thorsness said.

The FDA also has cut back on the amount of pain medication that can be provided to patients under Medicare, Wallington said. "Sometimes people just need more than the absolute numbers that these people are telling them they can use. So people are going without adequate medical care."

Judith R. Peres, Last Acts deputy director and the leader of the report's research team, said in the November statement that "dying patients and their families today suffer more than they should. We still have a long way to go to improve health care and policy for this segment of the American population."

More information on the Last Acts report card is available on the Robert Wood Johnson Foundation Website at: www.rwjf.org/special/betterend.



Scott Janssen
Gen. Manager



Debbie Janssen
Adm. Ass't



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Chapter Four

Advance Directives:

Living Wills, Durable Power of Attorney and Surrogate Consent

Imma Jones—an 88-year-old woman with lymphoma and diabetes—had undergone a difficult course of surgery and radiation that left her unable to swallow. Because she was still quite delirious, she could not communicate except for spontaneous moans in response to discomfort with her tubes. Ms. Jones had filled out a boilerplate advance directive form, but the form's vague language left her doctor wondering about her true wishes. Because the one-page form did not include naming a health care proxy, Ms. Jones also had authorized no one to make treatment decisions on her behalf. Given that and the poor prognosis for recovery, her doctor felt he should be the one to determine the course of her treatment. The scenario might have been different had advance care planning been an integral part of Ms. Jones' experience.

Introduction

As the powers of health care technology have advanced, so has the average age of death for Americans. More people are dying of slow, chronic illnesses, which often lead to a loss of competence and the ability to make decisions. Completing an *advance directive*—a statement, usually in writing, that delineates an individual's preferences and values for end-of-life care in advance of the time when he or she is no longer able to communicate such preferences—can help to ensure that end-of-life care wishes are followed, even when the individual can no longer directly participate in treatment decisions. (In theory, decisions about medical treatment generally should follow patient choice, as long as the patient remains competent and able to express preferences.)

The term advance directive also covers oral statements made to family or doctors regarding treatment decisions. Although all such communication is valuable, spoken statements usually will not carry the same legal force as written statements, and can be left open to interpretation.

Generally, advance directives take one of two forms. The first, called a *living will* or health care directive, is a written statement that typically includes a conditional statement about dying and expresses a person's general willingness to accept life-sustaining treatments or, conversely, to die without use of artificial intervention. The second, known as a *proxy designation*, involves delegation of decision-making authority to another individual. (Terminology can vary from state to state. For example, Florida uses the term, "surrogate," and Michigan uses "patient advocate.") Naming as one's health care agent a trusted family member or friend with whom one has discussed end-of-life issues and values is an important step in ensuring that treatment preferences will be followed. The designation is also referred to as a *durable power of attorney*—durable in that the authority of the agent continues, even after the principal becomes incompetent. Ideally, living will-style treatment instructions and designation of a proxy both are included in a written advance directive.

Even in the absence of advance directives, health care providers often involve families and friends in decisions affecting the treatment of a patient who is unable to make them independently. Some states have statutory provisions outlining a hierarchy of decision-makers, or *surrogates* (e.g., spouse, adult child, parent), in the event a patient becomes incapacitated and has not indicated a preference for a proxy.

Families and friends may disagree about the most appropriate course of treatment for the patient, or may be reluctant to speak up in defense of the patient's stated desire to avoid or continue heroic treatment, thereby leaving the decisions to physicians by

default. In other cases, a judge may appoint a guardian to authorize someone (who may or may not be a family member) to intervene in the process. Thus, the naming of a health care proxy helps to ensure that a patient's wishes are followed and helps to avoid disagreement and costly legal proceedings. Also, if an individual who completes a living will fails to share that information with his or her family and physician, or if the document is not readily accessible at the time important treatment decisions are being made, it may not have the opportunity to 'speak' on his or her behalf.

Question One

Are living wills enforceable without designation of a health care proxy?

Yes, although the appointment of a proxy usually is more effective than the exclusive reliance on a living will. The real question when discussing cessation of life-prolonging treatment is not *whether* but *when* treatment should stop. That question is not addressed adequately in most living wills, leaving family, friends and physicians to sort out what the dying person would have wanted.

The standard forms used by most states do not encompass the wide range of possible scenarios in which a patient can be involved; nor would it be realistic to try to do so. Appointment of a health care agent can help to address such deficiencies, especially when it is unclear who will act as the patient's proxy, should that become necessary. If, for example, a person is divorced with several adult children or, perhaps, has no family still living, appointment of a proxy can reduce confusion and arguments at a later date. It remains crucial, however, that the individual and the designated proxy discuss preferences and values as they relate to health care before a medical crisis arrives.

Question Two

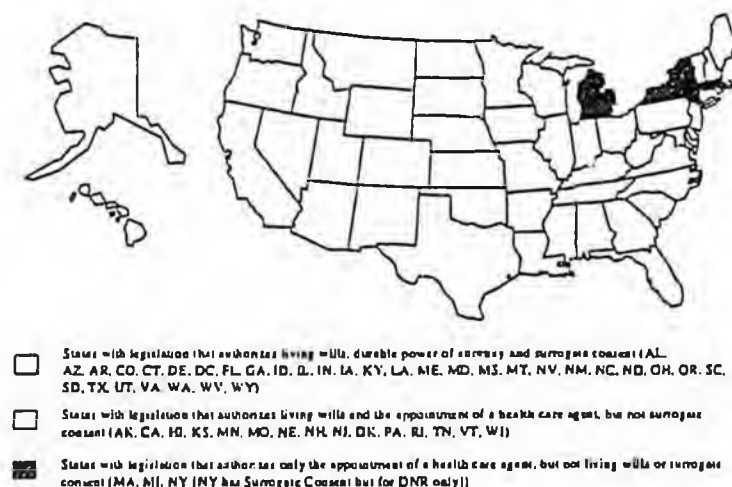
Does your state recognize advance directives?

Yes. All states recognize living wills and proxies, although the provisions of the various laws differ significantly. There are two accessible sources to obtain information about these state laws. First, state Medicaid offices have written descriptions of their own state's laws regarding advance directives as mandated by the federal Patient Self-Determination Act (Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, §§ 4206 and 4751). Second, the nonprofit organization, Choice in Dying, maintains a database on its web site of advance directives from each state.

More specifically, all but three states—Massachusetts, Michigan and New York—have laws authorizing living wills (see figure 12), although laws in those three jurisdictions allow for instructions to be included within the appointments of health care agents. As with living will instructions, all states have durable power of attorney statutes, although Alaska does not allow the agent to authorize termination of life-sustaining procedures.

In addition, most states have family consent or surrogate consent laws to address who makes health care decisions in the absence of an advance directive. Thirty-four states have statutes governing family consent or surrogate consent. In New York, the law pertains only to do-not-resuscitate orders.

Figure 12.
States with Living Wills, Appointment of Health Care Agents and Surrogate Consent
Laws



Source: ABA Commission on Legal Problems of the Elderly, 1997.

Question Three

Are the existing advance directive laws effective?

An advance directive is most helpful to assist individuals to begin thinking about alternatives for treatment at the end of life. It makes them consider important religious, familial and financial considerations that inevitably will affect treatment and care decisions. And, given that all states recognize the documents, completing one is an important step in ensuring that a patient's preferences for treatment are followed.

However, there are several deficiencies surrounding advance directives. First, only one of five adults has completed a living will at the time of death. Second, many states use living will forms that contain vague language—"heroic measures," for example, and "terminally ill," neither of which can be defined with any precision and both of which require a subjective determination. Third, most states have separate laws for living wills, durable power of attorney and surrogate consent. That piecemeal process has led to different definitions of witnessing requirements and terminal illness, as well as different reciprocity requirements between states. Such disparities have caused confusion among the public. Fourth, controversy persists about whether special conditions should be required for the discontinuation of artificially supplied nutrition and hydration. Finally, some states do not address reciprocity of patient advance directives across state lines. For example, if an elderly patient moves to another state to be cared for by an adult child, the living will might not be legally valid if the new state does not recognize documents drafted elsewhere.

**Question
Four**

How could legislators improve existing deficiencies and ensure that patients' treatment preferences are carried out?

1. Reduce inefficiency by combining various right-to-die statutes into one comprehensive act.

Figure 13.
States with Combined Advance Directive Statutes

Alabama	Maryland
Arizona	New Jersey*
Connecticut	New Mexico
Delaware	Oklahoma*
Florida	Oregon
Kentucky	Virginia
Maine	

*Does not include surrogate consent.

Source: ABA Commission on Legal Problems of the Elderly, 1997.

Living wills seem likely to be more effective if they include designation of a proxy. Thus, all state advance directive forms should be modified to provide for both proxy designation and treatment preferences. Having two separate forms—one for treatment preferences and one for appointment of a health care proxy—seems inefficient. States could make standard a single form that acts as both a living will and a health care proxy designation (although any patient can choose to complete only one or the other).

Thirteen states have merged their statutes into a combined advance directive law (see figure 13) that covers

at least living wills and durable power of attorney and, in most cases, surrogate consent in the absence of an advance directive. Of the 13, four—Alabama, Delaware, Maine and New Mexico—use the Uniform Health Care Decisions Act as a model.

The act—a revised model act created in 1993 by the National Conference of Commissioners on Uniform State Laws to rectify the conflicts among the different state statutes—

Figure 14.
States that Allow Close Friends as Surrogates

Arizona	Maryland
Colorado	New Mexico
Delaware	New York
Florida	North Dakota
Illinois	Oregon
Maine	West Virginia

Source: ABA Commission on Legal Problems of the Elderly, 1998.

combines living wills, durable power of attorney and surrogate consent in the absence of an advance directive; allows for instructions to be either written or oral; and does not require that the document be witnessed. It also includes an optional form for the advance directive. It is significantly simpler and more comprehensive than most state statutes and therefore serves as a good model.

States that have more recently enacted comprehensive laws have addressed the issues of family consent and nontraditional family and guardian consent. The laws all create a list of permissible surrogates, in order

- of priority. About a fourth of state surrogate consent laws include a "close friend" in the list of permissible surrogates (see figure 14) and Arizona now includes a "patient's domestic partner."
- 2. Ensure flexibility to allow patients to modify their living wills to become more specific as conditions worsen.

The standard forms used by many states do not include any reference for specific treatment preferences in various contexts. Rather, the language used by the boilerplate forms is often vague and inapplicable to many medical problems. Ideally, advance directives should be modified to allow for flexibility as a patient's needs change. Written preferences should address new issues and become more specific as a disease progresses and worsens.

- 3. Emphasize the importance of patients' rights and understanding.

Ideally, advance directive forms should be part of a larger process known as "advance care planning," in which a patient's values and wishes are updated repeatedly over time. Additionally, patients must understand what the forms actually entail. It is not enough for a lawyer or physician simply to ask a patient to check a box and sign on the dotted line.

The focus needs to be on the communication and dialogue surrounding the act of filling out a state-based form. Use of a values questionnaire, with questions such as the ones in Figure 15, can facilitate that process.

