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3007 Turnagain Street
Anchorage, Alaska 99501
April 5, 1982

Representative Michael F. Beirne
Pouch V MS 3100
Juneau, Alaska 99811

Dear Representatibe Beirne: *855*

I strongly urge passage of HB 854 the Living Will, and I
hope you will support this legislation.

The use of life support systems is a personal matter and
not a decision to be made by a doctor.

I am the captain of my fate . . . I am the master of my
soul."

Sincerely,

Dorothy Z Scott
Dorothy Z Scott

1280 East 17th Avenue
Anchorage, Alaska 99501
April 6, 1982

⁸⁵⁵
Please pass H B 854, the Living Will. This is not a
decision to be made by a doctor.

Sincerely,

Beatrice Emma Huff
Beatrice Emma Huff

SOCIETY FOR THE RIGHT TO DIE 
1981
Handbook

I

Legal Advances: Right to Die Legislation	1
Courts and the Dying Patient	3
Decision Making and the Incompetent Patient	5
Defining Death: 'Brain Death' Laws	6
Religious Attitudes	8

II

Model Bill: Discussion.....	9
Ten Right to Die Laws: Analysis and Comparison.....	10
Statutory Citations	16
Landmarks of the Right to Die Movement	17
Chart Comparing Right to Die Laws	18

III

Texts	
Model Bill	23
Arkansas Act.....	27
California Act	28
Idaho Act	34
Kansas Act	38
Nevada Act	42
New Mexico Act	46
North Carolina Act	50
Oregon Act	55
Texas Act	60
Washington Act.....	65

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*'Bodily decay is gloomy in prospect,
 but of all human contemplations
 the most abhorrent is body without mind.'*

Thomas Jefferson

Medical capabilities to prolong life have increased dramatically in recent years. Artificially extending the lives of the terminally ill when there is no cure in sight can lead to a tragic confrontation between medical technology and the human needs of the dying patient.

Right-to-die laws are a much-needed response to this confrontation. Their intent is to establish and protect the individual's right to a dignified death without recourse to unnecessary, unwanted and undignified medical treatment which serves only to prolong dying and cause needless suffering. A second objective is to free physicians and other health care professionals from liability for honoring the patient's written directive.

These 'living will' laws are a new form of legislation. The earliest — the California Natural Death Act — was signed into law in 1976. Laws were passed in seven additional states in 1977: Arkansas, Idaho, Nevada, New Mexico, North Carolina, Oregon and Texas. Two more laws, in Kansas and Washington, were enacted in 1979.

The ten statutes are an extension of the individual's right of informed consent. The right to refuse treatment is a recognized legal principle, but the dying patient is frequently unable to exercise that right. Moreover, the problem is compounded when cessation of certain procedures will probably result in death. The implications of "pulling the plug" on terminally ill patients cause concern to even the most compassionate of doctors, especially if the patient is unable to communicate his or her wishes.

There has been a definite movement away from leaving treatment decisions solely in the hands of the physician. Fear of long agonizing dying has prompted thousands to protect themselves in advance by executing "Living Will" documents. Right-to-die laws give legal recognition to such documents.

KEY POINTS OF LAWS

Each law presently enacted legally recognizes the right of a competent adult to refuse life-prolonging procedures if that adult is terminally ill. While not identical, they do contain certain basic similarities to provide necessary legal guidelines:

- Each provides the means for people to establish in advance that they do not want "heroic" measures used to prolong dying. This

prior refusal is in the form of a written document, which must be signed and witnessed.

- The laws give immunity to the physician who acts in accordance with this document and to health professionals who act under the physician's direction.
- These laws require medical confirmation of the patient's terminal condition. Thus, while the patient's role is strengthened, the physician's role is not diminished. The laws make clear that it is the physician who has the competence to know whether the patient is in a hopeless and irreversible terminal condition.
- The patient's directive is binding upon the physician in all states except Nevada and North Carolina. However, in four states — California, Idaho, Oregon and Texas — the directive is binding only if it is executed or re-executed after the diagnosis of a terminal condition. (Even if the document is non-binding, it is important evidence to advise the physician of the patient's wishes. In addition, it provides legal immunity for the physician who acts in accordance with its directions.)

RESULTS OF LEGISLATION

Experience with enacted legislation is significant, according to Sidney D. Rosoff, president of the Society for the Right to Die. "There has been no litigation as a result of legislation; fears of abuse have proved groundless. Overall, legislation has focused on appropriate and inappropriate application of medical technology; to clarify the rights of the terminally ill to refuse treatment; to set forth guidelines for physicians regarding the termination of life-support systems; to ease emotional anguish for families and physicians over whether heroic measures should be employed.

"Moreover, we have seen significant advances in improving on California's pioneering law. The most recent statutes draw largely from the best of previous legislation. The 1979 Kansas law can be considered the best of the laws enacted to date."

IMPLEMENTATION OF LAWS

A striking deficiency common in all states with right-to-die laws is that none of the ten states created any formal procedures to inform residents of their new rights and how to secure them. No central source was established in any state to provide the appropriate documents and guidelines for their use.

Hospital associations and medical societies have sought to educate their members as to the implications of the new statutes, but the public has been left singularly uninformed. The public is either

unaware that there is a law or it does not know where to get the proper forms. Public demand was evidenced by the response to a nationally syndicated "Dear Abby" column (August, 1980) telling readers about the ten states with "living will" laws. Following its publication, the Society for the Right to Die received some 90,000 requests for documents.

THE COURTS AND THE DYING PATIENT

Beginning in 1975, a number of right-to-die cases have been decided in the courts; the Quinlan case in New Jersey, the Saikewicz and Spring cases in Massachusetts, the Perlinutter case in Florida, the Brother Fox case in New York and the Severns case in Delaware.¹ While opinions have generally upheld the right to have treatment terminated, the cases have not been distinguished by a speedy resolution of the issues.

The emotional cost to families of these protracted legal battles is inestimable. The financial costs can be measured. Father Philip Eichner, a petitioner in a New York court case brought on behalf of Brother Joseph Fox, an 83-year-old comatose patient being maintained on a respirator, asked: "Who can afford all these doctors, lawyers and court procedures which serve to put the average family in a bind?"² Financial costs came to \$87,000 in hospital bill for five months of intensive care to maintain the patient's vegetative existence and an additional \$20,000 in legal fees.

When the Severns case had been in the Delaware courts for ten months, an editorial in a leading Delaware newspaper commented: ". . . the legal process is taking an emotional and financial toll . . . It is the absence of public policy on these matters which has placed the Severns case in the courts."³

Most of the cases which have come before the courts have involved incompetent patients. The courts have been far from unanimous as to possible candidates to make end-of-life decisions on behalf of such patients. The list includes the attending physician, the patient's next-of-kin or entire family, a hospital committee, the court, a court-appointed guardian and combinations of these decision-makers.

1. *Fact Sheets on leading cases are available from the Society for the Right to Die.*
2. John J. Parks, S.J. "Court Intervention and the Diminution of Patients' Rights: the Case of Brother Joseph Fox." *New England Journal of Medicine*, October 9, 1980.
3. "Delay's True Toll in a Living Death." *Wilmington News Journal*, October 5, 1980.

The New York Appellate court in the Brother Fox case emulated Massachusetts in decreeing that decisions "must reside with the judicial process and the judicial process alone." The New York court established a complicated set of procedures to be followed before life-sustaining measures could be withdrawn from a terminally ill patient in a persistent vegetative state: 1) certification of the patient's condition by the attending physician; 2) confirmation of the prognosis by a hospital committee of at least three physicians; 3) application to the court; 4) appointment of a guardian *ad litem*; 5) notification of the attorney general and district attorney who may then select additional physicians to examine the patient. These procedures probably require the participation of a minimum of four to six physicians, five attorneys and one judge before permission can be given to withdraw life-support systems. The ceding of decision-making responsibility to courts is viewed by many as an intrusion into the privacy relationship of patient/family and physician.

Court opinions are now recognizing the necessity for state legislatures to address this sensitive issue. In 1980, justices in three right-to-die cases stressed the need for legislative action to establish clear legal guidelines:

The Florida Supreme Court: "... the issue ... is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type issue which is more suitably addressed in the legislative forum. (*Satz v Perlmutter*, January, 1980.)

The New York Supreme Court, Appellate Division: "... an act of the New York legislature would ... be most welcome and appropriate. No one seriously doubts that the legislature has far greater capabilities to gather relevant data and to elicit expressions of pertinent opinion on the issues at hand. (*Eichner v. Dillon*, March, 1980.)

The Delaware Supreme Court: "... we earnestly invite the prompt attention of the General Assembly ... with the hope that it will enact a comprehensive State policy governing these matters which are, in the words of *Quinlan*, of 'transcendent importance.'" *In re Severus*, September, 1980.

In the ten states where right-to-die legislation has been enacted the physician and family become instructed agents to follow the patient's prior directions. Their legal documents, executed while the declarant is competent, direct that the patient's wishes be honored by family and physician "in the absence of the ability to give directions regarding the use of life-sustaining procedures."

A different approach is incorporated into a bill introduced in the Michigan legislature which would permit any adult to confer decision-making powers on someone designated in advance. The Michigan Medical Treatment Decision Act establishes guidelines for an individual to appoint a proxy by using "An Appointment of Agent" form contained in the proposed act.

