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COMMITTEE REPORT

HOUSE

(7)

FURTHER: JUDICIARY

3/6/85

Date: 28 March 1985

Mr. Speaker:

The Committee on HEALTH, EDUCATION AND SOCIAL SERVICES has had HB 269

"An Act relating to the rights of the terminally ill."

under consideration and reports it back as follows:

- do pass do not pass
- do pass with attached amendments(s)
- replace with CS for HB 269 (HESS) same title new title
- and recommends do pass
- AND attaches a "Letter of Intent" New Fiscal Note
- reports it back without recommendation Zero Fiscal Note Attached
- referred to the _____ Committee

MEMBERS SIGNING DO PASS

Katie Sullivan

Robin Taylor (vic chair)

Mr. Chamberlain

David W. ...

Steve ...

MEMBERS HAVING OTHER RECOMMENDATIONS:

Albert ... 100 rec

...

Mr. Chamberlain
CHAIRMAN

MEMORANDUM

TO: Rep. Niilo Koponen
FROM: Connie Jackson
DATE: March 25, 1985
RE: HB 269 - Terminally ill patients

IN YOUR FOLDER -----

- A copy of HB 269
- Sectional Analysis from Billy Berrier
- Patient Statistics from the Hospice of Juneau
- Position Paper from Dept. of Health & Social Services
- Article from Newsweek Magazine entitled "Arguing the Right to Die"
- Statutory Citations from states in the Lower 48 who have adopted similar legislation
- Newsletter from the "Society for the Right to Die"
- Newspaper clipping dated 2/11/85
- CSSB 140 (HESS)

NOTE:

Recent information indicates that there are 21 states plus the District of Columbia who have adopted this so-called natural death legislation, not 13 states as the position paper from DHSS reports. There are another 19 states currently considering this kind of legislation.

The Senate version of this bill, SB 140, was introduced by Sen. Eliason on 2/7/85. It's nearly identical to HB 269. SB 140 passed out of the Senate HESS Committee on 3/15/85 and is now in Senate Judiciary.

STATE OF ALASKA
THE LEGISLATURE

POUCHY STATE CAPITOL
JUNEAU, ALASKA 99911
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

March 22, 1985

SUBJECT: Sectional analysis of House Bill 269

TO: Representative Niilo Koponen
Co-Chair, House HESS Committee

FROM: Billy G. Berrier *BGB*
Director
Division of Legal Services

You have requested a sectional analysis of House Bill 269 relating to rights of the terminally ill.

I should point out that the bill is basically derived from a draft on the subject prepared by a drafting committee of the National Conference of Commissioners on Uniform State Laws. The draft was before the Conference for first reading at last year's annual meeting and will again be before the Conference for adoption at this year's annual meeting. The Conference prepares commentary which is accepted widely by courts as an aid to interpretation. Therefore I am also enclosing a copy of the draft and the draft commentary.

Sec. 18.12.080(a) allows execution by a competent adult of a declaration that if the declarant is determined to be in a terminal condition and the declarant is not able to make treatment that life sustaining procedures may be withheld or withdrawn. It requires signature by the declarant or by another at the declarant's direction and that the declaration be witnessed by two persons. It prescribes limitations on who may witness. It also provides that in the absence of actual knowledge a physician or health care provider may presume the declaration is valid and complies with law.

(b) provides that the declarant is responsible for notifying the doctor or health care provider who then must make the declaration part of the declarers medical record.

(c) creates a simple, nonexclusive form of declaration.

Sec. 18.12.020 allows revocation of the declaration at any time by any manner which communicates the intent to revoke without regard to mental condition or physical condition of the declarant. The revocation is effective as to a physician or health care provider only if communicated to them. The revocation must be made part of the declarant's medical record.

Sec. 18.12.030 requires that when a determination is made by a physician that a declarant's condition is terminal the determination must be recorded in the declarant's medical records.

Sec. 18.12.040(a) provides that the patient makes decisions regarding life sustaining procedures as long as the patient is able. The declaration governs use of these procedures only when the patient is not able to make the decisions.

(b) provides that the act does not prohibit application of any medical procedure specifically including comfort care.

(c) provides that unless the declaration provides otherwise, the declaration has no effect if the declarant is pregnant and it is probable the fetus could develop to the point of live birth.

Sec. 18.12.050 requires a physician or health care facility that is unable or unwilling to comply with the declaration must take all reasonable steps to transfer the declarant to another physician or facility.

Sec. 18.12.060(a) provides immunity from civil or criminal liability for a physician, a person who participates in withdrawal or a health facility in which withdrawal of life sustaining procedure occurs.

(b) provides that a physician, a health care facility or health care professional is not liable for actions under this chapter which are in accord with reasonable medical standards. (An example would be a physician's determination that a patient's condition is terminal).

Sec. 18.12.070 provides that failure to comply with the declaration, failure to transfer a declarant to another physician or facility or tampering with a declaration creates civil liability. It also provides that forgery of a declaration or willful concealment of a revocation which

directly causes life sustaining procedures to be withheld or withdrawn and death to be hastened is first degree murder.

Sec. 18.12.080(a) provides that, except where a person is required to execute a declaration as a condition of receiving insurance or health care service, withholding or withdrawal of life sustaining procedures under a declaration is neither suicide or homicide.

(b) provides that the making of a declaration does not effect obtaining life insurance or modify the terms of an existing policy but, no matter what a policy provides the withholding or withdrawal of life sustaining procedure does not impair or invalidate a life insurance policy.

(c) prohibits requiring a person to execute a declaration as a condition for being insured for or receiving health service.

(d) provides that this chapter creates no presumption that a person who has not executed the declaration intends or does not intend that life sustaining procedures be used when the person is in a terminal condition. The determination as to whether these procedures are to be used would be made as if this chapter did not exist.

(e) provides that this chapter does not impair a person's right to make decisions regarding use of life sustaining procedures as long as the patient is unable to do so and is cumulative to existing law regarding decisions to withdraw or withhold medical care.

(f) declares this chapter does not condone, authorize or approve mercy killing or euthanasia.

Sec. 18.12.090 recognizes declarations made in another state if the declaration is in compliance with the law of that state.

Sec. 18.12.100 defines certain terms used in this chapter.