The Florida Commission on Aging with Dignity created another model to help individuals make decisions about end-of-life care. Specifically, the Commission developed a form entitled *Five Wishes* which lists five questions to facilitate end-of-life discussions and decision-making. The questions address: 1) the kind of medical treatment you want or do not want; 2) how comfortable you want to be; 3) how you want people to treat you; 4) what you want loved ones to know; and 5) which person you want to make health care decisions for you when you can not make them.

Legislators could allow these types of questions to be appended to the state's form, thereby reducing the possibility that advance directives will substitute for discussion within families and between health care professionals and patients. Perhaps including advance care planning as a part of health professional education curricula also would help to emphasize its importance.

Figure 15.
Examples of Values Questions

1. *What do you value most about your life?*
2. *Do you think life should be preserved for as long as possible? Why or why not?*
3. *Can you think of any possible scenarios in which you might feel differently about the above question?*
4. *Do your religious beliefs affect the way you feel about death?*
5. *Should financial considerations be important when making decisions about medical care?*
6. *Have you talked with friends and family about these issues?*

4. Recognize other states' advance directives.

Advance directives written in one state often are of uncertain force in others, which means that, if a person lives in one state and receives medical care in another, portability can be a problem. Advance directive laws should allow for use of other state and nationally recognized forms, thereby assuring a higher likelihood that a person's preferences will be followed. States can be too restrictive by requiring that certain forms be used, thus creating a problem with reciprocity.

5. Address do-not-resuscitate orders for emergency medical services.

Figure 16.
States with Emergency Medical Service Do-Not-Resuscitate Laws

Alaska	Kansas	Pennsylvania
Arizona	Kentucky	Rhode Island
Arkansas	Maryland	South Carolina
California	Michigan	Tennessee
Colorado	Montana	Texas
Connecticut	Nevada	Utah
Florida	New Hampshire	Virginia
Georgia	New Jersey	Washington
Hawaii	New Mexico	West Virginia
Idaho	New York	Wisconsin
Illinois	Oklahoma	Wyoming

Source: ABA Commission on Legal Problems of the Elderly, January 1998.

A state law on advance directives cannot be considered complete without guidelines for emergency medical service (EMS) technicians. Keeping advance directive forms in patients' medical records is effective for clinical settings. But what of patients who receive home health care? How can they let their preferences be known should they need emergency treatment? It is customary medical practice to perform cardiopulmonary resuscitation (CPR) on anyone found to be in cardiac arrest—even though that action may not coincide with the wishes of all patients.

Thirty-three states have responded to the dilemma (see figure 16) by developing protocols to assist EMS technicians in withholding CPR in appropriate cases, thereby expanding the practical application of advance directives as a whole. Some states issue bracelets indicating a person's wish not to be resuscitated should he or she be found unconscious by EMS personnel. Others recommend to patients that they place the do-not-resuscitate form in a prominent place, so it will be obvious to anyone entering the home. States with laws addressing a variety of situations give their residents the greatest chance that their wishes will be followed.

6. Experiment with different strategies to make advance directives more accessible.

To inform the public of advance directives, some states are beginning to test varied approaches. For example, a handful of states—Alaska, Illinois, Minnesota, Missouri, South Dakota and Texas—allow for display of advance directives on drivers' licenses and identification cards. A few, such as California and Ohio, have even established state repositories and registries for advance directives.

We all have *wishes*.



We also have *choices*.

My Choices

An Advance
Directive for
Health Care
Choices

My Choices, an advance directive

My Choices can help you if you are ever too sick or injured to make your own medical decisions. This advance directive contains both a living will and a power of attorney for health care. As long as you are well enough, you make medical decisions for yourself. If you are ever unable to do so, *My Choices* legally transfers medical decision-making authority from you to your designated Representative and states your end-of-life care wishes. You do not need a lawyer to complete this form, though you may wish to consult one. It is important to note that your *My Choices* form is not set in stone. You can change your mind by simply completing a new *My Choices* form.

My Choices was created for Montana adults according to Montana law by a task force of citizens, doctors, nurses, lawyers, faith leaders, and advocates. It is designed to make advance care planning easier to complete and easier for health care providers to follow. *My Choices*

has become the standard in several hospitals and other health care facilities around Western Montana.

An advance directive can be much more than a legal document that ensures medical decisions honor your wishes. This booklet is designed to help you discuss medical treatment and end-of-life choices with your loved ones and health care providers. If you need help completing the *My Choices* form, contact your doctor or one of the organizations listed on page 6.

“I did this as

TERMS TO KNOW

Advance care planning: Decision-making process about care you would want to receive if you were unable to communicate or make decisions for yourself. Based on understanding your values, personal reflection, and discussion with loved ones, health care providers, and others.

Advance directive: A legal document that provides directions for your health care if you are not able to speak for yourself or make decisions. Can include both power of attorney for health care and living will.



Two men are in separate hospital rooms on the same floor. Each is dying. Both are unconscious. Both are surrounded by family. In one room, the family is arguing over their loved one's medical treatment.

"What should we do? What would he have wanted?" In the other room, the family is sharing memories of their loved one. They are telling stories. They are grieving. But they are at peace because they know what his wishes are and that they are being honored. Now imagine one of these men is your father. Which situation would you choose?

much for my family as for myself."

Living will: Your directions to health care providers for the end-of-life treatment you do and do not want if you are terminally ill, cannot speak or make decisions for yourself and are near death.

Power of attorney: A document appointing another person to make financial or business decisions. A power of attorney can be specially prepared so that it is valid if you ever become incapacitated. Also known as a "durable power of attorney."

Power of attorney for health care: A document appointing another person you choose as your

Representative to make all health care decisions for you at any point in your life if you cannot speak or make your own decisions. Also known as a "durable power of attorney for health care."

Representative: A person appointed in a power of attorney for health care to make health care decisions for you only if you cannot communicate or make decisions for yourself. Also called an agent, surrogate, or proxy.

Will: A document that states how you wish your possessions to be disposed of after your death.

“You don’t have to be old to get sick. You don’t have to be old to get injured.”

A woman, age 23, is climbing in the Mission Mountains when she falls 60 feet to a ledge below. Her injuries are life threatening. She is rescued from the ledge and flown to the hospital.



She is unconscious. You are her husband. The doctors tell you she is not likely to ever regain consciousness, though with machines she could be kept alive for quite some time. Would you know what she would have wanted?

Why complete a My Choices advance directive?

An advance directive allows you to maintain control over your own medical care even if you cannot speak for yourself or make your own decisions (temporarily or permanently).

The *My Choices* booklet is also designed to help you create an advance directive that reflects your ideals, beliefs, and choices. As important as it is to put your wishes on paper, *My Choices* isn’t meant to be kept to yourself.

It is imperative you share a copy of your completed advance directive with your family,

your health care Representative, primary care physician, and others who are important to you. Sharing the directive helps ensure your wishes will be honored. But there are other reasons to discuss *My Choices* with your family, friends, and caregivers.

Studies show that the stress of making health care decisions for a loved one—when that individual is incapable of doing so—is more than double the stress of losing that person. However, the stress is greatly reduced if the decision maker knows that he or she is following the patient’s wishes.

In other words, an advance directive isn’t only something you do to ensure your wishes are followed; it’s also something you do for the people you care about.

Please remove the form and continue reading.

My Choices

Advance Directive for Health Care

Print your full name,

Date of birth, and

Social Security number.

These directions apply only in situations when I am not able to make or communicate my health care choices directly. *[Put an X through any sections you are not completing at this time.]*

I. Health Care Representative (Power of Attorney for Health Care)

My Representative may make ALL health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

I wish to appoint a Representative: Yes No *[Go to Part II.]*

A. Primary Representative

I appoint _____ as my Representative.

Print Representative's Full Name

Representative's Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

B. Alternate Representatives

- If: 1) I revoke my Representative's authority; or
2) My Representative becomes unwilling or unable to act for me; or
3) My Representative is my spouse and I become legally separated or divorced,

I name the following person(s) as alternates to my Representative in the order listed.

1. _____ 2. _____

Print Alternate Representative's Full Name

Print Alternate Representative's Full Name

Address _____ Address _____

City _____ City _____

State _____ Zip _____ State _____ Zip _____

Home Ph _____ Work _____ Home Ph _____ Work _____

II. Terminal Conditions (Living Will)

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want if I cannot communicate or make my own decisions. These directions are only valid if BOTH of the following two conditions exist. IF:

1) I have a terminal condition;

AND

2) In the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment which only prolongs the dying process.

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

General Treatment Directions *[Check the boxes that express your wishes.]*

- I provide no directions at this time.
- I direct my attending physician to withdraw or withhold treatment that merely prolongs the dying process.

I further direct that: *[Check all boxes that apply.]*

- Treatment be given to maintain my dignity, keep me comfortable, and relieve pain even if it shortens my life.
 - If I cannot drink, I do not want to receive fluids through a needle or catheter placed in my body unless for comfort.
 - If I cannot eat, I do not want a tube inserted in my nose, mouth, or surgically placed in my stomach to give me food.
 - If I have a serious infection, I do not want antibiotics to prolong my life. Antibiotics may be used to treat a painful infection.
-
- I have attached additional directions regarding medical treatment to this form.
 - I have not attached additional directions to this form at this time.

III. I Have a Chronic Illness or Serious Disability *(Optional)*

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

A. Diagnosis: _____

B. Consult my physician. *[Name, phone]* _____

C. Special directions. *[Use additional pages if necessary.]* _____

IV. Signing, Witnessing This Advance Directive

A. Your Signature *[Ask two people to watch you sign and have them sign below. If you can, it's best to sign this document in front of a Notary Public.]*

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

I sign this document on the _____ day of _____, 20_____.

Signature *Print Full Name*

Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____

B. Ask Your Witnesses to Read and Sign

I declare that the person who signed this document is personally known to me, and has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud, or undue influence.

As a witness, I am NOT:

- The person appointed as Representative by this document;
- Financially responsible for this person's health care;
- Related to this person by blood, marriage, or adoption; and
- To the best of my knowledge, entitled to inherit any part of this person's estate under a will now existing or by operation of law.

1. _____ 2. _____
Signature *Date* *Signature* *Date*

Name _____ Name _____
Address _____ Address _____
City _____ City _____
State _____ Zip _____ State _____ Zip _____

C. Notarizing This Document (Optional, but recommended)

STATE OF _____ COUNTY OF _____

On this _____ day of _____, 20_____, the said known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

Notary Public for the State of _____
Residing at _____
My commission expires: _____

V. Special Directions

A. Spiritual Preferences

My religion: _____ My faith community: _____

Contact person: _____ I would like spiritual support. Yes No

B. Where I would like to be when I die: My home Hospital Nursing home
 Other: _____

C. Donation of Organs at My Death

I do **not** wish to donate any of my body, organs, or tissue.

I wish to donate my entire body.

