ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES
STANDING COMMITTEE
February 13, 2003
3:07 p.m.

MEMBERS PRESENT

Representative Peggy Wilson, Chair
Representative Carl Gatto, Vice Chair
Representative Cheryll Heinze
Representative Paul Seaton
Representative Kelly Wolf
Representative Sharon Cissna

MEMBERS ABSENT

Representative Mary Kapsner

COMMITTEE CALENDAR

HOUSE BILL NO. 25
"An Act relating to health care decisions, including do not resuscitate orders and the donation of body parts, and to powers of attorney relating to health care, including the donation of body parts; and providing for an effective date."

- HEARD & HELD

HOUSE BILL NO. 51
"An Act requiring pharmacists to include generic drug information on containers in which brand-name prescription drug orders are dispensed."

- MOVED CSHB 51(HES) OUT OF COMMITTEE

PREVIOUS ACTION

BILL: HB 25
SHORT TITLE:HEALTH CARE SERVICES DIRECTIVES
SPONSOR(S): REPRESENTATIVE(S)WEYHRAUCH

Jrn-Date	Jrn-Page		Action
01/21/03	0038	(H)	PREFILE RELEASED (1/10/03)
01/21/03	0038	(H)	READ THE FIRST TIME - REFERRALS
01/21/03	0038	(H)	HES, JUD, FIN

01/21/03	0038	(H)	REFERRED TO HES
02/13/03		(H)	HES AT 3:00 PM CAPITOL 106

BILL: HB 51
SHORT TITLE:LABELING OF PRESCRIBED DRUGS
SPONSOR(S): REPRESENTATIVE(S)SEATON

Jrn-Date	Jrn-Page		Action
01/21/03	0045	(H)	PREFILE RELEASED (1/17/03)
01/21/03	0045	(H)	READ THE FIRST TIME - REFERRALS
01/21/03	0045	(H)	HES, L&C
01/24/03	0065	(H)	COSPONSOR(S): MEYER
01/27/03	0079	(H)	COSPONSOR(S): GARA
02/10/03	0173	(H)	COSPONSOR(S): CROFT
02/13/03		(H)	HES AT 3:00 PM CAPITOL 106

WITNESS REGISTER

REPRESENTATIVE BRUCE WEYHRAUCH
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: As sponsor of HB 25, testified on the purpose of the bill and answered questions from the members.

MARIA WALLINGTON, M.D.
Providence Health System
Anchorage, Alaska
POSITION STATEMENT: Testified in support of HB 25, recommended minor changes in the bill, and answered questions from the members.

PAUL MALLEY, President
Aging with Dignity
Tallahassee, Florida
POSITION STATEMENT: Testified in support of HB 25 and provided the committee with information about Five Wishes.

MARK JOHNSON, Chief
Community Health and Emergency Medical Services
Division of Public Health
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Testified in support of HB 25.

MARIE DARLIN, Coordinator
Capitol City Task Force

AARP
Juneau, Alaska
POSITION STATEMENT: Testified in support of HB 25.

ACTION NARRATIVE

TAPE 03-13, SIDE A
Number 0001

CHAIR PEGGY WILSON called the House Health, Education and Social Services Standing Committee meeting to order at 3:07 p.m. Representatives Wilson, Gatto, Heinze, and Seaton were present at the call to order. Representatives Wolf and Cissna arrived as the meeting was in progress.

HB 25-HEALTH CARE SERVICES DIRECTIVES

Number 0051

CHAIR WILSON opened the hearing on HOUSE BILL NO. 25, "An Act relating to health care decisions, including do not resuscitate orders and the donation of body parts, and to powers of attorney relating to health care, including the donation of body parts; and providing for an effective date." Chair Wilson said the committee will hear testimony on the bill today, and take questions on the bill next week.