BGB:ojb
J13/018

D R A F T

FOR DISCUSSION ONLY

RIGHTS OF THE TERMINALLY ILL ACT

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

December 18, 1984, Draft

RIGHTS OF THE TERMINALLY ILL ACT
With Prefatory Note and Comments

The ideas and conclusions herein set forth, including drafts of proposed legislation, have not been passed upon by the Commissioners on Uniform State Laws. They do not necessarily reflect the views of the Committee, Reporters or Commissioners. Proposed statutory language, if any, may not be used to ascertain legislative meaning of any promulgated final law.

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RIGHTS OF THE TERMINALLY ILL ACT

PREFATORY NOTE

The Rights of the Terminally Ill Act authorizes an adult person to control decisions regarding administration of life-sustaining treatment by executing a declaration instructing a physician to withhold or withdraw life-sustaining procedures in the event the person is in a terminal condition and is unable to participate in medical treatment decisions. As the preceding sentence indicates, the scope of the Act is narrow. It does not address treatment of persons who have not executed such a declaration; it does not cover treatment of minors; and it does not address treatment decisions by proxy. Its impact is limited to treatment that is merely life prolonging, and to patients whose terminal condition is irreversible, whose death will soon occur, and who are unable to participate in treatment decisions. Beyond its narrow scope, the Act is not intended to implicate any existing rights and responsibilities of persons to make medical treatment decisions. The Act merely provides one way by which a terminally-ill patient's desires regarding the use of life-sustaining procedures can be legally implemented.

As of October of 1984, twenty-two states had enacted legislation in this area. These states are Alabama, Arkansas, California, Delaware, Florida, Georgia, Idaho, Illinois, Kansas, Louisiana, Mississippi, Nevada, New Mexico, North Carolina, Oregon, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. The District of Columbia also has an act covering this subject. Many other states have bills pending before their lawmaking bodies. The quality and scope of the enacted and proposed legislation varies significantly.

The purposes of the Act are (1) to encourage the effectiveness of a declaration in states other than the state in which it is executed through uniformity of scope and procedure, (2) to avoid the inconsistency in approach and quality which have characterized the early statutes, and (3) to present an Act which is simple, effective, and acceptable to persons desiring to execute a declaration and to physicians and health-care facilities whose conduct will be affected.

The Act's basic structure and substance is similar to that found in most of the existing legislation. Much of the Act's specific language conforms to usage established in existing statutes. In this respect the Act has drawn upon existing legislation in order to avoid further complexity and to permit its effective operation in light of prior enactments. Departures from existing statutes have been made, however, in order to simplify procedures, improve drafting, and clarify language. Selected provisions have been reworked to more adequately express a specific concept (i.e., life-sustaining procedure, terminal condition) or to reflect changes in established procedure (i.e., the qualifications of witnesses). The Act's stylistic and substantive departures from

existing legislation were pursued for the purposes of clarity and simplicity. The Act seeks to avoid the charge that its "procedural requirements are so cumbersome that it is unlikely that any but a small number of highly educated and motivated patients will be able to effectuate their desires." Barber v. Superior Court, ___ Cal. App.3d ___, ___, 195 Cal. Rptr. 484, 489 (Ct. App. 1983) (describing California's "Natural Death Act," the first legislation to be enacted in this area).

The Act is divided into twelve sections. Section 1 provides definitions. Section 2 relates to the making of a valid declaration. Revocation is addressed in Section 3. Sections 4, 5 and 6 cover the physician's determination of terminal condition, the treatment to be accorded a qualified patient, and the availability for transfer by unwilling physicians. Immunities and penalties are provided in Sections 7 and 8 respectively. Miscellaneous matters are addressed in Section 9. Section 10 provides for recognition of declarations lawfully executed and enforceable in other states. Section 11 provides for severability and Section 12 sets the time for the Act's taking effect.

RIGHTS OF THE TERMINALLY ILL ACT

SECTION 1. DEFINITIONS.

As used in this [Act]:

- (1) "Physician" [means a person licensed to practice medicine in this State.]
- (2) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.
- (3) "Health-care provider" means a person who is licensed, certified or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.
- (4) "Declaration" means a document executed in accordance with the requirements of Section 2.
- (5) "Qualified patient" means a patient who has executed a declaration in accordance with this [Act] and who has been determined by the attending physician to be in a terminal condition.
- (6) "Life-sustaining procedure" means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process.
- (7) "Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a relatively short time.

COMMENT

The Act defines "life-sustaining procedure" as any medical procedure or intervention that "will serve only to prolong the

dying process." The Act's definitions of "life-sustaining procedure" and "terminal condition" are interdependent and must be read together. This has caused drafting problems in many existing acts, and the proposed Act has been drafted so as to avoid the problems detected in existing legislation.

Most of the "life-sustaining procedure" and "terminal condition" definitions in existing statutes were considered problematical in that they (1) were tautological, defining "terminal condition" with respect to "life-sustaining procedure" and vice versa, and (2) defined terminal condition as requiring "imminent" death "whether or not" or "regardless of" the application of life-sustaining procedures. Strictly speaking, if death is "imminent" even with the full application of life-sustaining procedures, there is little point in having a statute permitting withdrawal of such procedures. The Act's definitions have attempted to avoid these problems.

For an example of the tautological problems, the "life-sustaining procedure" definition found in many statutes inserts the clause "and when, in the judgment of the attending physician, death will occur whether or not such procedure or intervention is utilized," after the phrase "will serve only to prolong the dying process" found in the draft's provision. Because the Act's life-sustaining procedure definition concerns only those procedures or interventions applied to "qualified patients" (i.e., those who have been determined to be in a terminal condition), and because a terminal condition is defined as "incurable or irreversible" with death resulting "in a relatively short time," the requirement that death be "inevitable" has been satisfied by the presence of "qualified patient" in the life-sustaining procedure definition. Therefore, this additional clause was excluded because it was considered merely repetitious and possibly confusing.

The Act defines "life-sustaining procedure" in an all-inclusive manner, dealing with those procedures necessary for comfort care or alleviation of pain separately in section 5(b), where it is provided that such procedures need not be withdrawn or withheld pursuant to a declaration. Most existing statutes incorporate "comfort care" as an exclusion from the definition of life-sustaining procedures. Because most such procedures are life-sustaining, however, the Act avoids definitional confusion by treating them in a separate provision that reflects the Act's policy more clearly, and better reflects the fact that comfort care does not involve a fixed group of procedures applicable in all instances.