Dr. Arnold Relman endorsed the proxy concept in an editorial in the *New England Journal of Medicine* (May 31, 1979): "The dilemma of decision-making for incompetent patients who are incurable is not easily resolved, but of all the suggested solutions the proxy chosen in advance by the patient seems best — far better, I am sure, than having decisions by a judge or even a family member when there has been no prior expression of confidence in that person by the patient."

There is little question that a personally appointed proxy can be a valuable adjunct in making choices and interpreting differences should the need arise. A flexible law should offer the double protection of directive and proxy by permitting the declarant's appointment of a proxy as part of the declaration form. For example, an optional provision could state:

In the absence of my ability to give directions regarding the use of life-sustaining procedures, I wilfully and voluntarily appoint _____ to accept or refuse medical treatment on my behalf and in my interest. I understand that if I have not filled in any name in this section, this directive will be given effect should the appropriate circumstances arise."

Decision-making questions grow more complicated when an incompetent patient has not previously documented his or her directions. Two states — Arkansas and North Carolina — address this circumstance in their laws. A third — New Mexico — affords protection for the terminally-ill minor. All three laws uphold the decision-making role of family members following appropriate medical confirmation of the patient's condition.

The North Carolina statute sets forth "Procedures for natural death in the absence of a declaration." It establishes rigid medical criteria in defining when these procedures would apply: the patient must be in a terminal, incurable and irreversible condition; he or she must be comatose with no reasonable possibility of returning to a cognitive sapient state and a vital function must be sustained by "extraordinary means." Confirmation must be made by a majority of a committee of three physicians. Request for discontinuance of a life-support system can be made by the person's spouse, a guardian of the person or by a majority of relatives of the first degree.

Arkansas law permits specified family members to execute a document on behalf of a minor or an adult when two physicians have certified that "extraordinary means would have to be utilized to prolong life" and when the patient is "physically or mentally unable to execute or is otherwise incapacitated from executing a document."

New Mexico has set guidelines to permit family members to act on behalf of a terminally ill minor, after certification of a terminal illness by two physicians, unless there is "contrary indication" by the patient or a family member. A petition for discontinuance of "maintenance medical treatment" must be certified by the state district court.

Although right-to-die laws encourage the execution of legally binding documents which would prevail in the event a dying patient is unable to participate in treatment decisions, there will always be circumstances in which no prior document exists. Substituted judgment in cases where the patient has not clearly set forth his or her wishes in advance raises the question of who should make the decision.

The New Jersey court in the *Quinlan* case vested decision-making in the family, in consultation with the attending physician and a hospital "Ethics Committee." Legislatures which have addressed the problem have placed confidence in the family as advised by one or more physicians to define the options.

North Carolina's requirement for confirmation of prognosis by a committee of three physicians could be useful in the event of differences of opinion. Recourse to the courts is always available in the rare circumstances where the statutory procedures do not suffice.

DEFINING DEATH

For 200 years, according to accepted common law definitions, life exists as long as breathing continues and the heart beats. Modern life-support systems have made it possible for cardiac and respiratory activity to be artificially maintained even when the brain has ceased to function.

In 1970, Kansas became the first state to enact a statutory definition of death, which provides that determination of death includes irreversible cessation of brain function. At the present time, 26 states have "brain death" laws.*

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has prepared a comprehensive report on "Medical, Legal and Ethical Issues in the Determination of Death." In May, 1980 the Commission's Executive Director met with representatives of the American Bar Association, the American Medical Association and the National Conference of Commissioners on Uniform State Laws. They arrived at the following proposed Uniform Determination of Death Act:

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

The proposed Act and "brain death" laws in general do not apply to patients in a persistent vegetative state, for example, Karen Quinlan who has been in a coma since April, 1975 but who possesses some brain activity.

The brain consists of three parts: the stem which controls functions of the heart and lungs; the midbrain in which emotional controls are centered and the cerebrum or "human" brain — the center which determines personhood and which distinguishes man from sub-human animals. Even though the cerebral cortex may be so impaired that there is no possibility of a return to consciousness, enough brain stem function could be retained to permit breathing and heartbeat without the aid of a respirator. Other artificial supports would probably be required, such as naso-gastric feedings and antibiotics, and a person could be kept "alive" biologically for some time without the possibility of ever returning to consciousness.

Many observers see the need to address the question of cerebral death and whether there is a moral obligation to keep such patients alive bodily when there is no possibility of a return to personhood.

* Alabama, Alaska, Arkansas, Connecticut, California, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Louisiana, Maryland, Michigan, Montana, Nevada, New Mexico, North Carolina, Oklahoma, Oregon, Tennessee, Texas, Virginia, West Virginia and Wyoming.

WIDE RELIGIOUS SUPPORT SHOWN

In a 1957 address, Pope Pius XII distinguished between "ordinary" and "extraordinary" means, stating that it is unnecessary to use extraordinary means to prolong life when recovery is no longer possible. In a further expansion of this principle, a statement from a 1974 U.S. Catholic Conference Document defines "extraordinary" as "all medicines, treatments and operations which cannot be obtained or used without excessive pain, expense or inconveniences or which, if used, would not offer reasonable hope of benefit."

The New Jersey Catholic Conference applied the teachings of the Catholic Church in an *amicus curiae* brief in the Karen Quinlan case, requesting the discontinuance of extraordinary means which were being used to sustain her. The position of the Church was also the basis of a petition by a Catholic priest seeking court permission for removal of a respirator from a member of a Catholic order who was comatose and who, according to medical advice, could not recover.

In 1980, the Vatican issued an eight-page "Declaration on Euthanasia" discussing problems arising from the use of modern life-support procedures. The document stated that a patient is permitted to refuse "forms of treatment that would only secure a precarious and burdensome prolongation of life."

A recent Harris survey indicated agreement of three major religious groups that a terminal patient should be allowed to die when no cure is in sight: Protestants 76%, Jews 75%, Catholics 70%. In the 1979 legislative session, the Massachusetts Council of Churches supported the Massachusetts right-to-die bill; three major church groups of South Carolina are on record in support of legislation in that state; the Michigan Council of Churches joined the Michigan State Medical Society and 20 other groups in endorsing the Michigan Medical Treatment Decision Act.

At hearings in Massachusetts, a Congregational minister, the Rev. Kenneth B. Wentzel said, "All churches stand forthrightly behind the (patient's) right to freedom of choice and peace of mind, such broad support being so nobly articulated by Pope Pius XII in 1957 . . . But I do not have the final authority to insure that right. Neither does his church. Nor his family. Nor does his doctor. For he will probably die in an institutional setting where death is seen as a technological failure, not as a significant natural event."

The extent of support for right-to-die legislation is indicative of the strong desire to ensure self-determination in the dying process.

TEN LAWS AND A MODEL BILL

Following is an analysis of the principal features of enacted legislation and a discussion of a Model Bill.

The YLS Model Bill was drafted in 1978 at the Yale School of Law in a Legislative Services Project sponsored by the Society for the Right to Die. Of the ten laws enacted to date, the Kansas statute (1979) most closely resembles the Model Bill.

It provides for an easily administered system of patient election secured by means of a document which can be executed *at any time*. A suggested form is included giving instructions to withhold or withdraw life-sustaining procedures in the event of a terminal condition as certified by two physicians. The bill makes clear that wishes expressed while the declarant is competent and never disavowed should remain valid in the event the declarant is no longer able to participate in medical treatment decisions. Provision is made for retraction by means of simple revocation procedures.

Although a declaration form is included in the bill, the document need only be followed "substantially," thereby permitting insertion of additional personalized directions or stipulations and allowing choices in areas where individuals may differ as to what they want or don't want at the end of their lives. The bill would also permit the declarant to designate a proxy. To protect the document's over-all validity such additions are severable.

The physician, while bound by standards of due care, is protected from civil and criminal liability for following a valid document. The obligations of the physician are clearly stated. It is his responsibility to follow the terms of the election in the same manner as an informed consent situation or to have the patient transferred to the care of another physician.

Although the bill does not contain a specific provision regarding withdrawal of treatment from minors, as does the New Mexico law, it does recognize the need for protection of the terminally ill minor. Thus, in the section which refers to competency the legislation states that "age of itself shall not be a bar to a determination of competency." A formal statement by a minor would serve as evidentiary evidence and would have advisory effect rather than directive effect.

Provisions are included to prevent abuse. For example, no one is required to sign a directive as a condition for receiving medical care; penalties are provided for forging a document or concealing knowledge of a revocation; witnesses to the document cannot stand to gain from the declarant's estate.

ARKANSAS

The Arkansas law (1977) omits many provisions usually contained in right-to-die legislation; on the other hand, its potential applicability is more comprehensive than any of the other statutes. It is one of two right-to-die laws which permits execution of a document on behalf of a terminally ill minor. (See New Mexico.) It also permits such action to be taken on behalf of an incompetent adult or someone otherwise unable to execute such a document on his or her own behalf.

Under Arkansas law, a person may state in writing an advance refusal of "artificial, extraordinary, extreme or radical medical or surgical means or procedures calculated to prolong his life. . ." Alternatively, he may request in writing that "extraordinary means" be used to "prolong life to the extent possible."

An individual indicates his or her choices as to treatment by means of a document which may be executed at any time. The document is drawn up with the same formalities as a will of property, requiring two witnesses and notarization.