Number 0132

REPRESENTATIVE BRUCE WEYHRAUCH, Alaska State Legislature, sponsor, told the committee that HB 25, on health care directives, is a bill that was passed by the House last year. He noted that Representatives Cissna, Kapsner, and Wilson worked on that bill, and he wants the committee to know that HB 25 is identical to that legislation. He said he is glad that there are a number of people present to testify because it will give the new members of the committee an opportunity to understand the purpose of the bill.

Number 0229

REPRESENTATIVE WEYHRAUCH shared personal reasons for wanting to see this legislation pass. He said his father passed away recently, and health care directives were a significant part of end-of-life decisions that his mother, along with her seven children, had to make on behalf of his father. He told the committee that as an attorney, he believes no matter what a lawyer does to make end-of-life decisions clean, neat, and legal, it never quite works that way. Anyone who has had to deal with death and dying knows that the decisions never are quite as clear as one would like.

Number 0277

REPRESENTATIVE WEYHRAUCH said he believes it is very important to do whatever can be done to make the end-of-life a time when dying people are surrounded by love. It should be a time when the family is there to nurture them, to show they care for them, and want their life to be as good as possible in that situation. The last thing families need is to be faced with a lot of stressful decisions on what someone they love may or may not want to do at the end-of-life phases. Representative Weyhrauch said the nightmare end-of-life existence his father had made him realize that there are some things worse in life than death.

Number 0336

REPRESENTATIVE WEYHRAUCH explained that the bill offers a comprehensive, simplified alternative in making end-of-life decisions. He said he was asked to sponsor this bill by individuals he respects who deal with end-of-life issues, senior issues, care issues, nursing issues, and medical issues. These people have been deeply touched by end-of-life experiences and want to see an expansion of options for people who want to prepare themselves for when they can no longer speak or act on their own behalf.

Number 0535

REPRESENTATIVE WEYHRAUCH explained that this bill puts all of these legal issues under one title. He mentioned an analogy that might help in understanding the purpose of this bill. He asked members to think of the frustrations many feel when trying to do something that requires going from one agency to another, one building to another, and one city to another to meet the requirements of a permit. Representative Weyhrauch said this kind of frustration has led to discussions in the legislature about streamlining the permitting process.

REPRESENTATIVE WEYHRAUCH said this bill would bring under one chapter the kinds of end-of-life decisions people have to make. It is a way to make it as easy as possible for the public at a time that is the most stressful, critical phase of life. This bill would address the organ donor program, DNR [do not resuscitate] program or comfort program, living will program, and health care durable power of attorney. While this allows people to make a statement at the end-of-life, it also serves as a guiding protocol in the case of an accident when emergency medical technicians are called. The bill takes all the current provisions related to end-of-life, and puts them in a critical one-stop look for these kinds of decisions. Representative Weyhrauch said he would be available to the committee should they require any additional information before the next meeting.

Number 0629

REPRESENTATIVE GATTO asked about the sectional analysis, page 3, section 13.52.050(a). He asked about the wording "to promptly communicate a health care decision to the patient." His concern is the ability to do that. If a patient is unresponsive, it is not possible to do that. Representative Gatto asked for clarification on this.

Number 0779

CHAIR WILSON offered her experience as a nurse. One of the first things that a hospital tries to do as an individual is admitted into the hospital is to communicate with the patient on preferences for medical treatment. The problem is that while all hospitals have to do that, they probably do it differently.

Number 0817

REPRESENTATIVE WEYHRAUCH responded that the bill says "if possible." The law is intended to be read in a commonsense way. He said it is absolutely absurd to communicate with an unconscious person. If a health care directive has been made for a patient, and the patient is unable to communicate, then the intent is to communicate with someone who can be trusted with fiduciary duty in watching over the patient's interest. If the patient has fulfilled some sort of health care directive in advance, then that directive is there for the health care professionals.

Number 0876

REPRESENTATIVE GATTO suggested that the language "when possible" be inserted [Sec. 13.52.050(a)] as a simple fix in the language to make this as clear as possible.

Number 0930

REPRESENTATIVE WEYHRAUCH said that in the bill [page 6, line 4] it says "if possible."