Subsection (7) of Section 1 is the "terminal condition" definition. The difficulty of trying to express such a condition in precise, accurate, but not unduly restricting language is obvious. A definition must preserve the physicians' professional discretion in making such determinations and it must reflect the decisions physicians normally make under such circumstances. Consequently, the draft's definition of terminal condition incorporates not only selected language from various state acts, but also suggestions from medical literature in the field.

First, the terminal condition definition requires that the condition be "incurable or irreversible." These adjectives were chosen over the similar phrase, "no possibility of recovery," because of the possibilities of ambiguity in the term "recovery" (i.e., recovery to "normal" or to some other stage). A number of state statutes now use "incurable" and/or "irreversible," and the terms appear to comport with the criteria applied by physicians in terminal care situations.

Subsection (7) also requires that the condition result in the death of the patient within a "relatively short time ... without the administration of life-sustaining procedures." These requirements differ to some degree from the language employed in most of the statutes. First, the decision that death will occur in a relatively short time is to be made without considering the possibilities of extending life with life-sustaining procedures. The alternative is that required by a number of states--that death be imminent whether or not life-sustaining procedures are applied. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research has noted that such a definition severely limits the group of terminally-ill patients able to qualify under these acts. It is precisely because life can be prolonged indefinitely by new medical technology that these acts have come into existence. To require a physician to determine that death will be imminent whether or not such procedures are utilized also may be contrary to what physicians actually consider under these circumstances. Though the Act intends to err on the side of prolonging life, it should not be made wholly ineffective as to the actual situation it purports to address. The provisions which require that death be imminent regardless of the application of life-sustaining procedures appear to have that effect. Therefore, such provisions have been excluded in the draft.

The terminal condition definition of subsection (7) requires that death result "in a relatively short time." Rejecting the "imminency" language employed in a number of statutes, this alternative is drawn from a terminal condition definition proposed in a recent article in the New England Journal of Medicine. Though the phrase, "relatively short time," is certainly not devoid of ambiguity, it allows the physician a degree of necessary discretion and avoids the narrowing implications of the word "imminent." This phrase, "relatively short time," also was suggested by medical experts, trained in such determinations, and reflects their best understanding of the factors involved in these decisions. In drafting the terminal condition definition deference to their professional knowledge was deemed especially appropriate.

The "relatively short time" formulation is employed to avoid both the unduly restricting meaning of "imminent" and the artificiality of another alternative--fixed time periods, such as 6 months, 1 year, or the like. The circumstances and inevitable variations in disorder and diagnosis make unrealistic a fixed time period. Physicians may be hesitant to make predictions under a fixed time period standard unless the standard of physician judgment is so loose as to be unenforceable. Under the Act's standard,

considerations such as the strength of the diagnosis, the type of disorder, and the like can be reflected in the judgment that death will result within a relatively short time, as they are now reflected in judgments physicians must and do make.

Finally, the life-sustaining procedure and terminal condition definitions exclude certain types of disorders, such as kidney disease requiring dialysis, and diabetes requiring continued use of insulin. This is accomplished in the requirement that terminal conditions be "irreversible," and that life-sustaining procedures serve "only to prolong the dying process." For purposes of the Act, diabetes treatable with insulin is "reversible," a diabetic person so treatable is not in the "dying process," and insulin is a treatment the benefits of which foreclose it serving "only" to prolong the dying process.

SECTION 2. DECLARATION RELATING TO USE OF LIFE-SUSTAINING PROCEDURES.

(a) Any competent adult] may execute a declaration at any time directing that life-sustaining procedures be withheld or withdrawn; provided, however, that such declaration is to be given operative effect only if the declarant's condition is determined to be terminal, and the declarant is not able to make treatment decisions. The declaration must be signed by the declarant, or another at the declarant's direction, and in either case must be witnessed by two persons. A physician or health-care provider may presume, in the absence of actual notice to the contrary, that the declaration complies with this Act and is valid.

(b) It shall be the responsibility of the declarant to notify his or her physician of the declaration. A physician or other health-care provider who is provided a copy of the declaration shall make it a part of the declarant's medical records.

(c) A declaration may, but need not, be in the following form:

DECLARATION

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

Signed this _____ day of _____, ____.

Signature _____

City, County and State of Residence _____

The declarant is known to me and voluntarily signed this document in my presence.

Witness _____

Address _____

Witness _____

Address _____

COMMENT

Section 2 sets out the minimal requirements regarding the making and execution of a valid declaration. A "sample" declaration form is offered in this section. The form is not mandatory, as some acts require; it "may, but need not, be" followed. The form provided also is not as elaborate as others. The drafters rejected a more detailed declaration for two reasons. First, the form is to serve only as an example of a valid declaration. A more elaborate form may have erroneously implied that a declaration more simply constructed would not be legally sufficient. Second, the sample form's simple structure and specific language attempts to provide notice of exactly what is to be effectuated through these documents to those persons desiring to execute a "living will" and the physicians who are to honor it.

The Act's provisions governing witnesses to a declaration have also been simplified. Section 2 provides only that the declaration be signed by the declarant in the presence of two witnesses. The draft does not require witnesses to meet any specific qualifications and, as such, departs quite significantly from the statutory law established in almost every state. Most states require that the witnesses at least be (1) not related to the declarant in blood or marriage, and (2) not entitled to inherit from the declarant under the state's intestacy laws or by will. Many states also require that the witnesses meet various other requirements.

Section 2 departs from existing statutory approaches for two primary reasons. First, the interest in simplicity mandates as uncomplicated a procedure as possible. It is intended that the Act present a viable alternative for those persons interested in participating in their medical treatment decisions in the event of a terminal condition.

Second, the absence of witness requirements relieves physicians of the inappropriate and perhaps impossible burden of determining whether the legalities of the witness requirements have been met. Many physicians understandably and rightly would be hesitant to make such decisions and, therefore, the effectiveness of the declaration might be jeopardized. Though ensuring protection against abuse in these situations is not to be overlooked, it is available through other less burdensome measures. The attending physicians and other health care professionals will be able, in most circumstances, to discuss the declaration with the patient and family and any suspicion of duress or wrongdoing can be discovered and handled by established hospital procedures.

The draft language reflects the judgment that the burdens of elaborate witness requirements (to both the patients and physicians) outweigh their usefulness. Virginia's recently enacted Natural Death Act defines a witness as a person not related by blood or marriage to the declarant. This approach may present a viable alternative to section 2 of the Act for those states which desire to mandate only minimal witness requirements.