The law contains no specific or suggested document form to be followed nor does it contain any provision for revocation of the document. Unlike other right-to-die laws, it contains no provision requiring physician certification of a terminal illness except when termination of treatment is requested on behalf of another.

Family members specified in the law or a legally appointed guardian can execute a document on behalf of a minor or an incompetent adult but only after written certification by two physicians that "extraordinary means would have to be utilized to prolong life."

CALIFORNIA

The California Natural Death Act (1976) is the nation's first right-to-die law. As such, it represented a constructive step toward establishing the right of the individual to determine the quality, time and dignity of his or her death. It is by no means a perfect piece of legislation. The history of its enactment is an example of legislative compromise and amendment and the law suffered from restrictions and limitations which were imposed.

A principal drawback of the California law is that the prescribed document is not legally binding unless it has been executed, re-executed 14 days after the diagnosis of a terminal condition. If the directive is executed prior to this time it is left to the physician to decide "whether the totality of circumstances . . . justify effectuating the directive." It is also left to the physician to determine the validity of the patient's directive. The directive has a five-year expiration date. The need to continue to re-execute the document is an

unreasonable requirement considering the ease with which the directive can be revoked under the law.

The simple and direct intent of the act can be understood by reading its preamble which sets forth the rationale of the law: the need to protect individual autonomy because of "considerable uncertainty . . . as to legality of terminating life-sustaining procedures when the patient has evidenced a desire that such procedures be withheld or withdrawn."

The individual's right is secured by means of a written directive, which must be in the form set out in the law. Guidelines are provided so that the physician, hospital, nurses and others involved in the patient's care can obey the directive without fear of liability.

Any California citizen over the age of 18 can execute the "Directive to Physicians" which instructs the attending physician to withdraw or withhold life-sustaining procedures in the event of a terminal condition and when death is "imminent," an unclear determinant which could be interpreted as hours, days, weeks or months.

Witnesses to the document cannot be family members, heirs or personnel connected with the attending physician or attached to the patient's health facility.

A physician's failure to comply with the directive of a "qualified" patient will be deemed unprofessional conduct unless he takes all steps necessary to transfer the patient to another physician who will effectuate the directive.

IDAHO

Idaho's Act Relating to the Right to Die (1977) is similar in many respects to the California Natural Death Act. It recognizes that an adult has the right to execute a written directive instructing his physician to withhold or withdraw life-sustaining procedures when such a person is in a terminal condition. The directive, which has a five-year expiration date, is legally binding only if executed after an individual has been diagnosed as having a terminal condition. Provisions regarding revocation procedures, immunity for health care personnel and insurance coverage are the same as California's law.

Idaho's law differs from the California Natural Death Act as follows:

- Its directive becomes operative only when a patient is comatose or otherwise unable to communicate with his physician.
- The directive requires notarization.
- Diagnosis of a terminal condition is by the attending physician only, with no second opinion required.
- There is no waiting period after the diagnosis of a terminal condition before a legally binding document can be executed.

- The physician is not required to determine the validity of the directive.
- The physician is not required to transfer a patient if he does not wish to comply with the patient's directive.
- The Idaho law contains no penalties for forgery or destruction of a declarant's document or for concealment of a revocation.
- The Idaho law does not contain California's exclusion of coverage of a dying woman, who is pregnant, nor does it contain special witnessing provisions for nursing home patients.

KANSAS

The Kansas law, enacted in 1979, represents the most effective legislation enacted to date, closely resembling the Model Bill.

Kansas is now one of four states which recognizes that a person in good health can execute, in advance, a legally binding directive to be honored when the declarant becomes terminally ill. The other states are Arkansas, New Mexico and Washington. This contrasts with California-style legislation (California, Idaho, Oregon and Texas) in which the directive is legally binding only if executed after the diagnosis of a terminal condition. It also contrasts with laws in Nevada and North Carolina where documents are advisory to the physician regardless of when they are executed.

Kansas law permits the same flexibility as does the Model Bill: it contains a document form but allowance is made for personalized instructions. The document must be dated, signed and witnessed. Excluded as witnesses are relatives, anyone who might benefit financially from the declarant's death and anyone financially responsible for the declarant's medical care. Should the declarant be incapable of signing a document, permission is granted to another person to sign the document in the declarant's presence and at the declarant's direction.

The patient is given the responsibility of notifying the physician of the existence of a legal document. The physician is then required to make it a part of the declarant's medical records. The physician is held legally responsible to act in accordance with the declaration or to arrange transfer of the patient to another physician. There is clear provision that no "presumption" can be inferred regarding the individual who has not executed a document, thereby protecting existing rights.

The Kansas law avoids most of the restrictive features of the California Natural Death Act. For example, as stated above, the declaration is legally binding whenever it is executed. There is no expiration date for the declaration, so that it remains in effect unless revoked. The physician is not required to determine the validity of

the declaration. It does not contain the determinant in the California Natural Death Act that medical procedures can be withdrawn only when "death is imminent."

NEVADA

Nevada's law (1977) sets forth a procedure whereby an adult executes a document requesting cessation of life-sustaining procedures when terminal, comatose or "otherwise incapable of communicating with his . . . physician."

The directive is never legally binding on the physician, who is required only to "give weight" to it but may also consider "other factors," which are unspecified.

The "Directive to Physicians" contained in the law states: "It is my intention that this directive be honored by my family and attending physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of my refusal." Section 12 of the law states that if a terminal patient becomes comatose or incapable of communicating "the physician shall give weight to the declaration as evidence of the patient's directions . . . but may also consider other factors in determining whether the circumstances warrant following the directions."

The law contains a suggested document form. Immunity from criminal and civil liability is provided for the physician and other medical personnel who follow the written directions of the patient.

The document must be witnessed, and Nevada law excludes the same categories of witnesses as does California. The law contains provision for revocation of the document as well as penalties for its falsification or forgery.

NEW MEXICO

The New Mexico "Right to Die Act" is a simple, well-drafted law. It is more comprehensive than most of the other statutes, however, in that it permits a document to be executed on behalf of a terminally ill minor by a family member under a careful system of safeguards, including provision for contrary indication by the minor and the need for court certification of the document.

It protects adults by providing that an individual of sound mind, having reached the age of majority, may execute a document directing that if he is ever certified by two physicians as suffering from a terminal illness then "maintenance medical treatment shall not be utilized for the prolongation of his life."

A physician who relies on the document and withholds treatment is "presumed to be acting in good faith" and is granted im-

munity for acting in accordance with the provisions of the law unless it is proved that he violated "reasonable professional care and judgment."

The law contains no document form. An individual can draw up his or her own statement, which must be witnessed and notarized. The document can be revoked by destruction or "contrary indication."

The section on terminally ill minors sets forth the following procedures: 1) certification of a minor's terminal condition by two physicians; 2) execution of a document on behalf of the minor by parent, guardian or adult spouse unless there is contrary indication by the minor or opposition by any of the above family members; 3) petition to the district court to certify the document. An evidentiary hearing may be held but is not required.

NORTH CAROLINA

The North Carolina statute, enacted in 1977 and amended in 1979, was proposed as the result of a two-year study by the General Statutes Commission. It is the only law which combines "natural death" and "brain death" in a single statute. It also establishes procedures to protect the irreversibly comatose patient who has not executed any prior declaration.

The North Carolina law contains a suggested declaration form which "authorizes" a physician to withhold or discontinue "extraordinary" means in the event of a terminal and incurable condition. The declaration must be signed, witnessed and certified by a notary public or clerk of the Superior Court.

North Carolina and Nevada are the only states where the physician is given discretion to interpret the patient's written dictates. The law states that the attending physician may rely upon an appropriate declaration to withhold or discontinue "extraordinary means" and is protected from criminal or civil liability for doing so. Confirmation of the declarant's condition by a second physician is required.

"Procedures for Natural Death in the Absence of a Declaration" permits family members to request cessation of extraordinary treatment of a patient who is comatose with no "reasonable possibility" of a return to a cognitive sapient state. The patient's condition must be "terminal," "incurable" and "irreversible" as confirmed by a majority of a committee of three physicians.

Those who can request the discontinuance of such measures are a spouse, a guardian or a majority of relatives of the first degree, in that order. If none of these are available it may be discontinued at the discretion of the attending physician.

Only North Carolina and Arkansas permit action to be taken by another on behalf of a incompetent adult patient. The North Carolina law, however, specifically addresses the problem of those patients, such as Karen Quinlan, who are in a persistent vegetative state, and the law only provides for the discontinuance of "extraordinary means." Presumably this would not include such maintenance measures as artificial feeding.

The North Carolina law contains a statutory definition of death which recognizes irreversible cessation of total brain function ("brain death") as a basis for such determination.

OREGON

Oregon's "Act Relating to the Right to Die" (1977) parallels the California Natural Death Act in most respects. The law contains a specific directive which must be used. An adult can execute the directive only on his own behalf. The directive is legally binding only when executed 14 days after the diagnosis of a terminal condition. The directive expires in five years.

The Oregon Law differs from California's as follows:

- It is not incumbent upon the physician to determine the validity of the directive. The directive is "valid on its face."
- There is no provision making the statute inapplicable to pregnant women.
- The Oregon law requires that the physician make a "reasonable effort" to transfer a qualified patient in the event that he feels unable to comply with the wishes set forth in a directive signed by the patient. There is no penalty for failure to do so.