REPRESENTATIVE GATTO responded that "if" is fine and he sees no reason to change the language.

Number 0962

REPRESENTATIVE CISSNA asked about merging a number of departmental regulations or provisions under this bill. If so, she asked, what are those changes?

Number 1029

REPRESENTATIVE WEYHRAUCH explained that when he referred to "department" it was in an analogous situation in referring to permitting when someone may be frustrated because of having to get one permit from one department, another agency, and another town. He said there was no intent in his reference to that to imply that somehow there are multiple departments involved in this legislation. What this bill is intended to do is to bring together under one statute the end-of-life health care decisions. He reiterated that the intent and language is the same as last year's bill.

Number 1084

REPRESENTATIVE CISSNA asked what are the changes and additions to existing law.

Number 1116

REPRESENTATIVE WEYHRAUCH said it takes current provisions related to the end-of-life and puts them in one chapter. Among those decisions are the organ donor program, living will program, "Comfort One" program or DNR program, and the expanded health care durable power of attorney.

Number 1157

REPRESENTATIVE CISSNA asked if there are actually specific changes to existing law.

Number 1165

REPRESENTATIVE WEYHRAUCH said in order to meet the chair's schedule, he will provide the committee with a list of what the law is now and what the law will be.

Number 1209

REPRESENTATIVE HEINZE asked about page 7, lines 1 through 4, where it talks about a health care provider's declining to comply with an individual instructions. She inquired about Jehovah's Witnesses who will not accept blood transfusions.

REPRESENTATIVE WEYHRAUCH responded that it is an individual decision on the part of a patient and a health care provider. If an institution does not want to comply with an individual's health care instruction that requires a medically ineffective decision, for example, the provider is not forced to comply. If a Jehovah's Witness or Christian Science believer who just wants to live life without medical intervention is not in agreement with treatment options, then he or she might not be in the right facility. The patient may need to go somewhere else where the kind of care that person wants is available, such as home care or a hospice facility.

Number 1249

REPRESENTATIVE HEINZE asked Representative Weyhrauch to clarify whether the health care provider may decline to follow the instructions of a patient. For example, if the child of a Jehovah's Witness came into a facility and was dying, but a transfusion would save the child, then the provider does have the right to override the wishes of the patient.

Number 1256

REPRESENTATIVE WEYHRAUCH responded that health care institutions may decline to comply with an instruction or direction on a decision that someone else has made.

Number 1311

MARIA WALLINGTON, M.D., Providence Health System, read the following statement regarding HB 25:

> I am a physician who practiced pediatric cardiology and pediatric intensive care here in Anchorage for 20 years. Three years ago I completed a Master's in Ethics and began working for the Providence Health

System in Alaska as their medical ethicist. One of my duties is to help patients, families, and health care providers who are faced with challenging decisions at the end-of-life. In this capacity I have encountered families and physicians whose efforts to do the right thing for patients has been complicated by lack of clear, unambiguous, supportive laws.

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

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

1. To recommend a single, comprehensive advance directive, which reduces confusion. Currently, the power of attorney [POA] and living will laws are not connected in any way.

2. Avoid mandatory forms or language for medical powers of attorney or combined living wills/medical powers of attorney, giving residents the freedom to express their wishes in their own way. Current POA forms are complex and difficult.

3. Give precedence to the agent's authority or most recent directive over the living will, recognizing that an agent has the advantage of being able to weigh all the facts and medical opinions in light of the

patient's wishes at the time a decision needs to be made.

4. Authorize default surrogates - typically, next of kin - to make health care decisions, including decisions about life support if the patient has not named someone. No current support in Alaska law [exists] for surrogates.

5. Include "close friend" in the list of permissible default surrogates, recognizing that family in today's world often extends beyond the nuclear family. Currently no clear statement for decisionmaking.