SECTION 3. REVOCATION OF DECLARATION.

(a) A declaration may be revoked at any time and in any manner by which the declarant is able to communicate his or her intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending physician or any health-care provider acting under the guidance of that physician upon communication to the physician or health-care provider by the declarant or by another to whom the revocation was communicated.

(b) The attending physician or health-care provider shall make the revocation a part of the declarant's medical record.

COMMENT

Section 3 provides for revocation of a declaration and is modeled after North Carolina's similar provision. Virtually every other statute sets out specific examples of how a declaration can be

revoked — by physical destruction, by a signed, dated writing, or by a verbal expression of revocation. A provision that freely allowed revocation and avoided procedural complications was desired. The simple language of Section 3 appears to meet these qualifications. It should be noted that the revocation is, of course, not effective until communicated to the attending physician or another health-care provider working under a physician's guidance, such as nursing facility or hospice staff. The draft, unlike many statutes, also does not explicitly require that a person relaying the revocation be acting on the declarant's behalf. Such a requirement could impose an unreasonable burden on the attending physician. The communication is assumed to be in good faith, and the physician may rely on it.

In employing a general revocation provision, it was intended to permit revocation by the broadest range of means. Therefore, for example, it is intended that a revocation can be effected in writing, orally, by physical defacement or destruction of a declaration, and by physical sign communicating intention to revoke.

SECTION 4. RECORDING DETERMINATION OF TERMINAL CONDITION AND CONTENTS OF DECLARATION.

When an attending physician who has been notified of the existence and contents of a declaration determines that the declarant is in a terminal condition, the physician must record that determination and the contents of the declaration in the declarant's medical record.

COMMENT

Section 4 of the draft Act requires that an attending physician record the determination that the patient is in a terminal condition in the patient's medical records. Many statutes label this procedure "certification." The draft does not use this term because it was considered an artificial and perhaps misleading attempt to qualify what physicians actually do in such situations. The section provides that an attending physician first must be notified of the declaration's existence. Second, if the attending physician determines that the patient is in a terminal condition, the physician is to make that determination part of the patient's medical records. There is no explicit requirement that the physician inform the patient of the terminal condition. That decision is to be left to the physician's professional discretion and, in the majority of circumstances, it is assumed that the patient will be informed. The draft also does not require, as do many statutes, that a physician other than the attending physician concur in the terminal condition determination. It appears to be

the established practice of most physicians to request a second opinion, and the Act is not intended to discourage such a practice. Requiring it, however, may represent unnecessary regulation of normal hospital procedures, and in smaller or rural health facilities, a second qualified physician may not be readily available to confirm the attending physician's determination.

Finally, under the Act a determination of terminal condition must be accompanied by notice to the physician of the contents of the declaration, and the physician must record the contents of the declaration in the medical record so that its specific language or any special provisions are known at later stages of treatment. It is assumed that "contents" of the declaration will be a copy of the declaration itself in most instances, although cases of an emergency character may arise, for example, in which the contents of a declaration can be reliably conveyed, and where obtaining a copy of the declaration prior to making decisions governed by it will be impracticable. In such cases, the substance of the declaration will suffice for recording purposes under Section 4.

SECTION 5. TREATMENT OF QUALIFIED PATIENTS.

(a) A qualified patient has the right to make decisions regarding use of life-sustaining procedures so long as the patient is able to do so. If a qualified patient is not able to make such decisions, the declaration shall govern decisions regarding use of life-sustaining procedures.

(b) This [Act] does not prohibit the application of any medical procedure or intervention, including the provision of nutrition and hydration, considered necessary to provide comfort care or to alleviate pain.

(c) Unless the declaration provides otherwise, the declaration of a qualified patient known to the attending physician to be pregnant shall be given no force or effect as long as it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining procedures.

COMMENT

Section 5(a) recognizes the right of patients who have made a declaration and are determined to be in a terminal condition to make decisions regarding use of life-sustaining procedures. Until unable to do so, such patients have the right to make such decisions independently of the terms of the declaration. In affording patients a "right to make decisions regarding use of life-sustaining procedures," the Act is intended to reflect existing law pertaining to this issue. As section 9(e) indicates, qualifications on a patient's right to force the carrying out of those decisions in a manner contrary to law or accepted standards of medical practice or hospital procedure, for example, are not intended to be overridden.

In Section 5(b) the Act uses the term "comfort care" in defining procedures that may be applied notwithstanding a declaration instructing withdrawal or withholding of life-sustaining procedures. The purpose for permitting continuation of life-sustaining procedures deemed necessary for comfort care or alleviation of pain is to allow the physician to take appropriate steps to insure comfort and freedom from pain, but not rigidly to dictate this judgment by statute. Many existing statutes employ the term "comfort care" in connection with the alleviation of pain, and the draft follows this example. Although the phrase "to alleviate pain" arguably is subsumed within the term comfort care, the additional specificity was considered helpful for both the doctor and layperson.

Section 5(b) also treats nutrition and hydration as life-sustaining procedures which can be continued in order to provide comfort care and alleviation of pain. This was deemed preferable to the approach in a few existing statutes, which treat nutrition and hydration as comfort care in all cases, regardless of circumstances, and exclude comfort care from the life-sustaining procedure definition.

It is debatable whether physicians or other professionals perceive the providing of nourishment through intravenous feeding apparatus or nasogastric tubes as comfort care in all cases or whether such procedures at times merely prolong the dying process. Whether procedures to provide nourishment should be considered life-sustaining treatment or comfort care appears to depend on the factual circumstances of each case and, therefore, such decisions should be left to the physician, exercising reasonable medical judgment, in consultation with the patient's family. A declarant may, however, specifically provide for continuation of these procedures in the declaration.

Section 5(c) addresses the problem of a qualified patient who is pregnant. The states which address this issue require that the declaration be given no force or effect during the pregnancy. Because this requirement inadvertantly may do more harm than good to the fetus, Section 5(b) provides a more suitable, if more complicated, determination. It is possible to hypothesize a situation in which life-sustaining procedures, such as medication,

may prove possibly fatal to a fetus which is at or near the point of viability outside the womb. In such cases, the Act's provision would permit the life-sustaining procedures to be withdrawn or withheld as appropriate in order best to assure survival of the fetus. Also, for example, if the qualified patient is only a few weeks pregnant and the physician, pursuant to reasonable medical judgment, determines that it is not probable that the fetus could develop to a point of viability outside the womb even with application of life-sustaining procedures, such procedures may also be withheld or withdrawn. Thus, the pregnancy provision attempts to honor the terminally-ill patient's right to refuse life-sustaining treatment without jeopardizing in any respect the likelihood of life for the fetus. A declaration may, however, include a provision specifying the precise intention of the declarant, and such language would be controlling notwithstanding Section 5(c).