TEXAS

The Texas "Natural Death Act" (1977) follows the California model. In 1979, the Texas legislature adopted two amendments proposed by Rep. Robert Bush: 1) to eliminate the five-year limitation on the effective duration of its "Directive to Physicians." 2) deletion of the .4-day waiting period after diagnosis of a terminal condition before a declarant could execute a binding directive.

Senator Ray Farabee, sponsor of the Texas Natural Death Act, and the Texas Medical Association have taken active measures to inform Texas residents of their rights under the law and to publicize and distribute its Directive to Physicians. It is Senator Farabee's opinion that the concepts embodied in the law have been broadly accepted but further improvements and simplifications could make it more effective.

WASHINGTON

The Washington Natural Death Act, sponsored by 20 state representatives and enacted in 1979, is a modification of the California Natural Death Act. It has effectively eliminated most of the unnecessary restrictions contained in the California statute.

Washington's "Directive to Physicians" is legally binding whenever it is executed. A directive must follow "essentially" the form contained in the law but may also include other specific directions. Physicians and other health care professionals are protected from liability complying with the directive after confirmation of a terminal condition by two physicians. If a physician refuses to effectuate the directive, he must make a "good faith effort" to transfer the qualified patient to another physician but faces no penalty for failure to do so.

The Washington law retains an unfortunate requirement from its California model: medical procedures can be withheld or withdrawn only when "death is imminent." This is a vague time factor and subject to a wide latitude of interpretation. It leaves considerable discretion as to the appropriate time for stopping some or all life-prolonging treatment because it is left to the judgment of the attending physician to determine when death is "imminent."

Statutory Citations for Right-to-Die Laws

Arkansas Act 879

Ark. Stat. Ann. (1977 Supp.) Stat. 82-3801 *et seq.*

California Natural Death Act (A.B. 3060)

Cal. Stat. 1976, Chapt. 1439, Code §
Health and Safety, § 7185 *et seq.*

Idaho Natural Death Act (S.B. 1164)

Idaho Code 39-4501 *et seq.*

Kansas Senate Bill 99

K.S.A. 6: 128, 101-109 (1979 Supp.)

Nevada Assembly Bill 8

Nev. Rev. Stat. § 449.540 *et seq.*

New Mexico Right to Die Act (S.B. 16)

N.M. Stat. Ann. (1977 Supp.) § 12-35-1 *et seq.*

North Carolina Right to Natural Death (S.B. 504)

N.C. Gen. Stat. 90-320 *et seq.*

Oregon Act "Rights with Respect to Terminal Illness" (S.B. 438)

Or. Rev. Stat. § 97.050 *et seq.*

Texas Natural Death Act (S.B. 148)

Vernon's Ann. Civ. St. Art. 4590h § 1 *et seq.*

Washington Natural Death Act (H.B. 264)

LANDMARKS OF THE RIGHT-TO-DIE MOVEMENT

1954 — Dr. Joseph Fletcher, theologian and biomedical ethicist, forced into the open a series of ethical issues surrounding medical care with his book *Morals and Medicine*, published in 1954. It dealt with the individual's freedom of action in a number of crucial decisions over life and death, among them human initiative in death and dying.

1957 — Address of Pope Pius XII distinguishing between "ordinary" and "extraordinary" means stating that it is unnecessary to use extraordinary means to prolong life when recovery is no longer possible.

1967 — Luis Kutner, a Chicago attorney, chairman of World Habeas Corpus, suggested a Living Will as a tangible way by which an individual could make his wishes known concerning his own dying.

1968 — Dr. Walter Sackett, a Florida legislator, introduced the first bill to make the Living Will a legally binding document.

1973 — Hearings on "Death with Dignity" before U.S. Senate Committee on Aging, chaired by Senator Frank Church.

1973 — American Hospital Association: *Patients Bill of Rights* approved; included right of informed consent and right to refuse treatment.

1975 — Publication of first *Legislative Manual* by the Society for the Right to Die; published and analyzed ten "death with dignity" bills introduced in state legislatures up to that time.

1976 — New Jersey Supreme Court decision in *Quinlan* established that the privilege of choosing death, in certain circumstances, takes precedence over the duty of the state to preserve life.

1976 — California Natural Death Act signed into law.

1977 — Laws passed in Arkansas, Idaho, Nevada, New Mexico, North Carolina, Oregon, Texas. Right-to-die bills introduced in 42 states.

1978 — YLS Model Bill drafted by Yale law students as part of a Yale Legislative Services project, undertaken in conjunction with the Society for the Right to Die.

1979 — Washington enacts Natural Death Act (H.B. 264), sponsored by 20 legislators. Kansas enacts Senate Bill 99, which closely resembles the Model Bill.

1980 — World Federation of Right to Die Societies formed at Oxford, England. Sidney D. Rosoff, president of U.S. Society, elected president.

1980 — Vatican's "Declaration on Euthanasia" re-affirms that dying need not be prolonged by "burdensome" life-support systems.

1980 — Florida becomes 26th state to enact "brain death" legislation.

1980 — Opinions by state supreme courts in right-to-die cases increased to four as Florida and Delaware join New Jersey and

Comparison of Right to Die Laws

	Arkansas ACT 879 March, 1977	California A.B. 3440 September, 1976
<i>Title</i>		Natural Death Act
<i>Purpose</i>	Permits an individual to "request or refuse in writing . . . procedures calculated to prolong his life."	To recognize the right of adult person to make a written directive instructing physician to withhold or withdraw life-sustaining procedures in event of terminal condition.
<i>Who May Elect?</i>	Any adult. Also permits a proxy to execute document on behalf of minor or incompetent.	Any adult person.
<i>How to Elect</i>	Voluntary execution of a document requiring two witnesses and notarization. If minor or incompetent, document can be executed by specified family members.	Voluntary execution of Directive to Physician, legally binding when executed 14 days after diagnosis of terminal condition; otherwise it is advisory.
<i>Is Form Included?</i>	No.	Yes.
<i>Formalities of Execution</i>	As with a will of property, two witnesses and notarization of document.	Directive requires 2 witnesses not related, nor entitled to estate nor in employ of physician. Must be made part of patient's medical record.
<i>How Long is Document Effective?</i>	In force unless revoked.	3 years.
<i>When Does Document Become Controlling?</i>	Is imperative except to state person's right to "die with dignity."	1) Certification of terminal condition by 2 physicians; 2) attending physician must determine validity of directive; 3) death must be "imminent" in judgment of physician.
<i>Revocation Procedures Specified?</i>	No.	Yes.
<i>Is Document Binding on Physicians?</i>	No penalty for non-compliance.	Yes. Unprofessional conduct for failure to comply unless arrangements made to transfer patient.
<i>Are There Immunity Provisions?</i>	Yes, for person, hospital or other medical institution.	Yes, for physician, health facility and health professionals.
<i>Penalties for Destruction, Concealment, Falsification Of Directive or Revocation</i>	No.	Yes.

	Idaho S.B. 1164 March, 1977	Kansas S.B. 99 April, 1979	Nevada A.B. 8 May, 1977
	Natural Death Act		
	To recognize right to execute written directive instructing physician to withhold or withdraw life-sustaining procedures when such a person is in a terminal condition.	To recognize an adult's right to make a written declaration instructing the physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.	To protect the terminal, comatose patient by means of an advance directive which is advisory only to physician.
	Adult persons diagnosed as terminal.	Any adult person.	Any adult person.
	Voluntary execution of a document which is legally binding if executed after diagnosis of a terminal condition.	Voluntary execution at any time of a written document directing the withholding or withdrawing of life-sustaining procedures in the event of a terminal illness.	Voluntary execution of "Directive to Physician."
	Yes.	Yes, but may include other specific directions.	Yes, but need only be followed "substantially."
	Signed, written directive, two witnesses with same exclusions as California. Requires notarization.	Signed, written, witnessed directive, same witness exclusions as California. Permits signing by another on behalf of declarant, incapable of so doing, in his/her presence and under his/her direction.	Directive requires two witnesses, same exclusions as California. Must be made part of patient's record.
	3 years.	In effect unless revoked.	In force unless revoked.
	After determination by attending physician that death is imminent if patient is unable to communicate instructions.	Upon certification of terminal condition by two physicians.	Advisory only.
	Yes.	Yes.	Yes.
	No penalty for non-compliance.	Yes. Failure to comply or effect the transfer of a qualified patient constitutes unprofessional conduct.	No. Physician shall give weight to declaration but may consider other factors.
	Yes, for physicians and health facilities.	Yes, for physician, health care professionals, medical care facilities.	Yes, for physician, hospital, health professional.
	No.	Yes.	Yes.