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

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

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

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

Number 1444

DR. WALLINGTON continued:

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

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

Number 1502

The second issue is a little more complex. On the bottom of page 4, top of page 5 under "decisions by surrogate" a class of surrogates and all classes with less priority are disqualified from making a decision if there are an even number of members in that class

> and they are evenly divided on a decision. For instance, consider an elderly widow who has had a stroke, cannot communicate, and needs decisions made for her on where she will be cared for long term. She has two adult children who cannot agree despite the best efforts of the health care professional to get agreement. Who makes the decision? After giving us surrogates, this section takes them away again and does not give any guidance for what the health care provider can do. Please consider authorizing the primary physician to break the tie by siding with the surrogate who, in his/her professional judgment, is acting in the best interest of the patient.
>
> One of the most challenging duties anyone can ever be called on to undertake is to make difficult medical decisions for another person. One of the best gifts we can give those who shoulder this burden on our behalf is having in place a good, informative advance health care directive. HB 25 will allow individuals to do this job of preparing for these end-of-life challenges better and will help health care providers better serve patients and their families when these challenges occur.
>
> In conclusion, as a medical professional who daily experience the reality of life and death, as an ethicist, and as a representative of Providence Health System in Alaska, I urge that you help all Alaskans who will someday face difficult health care decisions by supporting HB 25. Thank you for your attention.

CHAIR WILSON thanked Dr. Wallington and told her the committee would take her comments into consideration.

Number 1580

PAUL MALLEY, President, Aging with Dignity, testified in support of HB 25 and provided the committee with background information about the organization and the development of the "Five Wishes" advance directive [a legal document]. He told the committee that his is a private nonprofit organization that works nationally. He told the committee the group was founded by Jim Towey in 1986. When Mr. Towey was appointed by President Bush to direct the Office of Faith-Based and Community Initiatives, he was asked to serve as president of the organization. Mr. Towey developed this document called "Five Wishes," which is circulating all over the country in all 50 states; 5,000 organizations have distributed over 2,000,000 copies to individuals.

Number 1628

MR. MALLEY said Mr. Towey wrote Five Wishes based primarily on his experiences in working with Mother Teresa in Calcutta, India. He was her legal counsel for twelve years and also worked in her homes for the dying in India, Mexico, and Washington, D.C. He saw how people were cared for at the end-of-life, where their full needs were met, not just their medical needs. During their last moments of life, they had people by their side holding their hand and praying for them if that is what they wanted. He contrasted that with the way he saw people dying in America, where they are often hooked up to tubes and machines, when they would rather not be. Many are dying and being treated as if it were purely another medical moment, when it is so much more. Mr. Towey wrote Five Wishes as a way for people to put down in writing and communicate with their families what is important to them.

Number 1664

MR. MALLEY told the committee there were three goals that his organization had in mind when writing this document. First, the organization wanted to make it easy to understand so that people could fill it out in their living rooms and not have to wait until they go to a hospital or go to an attorney to do it. It includes more than just the medical issues, because in all the national research that has been done when people are asked what is important to them at the end-of-life, the most common response is, "I want to be in my home, and I want my family to be with me," for example. So that is important when talking about advanced-care planning. The third thing the organization wanted to facilitate is communication. It was important to help people talk with their families and there health care providers to make sure that all the questions are answered, that they know what kind of care that individual would want. "We" have 5,000 organizations that are distributing Five Wishes. These groups include hospices, hospitals, and work places that are giving it to their employees, such as, the U.S. Department of State, the U.S. Department of Justice, the U.S. Food and Drug Administration.

Number 1715

MR. MALLEY said in Florida, Governor Bush has been a big supporter of the organization's work and is actually giving copies of Five Wishes to every state employee. When Five Wishes was developed the organization got the support of the Robert Wood Johnson Foundation and had legal counsel from the American Bar Association. The organization wanted it to be a legally valid document in as many states as possible. He told the committee that today it is valid in 35 states, according to the American Bar Association. That count does not include Alaska; hopefully, it will by the end of the year. The reason it is not legal is due to the mandatory form requirement and the Alaska durable power of attorney for health care. Alaska's current statute requires that residents of Alaska use that form, and that form only. Mr. Malley said he cannot say, without a doubt, that Five Wishes meets the legal requirement, and that is why the work the committee is doing today is so important. This bill will make the statutes more streamlined by putting them all together, and allowing residents to express their own wishes, in their own words, to talk about what is important to them.