SECTION 6. TRANSFER OF PATIENTS.

(a) An attending physician who is unwilling to comply with the requirements of Section 4 or who is unwilling to comply with the declaration of a qualified patient in accordance with Section 5 shall take all reasonable steps to effect the transfer of the declarant to another physician.

(b) If the policies of a health-care facility preclude compliance with the declaration of a qualified patient under this [Act], that facility shall take all reasonable steps to effect the transfer of the patient to a facility in which the provisions of the [Act] can be carried out.

COMMENT

Section 6 is designed to address situations in which a physician, for personal or ethical reasons, is unwilling to make and record a determination of terminal condition, or to respect the decisions of the patient regarding withholding or withdrawal of life-sustaining procedures. In such instances, the physician must take all reasonable steps to transfer the patient to another physician. Subsection (b) imposes a parallel duty on health-care facilities whose policies would foreclose compliance with the Act's provisions and the stated wishes of the declarant.

SECTION 7. IMMUNITIES.

(a) In the absence of actual notice of the revocation of a declaration, the following, while acting in accordance with the requirements of this [Act], are not subject to civil or criminal liability or guilty of unprofessional conduct:

(1) A physician who causes the withholding or withdrawal of life-sustaining procedures from a qualified patient.

(2) A person who participates in the withholding or withdrawal of life-sustaining procedures under the direction or with the authorization of a physician.

(3) The health-care facility in which such withholding or withdrawal occurs.

(b) A physician is not subject to civil or criminal liability for actions under this [Act] which are in accord with reasonable medical standards.

SECTION 8. PENALTIES.

(a) A physician who willfully fails to transfer in accordance with Section 6 shall be guilty of [a class _____ misdemeanor].

(b) A physician who willfully fails to record the determination of terminal condition in accordance with Section 4 shall be guilty of [a class _____ misdemeanor].

(c) Any person who willfully conceals, cancels, defaces, or obliterates the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another shall be guilty of [a class _____ misdemeanor].

(d) Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 3, with the intent to cause a withholding or withdrawal of life-sustaining procedures, shall be guilty of [a class _____ misdemeanor].

COMMENT

Section 8 provides criminal penalties for specific conduct that violates the Act. Subsections (a) and (b) provide that a physician's failure to transfer a patient or record the diagnosis of terminal condition constitutes a misdemeanor. Subsection (c) makes certain willful actions which could result in the unauthorized prolongation of life a misdemeanor. Subsection (d) governs acts which are intended to cause the unauthorized withholding or withdrawal of life-sustaining treatment, thereby advancing death.

The latter provision departs significantly from most existing statutes. Most statutes provide penalties for intentional conduct that actually causes the death of a declarant, and define such conduct as murder or a high degree felony. The draft does not take this approach. Assuming that such conduct will already be covered by a state's criminal statutes, the draft only addresses the situations in which the actor willfully falsifies or forges the declaration of another or conceals or withholds knowledge of revocation with the intent to cause the withholding or withdrawal of life-sustaining procedures. To be criminally sanctioned as a misdemeanor under the draft the circumscribed conduct need not cause the death of a declarant. The approach taken by most states, that of providing a felony penalty for those acts that actually caused death, was considered unnecessary. A specific penalty for the conduct described in Section 8(d), however, was deemed appropriate as existing criminal codes may not adequately address it.

SECTION 9. GENERAL PROVISIONS.

(a) Death resulting from the withholding or withdrawal of life-sustaining procedures pursuant to a declaration and in accordance with this [Act] does not, for any purpose, constitute a suicide or homicide.

(b) The making of a declaration pursuant to Section 3 does not affect in any manner the sale, procurement, or issuance of any policy of life insurance, nor is it deemed to modify the terms

of an existing policy of life insurance. No policy of life insurance is legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health-care facility, or other health-care provider, and no health-care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital plan, may require any person to execute a declaration as a condition for being insured for, or receiving, health-care services.

(d) This [Act] creates no presumption concerning the intention of an individual who has not executed a declaration with respect to the use, withholding, or withdrawal of life-sustaining procedures in the event of a terminal condition.

(e) Nothing in this [Act] shall be interpreted to increase or decrease the right of a patient to make decisions regarding use of life-sustaining procedures so long as the patient is able to do so, nor impairs or supercedes any right or responsibility that any person has to effect the withholding or withdrawal of medical care in any lawful manner. In that respect, the provisions of this [Act] are cumulative.

(f) This [Act] does not condone, authorize or approve mercy killing or euthanasia.

SECTION 10. RECOGNITION OF DECLARATIONS EXECUTED IN OTHER STATES.

A declaration executed in another state in compliance with the law of that state shall be effective for purposes of this Act.

SECTION 11. SEVERABILITY.

If any provision of this [Act] or its application to any person or circumstance is held invalid, such invalidity does not affect other provisions or applications of this [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

SECTION 12. TIME OF TAKING EFFECT.

This [Act] takes effect on _____.

LIVING WILL/NATURAL DEATH ACTS

Statutory Citations

ALABAMA NATURAL DEATH ACT, Ala. Code secs. 22-8A-1-10 (1981).

Written declaration required; signed in presence of two disinterested witnesses who must be at least 19 years old. Declaration form in law, but may include personalized instructions. Invalid during pregnancy. Physician must be notified of document's existence, make it part of medical record. In effect until revoked; may be revoked at any time. Immunity to physician, health care professional and facility for good faith compliance with declaration. Compliance with declaration or transfer of patient required. Criminal penalties for concealment or falsification.

ARKANSAS DEATH WITH DIGNITY, Ark. Stat. Ann. secs. 82-3801-3804 (1977).

Written declaration required, executed with same formalities as required for execution of a will. Minor or adult mentally or physically incapacitated may have form executed by another, e.g., parent, spouse, guardian, as specified in statute; must contain signed statements by two physicians. Immunity from liability for person, hospital or other medical facility acting in compliance.

CALIFORNIA NATURAL DEATH ACT, Cal. Health & Safety Code secs. 7185-7195 (1976).