I wish to donate only the following: *[Check all that apply]*

Any organs, tissues, or body parts Heart Kidneys Lungs

Bone marrow Eyes Skin Liver Other(s)

D. After Death Care: *[Care of my body, burial, cremation, funeral home preference]*

E. Additional Directions: *[Use additional pages if necessary.]* _____

Signature _____ Date _____

F. Distributing This Document

I plan to send copies of this document to the following people or locations:

Representative: _____ Family Member: Relationship _____

Name _____ Name _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Home Ph _____ Work _____ Home Ph _____ Work _____

Physician: _____ Hospital: _____

Name _____ Name _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Home Ph _____ Work _____ Home Ph _____ Work _____

Clergy: _____ Other: _____

Name _____ Name _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Home Ph _____ Work _____ Home Ph _____ Work _____

My Choices was created by the Advance Care Planning Task Force of the Missoula Demonstration Project (406/728-1613). Members of this task force represent Missoula hospitals, home care agencies, hospice, long-term care facilities, Missoula Aging Services, Coalition of Montanans Concerned with Disabilities, AARP, public health, physicians, nurses, physician assistants, social workers, emergency medical technicians, attorneys, and clergy. Version 3.0. A printable version of *My Choices* can be downloaded at www.missoulademonstration.org.

Who should have a *My Choices* advance directive?

Everyone over the age of 18 can benefit from completing *My Choices*. Serious injury, sudden illness, and the onset of disease are not always tied to age. Still, there are points in life when people are more likely to consider or have the opportunity to complete a *My Choices* advance directive: prior to a hospital stay, after the death of a loved one, when creating or revising a will, after retirement, or when entering a long-term care facility.

Because life goals and values often evolve as we age, *My Choices* is meant to be a changeable, evolving document. People who complete advance directives often review and alter them as their wishes, health, and lives change. Even if there are no dramatic

changes in your life or health, we suggest reviewing your advance directive annually to make sure it continues to reflect your wishes.

Is *My Choices* all I need to ensure my wishes are honored?

You can help ensure your wishes will be honored by doing three things. First, complete the *My Choices* form and sign it in front of two witnesses or a Notary Public. Second, talk about it and your wishes with your Representative, close family members and friends, your doctor, and anyone else who is important to you. And, third, give each person a copy of your *My Choices* form and bring a copy to your local hospitals for your medical records.

To ensure your advance directive is honored:

- **Notarize your advance directive.** While most states will accept your advance directive, notarizing helps prove the document's authenticity and can help avoid confusion.
- **Check states you travel to frequently.** Since it is a legal document valid in Montana, the *My Choices* form should be honored when you travel in all states. However, if you live part of the year in another state, visit www.partnershipforcaring.org or call (800) 989-9455 for state-specific forms.
- **Discuss your choices with several people.** Obviously, it is imperative to discuss the contents of your advance directive with your Representative. It is also important to discuss them with your doctor, family, and others who are important to you. The more people who know your wishes, the more likely it is these wishes can be honored.
- **Distribute multiple copies.** In addition to discussing your advance directive, distribute copies to your Representative, family, doctor, and hospital medical file. Keep the original in a safe but accessible place at home (not a safe deposit box).
- **Review your advance directive annually.** It is possible your directive may become outdated if it is not reviewed periodically. For example, your Representative or Alternate Representatives may have new addresses or phone numbers. Even if you don't change anything, it is best to review your directive annually, or more frequently if you have significant life or health changes.

For another copy of *My Choices*, go to www.missoulademonstration.org.

Advance health care planning, a three-step process.

1. Determine your goals for medical treatment.

While it is impossible to anticipate all of the different medical decisions that may come up, you can make your preferences clear by stating your goals for medical treatment.

What do you want treatment to accomplish? Do you want it to prolong your life whatever the quality? If life-sustaining treatment could not restore consciousness or your ability to communicate, would you prefer to be kept comfortable rather than receive life-prolonging treatment?

In forming your treatment goals, it is often helpful to consider your wishes about different end-of-life treatments. With these goals in mind, would you want to be kept alive with a feeding tube, intravenous fluids, or antibiotics? The answers to these kinds of questions will reflect important values that you hold and will help you shape your goals of treatment.

Knowing your goals for treatment will make it easier for your family and physicians to make medical decisions on your behalf, should you ever become unable to make your own decisions. If a given treatment would help achieve your goals, it would likely be provided. If not, the treatment most likely would not be provided.

The following questions may help in determining your values and goals.

How do you feel about your current health?

How important are independence and self-sufficiency in your life?

How do you imagine handling illness, disability, dying, and death?

How might your personal relationships affect medical decision making, especially near the end of life?

What role should doctors and other health professionals play in such decisions?

What kind of living environment would be acceptable to you if you became seriously ill or disabled? Would you want to live in a nursing home or assisted living facility? Receive in-home care?

How much should the cost to your family be a part of the decision-making process?

What role do religious or spiritual beliefs play in decisions about your health care?

What are your thoughts about living life's final stages? What are your hopes and fears?

2. Choose your Representative.

Choosing your Representative is the most important part of this process. He or she will have great power over your health and personal care if you cannot make your own decisions.

When choosing a Representative, think about these questions:

- A. *Is this person willing to be your Representative?*
- B. *Have you discussed your life values and health care wishes with this person?*
- C. *Is he or she willing to and capable of following your directions?*
- D. *Can this person make difficult decisions when under stress?*

Choose one person to serve as your Representative to avoid disagreements. If you appoint two or more Representatives to serve together and they disagree, your health care providers will have no clear direction. If possible, appoint at least one Alternate Representative in case your Representative is not available.

Take the time to have heart-to-heart conversations with your Representative and each alternate. Let other close family members know whom you have chosen and why.

If you can think of no one you trust to carry out this responsibility, then do not name a Representative. Make sure, however, that you provide instructions that will guide your doctor or a court-appointed decision maker.

3. Complete the My Choices form.

An advance directive does not have to give directions or guidelines to your Representative. However, if you have specific wishes or

preferences, you should spell them out in the document itself. You may add additional pages to the form if necessary.

No matter how much direction you provide, your Representative will still need considerable discretion and flexibility. Write instructions carefully so they do not restrict the authority of your Representative in ways you do not intend.

Getting More Assistance

To learn more about completing an advance directive, contact any of the following.

- **Missoula Aging Services**
227 W. Front St., Missoula, MT 59802
(406) 728-7682 or (800) 551-3191
Provides basic consultation, materials, attorney referrals, and a free notary service.
- **Community Medical Center**
2827 Fort Missoula Rd., Missoula, MT 59804
(406) 327-4063, 327-4064 or 327-4059
Provides *My Choices* advance directive forms, information, and advice.
- **St. Patrick Hospital and Health Sciences Center**
500 West Broadway
P.O. Box 4587, Missoula, MT 59806
(406) 329-5802, 329-5789 or 329-2675
Provides *My Choices* advance directive forms, information, and advice.
- **State Bar of Montana**
Lawyer Referral Service
(406) 449-6577
Provides names of local lawyers who can advise you.
- **Missoula Demonstration Project**
320 E. Main St., Missoula, MT 59802
(406) 728-1613
www.missoulademonstration.org
Provides resources, referrals, and a free lending library.
- **Partnership for Caring:**
America's Voices for the Dying
1620 Eye Street NW, Suite 202, Washington, DC 20007
(202) 296-8071, Hotline: (800) 989-9455
www.partnershipforcaring.org
Provides information and state-specific forms on its Web site.

My Choices was created by the Advance Care Planning Task Force of the Missoula Demonstration Project to offer a standard advance directive form for use throughout Montana.

Current and Former Advance Care Planning Task Force Members:

Fr. Roger Blanchette
Ira Byock, MD
Kevin Cottrill, MSW
Rev. Dan Dixon
Janice Ford, BSW
Muriel Friedman, MD
Nancy Gibson, JD
Suzanne Goold, MSW
Brooke Jaqueth
Stuart Julian, BA
Edna Kinsella, RN, ANP
Otto Koester
Susan Kohler
Anne Laurie
Ellen Leahy, RN
Bonnie Lee
Peter Leech, MSW, LCSW
Steve McNeece, MA, NHA
Dana Michel, BSW
Betsy Mulligan, MSW
Judy O'Brien, BHS
Bernard O'Conner
Mindy Opper, PA-C
Deb Overholtzer, RN, DON
Dorothy Schweer, RN
Mary Anne Sladich-Lantz
Azara Stinger
Bill Taylor, RN, EMT-P

Linda Tracy
Monica Trimble, MSW
Lanell Turner, BSW
Bill Woody
Elizabeth Yahner, BSW

Task Force Member Organizations:

AARP – Montana
Blue Mountain Clinic
Coalition of Montanans Concerned with Disabilities
Community Medical Center
Evergreen at Missoula
First Christian Church
Hillside Manor
Missoula Aging Services
Missoula City-County Health Department
Missoula Demonstration Project
Missoula Emergency Services
Nightingale Nursing and Caregiving Services
Palliative Care Services
Parish Nursing Program
Partners in Home Care, Inc.
Retirees
Riverside Health Care Center
Rural Institute on Disabilities
St. Patrick Hospital and Health Sciences Center
Senior Advocates
Village Health Care Center
Western Montana Clinic

MISSOULA DEMONSTRATION PROJECT, INC.

320 E. Main St. • Missoula, Montana • 59802

www.missoulademonstration.org

Created with funding from the Robert Wood Johnson Foundation. Portions adapted with permission from a publication originally produced by AARP, the American Bar Association and the American Medical Association.

Hand-out from Dartmouth Hospital
to routine in-patients & ambulatory
clients

If you wish to change an Advance Directive while you are in the hospital, you should notify your physician. Even without a change in writing, your wishes will be honored as long as you can communicate them to your care providers.

What if I execute an Advance Directive in one State and am hospitalized in another?

The laws in most States are similar to one another. Your Advance directives may be honored in another State. If you spend a great deal of time in a State other than the one where your Advance Directives were executed, you may wish to make sure that your documents adhere to the laws of both States.

Who should I ask if I have questions?

Questions about Advance Directives can be discussed with your physician, your pastor, your attorney, and/or members of your family. If you have questions while you are in the hospital, the staff of the Social Work Services Department is available to assist in answering those questions.

Sample forms

The sample forms provided are taken directly from the Alaska law. If you wish to make changes to these documents, please consult an attorney to ensure that your documents adhere to State law.

Advance Directives—

Putting your health care choices in writing

Make your own decisions about your health care.

On December 1, 1991 new federal legislation went into effect requiring hospitals, nursing homes, and home health agencies to ask all adults (at the time of admission) if they have completed any "Advance Directives" and to tell them that they have the right to do so if they have not. Advance Directives are documents such as a Durable Power of Attorney, Living Will, or an Anatomical Gift Declaration. The Living Will and Anatomical Gift Declaration can be combined into a document known as "Alaska Living Will Declaration".

What kinds of decisions need to be considered?

National headlines and court cases have focused on difficult decisions families face when a loved one hasn't given Advance Directives. These decisions may include your preferences about withholding or removing life sustaining equipment and nutrition, or donating organs or tissue. Although we often think that these choices don't apply to young people, the Patient Self-Determination Act applies to all adults.