Number 1800

MR. MALLEY said he would like to share with the committee something that happened two weeks ago. He met a woman in a small town in New England after he had just given a presentation. She came up to him with a tear in her eye. She told him the story of her husband, who had died a year ago. He had been in a coma for the last 28 days of his life; however, before he went into a coma he filled out his Five Wishes. During the time that he was sick and his family was with him, his Five Wishes were placed on the nightstand beside his bed in the hospital. When the family came in, they did not know what to do, but they picked up his Five Wishes, and knew he wanted to have pictures of his grandkids by him; he wanted his favorite afghan brought in; he wanted his church notified so his pastor would come in and pray with him. This helped them care for their loved one the way he wanted to be. When the 28th day came, and the doctor said it is not likely he will be able to recover, one son refused to allow his dad to be taken off life-support treatment. She said they told him this was your father's decision to make and he made it. She showed him his father's wishes in his father's own writing and his own signature. So the son said if that is what dad wants, that is what should be done. He was able to follow his father's wishes. Beyond that, on wish number 5, the father had wished that his family members would make peace with each other if they could before his death. The woman told him that two of her sons had not spoken for five years, and they spoke on that day, and have been great friends ever since. It is something that would not have happened if this conversation about advanced care had not happened.

MR. MALLEY said in closing, he would like to assist or answer any questions that might be helpful.

Number 1893

REPRESENTATIVE SEATON asked Representative Weyhrauch if passing this law would preempt or make invalid the durable powers of attorney that are currently on file. He asked if he could provide an answer on this issue at the next hearing of the bill.

Number 1930

MARK JOHNSON, Chief, Community Health and Emergency Medical Services, Division of Public Health, Department of Health and Social Services (DHSS), testified in support of HB 25. He said the Department of Health and Social Services' interest in the bill is with section 13.52.060, which is on page 7 of the draft bill and deals with the DNR [do not resuscitate] protocol and identification requirements. He said that DHSS adopted regulations in 1996 based on legislation that was passed in 1994 which mandated that the department do this, and as a result the "Comfort One" program was adopted. He said the Comfort One program procedure identifies and respects the wishes of patients in the out-of-hospital environment who do not want life-saving measures such as CPR [cardiopulmonary resuscitation] performed on them when their breathing and heart stops. He told the committee a Comfort One participant can be identified through the use of an enrollment form, wallet card, and optional bracelet, which are obtained from a physician and serve to alert health care providers that the patient has been issued a valid DNR order and that CPR should not be performed. If the patient has made an anatomical gift and is in the hospital, the DNR order will not take effect until the donated organ can be evaluated to see if it is suitable for donation. This bill is consistent with that procedure and the department is supportive.

Number 2006

MARIE DARLIN, Coordinator, Capitol City Task Force, AARP, testified in support of HB 25. She told the committee she represents [AARP's] 71,000 Alaskan members. She said the task force includes representatives from other senior and retiree organizations who have similar concerns. She asked the committee to review the letter in the bill packet from Alaska AARP in support of HB 25. She said considerable time was spent last year on this health directives legislation. While the bill passed the House, the Senate ran out of time to pass the bill. In a 2002 survey of AARP members in Alaska, health care was listed as one of their top legislative concerns; therefore, this advanced directives legislation is one of AARP's priorities. She urged support of HB 25.

Number 2080

REPRESENTATIVE GATTO asked Ms. Darlin if she has ever met anyone who opposes this legislation or the concept of this legislation.

Number 2090

MS. DARLIN said there were Senators who had questions on some aspects of the bill last year; however, she said she feels that all the questions were answered.