Comparison of Right to Die Laws

	New Mexico S.B. 16 April, 1977	North Carolina S.B. 504 June, 1977
Title	Right to Die Act	Right to a Natural Death; Brain Death.
Purpose	To allow an adult of sound mind to execute a document directing withholding of maintenance medical treatment when certified as terminal; also has provisions for terminally-ill minor.	To provide a procedure for the individual's right to a peaceful and natural death.
Who May Elect?	1) Adult of sound mind. 2) On behalf of a terminally-ill minor by specified family members with court certification.	Competent individual. No age provision specified. Also on behalf of terminal, comatose patients by specified family members.
How to Elect	Voluntary execution of document with same formalities as will. On behalf of minor by family member after certification of terminal condition by two physicians and requiring court certification of document.	Voluntary execution of an advisory document directing the withholding or discontinuance of extraordinary means.
Is Form Included?	No.	Yes, a suggested form to meet requirements of law: "Declaration of a Desire for a Natural Death."
Formalities of Execution	Requires two witnesses and notarization.	Signed declaration with 2 witnesses, same exclusions as California. Must be "Proved" before notary or clerk of court.
How Long is Document Effective?	In effect unless revoked.	Valid until revoked.
When Does Document Become Controlling?	After certification of terminal illness by two physicians.	Upon certification of terminal condition by 2 physicians.
Revocation Procedures Specified?	Yes.	Yes.
Is Document Binding on Physicians?	Yes, but no penalty for noncompliance.	No. Only advisory.
Are There Immunity Provisions?	Yes.	Yes.
Provisions for Destruction, Concealment, Falsification of Directive or Revocation	Yes.	No.

	Oregon S.B. 438 June, 1977	Texas S.B. 143 August, 1977	Washington H.B. 264 March, 1979
Act Relating to the Right to Die.	Act Relating to the Right to Die.	Natural Death Act	Natural Death Act
Purpose	To allow an individual to execute or re-execute a directive directing the withholding or withdrawal of life-sustaining procedures should declarant become a qualified patient.	To establish a procedure for a person to provide in advance for the withdrawal or withholding of life-sustaining procedures in event of a terminal condition.	To allow adults to control decisions relating to their own medical care, including decision to have life-sustaining procedures withheld or withdrawn in event of terminal condition.
Who May Elect?	Adult of sound mind.	Any adult person	Any person at least 18 years old, of sound mind.
How to Elect	Directive must be signed 14 days after diagnosis and certification of terminal illness to be legally binding.	Voluntary execution of Directive to Physicians legally binding when executed after the diagnosis of a terminal condition; otherwise it is advisory.	Voluntary execution of advance directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition.
Is Form Included?	Yes.	Yes.	Yes, but may include other specific directions.
Formalities of Execution	Directive requires 2 witnesses not related, nor entitled to estate nor in employ of physician. Directive must be placed in patient's medical record.	Directive requires 2 witnesses not related, nor entitled to estate nor in employ of physician. Must be made part of patient's medical record.	Signed declaration, requiring two witnesses with same exclusions as California. To be made part of patient's medical record.
How Long is Document Effective?	Five years.	In force until revoked.	In force unless revoked.
When Does Document Become Controlling?	When attending physician determines "death is imminent" and when life-prolonging procedures would only prolong dying. Physician need not determine validity of directive.	Upon diagnosis and certification of terminal condition by two physicians (one the attending). Physician must determine validity of directive.	Upon written verification of terminal condition by two physicians when life-sustaining procedures would only prolong "moment of death."
Revocation Procedures Specified?	Yes.	Yes.	Yes.
Is Document Binding on Physicians?	No. Shall make "reasonable effort" to transfer patient.	Yes. Unprofessional conduct for failure to comply unless arrangements made to transfer patient.	No. Must make a "good faith effort" to transfer patient.
Are There Immunity Provisions?	Yes.	Yes.	Yes. Physician, health personnel and facility.
Provisions for Destruction, Concealment, Falsification of Directive or Revocation	Yes.	Yes.	Yes.



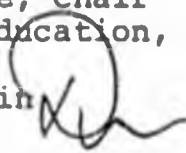
Alaska State Legislature

House of Representatives

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

TO: Rep. Mike Beirne, Chair
House Health, Education, & Social Services Committee

FROM: Rep. Don Clocksin 

SUBJECT: HB 855--Right to a Natural Death

DATE: March 2, 1982

House Bill 855 has been referred to your committee. The bill legalizes the living will, thus recognizing the right of a person to make medical decisions in the case of terminal illness.

As you know, dramatic advances in medicine have resulted in the use of a variety of life-sustaining measures to prolong the dying process. Many individuals feel that the use of such measures causes needless suffering and interferes with self-determination in the dying process.

Such laws are relatively new. Since 1976, 10 states have passed legislation recognizing an individual's right to a dignified death without recourse to unwanted medical treatment.

Support for such legislation is broad, both in Alaska and nationally. The Older Persons Action Group of Alaska included legalization of the "living will" in its 1982 legislative priorities. The Older Alaskans Commission and the Alaska delegates to the White House Conference on Aging also support such legislation.

A recent national Harris survey showed that three major religious groups agree that a terminal patient should be allowed to die when there is no cure in sight (Protestants 76%; Jews 75%; Catholics 70%). In 1957, Pope Pius XII stated that it is unnecessary to use extraordinary means to prolong life when recovery is no longer possible. The Vatican position has been reconfirmed as recently as 1980.

Enclosed is a summary of the major provisions of HB 855 as well as a copy of excerpts from the 1981 Handbook of the Society for the Right to Die.

Please feel free to contact this office for further information concerning this bill. I urge you to take early action on this legislation.



Alaska State Legislature

House of Representatives

SUMMARY OF HOUSE BILL 855

Rep. Don Clocksin

Pouch V

State Capitol

Juneau, Alaska 99811

Official Business

Right to a Natural Death

Purpose: Recognizes the fundamental right of adults in Alaska to control the decision to have life-sustaining procedures withheld or withdrawn in the case of a terminal condition.

Declaration Form: The central feature of the bill, commonly called the living will. The bill outlines a general form for a person to express, in writing, desires relating to artificial prolongation of death. The form includes an express statement that it is executed wilfully and voluntarily and voids the effect of the declaration if the patient is found to be pregnant. Two people must witness the declaration. It is the responsibility of the declarant to provide notification of its existence to the attending physician.

Revocation: Outlines actions, including written and verbal, which revoke the declaration.

Physicians' Responsibility: Outlines the steps a physician must follow for written certification of a declarant's terminal condition in the event of such diagnosis. If a physician refuses to comply with the declaration of a qualified patient, the physician must arrange to transfer the patient to another physician who will carry out the wishes of the person.

Immunity: A physician, health facility, or licensed health professional acting under the direction of a physician is immune from any liability if they act in accordance with the provisions of the bill.

Penalties: Penalizes persons who conceal or damage another's declaration; who falsify or forge a declaration; who conceal or withhold knowledge of a revocation; or who forge a revocation of a declaration. Provides for civil liability for an attending physician who fails to comply with the declaration of a qualified patient.

Definitions: Outlines who is an attending physician; what is a declaration; what are life-sustaining procedures; and how a patient qualifies for treatment under the chapter as provided for in the bill.

Miscellaneous: Clarifies that failure to make a declaration does not affect life insurance, health insurance, or health care services. Expressly states that failure to execute a declaration does not create any presumption, and that execution and following of a declaration does not constitute a suicide.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
TRANSPORTATION SECTION

POUCH K - STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE: (907) 485-3630

March 11, 1982

The Honorable Michael Beirne
Chairman
Health, Education & Social Services Committee
House of Representatives
Alaska State Legislature
Pouch Y
Juneau, Alaska 99811

Re: HB 855 (right to natural
death)

Dear Representative Beirne:

Your committee's assistant, Jody Sutherland, has invited the Department of Law to comment on this bill which is scheduled for hearing on March 12, 1982. Unfortunately, the attorneys in our human services section are all in Anchorage this week and we will not be able to review this bill and offer our comments on it until next week.

Thank you for this opportunity to offer our views on this bill.

Yours truly,

WILSON L. CONDON
ATTORNEY GENERAL

By:



Arthur H. Peterson
Assistant Attorney General

AHP:cdd

cc: The Honorable Donald E. Clocksin
House of Representatives
Alaska State Legislature

Keith Specking
Legislative Assistant
Governor's Office

Hon. Mike Beirne

-2-

March 11, 1982

cc: (con't)

Bruce M. Botelho
Assistant Attorney General
Human Services Section
Juneau

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 855
Title "An Act relating to the right to a natural death."
Requested by Repr. Bairne, House HESS Committee Date March 10, 1982

II. FISCAL DETAIL
Agency Affected Department of Law
Program Category Affected Administration of Justice
BRU, Program, Or Subprogram(s) Affected Prosecution
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

This bill will not have a fiscal impact on the department's activities.

IV. DATE March 11, 1982 PREPARED BY Richard I. Pegues, Director, Adm. Svcs.
AGENCY Department of Law
PHONE 465-3672
Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

Committee members
Older Alaskans Comm.
CPAG people

Rep. Jerry Martin

Alaska State Legislature

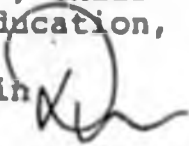
House of Representatives



Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

TO: Rep. Mike Beirne, Chair
House Health, Education, & Social Services Committee

FROM: Rep. Don Clocksin 

SUBJECT: HB 855--Right to a Natural Death

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Enclosed is a summary of the major provisions of HB 855 as well as a copy of excerpts from the 1981 Handbook of the Society for the Right to Die.

Please feel free to contact this office for further information concerning this bill. I urge you to take early action on this legislation.