What is a Living Will?

A Living Will is an Advance Directive which states the type of medical care you want (or do not want) if you become unable to make your own decisions. It is called a "Living Will" because it takes effect while you are still living. The Living Will goes into effect if you are unable to participate in decision making and your condition is considered to be incurable or irreversible and terminal within a "relatively short time".

What is a Durable Power of Attorney for Health Care?

A Durable Attorney for Health Care is an Advance Directive which gives someone you trust the authority to make health care decisions on your behalf should you become unable to make them for yourself. It is called durable because it continues in effect if you should become unable to act in your own behalf. It is very important that the person you designate as your agent understand the health care decisions you would like to have made for you.

What is an Anatomical Gift Declaration?

An Anatomical Gift Declaration allows a person to donate tissue or organs at the time of their death. It also allows a physician to carry out the appropriate procedures for removing and/or transplanting the designated organs or tissue. If a person has both a Living Will and an Anatomical Gift Declaration, the Anatomical Gift Declaration takes precedence until the donated organ(s) can be evaluated.

Do I need to have all three of these documents?

The Living Will, Durable Power of Attorney, and Anatomical Gift Declaration are three distinctly different documents. Each person must decide which of these documents (described above) will assure that their specific wishes will be carried out.

What is the hospital's policy regarding Advance Directives?

It is the hospital's policy to honor properly executed Advance Directives. If a patient's attending physician cannot carry out the patient's wishes, it is the responsibility of that physician to assist the patient and/or family in obtaining the services of another physician who can.

The hospital will not discriminate against any patient because of the content of their properly executed Advance directive or their lack of any of these documents.

What should I do with my Advance Directives after completing them?

Keep the original documents in a safe place where a family member or your agent can easily retrieve them if necessary. Give copies to your agent, physician, attorney, family members, clergy member or anyone you want to know the decisions you have made for yourself.

Who may serve as a witness to my Advance Directives?

Living Wills and Anatomical Gift Declarations can either be signed by two witnesses or by a notary. A Durable Power of Attorney must be notarized. These witnesses must be at least 18 years of age and cannot be related to you by blood or marriage. By hospital policy ~~or~~ hospital employee or attending physician can witness or notarize these documents.

Can I change my mind after I have executed an Advance Directive?

You may change or cancel these documents at any time. Any change should be written, signed, and dated and copies should be given to your physician and to others who received your original documents.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Section 1. DESIGNATION OF AGENT

I _____ (Principal), residing

at _____

Street Address

City

State

Zip

hereby appoint: _____

Name

Street Address

City

State

Zip

Work Phone

Home Phone

as my agent with the powers set out below.

If the agent named above is unable or unwilling to serve or continue to serve, then I appoint the following agent(s) to serve with the same powers:

First Alternate:

Name

Street Address

City

State

Work Phone

Home Phone

Second Alternate:

Name

Street Address

City

State

Work Phone

Home Phone

Section 2. STATEMENT OF POWERS

I hereby grant to my Agent named above full power and authority to make health care decisions on my behalf when I have been determined to be incapable of making an informed decision on my own behalf. My Agent is to have the same authority to make health care decisions for me as I would have had if I had the capacity to make them. My Agent's authority is effective as long as I am incapable of making an informed decision.

The powers of my Agent shall include, but not be limited to, the following:

"ALASKA LIVING WILL DECLARATION"

I, _____
(Name of Declarant)

of _____
(Address of Declarant)

declare that if I should have an incurable or irreversible condition that will cause my death within a relatively short time, it is my desire that my life not be prolonged by administration of life-sustaining procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain.

I desire to include the following options.

(Please place your initials in the blank opposite the category desired.)

_____ I do desire that nutrition or hydration (food and water) be provided by gastric tube or intravenously if necessary.

_____ I do not desire that nutrition or hydration (food and water) be provided by gastric tube or intravenously if necessary.

_____ Other directives:

ORGAN DONATION (OPTIONAL)

In the event of my death, I donate the following part(s) of my body for the purposes identified in AS 13.50.020:

Tissue:

_____ Eyes
_____ Bone and connective tissue
_____ Skin
_____ Heart
_____ Other: _____

Limitations: _____

Organ:

_____ Heart
_____ Kidney(s)
_____ Liver
_____ Lung(s)
_____ Pancreas
_____ Other: _____

Signed this _____ day of _____, _____.

(Signature)

(Address)

(Date of Birth)

(Social Security Number)

PATIENT'S RIGHTS BARTLETT REGIONAL HOSPITAL

Bartlett Regional Hospital will abide by the following Patient's rights (as set forth in 7 AAC 12.890, 42 CFR Part 482; AS 18.05.040; AS 18.20.10)

While you are a patient at Bartlett Regional Hospital, we will do our best to respect your personal rights. You or your representative may expect:

1. Considerate and respectful care, that recognizes your dignity and individuality.
2. Protection of your right to privacy and confidentiality of information related to your medical care; including access to a telephone to make and receive confidential calls; and the ability to send or receive unopened correspondence.
3. Clear explanations of your condition, proposed treatments or procedures, the benefits or drawbacks of the proposed treatment, expected recuperation and the likelihood of success of treatments or procedures.
4. Willingness to let you and your family take the lead in decision making regarding your care and treatment.
5. A safe and secure setting free from abuse/ harassment.
6. Compliance with your request to refuse treatment or to have medically necessary and appropriate treatment provided.
7. Our compliance with your advance directives, per Alaska Law.
8. Freedom from any type of discrimination on the basis of age, race, color, sex, creed, national origin, marital status, sexual orientation or disability.
9. Access to protective services, from counseling to guardianship, to help you reach your maximum level of independence.
10. Access to an interpreter, your own of the hospitals.
11. Services of the hospital chaplain when you request them.
12. Assistance in obtaining financial aid or counseling, if needed.
13. Attentive, courteous response to any concerns or complaints you and your family may have.
14. Freedom from seclusion or restraints that are not medically necessary.
15. Access to the information contained in your medical record within a reasonable timeframe.
16. Upon request, information regarding services that are available in the hospital and their cost, including any costs for services or personal care items not covered by the facility's basic per diem rate or not covered under title XVII or Title XIX of the Social Security Act.
17. To have the rights of minors assured by prompt and consistent interpretation of patient rights to a patient or legal guardian.

PATIENT AND FAMILY GRIEVANCE

Patients and their families have the right to file a grievance regarding events occurring during their stay at BRH when a complaint is not mutually resolved. The Patient and Family Grievance Policy will be followed in the event of a grievance. In addition, you have the right to lodge a complaint with the Office of Health Facilities Licensing & Certification, Department of Health and Social Services, 4730 Business Park Blvd, Suite 18, Anchorage, Alaska 99503-7137, 907 561-8081. Your presentation of a complaint will not impact the future availability of care or services at BRH.

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB0025CS(JUD)-DHSS-DPH-01-21-04
() Publish Date: _____

Revision Date/Time (Note if correction): 1/20/2004

Dept. Affected: Health & Social Services

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

Sponsor: WEYRAUCH

Requester: _____ Component No. 2078

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2004) cost: _____
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: Doug A. Bruce Phone 465-3090
Division: Public Health Date/Time 01/20/2004
Approved by: Joel S. Gilbertson, Commissioner Date 01/21/2004
Agency: Department of Health and Social Services

ALASKA STATE LEGISLATURE

Representative Bruce Weyhrauch

HOUSE DISTRICT 4

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
99801-1182

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

March 3, 2004

Senator Fred Dyson
Capitol Building
Room 121
Juneau, Alaska 99801

Regarding: HB 25 Advance Health Care Directives

Dear Senator Dyson:

On Monday, the Senate Health & Social Services Committee will be taking up HB 25, but before that I wanted to take a moment and offer some introductory words to you regarding this critically important concept. HB 25 ~ Healthcare Directives was inspired by the Five Wishes legislation that has been adopted by 37 states since 1993. 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.

Additionally, HB 25 takes a more comprehensive approach to advance directives in that it collects all of the existing provisions related to end-of-life healthcare decisions and places them in one chapter under Alaska law. These statutory provisions that are repealed and re-enacted include:

- The organ donation program;
- The Living Will Program;
- The Comfort One Do-Not-Resuscitate program;
- An expanded healthcare durable power of attorney for health care.

Essentially, HB 25 brings all of the health care related provisions into one, easy to access and coordinated site. Something like one stop shopping. In point of fact, the only "new law" introduced by the legislation is the concept of the surrogate for health care decisions found in section 13.52.025.

From the beginning, my office has worked very closely with my colleagues in committee as well as a number of stakeholders to ensure that the final product is as faultless as possible. As you join in the review of HB 25 in the HESS committee, I wanted you to know whom these individuals are, and I invite you to contact any one of them if you have a particular question or concern. Of course, you can also discuss any aspect of HB 25 with myself, or my staff.

Panel of Advisors

<u>Subject</u>	<u>Advisor</u>
Surrogates, DNRs, Living Wills, optional form, practical aspects & typical scenarios of health care issues that HB 25 touches	Dr. Maria Wallington, MD Medical Ethicist Providence Hospital 907 261-6077
Advance directives for mental health treatment & issues related to disability	Edie Zukauskas Attorney Disability Law Center 907 565-1002
DNRs, the state's Comfort One Program & issues related to emergency health care out side of the hospital	Shelley Owens Mark Johnson Dept. of Health & Social Services 907 465-3028
Anatomical gifts	Bruce Zalneraitis Life Alaska (Alaska's organ procurement organization) 907-562-5333
Pain treatment	Carole Edwards, RN Oncology Nurses Society 907-789-3345

Once again, I want to thank you for your thoughtful work on HB 25 and I look forward to working with you and your staff in committee.

Sincerely,

Representative Bruce Weyhrauch

Hawaii

[§327E-5] Health-care decisions; surrogates. (a) A patient may designate or disqualify any individual to act as a surrogate by personally informing the supervising health-care provider. In the absence of such a designation, or if the designee is not reasonably available, a surrogate may be appointed to make a health-care decision for the patient.

(b) A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available. Upon a determination that a patient lacks decisional capacity to provide informed consent to or refusal of medical treatment, the primary physician or the physician's designee shall make reasonable efforts to notify the patient of the patient's lack of capacity. The primary physician, or the physician's designee, shall make reasonable efforts to locate as many interested persons as practicable, and the primary physician may rely on such individuals to notify other family members or interested persons.

(c) Upon locating interested persons, the primary physician, or the physician's designee, shall inform such persons of the patient's lack of decisional capacity and that a surrogate decision-maker should be selected for the patient.

(d) Interested persons shall make reasonable efforts to reach a consensus as to who among them shall make health-care decisions on behalf of the patient. The person selected to act as the patient's surrogate should be the person who has a close relationship with the patient and who is the most likely to be currently informed of the patient's wishes regarding health-care decisions. If any of the interested persons disagrees with the selection or the decision of the surrogate, or, if after reasonable efforts the interested persons are unable to reach a consensus as to who should act as the surrogate decision-maker, then any of the interested persons may seek guardianship of the patient by initiating guardianship proceedings pursuant to chapter 551. Only interested persons involved in the discussions to choose a surrogate may initiate such proceedings with regard to the patient.