Written declaration required; signed in presence of two disinterested witnesses. Form in statute must be followed. Patient in skilled nursing facility cannot execute directive unless one witness is state-appointed advocate. Invalid during pregnancy. Revocation at any time. Effective for five years. Immunity from civil or criminal liability for physician, health facility, and licensed health professional acting under physician's direction. Declaration valid if executed after terminal diagnosis, but if not can be given weight as evidence of patient's wishes. Physician must comply with directive or arrange transfer, or will be guilty of unprofessional conduct. Criminal penalties for certain acts of falsification or concealment of a directive.

DELAWARE DEATH WITH DIGNITY ACT, Del. Code Ann. tit. 16 secs. 2501-2509 (1982).

Written declaration; signed in presence of two disinterested witnesses. Invalid during pregnancy. Adult by written declaration may appoint agent who may accept or refuse treatment. Revocation at any time. Declaration to be made part of medical record. Effective for 10 years. Resident in nursing home or related institution must have declaration witnessed by special state-appointed advocate. Immunity from civil and criminal liability for physician, individual acting under physician's discretion, and health facility for good faith compliance. Criminal penalties for falsification or concealment.

DISTRICT OF COLUMBIA NATURAL DEATH ACT OF 1981, D.C. Code Ann. secs. 6-2421-2430 (1982).

Written declaration, signed in presence of two disinterested witnesses. Physician to be notified of declaration and to place in medical record. Form in statute but modifications allowed. Patient in intermediate care or skilled nursing facility may execute declaration if one witness is state-appointed advocate. Revocation at any time. Patient's desires always supercede declaration. Physician must comply or transfer, or commit act of unprofessional conduct. Immunity from civil and criminal liability for physician, health care professional, health facility or employee. Criminal penalties for falsification or concealment.

FLORIDA LIFE PROLONGING PROCEDURE ACT, Fla. Stat., ch. 84-58, secs. 765.01-.15 (1984).

Written declaration, witnessed by unrelated persons. Oral declaration signed in declarant's presence. Physician to be notified of declaration and make it part of medical record. Form in statute but may be modified. Revocation at any time by any method. If no declaration, withholding or withdrawal of life-prolonging procedures from incompetent adult may occur if consultation and written agreement between physician and certain specified individuals, e.g., spouse, guardian, parent, witnessed by two persons. Physician refusing to comply must transfer. Invalid if pregnant. Immunity from civil or criminal liability for health care facility, physician or person acting under physician's direction for compliance. Criminal penalties for falsification or concealment.

GEORGIA LIVING WILLS ACT, Ga. Code Ann. secs. 31-32-1-12 (1984).

Written declaration signed in presence of two disinterested witnesses. Form prescribed in statute if declaration made while patient in hospital or skilled nursing facility must also be witnessed by medical director or medical staff chief. Revocation at anytime. Effective for seven years. Invalid during pregnancy. Immunity from civil or criminal liability for physician, person acting upon his/her direction, hospital, skilled nursing facility and any agent or employee for good faith compliance. No person civilly liable for failure to comply; unwilling physician to discuss with next of kin or guardian and attempt transfer. Criminal liability for falsification, concealment.

IDAHO NATURAL DEATH ACT, Idaho Code secs. 39-4501-4508 (1977).

Written declaration signed in presence of two disinterested witnesses. Prescribed form in statute. Revocation at any time. Effective for five years. Immunity from civil and criminal liability for physician and health facility for compliance.

ILLINOIS LIVING WILL ACT, Ill. Ann. Stat. ch. 110 1/2 secs. 701-710 (Smith-Hurd 1984).

Written declaration executed with same formalities as valid will under Probate Act: Form in statute, but modifications allowed. Invalid during pregnancy. Revocation at any time. Declarant to notify physician, and physician to place copy in medical record. Unwilling physician to transfer patient. Immunity from civil and criminal liability for physician, licensed health care professional, medical care facility or employee thereof for compliance in good faith. Criminal penalties for falsification and concealment.

KANSAS NATURAL DEATH ACT, Kan. Stat. Ann. secs. 65-28, 101-109 (1979).

Written declaration signed in presence of two disinterested witnesses. Form in statute but modifications allowed. Invalid during pregnancy. Revocation at any time. Physician to comply or transfer or be guilty of unprofessional conduct. Immunity from civil or criminal liability for physician, licensed health care professional, medical care facility or employee thereof for compliance. Criminal penalties for falsification and concealment.

LOUISIANA LIFE-SUSTAINING PROCEDURES, La. Rev. Stat. secs. 40:1299.58.1-.10 (1984).

Written declaration signed in presence of two disinterested witnesses. Oral declaration in presence of physician and two witnesses subsequent to terminal diagnosis. Form in statute but modifications allowed. Physician to be notified of declaration and to put it in medical record. If oral, physician to note in record. Revocation at any time. Procedures for decision in absence of declaration, based on agreement between physician and specified surrogate. Procedures for execution of document on behalf of terminally ill minor; certification by court required. Physician to comply with declaration or transfer. Immunity from civil or criminal liability for health care facility, physician or other acting under physician's direction. Criminal penalties for falsification or concealment.

MISSISSIPPI ACT, Senate Bill No. 2364, ch. 365, Laws of 1984.

Written declaration signed in presence of two disinterested witnesses. Form for declaration in statute but modifications allowed; must be filed with state board of health. Revocation in writing in presence of two disinterested witnesses. Form in statute but modifications allowed; must be filed with state board of health; however, if declarant unable to revoke in writing, may be oral. Physician must report and receive copy of document from board of health before complying. Unwilling physician or medical facility must cooperate in transfer. Immunity for physician for compliance. Criminal penalties for falsification or concealment.

NEVADA WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING PROCEDURES, Nev. Rev. Stat. secs. 449.540-690 (1977).

Written declaration executed in same manner as a will, except disinterested witness required. Form in statute, but modifications allowed. Physician to give weight to declaration but may consider other factors. Revocation at any time. Immunity for hospital, other health care facility, physician or person working under physician's direction for compliance or failure to comply. Penalties for falsification or concealment.

NEW MEXICO RIGHT TO DIE ACT, N.M. Stat. Ann. secs. 24-7-1-11 (1977).

Document executed with same formalities as required by probate act. Provision of execution on behalf of a minor. Revocation at any time. Immunity for physician, hospital or medical institution or its employees for compliance or failure to comply. Penalties for falsification or concealment.