①

To: The Honorable Representatives
on the Health, Education, &
Social Services Committee

Today you are considering a bill that would allow a person to commit suicide, with the sanction of the state government: HB 855. Even more so, it would make criminals of Doctors who refuse to be complicit in this Nazi practice, in violation of the high ethics of their calling.

The Hippocratic oath is still a precious thing to many of our Physicians, and to demean them in such a manner only worsens the relationship of trust that we have with them. If I knew my doctor wasn't totally committed to my staying alive I would feel very uneasy, expecting him to ask me at any time to sign a piece of paper because I was just going to die eventually anyway and he needed the bed space. The will to live should be supported by a Physician not undermined by him.

(3)

During the Nuremberg War Crimes Tribunal in 1946-47 the Nazis were condemned for these procedures but yet some people are trying to revive them as part of a cost/benefit analysis. Mass annihilations of the mentally ill was carried under the name of "Action T-4" at the beginning of the war but the practice had to stop as the elderly and sick had begun to get stirred up and ask questions when they were put into the ranks of "useless eaters". "Ballast-istengen" or "Dead weights" they were called and many argued that the burden of thousands of very ill people could not afford to be kept alive.

We have the technology to keep them alive for as long as possible and we should see it and not worry about how much it costs. You may say this bill doesn't require people to be killed off but it is a first step and it sets a mood in the public's eyes. We

(3)

all have heard of Reaganomics
and Budget Director David
Stockman, I know Alaska
is losing some oil revenue
but I hate to think that
our old people might think
that nobody cares. Don't
allow this to happen because
the bank balance might look
a little better with a few
less sick people to take
care of. Much has been done
- in the line of research to
keep people alive and people
who were "terminally ill"
20 years ago (or less), because
of research into the causes
and cures of disease we have
made giant strides in
technology. We all can look
forward to living longer
than our fathers. Would
you stop this process by
saying we don't have to
keep terminally ill people
alive so why look for cases
I know there is a current
running through this country
and in fact the world,
which believes there are
too many people, too
many mouths at nature's

10

Table list if you look at
a growing dynamic country
like Japan which is fast
over taken the U.S. in
technology they are saying
that they don't have enough
people. They need more to
keep an increasing tech
rate of growth down.

They can't get anything
filling off people they
need to stimulate growth
in the people need to
be saved for as a part
of a necessary overhead.
Depressions don't let passive
authorities turn to active money
filling, society cannot afford
to lose that much

Thank you

7nd Station St.
5895 Loman St.
Gaines, Ark
99801

Judy
For you
information
Dennis

MUSICK, PEELER & GARRETT

A LAW PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS

ONE WILSHIRE BOULEVARD
LOS ANGELES, CALIFORNIA 90017

TELEPHONE (213) 629-7600
FLEX 67-7491
TELECOPIER (213) 624-1376

ELVON MUSICK 1800-1088
LEROY A. GARRETT 1800-1083

WASHINGTON D.C. OFFICE
SUITE 1115 AND BUILDING
1200 EIGHTEENTH STREET N.W.
WASHINGTON, D.C.
1001 775-1427

NEWPORT BEACH OFFICE
SUITE 600
4000 MACARTHUR BOULEVARD
NEWPORT BEACH, CALIFORNIA
(714) 758-6100

DENVER OFFICE
SUITE 1808
718 SEVENTEENTH STREET
DENVER, COLORADO
(303) 855-8701

WIRELESS DIRECT DIAL NUMBER

March 9, 1982

(213) 629-7691

Mr. Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Re: Natural Death Act/House Bill No. 855

Dear Dennis:

You have asked us to review House Bill No. 855, "An Act relating to the right to a natural death," for the purposes of identifying the legislation's potential impact on the obligations and liabilities of hospitals and nursing homes and recommending changes in the draft where appropriate.

In view of the philosophical, medical, and legal issues involved in the so-called "right to a natural death," the relevant federal and state cases, and the California Natural Death Act, California Health and Safety Code, Section 7185 et seq., we have made the following recommendations for changes in the draft legislation:

- (1) Define who is an "adult person";
- (2) Reconsider and refine the declarant's option to appoint a third-party to accept or refuse medical treatment;
- (3) Prohibit "interested persons" from serving as witnesses to a directive;
- (4) Refine the provision allowing a declarant to add "special directions" to a directive;
- (5) Establish a term of years during which a directive is valid and a means for resolving the issue of multiple directives;

Mr. Dennis L. DeWitt
March 9, 1982
Page Two

(6) Require the attending physician to determine that a directive complies with the statute, that the directive corresponds to the patient's desires, that the medical preconditions to withholding or withdrawing treatment have been met, and to be responsible for implementing the directive;

(7) Establish that any form of revocation shall become effective only upon communication to the attending physician;

(8) Provide comprehensive immunity for hospitals, physicians and other health care providers who act in accordance with the statute; and

(9) Clarify that the legislation does not preempt other legal methods by which life-sustaining procedures may be withdrawn or withheld in the event of a terminal condition.

Background

Recently, federal and state cases have concluded that the constitutional right to privacy, derived, in part, from the principles embodied in the Fifth and Fourteenth Amendments to the United States Constitution, includes the right of a competent adult to give consent for or to refuse medical treatment, even if the refusal is expected to result in death. In the matter of Karen Quinlan, 355 A.2d 467 (N.J. 1976); Superintendent of Belcher-town State School v. Saikewicz, 370 N.E.2d 417 (Mass., 1977); In the matter of Earle Spring, 405 N.E.2d 115 (Mass. Sup. Ct., 1980); Severns v. The Wilmington Medical Center, et al., 421 A.2d 1334, (Del. Sup. Ct., 1980); Satz v. Perlmutter, 379 So.2d 359 (Fla. Sup. Ct., 1980), 93 A.L.R.3d 67, "Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life"; see also, Roe v. Wade, 410 U.S. 113 (1973); Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980), cert. granted 49 U.S.L.W. 3788, Rennie v. Klein, 462 F.Supp. 1131 (D.C. N.J., 1978).

Nonetheless, judicial recognition of this right has not always resulted in a clear resolution of the potential liability of hospitals, physicians and other health care providers when presented with the patient who refuses life-supporting treatment or medical technology.

Insofar as the potential liability of hospitals and nursing homes for either implementing or ignoring a patient's

Mr. Dennis L. DeWitt
March 9, 1982
Page Three

desire to withhold or withdraw lifesaving procedures, it is important, initially, to distinguish between withholding and withdrawing treatment. Simply stated, withholding treatment is an act of omission while withdrawing treatment is an affirmative act, terminating treatment which has already been initiated.

As a general rule, a hospital^{1/} and its employees have a duty to provide a patient with all available life-sustaining care.^{2/} This common law duty is supplemented by the hospital's obligations to a patient set forth in its contract with the patient, its statutory and regulatory duties pursuant to its licensure, and the criminal code. As a result, while different considerations may be involved in withholding and withdrawing lifesaving treatment under varying circumstances,^{3/} if a hospital permits either act to occur, the facility and its employees may be subject to various forms of civil and criminal liability. The hospital's liability may be based upon the principle of respondeat superior by which it is liable for the acts or omissions of its employees and apparent agents, Rice v. California Lutheran Hospital, 27 Cal.2d 296 (1945); Seneris v. Haas, 43

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- 1/ As it is often assumed and sometimes expressly held that rules applicable to a private hospital are also applicable to nursing homes, see 83 A.L.R.3d 871 at 875, the following discussion regarding hospitals is relevant to nursing homes as well.
 - 2/ John F. Kennedy Memorial Hospital v. Heston, 279 A.2d 670 (N.J. 1971); but cf. Belchertown State School v. Saikewicz, supra, wherein the court noted that prevailing medical practice does not without exception, demand that all efforts toward life prolongation be made in all circumstances, but seems to recognize that the dying are more often in need of comfort than of treatment, 370 N.E.2d at 425-426.
 - 3/ For example, withdrawing treatment already instituted may result in significant patient discomfort without proper preparations, while an order to withhold treatment must be properly communicated to avoid having life-sustaining emergency treatment applied by uninformed personnel. In all instances, however, the comfort and dignity of the patient should be maintained.

Mr. Dennis L. DeWitt
March 9, 1982
Page Four

Cal.2d 811 (1955), or based upon corporate negligence whereby the hospital may be liable for breach of its general duty of care to its patients for failing to properly supervise its medical staff, Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966).

Even if a hospital refuses to implement a patient's request to have allegedly necessary lifesaving treatment withdrawn or withheld, the hospital may be liable for assault and battery and possibly, invasion of privacy based upon the rule that a patient must consent to medical treatment, except in cases of emergency. Schloendorff v. Society of New York Hospitals, 105 N.E. 92 (N.Y. 1914); see also, 97 A.L.R.3d at 70-71.

As a result, any legislation intended to assure that a patient may meaningfully exercise his judicially recognized right to refuse life-sustaining procedures must resolve, to the maximum extent practical given the controversy inherent in this subject, the legitimate concerns of hospitals regarding their potential liability; otherwise continued institutional uncertainty may impede a patient's attempt to invoke his right to a natural death. The best way for the Alaska Legislature to accomplish this goal is to provide a clear and effective procedure by which a patient may exercise his right to refuse life-sustaining treatment so that the hospital and its employees are not put in the position of having to guess whether or not the right has been exercised effectively and, hence, whether or not treatment may be withdrawn or withheld.