(e) If any interested person, the guardian, or primary physician believes the patient has regained decisional capacity, the primary physician shall reexamine the patient and determine whether or not the patient has regained decisional capacity and shall enter a decision and the basis for such decision into the patient's medical record and shall notify the patient, the surrogate decision-maker, and the person who initiated the redetermination of decisional capacity.

(f) A surrogate who has been designated by the patient may make

health-care decisions for the patient that the patient could make on the patient's own behalf.

(g) A surrogate who has not been designated by the patient may make all health-care decisions for the patient that the patient could make on the patient's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future.

The surrogate who has not been designated by the patient shall make health-care decisions for the patient based on the wishes of the patient, or, if the wishes of the patient are unknown or unclear, on the patient's best interest.

The decision of a surrogate who has not been designated by the patient regarding whether life-sustaining procedures should be provided, withheld, or withdrawn shall not be based, in whole or in part, on either a patient's preexisting, long-term mental or physical disability, or a patient's economic status. A surrogate who has not been designated by the patient shall inform the patient, to the extent possible, of the proposed procedure and the fact that someone else is authorized to make a decision regarding that procedure.

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

(i) A supervising health-care provider shall require a surrogate to provide a written declaration under the penalty of false swearing stating facts and circumstances reasonably sufficient to establish the claimed authority. [L 1999, c 169, pt of §1]

[Previous](#)

[Next](#)

Delaware Advance Health-Care Directive

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding anatomical gifts and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions. You may also 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, an agent may not have a controlling interest in or be an operator or employee of a residential long-term health-care institution at which you are receiving care.

If you do not have a qualifying condition (terminal illness/injury or permanent unconsciousness), your agent may make all health-care decisions for you except for decisions providing, withholding or withdrawing of a life sustaining procedure. Unless you limit the agent's authority, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition unless it's a life-sustaining procedure or otherwise required by law.

(b) Select or discharge health-care providers and health-care institutions;
If you have a qualifying condition, your agent may make all health-care decisions for you, including, but not limited to:

(c) The decisions listed in (a) and (b).

(d) Consent or refuse consent to life sustaining procedures, such as, but not limited to, cardiopulmonary resuscitation and orders not to resuscitate.

(e) Direct the providing, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. 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. Space is also provided for you to add to the choices you have made or for you to write out any additional instructions for other than end of life decisions.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 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. It is required that 2 other

individuals sign as witnesses. 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 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.

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(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)

Surrogate
options

Delaware

(home phone)

(work phone)

(2) AGENT'S AUTHORITY: If I am not in a qualifying condition my agent is authorized to make all health-care decisions for me, except decisions about life-sustaining procedures and as I state here; and if I am in a qualifying condition, my agent is authorized to make all health-care decisions for me, except as I state here:

(Add additional sheets if necessary.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions. As to decisions concerning the providing, withholding and withdrawal of life-sustaining procedures my agent's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.

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

I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

I nominate the following to be guardian in the order designated:

I do not nominate anyone to be guardian.

PART 2: INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not 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.

(6) END-OF-LIFE DECISIONS: If I am in a qualifying condition, 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:

Choice Not To Prolong Life

I do not want my life to be prolonged if: (please check all that apply)

_____ (i) I have a terminal condition (an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery) and regarding artificial nutrition and hydration, I make the following specific directions:

	I want used	I don't want used
Artificial nutrition by a conduit	_____	_____
Hydration through a conduit	_____	_____

_____ (ii) I become permanently unconscious (a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma) and regarding artificial nutrition and hydration, I make the following specific directions:

	I want used	I don't want used
Artificial nutrition by a conduit	_____	_____
Hydration through a conduit	_____	_____

Choice To Prolong Life

_____ I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

RELIEF FROM PAIN: Except as I state in the following space, I direct treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(7) OTHER MEDICAL INSTRUCTIONS: (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:

(Add additional sheets if necessary.)

PART 3: ANATOMICAL GIFTS AT DEATH

(OPTIONAL)

(8) I am mentally competent and 18 years or more of age.

I hereby make this anatomical gift to take effect upon my death. The marks in the appropriate squares and words filled into the blanks below indicate my desires.

I give: my body; any needed organs or parts; the following organs or parts: _____.

To the following person or institutions the physician in attendance at my death; the hospital in which I die; the following named physician, hospital, storage bank or other medical institution; the following individual for treatment; for the following purposes: any purpose authorized by law; transplantation; therapy; research; medical education.

PART 4: PRIMARY PHYSICIAN

(OPTIONAL)

(9) 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)

Primary Physician shall mean a physician designated by an individual or the individual's agent or guardian, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

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

(11) SIGNATURE: Sign and date the form here: I understand the purpose and effect of this document.

(date)

(sign your name)

(address)

(print your name)

(city)

(state)

(zip code)

(12) SIGNATURES OF WITNESSES:

Statement Of Witnesses

SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del.C. §§ 2502 and 2503, in our presence, who in his/her presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

- A. That the Declarant is mentally competent.
- B. That neither of them:
 1. Is related to the declarant by blood, marriage or adoption;
 2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health care directive, is so entitled by operation of law then existing;
 3. Has, at the time of the execution of the advance health-care directive, a present or inchoate claim against any portion of the estate of the declarant;
 4. Has a direct financial responsibility for the declarant's medical care;
 5. Has a controlling interest in or is an operator or an employee of a residential long-term health-care institution in which the declarant is a resident; or
 6. Is under eighteen years of age.

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____, is at the time of the execution of the advance health-care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

First witness

I am not prohibited by § 2503 of Title 16 of the Delaware Code from being a witness.

(print name)

(address)

(city, state, zip code)

(signature of witness)

(date)

Second witness

I am not prohibited by § 2503 of Title 16 of the Delaware Code from being a witness.

(print name)

(address)

(city, state, zip code)

(signature of witness)

(date)

23-LS0137U
Bannister
2/11/04

CS FOR HOUSE BILL NO. 25()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-THIRD LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

**Sponsor(s): REPRESENTATIVES WEYHRAUCH, Ogg, Kookesh, Seaton, Crawford, Joule, Gara, Masek,
Morgan**

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to health care decisions, including do not resuscitate orders,
2 anatomical gifts, and mental health treatment decisions, and to powers of attorney
3 relating to health care, including anatomical gifts and mental health treatment
4 decisions; and providing for an effective date."

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

6 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
7 to read:

8 **PURPOSE AND INTENT.** (a) A principal purpose of this Act is to provide a
9 comprehensive coordinated approach to the making of health care decisions, including
10 anatomical gifts. To achieve this purpose, this Act repeals the current statutory devices that
11 cover health care decisions and consolidates the subject into one chapter.

12 (b) It is the intent of this Act to

13 (1) establish the right of a patient to control the patient's own health care
14 decisions; and

1 (2) create, in the absence of evidence to the contrary, a presumption that the
2 patient intends to be kept alive, including by use of life-sustaining procedures, until given the
3 opportunity to make health care decisions directly or through an agent, a surrogate, or a
4 guardian.

5 * **Sec. 2.** AS 12.65.100 is amended to read:

6 **Sec. 12.65.100. Unclaimed bodies.** When a person dies and no person
7 appears to claim the body for burial, and no provision is made for the body under
8 AS 13.52 [AS 13.50], the Department of Health and Social Services, upon
9 notification, shall request a court order authorizing the body to be plainly and decently
10 buried or cremated and the remains decently interred. A judicial officer shall issue the
11 requested order upon the sworn testimony or statement of a representative of the
12 Department of Health and Social Services that a person has not appeared to claim the
13 body for burial and provision is not made for the body under AS 13.52 [AS 13.50].

14 * **Sec. 3.** AS 13 is amended by adding a new chapter to read:

15 **Chapter 52. Health Care Decisions Act.**

16 **Sec. 13.52.010. Advance health care directives.** (a) Except as provided in
17 AS 13.52.170(a), an adult or emancipated minor may give an individual instruction.
18 Except as provided in AS 13.52.170(b), the instruction may be oral or written. The
19 instruction may be limited to take effect only if a specified condition arises.

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

26 (1) signed by at least two individuals, each of whom witnessed either
27 the signing of the instrument by the principal or the principal's acknowledgment of the
28 signature of the instrument; or

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

30 (c) Unless related to the principal by blood, marriage, or adoption, an agent
31 under a durable power of attorney for health care may not be an owner, operator, or

1 employee of the health care institution at which the principal is receiving care.

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

3 (1) a health care provider;

4 (2) an employee of a health care provider or facility; or

5 (3) the agent.

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

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

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

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

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

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

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

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

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

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

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

5 (k) An advance health care directive is valid for purposes of this chapter if it
6 complies with this chapter or if it was executed in compliance with the laws of the
7 state where it was executed, but this subsection does not authorize the administration,
8 withholding, or withdrawal of health care otherwise prohibited by the laws of this
9 state.

10 **Sec. 13.52.020. Revocation of advance health care directive.** (a) Except in
11 the case of mental illness under (c) of this section, a principal may revoke the
12 designation of an agent only by a signed writing or by personally informing the
13 supervising health care provider.

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

17 (c) In the case of mental illness, an advance health care directive may be
18 revoked in whole or in part at any time by the principal if the principal does not lack
19 capacity and is not incompetent, a revocation is effective when a capable, competent
20 principal communicates the revocation to the attending physician or other health care
21 provider, and the attending physician or other health care provider shall note the
22 revocation on the principal's medical record. In the case of mental illness, the
23 authority of a named agent and an alternative agent named in the advance health care
24 directive continues in effect as long as the advance health care directive appointing the
25 agent is in effect or until the agent has withdrawn. For the purposes of this subsection,
26 a principal is considered incompetent when it is the opinion of the court in a
27 guardianship proceeding under AS 13.26, the opinion of two physicians, at least one
28 of whom is a psychiatrist, or the opinion of a physician and a professional mental
29 health clinician, that an individual's ability to receive and evaluate information
30 effectively or communicate decisions is impaired to the extent that the individual lacks
31 the capacity to make mental health treatment decisions.

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

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

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

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

15 **Sec. 13.52.030. Decisions by surrogate.** (a) Except in the case of mental
16 health treatment and except as provided by AS 13.52.180(a) and (b), a surrogate may
17 make a health care decision for a patient who is an adult or emancipated minor if an
18 agent or guardian has not been appointed or the agent or guardian is not reasonably
19 available, and if the patient has been determined by the primary physician to lack
20 capacity.

21 (b) A surrogate may make a decision regarding mental health treatment for a
22 patient who is an adult or emancipated minor if

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

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

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

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

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

29 (c) Except as provided for anatomical gifts in AS 13.52.170(b), an adult or
30 emancipated minor may designate an individual to act as surrogate by personally
31 informing the supervising health care provider. Except as provided by AS

1 13.52.180(a) and (b), in the absence of a designation, or if the designee is not
2 reasonably available, a member of the following classes of the patient's family who is
3 reasonably available, in descending order of priority, may act as surrogate:

4 (1) the spouse, unless legally separated;

5 (2) an adult child;

6 (3) a parent; or

7 (4) an adult sibling.