Number 2105

REPRESENTATIVE GATTO asked if she is aware of even one person who is opposed to the concept of the bill.

MS. DARLIN replied not that she can remember.

[HB 25 was held over]

CHAIR WILSON called a brief at ease at 3:50 p.m. She called the committee back to order at 3:52 p.m.

HB 51-LABELING OF PRESCRIBED DRUGS

Number 2127

CHAIR WILSON announced that the next bill the committee will hear is HOUSE BILL NO. 51, "An Act requiring pharmacists to include generic drug information on containers in which brand-name prescription drug orders are dispensed."

Number 2148

REPRESENTATIVE SEATON, sponsor of HB 51, explained that the bill was generated from a public health and safety concern for many people across Alaska, especially senior citizens, who are having trouble with medications labeling. Representative Seaton told the members that prescription medications can be a brand name or generic name, and while the medication itself is the same, it does not have labeling which reflects that. He said that when an individual gets medication filled from a pharmacy and it is filled with a generic medication, the generic name will be on the label. However, most often, if the prescription is filled with a brand name, only the brand name will appear on the label. Representative Seaton told the committee that often individuals are double filling the medication because they do not notice the medications are the same. He said if an individual were only taking one pill with chronic illnesses it would not be as great a problem, but what has happened now is medicines have become much more prolific to treat specific parts of diseases, so people end up taking six, seven, eight, or more medications to treat their conditions.

Number 2230

REPRESENTATIVE SEATON said that he has talked to people who have double dosed their children who have chronic illnesses. He said the bill requires that any prescription that has a brand name must also have the generic name on the label to protect consumers by ensuring they can tell it is the same medicine. He said any brand name would also have the generic name on the label.

Number 2250

REPRESENTATIVE SEATON asked the members to review the letters of support in the bill packet from groups such as AARP, Pioneer Homes' pharmacists, Aetna Insurance Company, senior citizen centers, and many more.

Number 2267

REPRESENTATIVE SEATON pointed out research done by the Legislative Research Services, which found under the Institute for Safe Medicine Practices (ISMP) that 15 percent of reported medication errors are due to confusion because of drug names [found in the Joint Commission on Accreditation of Healthcare Organizations]. Representative Seaton said that according to the U.S. Food and Drug Administration the number of medication errors can be greatly reduced by doing 15 things, and one of those is to provide brand and generic names on all medication labels.

Number 2290

REPRESENTATIVE GATTO asked about the drug labeling print size.

REPRESENTATIVE SEATON said the size of the label is not addressed in the bill. He said the labels used as examples are actual copies of prescription labels. He said whenever the brand name of a medication is used, the generic name would also appear on the label.

TAPE 03-13, SIDE B
Number 2335

REPRESENTATIVE GATTO asked Representative Seaton what "W/F" means?

Number 2328

REPRESENTATIVE SEATON said he does not know.

Number 2321

CHAIR WILSON told the committee Representative Seaton has requested a friendly amendment, to his bill. Chair Wilson read the requested amendment, which said:

> on page 1, line 11, delete the word "below", and add the word "near."

REPRESENTATIVE SEATON spoke to the amendment by saying the reason for this friendly amendment is to accommodate some computer programs that already have a space designated for the generic name when using a brand-name medication. That space may be above, below, or beside the brand name. The intent in the bill is to make sure the consumers have the information, and it is not necessary that it conform to a particular format.

Number 2259

REPRESENTATIVE GATTO moved to adopt the foregoing as Amendment 1. There being no objection, it was so ordered.

Number 2234

REPRESENTATIVE HEINZE moved to report HB 51, as amended, out of committee with individual recommendations and a zero fiscal note. There being no objection, CSHB 51 (HES) was reported from the House Health, Education and Social Services Standing Committee.

ADJOURNMENT

Number 2205

There being no further business before the committee, the Health, Education and Social Services Standing Committee meeting was adjourned at 4:00 p.m.