Accordingly, House Bill No. 855 should clearly define who has the authority to make the decision to refuse life-supporting treatment, how such a decision is to be made, when the decision is to be implemented, and who is responsible for carrying out the decision. Finally, the legislation should establish that a person or health facility acting according to the statute is not subject to either criminal or civil liability. These points serve to focus our review of the draft legislation.

Analysis

- A. Who Has The Authority To Make The Decision To Refuse Life-Sustaining Procedures?

MUSICK, PEELER & GARRETT

Mr. Dennis L. DeWitt
March 9, 1982
Page Five

The patient, of course, is the primary decision maker. Accordingly, House Bill No. 855 recognizes the "right of an adult person to make a written declaration instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition." Section 1. However, the words "adult person" are never defined. Consequently, we recommend that language be added to define "adult person" to clarify, as an example, whether the term includes emancipated minors.

In addition, although the legislation recognizes the right of an adult person to execute a directive, the proposed form includes a provision whereby the declarant may designate a person to accept or refuse medical treatment on behalf of the declarant if the latter is unable to give directions regarding the use of life-sustaining procedures. Section 18.12.010(c). This option may create considerable confusion if a patient also has a court appointed representative, such as a conservator, and the conservator and the declarant's appointee disagree on the appropriateness of lifesaving treatment. Similar disputes could arise between the declarant's appointee and the declarant's family.

Furthermore, the declarant's appointee may be unavailable, incompetent or deceased. However, if the declarant's appointee cannot be contacted, it is not clear whether the power of appointment becomes inoperative and the general directive survives or the entire directive becomes ineffectual. Moreover, the Bill does not state who is to make the determination whether the patient is able to give his own directions regarding withholding and withdrawing treatment and, in the event the patient is not competent, whether the appointee is competent to fulfill his duties.

Therefore, we recommend that the Legislature reconsider this provision, and, if a decision is made to retain the concept, that it be refined to conform to existing law providing for the appointment of legal representatives authorized to make decisions regarding medical treatment to avoid disputes between appointees and such other legal representatives. Also, it should be made clear that a court or a legally authorized representative other than a person appointed pursuant to a directive cannot thwart an otherwise valid directive or the directions of a competent appointee. Further, the legislation should be revised to set forth the proper response in the event the declarant's appointee is unavailable or incompetent.

Mr. Dennis L. DeWitt
March 9, 1982
Page Six

B. How Is The Decision To Refuse Life-Sustaining Treatment To Be Made?

House Bill No. 855 prescribes the language and form by which an adult person may make the declaration of his desire that he be permitted to die naturally under certain terminal conditions.

We will not attempt to address all the differences between the proposed directive and that contained in California's Natural Death Act. However, we recommend that the Legislature reconsider its acceptance of an "interested party" as one of the two witnesses to a directive, Section 18.12.010(a). Furthermore, we also recommend that the Legislature specifically provide that no person who is involved with the patient's treatment or hospitalization can be a witness. Any suspicion concerning an "interested party's" motivations may result in legal challenges to the validity of the directive and, hence, considerable confusion and potential liability for the affected hospital.

Also, the prescribed form would allow the declarant to add "special directions" to the directive. Section 18.12.010(c). The Legislature should clarify whether such directions added after the date of execution and subscription of the directive are invalid.

Further, the Legislature should consider providing a term of years during which a directive would be valid and, in the case of multiple directives, a means by which to resolve which directive, if any, is operational.

C. When Is A Valid Directive To Be Implemented?

As presently drafted, House Bill No. 855 states that a directive is to be effectuated upon the occurrence of the following preconditions:

(1) The declarant has an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined the patient, one of whom must be the attending physician; and

(2) The physicians have determined that the declarant's death will occur whether or not lifesaving procedure are used; and

Mr. Dennis L. DeWitt
March 9, 1982
Page Seven

(3) Where the application of life-sustaining procedures would serve only to artificially prolong the dying process of the declarant. Section 18.12.010(c).

Although we do not recommend at this time amendments to these preconditions, we believe that the Legislation should be revised to require that the attending physician be required to determine that the directive complies with the statute, that the directive corresponds to the patient's desires, and that the medical preconditions have been met before the physician is authorized to withdraw or withhold lifesaving treatment. These recommendations are presented in more specific form below.

D. Who is Responsible For Implementing A Valid Directive?

The primary and ultimate responsibility for the care and treatment of the patient lies with the attending physician. The decision to discontinue life support measures falls within the ambit of that responsibility. In addition to making the basic decision, based upon the patient's desire, that life support procedures should be withdrawn or withheld, we recommend that the physician assume the responsibility for implementing a valid directive by actually performing the act of discontinuing or, in the alternative, ordering that no lifesaving treatment be applied. This will provide hospitals with a clear designation of authority upon which to rely in permitting implementation of the patient's directive, will reduce the possibility of mistake based on miscommunication, and, as a result, will serve to reduce the potential liability of hospitals and their employees.

Although House Bill No. 855 provides for a "Physician's Responsibility," Section 18.12.030, it does not set forth a comprehensive statement of such responsibility and, in Section 18.20.040(c) apparently makes a health care facility responsible for determining whether or not a patient's directive is valid. Therefore, we recommend that the legislation be revised to provide that the attending physician is responsible for (1) determining that the directive complies with the statute, (2) if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accordance with the desires of the patient, (3) that the medical preconditions have been met, and (4) implementing a valid directive or transferring the patient to another physician who will

Mr. Dennis L. DeWitt
March 9, 1982
Page Eight

effectuate the directive of a qualified patient. The present provision referring to a health facility's role in determining whether or not a directive is valid should be deleted.

Furthermore, the attending physician should also be the person responsible for determining the validity of and the appropriate response to a notice of revocation. Consequently, we recommend that any form of revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant.

E. Provision Of Immunity For Hospitals, Physicians, And Other Health Care Providers Acting In Accordance With The Statute.

Once the Legislature has made the policy decision to provide a mechanism by which a competent adult patient may refuse life-sustaining procedures, the controversy inherent in this process makes it necessary for the Legislature to establish that hospitals, physicians, and other health care providers acting in accordance with the statutory process are immune from civil and criminal liability.

As presently drafted, the immunity provisions of House Bill No. 855 are somewhat ambiguous. For example, Section 18.20.040(d) provides that a physician, health facility or licensed health professional acting under the statute "are not subject to civil liability, unless negligent, and are not guilty of a criminal act of unprofessional conduct."

We recommend that the following provisions, taken, in part, from the California Natural Death Act, be incorporated into the proposed legislation to provide a more comprehensive statement of immunity:

"(1) There shall be no criminal or civil liability on the part of any person or health facility for failure to act upon a revocation made pursuant to this Act unless that person or health facility has actual knowledge of the revocation.

"(2) No physician or health facility which, acting in accordance with the require-

MUSICK, PEELER & GARRETT

Mr Dennis L. DeWitt
March 9, 1982
Page Nine

ments of this Act, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom. No licensed health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this Act shall be subject to any civil liability. No physician or licensed health professional acting under the direction of a physician, who participates in accordance with the provisions of this chapter shall be guilty of any criminal act or of unprofessional conduct.

"(3) No physician, health facility, or licensed health professional acting under the direction of physicians, shall be criminally or civilly liable for failing to effectuate the directive of a qualified patient pursuant to this Act. A failure by a physician to effectuate the directive of a qualified patient pursuant to this Act shall constitute unprofessional conduct if the physician refuses to make the necessary arrangements, or fails to take the necessary steps, to effect the transfer of the qualified patient to another physician who effectuates the directive of a qualified patient."

As a related matter, it should be recognized that House Bill No. 855 does not consider the potential problem of a physician and hospital being presented with an invalid directive by an otherwise "qualified patient."

The Legislature may want to consider providing hospitals, physicians and other health care providers who fail to follow an invalid directive with immunity from civil or criminal liability. As you may recall, California Natural Death Act distinguishes between "binding" and "nonbinding" directives, California Health and Safety Code Section 7191(a)-(c), and extends such immunity to physicians and other licensed health professionals who refuse to effectuate nonbinding directives. At the same time,

MUSICK, PEELER & GARRETT

Mr. Dennis L. DeWitt
March 9, 1982
Page Ten

California's statute recognizes that the professional may "give weight" to a nonbinding directive as he considers the appropriate care for the patient under all the circumstances. Id.

We hope that you will find these recommendations helpful as you develop your position regarding House Bill No. 855. If you desire a more extended analysis of this legislation, we will be most pleased to prepare such an analysis and a draft bill incorporating more comprehensive recommendations.

Finally, I have enclosed "Guidelines For Discontinuance of Cardiopulmonary Life-Support Systems Under Specified Circumstances" prepared by the Joint Ad Hoc Committee on Bio-medical Ethics of the Los Angeles County Medical Association and the Los Angeles County Bar Association for your review. The "Guidelines" were recently endorsed by the California Medical Association.

Sincerely,



M. Steven Lipton
for MUSICK, PEELER & GARRETT

ANG:apk

Enclosure

2620 E. 42nd Avenue, Apt. 3
Anchorage, Alaska 99504
April 26, 1982

Honorable Michael F. Beirne
Chairman, HESS Committee
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

RE: HB 855 - Right to Natural Death

Dear Representative Beirne:

At this time I would like to summarize my testimony given at the teleconference hearing of March 12, 1982, before your committee relating to HB 855: An Act Relating to the Right to a Natural Death. The views and analysis are primarily mine.