8 (d) Except as provided by AS 13.52.180(a) and (b), if none of the individuals
9 eligible to act as surrogate under (c) of this section is reasonably available, an adult
10 who has exhibited special care and concern for the patient, who is familiar with the
11 patient's personal values, and who is reasonably available may act as surrogate.

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

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

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

31 (h) A health care decision made by a surrogate for a patient is effective

1 without judicial approval.

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

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

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

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

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

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

19 **Sec. 13.52.045. Pregnancy.** (a) Before implementing a health care decision
20 for a woman of childbearing age that would affect a fetus if present, the supervising
21 health care provider shall take reasonable steps to determine whether the woman is
22 pregnant.

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

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

27 (2) the directive or decision is to withhold or withdraw health care;

28 (3) the withholding or withdrawal of the health care would, in
29 reasonable medical judgment, be likely to result in the death of the patient; and

30 (4) it is probable that the fetus could develop to the point of live birth
31 if the health care were provided.

1 (c) This section does not apply to emergency medical technicians or
2 ambulance drivers when providing emergency services in the field.

3 **Sec. 13.52.050. Obligations of health care provider.** (a) Before
4 implementing a health care decision made for a patient, a supervising health care
5 provider, if possible, shall promptly communicate to the patient the decision made and
6 the identity of the person making the decision.

7 (b) Except as provided in AS 13.52.200, a supervising health care provider
8 who knows of the existence of an advance health care directive, a revocation of an
9 advance health care directive, or a designation or disqualification of a surrogate shall
10 promptly record its existence in the patient's health care record, shall request a copy if
11 it is in writing, and shall arrange for its maintenance in the health care record if a copy
12 is furnished.

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

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

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

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

27 (e) A health care provider may decline to comply with an individual
28 instruction or a health care decision for reasons of conscience, except for a do not
29 resuscitate order. A health care institution may decline to comply with an individual
30 instruction or health care decision if the instruction or decision is contrary to a policy
31 of the institution that is expressly based on reasons of conscience and if the policy was

1 timely communicated to the patient or to a person then authorized to make health care
2 decisions for the patient.

3 (f) A health care provider or institution may decline to comply with an
4 individual instruction or a health care decision that requires medically ineffective
5 health care or health care contrary to generally accepted health care standards
6 applicable to the health care provider or institution. In this subsection, "medically
7 ineffective health care" means health care that according to reasonable medical
8 judgment cannot cure the patient's illness, cannot diminish its progressive course, and
9 cannot effectively alleviate severe discomfort and distress.

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

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

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

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

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

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

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

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

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

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

16 (f) A physician may not revoke a do not resuscitate order at the request of a
17 person, and a person may not make a do not resuscitate order ineffective, unless the
18 person making the request or proposing to make the order ineffective is the person
19 who requested the physician to issue the order. However, if the person for whom the
20 order has been issued is not capable of expressing an opinion on the subject, the
21 request or proposal may be made by the parent or guardian of the person for whom the
22 order has been issued if the person for whom the order has been issued is under 18
23 years of age.

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

28 **Sec. 13.52.080. Immunities.** (a) If a health care provider or health care
29 institution makes reasonable efforts, with a level of diligence appropriate to the
30 seriousness and urgency of the situation, to ensure the validity of an advance health
31 care directive or a person's assumption of authority to make health care decisions for a

1 patient, a health care provider or institution acting in good faith and in accordance
2 with generally accepted health care standards applicable to the health care provider or
3 institution is not subject to civil or criminal liability or to discipline for unprofessional
4 conduct for

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

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

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

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

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

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

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

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

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

28 **Sec. 13.52.085. Discriminatory treatment prohibited.** When determining
29 the best interest of a patient under this chapter, health care treatment may not be
30 denied to a patient because the patient has a disability or is expected to have a
31 disability.

1 **Sec. 13.52.090. Statutory damages.** (a) A health care provider or institution
2 that intentionally violates this chapter is liable to the aggrieved individual or the
3 individual's estate for damages of \$10,000 or actual damages resulting from the
4 violation, whichever is greater, plus attorney fees as provided by court rule.

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

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

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

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

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

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

31 (b) Notwithstanding any other provision of law, if the withholding or

1 withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures is
2 consistent with this chapter, death resulting from the withholding or withdrawal of
3 cardiopulmonary resuscitation or other life-sustaining procedures under a do not
4 resuscitate order, under the protocol for do not resuscitate orders established under
5 AS 13.52.060, or under a do not resuscitate identification found on an individual does
6 not, for any purpose, constitute a suicide or homicide.

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

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

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

27 (f) This chapter does not authorize mercy killing, assisted suicide, euthanasia,
28 or the provision, withholding, or withdrawal of health care, to the extent prohibited by
29 other statutes of this state.

30 (g) This chapter does not authorize or require a health care provider or
31 institution to provide health care contrary to generally accepted health care standards

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applicable to the health care provider or institution.

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

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

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

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

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

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

Sec. 13.52.170. Making, amending, revoking, and refusing to make anatomical gifts by individual. (a) An individual who is at least 18 years of age may

(1) make an anatomical gift for any of the purposes stated in AS 13.52.210(a);

- 1 (2) limit an anatomical gift to one or more of those purposes; or
2 (3) refuse to make an anatomical gift.

3 (b) An anatomical gift may be made only by a document of gift signed by the
4 donor. If the donor cannot sign, the document of gift shall be signed by another
5 individual and by two witnesses, all of whom have signed at the direction and in the
6 presence of the donor and of each other, and state that it has been signed at the
7 direction and in the presence of the donor and of each other.

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

11 (d) A document of gift may designate a particular physician or surgeon to
12 carry out the appropriate procedures. In the absence of a designation or if the designee
13 is not available, the donee or other person authorized to accept the anatomical gift may
14 employ or authorize any physician, surgeon, technician, or enucleator to carry out the
15 appropriate procedures.

16 (e) An anatomical gift by will takes effect upon death of the testator, whether
17 or not the will is probated. If, after death, the will is declared invalid for testamentary
18 purposes, the validity of the anatomical gift is unaffected.

19 (f) Notwithstanding AS 13.52.020, a donor may amend or revoke an
20 anatomical gift, not made by will, only by

- 21 (1) a signed statement;
22 (2) an oral statement made in the presence of two individuals;
23 (3) any form of communication during a terminal illness or injury
24 addressed to a physician or surgeon; or
25 (4) the delivery of a signed statement to a specified donee to whom a
26 document of gift had been delivered.

27 (g) Notwithstanding AS 13.52.020, the donor of an anatomical gift made by
28 will may amend or revoke the gift in the manner provided for amendment or
29 revocation of wills, or as provided in (f) of this section.

30 (h) An anatomical gift that is not revoked by the donor before death is
31 irrevocable and does not require the consent or concurrence of any person after the

1 donor's death.

2 (i) An individual may refuse to make an anatomical gift of the individual's
3 body or part by

4 (1) a writing signed in the same manner as a document of gift;

5 (2) a statement attached to or imprinted on a donor's motor vehicle
6 operator's or chauffeur's license;

7 (3) any other writing used to identify the individual as refusing to
8 make an anatomical gift;

9 (4) during a terminal illness or injury, an oral statement or other form
10 of communication.

11 (j) In the absence of contrary indications by the donor, an anatomical gift of a
12 part is not a refusal to give other parts or a limitation on an anatomical gift under
13 AS 13.52.180.

14 (k) In the absence of contrary indications by the donor, a revocation or
15 amendment of an anatomical gift is not a refusal to make another anatomical gift. If
16 the donor intends a revocation to be a refusal to make an anatomical gift, the donor
17 shall make the refusal under (i) of this section.

18 **Sec. 13.52.180. Making, revoking, and objecting to anatomical gifts by**
19 **others.** (a) Any member of the following classes of persons, in the order of priority
20 listed, may make an anatomical gift of all or a part of the decedent's body for an
21 authorized purpose, unless the decedent, at the time of death, has made an unrevoked
22 refusal to make that anatomical gift:

23 (1) the spouse of the decedent;

24 (2) an adult son or daughter of the decedent;

25 (3) either parent of the decedent;

26 (4) an adult brother or sister of the decedent;

27 (5) a grandparent of the decedent; and

28 (6) a guardian of the person of the decedent at the time of death.

29 (b) An anatomical gift may not be made by a person listed in (a) of this section
30 if

31 (1) a person in a prior class is available at the time of death to make an

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anatomical gift;

(2) the person proposing to make an anatomical gift knows of a refusal or contrary indications by the decedent; or

(3) the person proposing to make an anatomical gift knows of an objection to making an anatomical gift by a member of the person's class or a prior class.

(c) An anatomical gift by a person authorized under (a) of this section shall be made by

(1) a document of gift signed by the person; or

(2) the person's telegraphic, recorded telephonic, or other recorded message, or another form of communication from the person that is contemporaneously reduced to writing and signed by the recipient.

(d) An anatomical gift by a person authorized under (a) of this section may be revoked by any member of the same or a prior class if, before procedures have begun for the removal of a part from the body of the decedent, the physician, surgeon, technician, or enucleator removing the part knows of the revocation.

(e) A failure to make an anatomical gift under (a) of this section is not an objection to the making of an anatomical gift.

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

**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

1 (place) (city)

2 in

3 _____.

4 (state)

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

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

11 I hereby give (check boxes applicable):

12 any needed organs, tissues, or parts;

13 the following organs, tissues, or parts only:

14 _____;

15 the following purposes only:

16 _____.

17 _____

18 (date) (signature of survivor)

19 _____

20 (address of survivor)

21 **Sec. 13.52.200. Routine inquiry and required request; search and**
22 **notification.** (a) On or before admission to a hospital, or as soon as possible after
23 admission, a person designated by the hospital shall ask each patient who is at least 18
24 years of age: "Are you an organ or tissue donor?" If the answer is affirmative, the
25 person shall request a copy of the document of gift. If the answer is negative or there
26 is no answer and the attending physician consents, the person designated shall discuss
27 with the patient the option to make or refuse to make an anatomical gift. The answer
28 to the question, an available copy of any document of gift or refusal to make an
29 anatomical gift, and any other relevant information, shall be placed in the patient's
30 medical record.

31 (b) If, at or near the time of death of a patient, there is no medical record that

1 the patient has made or refused to make an anatomical gift, the hospital administrator
2 or a representative designated by the administrator shall discuss the option to make or
3 refuse to make an anatomical gift with the family of the patient and request the making
4 of an anatomical gift under AS 13.52.180(a). The request must be made with
5 reasonable discretion and sensitivity to the circumstances of the family. A request is
6 not required if the gift is not suitable, based upon accepted medical standards, for a
7 purpose specified in AS 13.52.210. An entry shall be made in the medical record of
8 the patient, stating the name and affiliation of the individual making the request, and
9 of the name, response, and relationship to the patient of the person to whom the
10 request was made. The commissioner of health and social services shall adopt
11 regulations to implement this subsection.