NORTH CAROLINA RIGHT TO NATURAL DEATH ACT, N.C. Gen. Stat. secs. 90-320-322 1977, amend. 1979, 1981, 1983).

Written declaration signed in presence of two disinterested witnesses and proved by certification of a court clerk or notary. Form in statute. Revocation at any time. Immunity for any person, institution or facility for compliance. In absence of declaration, withdrawal or withholding allowed if agreement of spouse, guardian, majority of relatives, or, if none available, attending physician.

OREGON RIGHTS WITH RESPECT TO TERMINAL ILLNESS, Or. Rev. Stat. secs. 97.050-.090 (1977, amend. 1983).

Written declaration signed in presence of two disinterested witnesses. If patient in nursing home, one witness must be state-appointed. Form in statute. Revocation at any time. Effective for five years. Physician to note in medical record. Unwilling physician to make effort to transfer. No duty for physician, licensed health profession or medical facility to participate in directive. Immunity for physician, licensed health professional, and health facility for compliance. Penalties for falsification or concealment.

TEXAS NATURAL DEATH ACT, Tex. Stat. Ann. Art. 4590h (1977, amend. 1983).

Written declaration signed in presence of two disinterested witnesses. Form in statute. Execution/re-execution after terminal diagnosis. Revocation at any time. Immunity for physician, health facility, health care professional for compliance. Penalties for falsification or concealment.

VERMONT TERMINAL CARE DOCUMENT, Vt. Stat. Ann. tit. 18, secs. 5251-5262 and tit. 13 sec. 1801 (1982).

Written declaration signed in presence of two disinterested witnesses. Form in statute, but modifications allowed. Duty to deliver document to physician or hospital. Revocation at any time. Physician to comply or transfer. Immunity from civil or criminal liability for physician, nurse, health professional, or hospital for compliance. Criminal penalties for falsification or concealment.

VIRGINIA NATURAL DEATH ACT, Va. Code secs. 54-325.8:1-13 (1983).

Written declaration signed in presence of two witnesses. Oral declaration in presence of physician and two witnesses. Physician to be notified and place in record. Suggested form in statute. Revocation at any time. In absence of declaration, life-prolonging procedures may be withdrawn or withheld in appropriate circumstances when agreement between physician and specified persons. Unwilling physician to transfer. Immunity from civil or criminal liability for health care facility, physician or person acting under physician's direction. Criminal penalties for falsification or concealment.

WASHINGTON NATURAL DEATH ACT, Wash. Rev. Code Ann. secs. 70.122.010-70.122.905 (1979)

Written declaration signed in presence of two disinterested witnesses. Form in statute, but modifications allowed. Physician to place in medical record. Unwilling physician to make effort to transfer. Revocation at any time. Immunity for physician, licensed health personnel, and health facility. Penalties for falsification and concealment.

WEST VIRGINIA NATURAL DEATH ACT, W.Va. Code, ch. 16, art. 30 secs. 1-10 (1984).

Written declaration signed in presence of two disinterested witnesses. Form in statute but modifications allowed. Physician to be notified of declaration and to place in medical record. All health care facilities to develop system to identify chart containing declaration. Revocation at any time. Unwilling physician to transfer patient. Immunity for physician, licensed health care professional, health facility or employee thereof. Criminal penalties for falsification and concealment.

WISCONSIN NATURAL DEATH ACT, Wisc. Stat. secs. 154.01 et seq. as created by 1983 Wisconsin Act 202 (1984).

Written declaration signed in presence of two disinterested witnesses. Effective for five years. Form in statute. Revocation at any time. Immunity for physician, inpatient health care facility, and health care professional acting under physician's direction. Penalties for falsification and concealment.

WYOMING ACT, Wy. Stat. 33-26 secs. 144-151 (1984).

Written declaration signed in presence of two disinterested witnesses. Declarant to notify physician. Physician to place in medical record. Form in statute but modifications allowed. Revocation at any time. Physician to comply or transfer. Immunity for physician, licensed health care professional, medical care facility or employee thereof. Penalties for falsification and concealment.

Arguing the Right to Die

When William F. Bartling lay dying of emphysema and a variety of other serious illnesses, he asked the doctors at the Glendale Adventist Medical Center to turn off his respirator and allow him to die peacefully. Like anyone else, he preferred to live, he indicated with a painful nod of his head, but he couldn't bear the treatment any longer. Still, the doctors refused to unplug him: they were healers, they insisted, not executioners. While both sides squabbled in court, Bartling finally died last November, with the ganglia of high-tech medicine still attached to his shriveled body. Last week a California appeals court resurrected his case and announced a posthumous victory: competent adult patients, the judges declared, have a constitutional right to refuse medical treatment, even when they are facing death. "It's the patient that has the problem," says lawyer Richard Scott, who kept Bartling's case alive, "and by God it's going to be the patient that makes the decision."

In simpler times, William Bartling would have died at home, far from the ethical questions a bivalve respirator brings to life. Now, however, thanks to stunning advances in emergency medicine, hospitals have become the nation's charnel houses: roughly 80 percent of

Americans who die each year die in hospitals or nursing homes. That dramatic change has led to problems that the law isn't quite ready to sort out and a growing right-to-die movement which vigorously insists that sick people should have the last word about their own lives.

Machines: "We want self-determination for the patient, whether that means continuing treatment or dying with dignity," says Alice V. Mehling, executive director of the Society for the Right to Die. Mehling, her 120,000 members and a handful of similar groups stand within a thoroughly respectable common-law tradition that says a man is master of his body and can refuse medical treatment. But that doctrine developed long before the advent of machines that won't allow a body to quit. Even when machines are not involved, as in the case of Elizabeth Bouvia—the cerebral-palsy victim who was prevented by a hospital from starving herself to death—the law is in question.

Both legislatures and courts have the death issues on their dockets. The District of Columbia and 22 states have adopted "liv-

ing will" laws that permit mentally competent adults to declare—before they get sick—that they don't want their lives prolonged artificially. A court in New York has also embraced this notion. More than 35 states now have "brain death" laws that allow respirators to be withdrawn when a



Bartling: 'It's the patient that has the problem'

patient no longer shows any sign of brain activity. New York doesn't have that statute, but last week a state judge essentially followed it by ordering a suburban hospital to unplug a comatose man from his life-support system.