The sponsors of HB 855 are to be commended for their efforts to protect patients' rights against the unwanted and unwarranted intrusion of health care people and members of one's own family. Hopefully, the bill would not be misused by a few to save money for society by not providing medical care for people who would wish to have, and could benefit from medical care.

My comments will pertain to three areas: (1) some specifics of HB 855 which may create problems, mainly definitions; (2) some possible consequences and general implications of the bill; and (3) a consideration of options.

I. Some Specifics of HB 855 That May Cause Problems:

- (1) The phrase "terminal condition" which is central to the bill is not defined. For some, including some physicians, one may be seen in an exaggerated sense as dying from birth; for others, after maturity; for others, after some deterioration associated with old age. There are some further problems: could cases similar to Karen Ann Quinlan be taken off respirators only if one is terminal? So that a non-terminal person on a respirator must be maintained on that respirator even though there is no expectation of any form of recovery. Or does one consider a case like Quinlan to be in a terminal condition though she has breathed on her own for six years?
- (2) In the section on Definitions, definition (3) "life-sustaining procedures" Part (B) is too restrictive as to comfort care, where the word "medical" seems to exclude other kinds of care necessary for comfort care. A possible reading might be "medical AND NURSING procedures considered necessary to provide comfort care." A better and more inclusive phrasing would be to say "medical AND OTHER TYPES OF procedures." This would include such things as fluids, nutrition, bed care, etc., without such an addition situations might arise where the ethics of the nursing profession and the morality of individuals might be placed in a state of compromise based on the present wording. Similar changes in wording should be in the Declaration itself.

- (3) In Sec. 18.12.010, paragraph (c) on page 2, the sentence "If a specific direction is held to be invalid, the invalidity does not affect other directions of the declaration that can be given effect without the invalid direction" is a superb exercise in non-specificity, challenging one's intelligence. Presumably the active hastening of a patient's death such as mercy killing would be considered to be an invalid direction, yet none of this is clarified in the bill. A direction asking for 50 cc of oxygen into one's blood stream or 100 mg of insulin would be invalid directions. Some content is needed as to the meaning of "invalidity," especially touching upon mercy killing, homicide, and being an accomplice to a suicide.
- (4) In the Purpose, in order to avoid a connotation of conferral of rights by the legislature or by this bill, the word "pre-existing" be inserted before the word "right" so the new wording would read: ". . . the legislature declares that the laws of the state recognized the PRE-EXISTING right of an adult person to make a written declaration . . ." In the Declaration a similar change might be used changing "my legal right" to "my pre-existing right."

II. General Implications and Possible Consequences:

- (1) The proxy/guardian paragraph in the Declaration is very good by its inclusion, for it allows for greater flexibility to meet the contingencies and new realities of the situation, many of which cannot foresee years in advance.
- (2) If the purpose of the act is to reassert the rights of patients as to their medical care, then it is not clear that HB 855 furthers that purpose. As it stands, certification of "terminal condition" is left to two physicians; hence the control and responsibility devolves onto the physicians and not really the patient.
- (3) As far as the "invalidity" statement discussed in 1-3 above, two problems arise: what constitutes the content of invalidity? And who is to decide? Lawyers, courts, physicians, hospitals, nurses, family?
- (4) The living will aims at protecting the patient and his autonomy; however, many other autonomies are involved. Conscience clauses would help to protect health care professionals, their ethics and integrity.
- (5) What are the consequences of this bill toward those not included since they are not adults: infants, minors, retarded, those who have not made a statement? Does one need a living will in order to withdraw life support systems? What if one is not terminal but does not wish further burdensome treatments? Rather than widening the scope of withdrawing or limiting of life-prolonging treatments, the bill, in effect, seems restrict it to the incurably terminal patient. This would be a very limited criterion. Better criteria would be the uselessness of the therapy and burdens and non-benefit of the therapies from the point of view of the patient.

- (6) Finally, the likely result will be to encourage the medical profession toward undertreatment of those with living wills and overtreatment of those without a living will. If a patient with a living will is possibly terminal -- and there is difficulty in knowing this -- one is safer in not treating that person for his eventual (possible) death is proof that treatment ought not to have been begun and even possible recovery might still be seen as battery. For those without living wills it is safer to treat even beyond some reasonable point since there is no declaration of his intention.

III. Possible Options and Recommendations:

- (1) HB 855 might be amended to correct for deficiencies mentioned in I. (above) and others, yet in my judgement the consequences mentioned in I. (above) seem to far outweigh the advantages of the existence of such a law.
- (2) No law may be preferable to a law which creates more problems than it solves.
- (3) My personal preference would be to redo the bill, if a bill seems necessary. If the purpose of the bill is to protect patients' rights against unwanted and unwarranted intrusions of one's family or health care professionals, then a bill centered around proxy/guardian would best succeed. The most acceptable and least dangerous form of legislation is one whereby a person in good health or otherwise, names a proxy who will have decisive say in stating the patient's best interest during the patient's incompetency. While competent the patient should maintain his right of self-determination as to the medical care so they coincide with his best interest and values and while incompetent the patient may update his proxy on his position. The living will concept would fall into a secondary position, serving as the guidelines for the proxy to use as to his best interests, but allowing the proxy to interpret these and his knowledge of the patient's wishes vis-a-vis the contingencies and realities of the actual situation.

I hope these comments are beneficial to your deliberations.

Sincerely,


(Rev.) Ted Zembal, S.J.

cc: Honorable Terry Martin
Honorable Bette Cato
Honorable Hugh Malone
Honorable Sarah J. Smith
Honorable Donald Clocksin
Honorable Brian Roners

262 E. 42nd Avenue
Anchorage, Alaska 99503
April 7, 1982

Honorable Michael F. Beirne
Chairman, HESS Committee
P.O. Box 41539
Anchorage, Alaska 99501

RE: HB 855, Right to Natural Death

Dear Representative Beirne:

At this time I would like to summarize my testimony given at the teleconference hearing of March 12, 1982, before your committee relating to HB 855: An Act Relating to the Right to a Natural Death. The views and analysis are primarily mine.

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My comments will pertain to three areas: (1) some specifics of HB 855 which may create problems, mainly definitions; (2) some possible consequences and general implications of the bill; and (3) a consideration of options.

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- (4) In the Purpose, in order to avoid a connotation of conferral of rights by the legislature or by this bill, the word "pre-existing" be inserted before the word "right" so the new wording would read: ". . . the legislature declares that the laws of the state recognized the PRE-EXISTING right of an adult person to make a written declaration . . ." In the Declaration a similar change might be used changing "my legal right" to "my pre-existing right."

II. General Implications and Possible Consequences:

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- (4) The living will aims at protecting the patient and his autonomy; however, many other autonomies are involved. Conscience clauses would help to protect health care professionals, their ethics and integrity.

- (5) What are the consequences of this bill toward those not included since they are not adults: infants, minors, retarded, those who have not made a statement? Does one need a living will in order to withdraw life support systems? What if one is not terminal but does not wish further burdensome treatments? Rather than widening the scope of withdrawing or limiting of life-prolonging treatments, the bill, in effect, seems to restrict it to the incurably terminal patient. This would be a very limited criterion. Better criteria would be the uselessness of the therapy and burdens and non-benefit of the therapies from the point of view of the patient.
- (6) Finally, the likely result will be to encourage the medical profession toward undertreatment of those with living wills and overtreatment of those without a living will. If a patient with a living will is possibly terminal -- and there is difficulty in knowing this -- one is safer in not treating that person for his eventual (possible) death is proof that treatment ought not to have been begun and even possible recovery might still be seen as battery. For those without living wills it is safer to treat even beyond some reasonable point since there is no declaration of his intention.

III. Possible Options and Recommendations:

- (1) HB 855 might be amended to correct for deficiencies mentioned in I (above) and others, yet in my judgement the consequences mentioned in II (above) seem to far outweigh the advantages of the existence of such a law.
- (2) No law may be preferable to a law which creates more problems than it solves.
- (3) My personal preference would be to redo the bill, if a bill seems necessary. If the purpose of the bill is to protect patients' rights against unwanted and unwarranted intrusions of one's family or health care professionals, then a bill centered around proxy/guardian would best succeed. The most acceptable and least dangerous form of legislation is one whereby a person in good health or otherwise, names a proxy who will have decisive say in stating the patient's best interest during the patient's incompetency. While competent, the patient should maintain his right of self-determination as to the medical care so they coincide with his best interest and values and while competent the patient may update his proxy on his position. The living will concept would fall into a secondary position, serving as the guidelines for the proxy to use as to his best interests, but allowing the proxy to interpret these and his knowledge of the patient's wishes vis-a-vis the contingencies and realities of the actual situation.

Honorable Michael F. Beirne
April 7, 1982

4

I hope these comments are beneficial to your deliberations.

Sincerely,

A handwritten signature in cursive script that reads "Ted Zembal, S.J." The signature is written in dark ink and is positioned above the typed name.

(Rev.) Ted Zembal, S.J.

cc: Honorable Terry Martin
Honorable Bette Cato
Honorable Hugh Malone
Honorable Sarah J. Smith
Honorable Donald Clocksin
Honorable Brian Rogers