12 (c) The following persons shall make a reasonable search for a document of
13 gift or other information identifying the bearer as a donor or as an individual who has
14 refused to make an anatomical gift:

15 (1) a law enforcement officer, fire fighter, paramedic, or other
16 emergency rescuer finding an individual who the searcher believes is dead or near
17 death; and

18 (2) a hospital, upon the admission of an individual at or near the time
19 of death, if there is not immediately available any other source of that information.

20 (d) If a document of gift or evidence of refusal to make an anatomical gift is
21 located by the search required by (c)(1) of this section, and the individual or body to
22 whom it relates is taken to a hospital, the hospital must be notified of the contents, and
23 the document or other evidence must be sent to the hospital.

24 (e) If, at or near the time of death of a patient, a hospital knows that an
25 anatomical gift has been made under AS 13.52.170 or 13.52.180(a), or that a patient or
26 an individual identified as in transit to the hospital is a donee, the hospital shall notify
27 the donee if one is named and known to the hospital; if not, the hospital shall notify an
28 appropriate procurement organization. The hospital shall cooperate in the
29 implementation of the anatomical gift or release and removal of a part.

30 (f) Notwithstanding AS 13.52.090, a person who fails to discharge the duties
31 imposed by this section is not subject to criminal or civil liability but is subject to

1 appropriate administrative sanctions.

2 **Sec. 13.52.210. Persons who may become donees; purposes for which**
3 **anatomical gifts may be made.** (a) The following persons may become donees of
4 anatomical gifts for the purposes stated:

5 (1) a hospital, physician, surgeon, or procurement organization for
6 transplantation, therapy, medical or dental education, research, or advancement of
7 medical or dental science;

8 (2) an accredited medical or dental school, college, or university for
9 education, research, or advancement of medical or dental science; or

10 (3) a designated individual for transplantation or therapy needed by
11 that individual.

12 (b) An anatomical gift may be made to a designated donee or without
13 designating a donee. If a donee is not designated or if the donee is not available or
14 rejects the anatomical gift, the anatomical gift may be accepted by any hospital.

15 (c) If the donee knows of the decedent's refusal or contrary indications to
16 make an anatomical gift or that an anatomical gift by a member of a class having
17 priority to act is opposed by a member of the same class or a prior class under
18 AS 13.52.180(a), the donee may not accept the anatomical gift.

19 **Sec. 13.52.220. Delivery of document of gift.** (a) Delivery of a document of
20 gift during the donor's lifetime is not required for the validity of an anatomical gift.

21 (b) If an anatomical gift is made to a designated donee, the document of gift,
22 or a copy, may be delivered to the donee to expedite the appropriate procedures after
23 death. The document of gift, or a copy, may be deposited in any hospital, procurement
24 organization, or registry office that accepts it for safekeeping or for facilitation of
25 procedures after death. On request of an interested person, upon or after the donor's
26 death, the person in possession shall allow the interested person to examine or copy
27 the document of gift.

28 **Sec. 13.52.230. Rights and duties at death.** (a) Rights of a donee created by
29 an anatomical gift are superior to rights of others except with respect to autopsies
30 under AS 13.52.260(b). A donee may accept or reject an anatomical gift. If a donee
31 accepts an anatomical gift of an entire body, the donee, subject to the terms of the gift,

1 may allow embalming and use of the body in funeral services. If the gift is of a part of
2 a body, the donee, upon the death of the donor and before embalming, shall cause the
3 part to be removed without unnecessary mutilation. After removal of the part, custody
4 of the remainder of the body vests in the person under obligation to dispose of the
5 body.

6 (b) The time of death of a donor must be determined by a physician or surgeon
7 who attends the donor at death or, if none, the physician or surgeon who certifies the
8 death. Neither the physician or surgeon who attends the donor at death nor the
9 physician or surgeon who determines the time of death may participate in the
10 procedures for removing or transplanting a part unless the document of gift designates
11 a particular physician or surgeon under AS 13.52.170(d).

12 (c) If there has been an anatomical gift, a technician may remove any donated
13 parts and an enucleator may remove any donated eyes or parts of eyes, after
14 determination of death by a physician or surgeon.

15 **Sec. 13.52.240. Coordination of procurement and use.** Each hospital in this
16 state, after consultation with other hospitals and procurement organizations, shall
17 establish agreements or affiliations for coordination of procurement and use of human
18 bodies and parts.

19 **Sec. 13.52.250. Sale or purchase of parts prohibited.** (a) A person may not
20 knowingly, for valuable consideration, purchase or sell a part for transplantation or
21 therapy if removal of the part is intended to occur after the death of the decedent.

22 (b) Valuable consideration does not include reasonable payment for the
23 removal, processing, disposal, preservation, quality control, storage, transportation, or
24 implantation of a part.

25 (c) A person who violates this section is guilty of a class C felony.

26 **Sec. 13.52.260. Examination, autopsy, liability.** (a) An anatomical gift
27 authorizes any reasonable examination necessary to assure medical acceptability of the
28 gift for the purposes intended.

29 (b) The provisions of AS 13.52.170 - 13.52.280 are subject to the autopsy
30 provisions of AS 12.65.

31 (c) A hospital, physician, surgeon, coroner, medical examiner, local public

1 health officer, enucleator, technician, or other person who acts in accordance with
2 AS 13.52.170 - 13.52.280 or with the applicable anatomical gift law of another state or
3 attempts in good faith to act in accordance with AS 13.52.170 - 13.52.280 or with the
4 applicable anatomical gift law of another state is not liable for that act in a civil action
5 or criminal proceeding.

6 (d) An individual who makes an anatomical gift under AS 13.52.170 or
7 13.52.180 and the individual's estate are not liable for any injury or damage that may
8 result from the making or the use of the anatomical gift.

9 **Sec. 13.52.270. Applicability provisions.** AS 13.52.170 - 13.52.280 apply to
10 a document of gift, revocation, or refusal to make an anatomical gift signed by the
11 donor or a person authorized to make or object to making an anatomical gift before,
12 on, or after the effective date of this bill section.

13 **Sec. 13.52.280. Uniformity of application and construction.** AS 13.52.170
14 - 13.52.280 shall be applied and construed to carry out their general purpose to make
15 uniform the law with respect to the subject of AS 13.52.170 - 13.52.280 among states
16 enacting these provisions.

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

23 ADVANCE HEALTH CARE DIRECTIVE

24 Explanation

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

1 contains the substance of this form or otherwise complies with the
2 requirements of AS 13.52.

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

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

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

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

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

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

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

29 Part 2 of this form lets you give specific instructions for your
30 end-of-life health care to the extent allowed by law. Choices are
31 provided for you to express your wishes regarding the provision,

1 withholding, or withdrawal of treatment to keep you alive, including
 2 the provision of artificial nutrition and hydration, as well as the
 3 provision of pain relief medication. Space is provided for you to add to
 4 the choices you have made or for you to write out any additional
 5 wishes.

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

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

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

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

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

25 PART 1

26 DURABLE POWER OF ATTORNEY FOR
 27 HEALTH CARE DECISIONS

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

30 _____

31 (name of individual you choose as agent)

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(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.)

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

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

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

25 PART 2

26 INSTRUCTIONS FOR HEALTH CARE

27 If you are satisfied to allow your agent to determine what is best
28 for you in making health care decisions, you do not need to fill out this
29 part of the form. If you do fill out this part of the form, you may strike
30 any wording you do not want. There is a state protocol that governs the
31 use of do not resuscitate orders by physicians and other health care

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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

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(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

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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: _____

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(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

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(OPTIGNAL)

(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

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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)

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

ALTERNATIVE NO. 2

State of Alaska

_____ Judicial District

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

(insert name of notary public) appeared

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

Notary Seal

(signature of notary public)

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

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

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

(3) "anatomical gift" means an individual instruction that makes a donation of all or a part of an individual's body to take effect upon or after death;

(4) "artificial nutrition and hydration" means medically appropriate nutrition and hydration delivered

(A) through an intravenous needle placed directly in a vein;

(B) by a tube that is inserted into a functioning gastrointestinal tract; or

(C) through a catheter inserted in a large vein where there is greater blood flow to dissolve the nutrients;

(5) "best interest" means that the benefits to the individual resulting

1 from a treatment outweigh the burdens to the individual resulting from that treatment
2 and includes

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

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

7 (C) the degree to which the individual's medical condition, the
8 treatment, or the withholding or withdrawal of treatment, results in a severe
9 and continuing impairment;

10 (D) the effect of the treatment on the life expectancy of the
11 patient;

12 (E) the prognosis of the patient for recovery, with and without
13 the treatment;

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

16 (G) the religious beliefs and basic values of the individual
17 receiving treatment, to the extent that these may assist in determining benefits
18 and burdens;

19 (6) "capacity" means an individual's ability to understand the
20 significant benefits, risks, and alternatives to proposed health care and to make and
21 communicate a health care decision;

22 (7) "cardiopulmonary resuscitation" means cardiopulmonary
23 resuscitation or a component of cardiopulmonary resuscitation;

24 (8) "decedent" means a deceased individual, including a stillborn
25 infant, or dead fetus;

26 (9) "department" means the Department of Health and Social Services;

27 (10) "document of gift" means a card, a statement attached to or
28 imprinted on a driver's license, a will, an advance health care directive under
29 AS 13.52.300, or another writing used to make an anatomical gift;

30 (11) "donor" means an individual who makes an anatomical gift;

31 (12) "do not resuscitate identification" means an identification card,

1 form, necklace, or bracelet that carries the standardized design or symbol developed
2 by the department under AS 13.52.060 to signify, when carried or worn, that the
3 carrier or wearer is an individual for whom a physician has issued a do not resuscitate
4 order;

5 (13) "do not resuscitate order" means a directive from a licensed
6 physician that emergency cardiopulmonary resuscitation should not be administered to
7 a qualified patient;

8 (14) "emancipated minor" means a minor whose disabilities have been
9 removed under AS 09.55.590 or who has arrived at the age of majority as determined
10 under AS 25.20.020;

11 (15) "enucleator" means an individual who is licensed or certified by
12 the State Medical Board, by another state agency, by a professional peer group
13 organization, by a procurement organization, or by a hospital to remove or process
14 eyes or parts of eyes;

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

17 (17) "guardian" means a judicially appointed person having authority
18 to make a health care decision for an individual;

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

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

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

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

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

1 institutions; and

2 (D) the administration or withdrawal of psychotropic
3 medications, the use of electroconvulsive treatment, and the admission to a
4 mental health facility;

5 (E) making an anatomical gift at death;

6 (20) "health care institution" means an institution, facility, or agency
7 licensed, certified, or otherwise authorized or permitted by law to provide health care
8 in the ordinary course of business;

9 (21) "health care provider" means an individual licensed, certified, or
10 otherwise authorized or permitted by law to provide health care in the ordinary course
11 of business or practice of a profession;

12 (22) "hospital" means

13 (A) a facility licensed, accredited, or approved as a hospital
14 under the laws of a state; or

15 (B) a facility operated as a hospital by the United States
16 government, a state, or a subdivision of a state;

17 (23) "individual instruction" means an individual's direction
18 concerning a health care decision for the individual;

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

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

24 (26) "mental health treatment" means electroconvulsive treatment,
25 treatment with psychotropic medication, or admission to and retention in a health care
26 facility for mental health treatment;

27 (27) "part" means an organ, tissue, an eye, a bone, an artery, blood,
28 fluid, or another portion of a human body;

29 (28) "person" means an individual, corporation, business trust, estate,
30 trust, partnership, joint venture, association, government, governmental subdivision,
31 governmental agency, or another legal or commercial entity;

1 (29) "physician" or "surgeon" means an individual licensed or
2 otherwise authorized to practice medicine and surgery or osteopathy and surgery under
3 the laws of any state;

4 (30) "power of attorney for health care" means the designation of an
5 agent to make health care decisions for the individual granting the power;

6 (31) "primary physician" means a physician designated by an
7 individual, or by the individual's agent, guardian, or surrogate, to have primary
8 responsibility for the individual's health care or, in the absence of a designation or if
9 the designated physician is not reasonably available, a physician who undertakes the
10 responsibility;

11 (32) "procurement organization" means a person licensed, accredited,
12 or approved under the laws of a state for procurement, distribution, or storage of
13 human bodies or parts;

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

20 (34) "reasonably available" means able to be contacted with a level of
21 diligence appropriate to the seriousness and urgency of a patient's health care needs,
22 and willing and able to act in a timely manner considering the urgency of the patient's
23 health care needs;

24 (35) "state" means a state, territory, or possession of the United States,
25 the District of Columbia, or the Commonwealth of Puerto Rico;

26 (36) "supervising health care provider" means the primary physician or
27 the physician's designee, or the health care provider or the provider's designee who has
28 undertaken primary responsibility for an individual's health care;

29 (37) "surrogate" means an individual, other than a patient's agent or
30 guardian, authorized under this chapter to make a health care decision for the patient;

31 (38) "technician" means an individual who is licensed or certified by

1 the State Medical Board to remove or process a part.

2 **Sec. 13.52.395. Short title.** This chapter may be cited as the Health Care
3 Decisions Act.

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

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

20 (b) An employee of the department who processes an identification card
21 application, other than an application received by mail, shall ask the applicant orally
22 whether the applicant wishes to execute an anatomical gift [OR A LIVING WILL].
23 The department shall, by placement of posters and brochures in the office where the
24 application is taken, and by oral advice, if requested, make known to the applicant the
25 procedure necessary to execute an anatomical [A] gift under AS 13.52 [AS 13.50 OR
26 A LIVING WILL UNDER AS 18.12].

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

28 (c) An employee of the department who processes an application for
29 registration or renewal of registration, other than an application received by mail or an
30 application for registration under AS 28.10.152, shall ask the applicant orally whether
31 the applicant wishes to execute an anatomical gift [OR A LIVING WILL]. The

1 department shall make known to all applicants the procedure for executing an
2 anatomical [A] gift under AS 13.52 (Health Care Decisions Act) [AS 13.50
3 (UNIFORM ANATOMICAL GIFTS ACT) OR A LIVING WILL UNDER AS 18.12
4 (LIVING WILLS AND DO NOT RESUSCITATE ORDERS)] by displaying posters
5 in the offices in which applications are taken, by providing a brochure or other written
6 information to each person who applies in person or by mail, and, if requested, by
7 providing oral advice.

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

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

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

20 (b) The department shall provide, at the time that an operator's license is
21 issued, a form for a document by which the owner of a license may make an
22 anatomical gift under AS 13.52 [AS 13.50 OR A LIVING WILL UNDER AS 18.12].
23 The document (1) may not be larger than an operator's license, (2) must contain
24 sufficient space for the signature of two witnesses [OR A PERSON WHO IS
25 QUALIFIED TO TAKE ACKNOWLEDGMENTS UNDER AS 09.63.010], and (3)
26 [MUST USE THE FORMS AND DESIGNS DEVELOPED UNDER AS 18.12.037,
27 AND (4)] must provide a means by which the owner may cancel the anatomical gift
28 [OR THE LIVING WILL]. If the document is executed by the applicant, it shall be
29 sealed in plastic and attached to the license. [A SYMBOL DEVELOPED UNDER
30 AS 18.12.037 INDICATING THE EXISTENCE OF THE ANATOMICAL GIFT OR
31 LIVING WILL DOCUMENT MUST BE DISPLAYED IN THE LOWER RIGHT-

1 HAND CORNER ON THE FACE OF THE DRIVER'S LICENSE.]

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

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

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

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

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

27 (f) A patient capable of giving informed consent has the absolute right to
28 accept or refuse electroconvulsive therapy or aversive conditioning. A patient who
29 lacks substantial capacity to make this decision may not be given this therapy or
30 conditioning without a court order unless the patient expressly authorized that
31 particular form of treatment in an advance health care directive [A

1 DECLARATION] properly executed under AS 13.52 [AS 47.30.950 - 47.30.980] or
2 has authorized an agent or surrogate under AS 13.52 [ATTORNEY-IN-FACT] to
3 make this decision and the agent or surrogate [ATTORNEY-IN-FACT] consents to
4 the treatment on behalf of the patient.

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

6 **Sec. 47.30.836. Psychotropic medication in nonemergency.** An evaluation
7 facility or designated treatment facility may not administer psychotropic medication to
8 a patient in a situation that does not involve a crisis under AS 47.30.838(a)(1) unless
9 the patient

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

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

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

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

22 (d) An evaluation facility or designated treatment facility may administer
23 psychotropic medication to a patient without the patient's informed consent if the
24 patient is unable to give informed consent but has authorized the use of psychotropic
25 medication in an advance health care directive [A DECLARATION] properly
26 executed under AS 13.52 [AS 47.30.950 - 47.30.980] or has authorized an agent or
27 surrogate under AS 13.52 [ATTORNEY-IN-FACT] to consent to this form of
28 treatment for the patient and the agent or surrogate [ATTORNEY-IN-FACT] does
29 consent.

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

31 (d) Upon the filing of a petition under (b) of this section, the court shall direct

1 the office of public advocacy to provide a visitor to assist the court in investigating the
2 issue of whether the patient has the capacity to give or withhold informed consent to
3 the administration of psychotropic medication. The visitor shall gather pertinent
4 information and present it to the court in written or oral form at the hearing. The
5 information must include documentation of the following:

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

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

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

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

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

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

22 (3) a statement of what actions, if any, the resident's representative is
23 authorized to take on the resident's behalf;

24 (4) a copy of the resident's assisted living plan;

25 (5) a copy of the residential services contract between the home and
26 the resident;

27 (6) a notice, as required under AS 47.33.030, regarding the depository
28 in which the resident's advance payment money is being held;

29 (7) written acknowledgment [ACKNOWLEDGEMENT] by the
30 resident or the resident's representative that the resident has received a copy of and has
31 read, or has been read the

- 1 (A) resident's rights under AS 47.33.300;
- 2 (B) resident's right to pursue a grievance under AS 47.33.340;
- 3 (C) resident's right to protection from retaliation under
- 4 AS 47.33.350;
- 5 (D) provisions of AS 47.33.510, regarding immunity; and
- 6 (E) home's house rules;
- 7 (8) an acknowledgment [ACKNOWLEDGEMENT] and agreement
- 8 relating to home safekeeping and management of the resident's money, as required by
- 9 AS 47.33.040;
- 10 (9) a copy of the resident's living will, if any, or an advance health
- 11 care directive made under AS 13.52, if any; and
- 12 (10) a copy of a power of attorney or other written designation,
- 13 including an advance health care directive made under AS 13.52, of an agent,
- 14 representative, or surrogate by the resident.

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

16 13.50.016, 13.50.020, 13.50.030, 13.50.040, 13.50.050, 13.50.060, 13.50.065, 13.50.068,

17 13.50.070, 13.50.080, 13.50.090; AS 18.12.010, 18.12.020, 18.12.030, 18.12.035, 18.12.037,

18 18.12.040, 18.12.050, 18.12.060, 18.12.070, 18.12.080, 18.12.090, 18.12.100; AS 47.30.950,

19 47.30.952, 47.30.954, 47.30.956, 47.30.958, 47.30.960, 47.30.962, 47.30.964, 47.30.966,

20 47.30.968, 47.30.970, 47.30.972, and 47.30.980 are repealed.

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

22 read:

23 CONTINUING EFFECT OF EXISTING DOCUMENTS. (a) An anatomical gift

24 made under AS 13.50 or AS 18.12, repealed by sec. 15 of this Act, before the effective date of

25 secs. 1 - 15 of this Act continues in effect under AS 13.50 or AS 18.12, as those chapters exist

26 before the effective date of secs. 1 - 15 of this Act, until the donation is revoked.

27 (b) A power of attorney that is made under AS 13.26.332(L), 13.26.335(1), or

28 13.26.344(I), repealed by sec. 15 of this Act, before the effective date of secs. 1 - 15 of this

29 Act and that contains authority for health care services under AS 13.26.332(L),

30 AS 13.26.335(1), or 13.26.344(I), repealed by sec. 15 of this Act, continues in effect under

31 AS 13.26.332(L), 13.26.335(1), and 13.26.344(I), as those provisions exist before the

1 effective date of secs. 1 - 15 of this Act, until the power of attorney is revoked.

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

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

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

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

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

16 TRANSITION: REGULATIONS. The Department of Health and Social Services
17 may proceed to adopt regulations necessary to implement the changes made by secs. 1 - 15 of
18 this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not
19 before January 1, 2005.

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

22 CONTINUING EFFECT OF CURRENT REGULATIONS. (a) The regulations
23 found at 7 AAC 16, as modified by (b) of this section, continue in effect on and after
24 January 1, 2005, until the Department of Health and Social Services adopts the regulations
25 authorized under sec. 18 of this Act.

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

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

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

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

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

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

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

6 * Sec. 21. Except as provided in sec. 20 of this Act, this Act takes effect January 1, 2005.

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: F 30025CS(JUD)-DHSS-DPH-01-21-04
() Publish Date: _____

Revision Date/Time (Note if correction): 1/20/2004 Dept. Affected: Health & Social Services

Title: HEALTH CARE DECISIONS/DO NOT RESUSCITATE ORDERS/DONATION OF BODY PARTS Public Health

Component: Community Health/EMS Services

Sponsor: WEYRAUCH

Requester: _____ Component No. 2078

Expenditures/Revenues (Thousands of Dollars)

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

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

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2004) cost: _____

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: Doug A. Bruce
Division: Public Health
Approved by: Joel S. Gilbertson, Commissioner
Agency: Department of Health and Social Services

Phone 465-3090
Date/Time 01/20/2004
Date 01/21/2004