Judges don't want to decide these questions: in recent years, several state courts have pleaded with legislatures to resolve them instead. But even in the best of circumstances, it's hard to draft comprehensive laws. For instance, in Bartling's case, the hospital contended that he was not competent to make his choice—"too depressed" was the diagnosis—and that if he had been in a healthier state of mind, he could have survived being weaned off his respirator. The administrators wanted a court to make the judgment call. The decision upholding Bartling

followed earlier rulings in Florida and New York. "The ruling brings California into the mainstream of the developing law," says USC law professor Alexander Capron.

But the law is moving in fits and starts. Paying heed to the well-considered decision of a sick person is a good bit easier than determining the fate of a lingering, comatose incompetent. In such cases, who decides? Many courts turn to relatives. But what if there aren't any, or they disagree? In a controversial decision, a Massachusetts court allowed that it would invoke its own "substitute judgment" on behalf of a mentally ill woman. Other courts lean heavily on experts. Last November the Minnesota Supreme Court, having turned to three hospital ethics committees to review a dying loner's case, followed their collected wisdom and ordered him off the respirator. "It's the first time ethics committees played a significant role in the court," says Dr. Ronald E. Cranford, a neurologist and ethics specialist. "This is going to happen increasingly in the future."

Damages: There will certainly be more opportunities, since many doctors and hospitals are determined to move cautiously. Some cite ethical concerns. Others fear indictments for homicide or aiding a suicide, even though most living-will laws specifically grant immunity to doctors who follow them. In 1982 two California doctors who, at the request of his family, removed a respirator from a comatose patient were charged with murder—but the indictments were later dismissed. And in this age of malpractice litigation, everyone worries about being sued for stopping treatment. But failure to follow a patient's wishes may turn out to be just as risky. Last May an Ohio appeals court ordered a trial in a lawsuit filed by the survivors of a "vegetative" patient whom doctors refused to disconnect from a life-support system even after the family obtained a court order. Now the family claims the doctors committed a battery on the patient, and they want damages.

The cases keep coming. Much attention is focused on a case now pending before the New Jersey Supreme Court, which is considering whether doctors could have properly stopped feeding a comatose 84-year-old woman who was incurably ill. That decision is expected to be announced soon. In the meantime, while the law struggles along, patients, families and doctors across the country make most life-and-death decisions privately—final judgments that the survivors must live with long after the courthouse doors swing closed.

ARIC PRESS with DAVID T. FRIENDLY in Los Angeles, FRANK MAIER in Chicago, RENEE MICHAEL in New York and DIANE WEATHERS in Washington



Bouvia: Death on the docket

POSITION PAPER

HOUSE BILL NO. 269

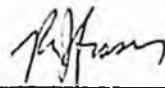
For "An Act relating to the rights of the terminally ill."

The right of a competent individual to decide whether life-sustaining procedures should be used in the face of a terminal illness or injury has received increasing attention in recent years as medical technology has advanced and individual cases have received media attention.

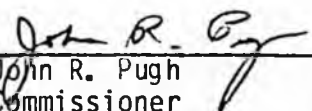
This bill provides a process through which a competent adult can participate in decisions regarding his or her care when afflicted with a terminal condition. "Terminal condition" is an incurable or irreversible condition that, without the administration of life-sustaining procedures, will result in death in a relatively short time. The bill permits a competent adult to execute a declaration directing the withholding or withdrawal of life-sustaining measures. The declaration comes into effect only (1) if a terminal condition is determined to exist and (2) if the affected person is incapable at that time of making treatment decisions.

According to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 13 states and the District of Columbia have adopted so-called natural death legislation. The proposed legislation appears to be generally similar to the major provisions in other states.

The Department of Health and Social Services supports intent of this bill. It is assumed the Department of Law is reviewing it for adequacy of legal safeguards for declarants and for health care providers.

Recommended by: 
Robert I. Fraser, M.D.
Director
Division of Public Health

Date: 12 MAR 85

Approved by: 
John R. Pugh
Commissioner
Department of Health &
Social Services

Date: 3/15/85

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: HB 269
 Title: Rights of terminally ill
 Sponsor: Clocksie et al.
 Requestor: _____
 Date of Request: 3/11/85

FISCAL DETAIL

Agency Affected: Health & Social Services
 Program Category Affected: Public Health
 BRU, Program or Subprogram(s) Affected: _____
State Health Services

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 SUPPLIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
500 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS	0	0	0	0	0	0
800 MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: Attach a separate page if necessary

Prepared By: Robert I. Fraser, M.D. Phone: 465-3090
 Division: Public Health Date: _____

Approved by Commissioner: J.R.G. Date: 4/5/85
 Agency: Dept. of Health & Social Services JCC

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

DN 2-11-85

Measure would give terminally ill patients the right to die

By Associated Press

JUNEAU — Terminally ill patients would be allowed to refuse life-prolonging medical treatment under legislation sponsored by Sen. Dick Eliason, R-Sitka.

The measure (SB140), introduced Thursday, is aimed at protecting each individual's right to a dignified death without unnecessary medical treatment, Eliason said.

"There's a lot of interest in the concept, especially with the medical technology we have today," Eliason said today. "It's a sensitive subject, but it makes sense.

"It would give a person an opportunity to have some influence about how he or she ends it all," he said. "The bill has four or five co-sponsors and some support from elderly groups."

The legislation does not con-

done, authorize or approve mercy killing, but it recognizes the right of each individual to decide in advance they do not want unnecessary medical treatment, Eliason said.

The bill also would free physicians and other health

care professionals from any liability for honoring a patient's written request.

Similar legislation has been approved by 21 states and 19 others are considering right-to-life bills, Eliason said.

Society For The Right To Die

NEWSLETTER

FALL 1984

N.Y. Governor Appoints Task Force on Right to Die

New York's Governor Mario Cuomo in October announced his intention to establish a task force on "Life and the Law" to recommend policy on the right-to-die issue for action by the legislature. "Like it or not," Governor Cuomo told an audience at St. Francis College in Brooklyn, "we are increasingly involved in life and death questions to which we have no consistent response. Science is leaving us in the dust."

Earlier, State Health Commissioner Dr. David Axelrod, under pressure from a Grand Jury which found highly questionable "Do Not Resuscitate" procedures at a Queens Hospital (SRD Spring '84 Newsletter, page 2), had suggested the drafting of DNR legislation giving physicians and hospitals legal authority to withhold emergency measures from terminally ill patients. This legislation has also been urged by the New York State Medical Society and the city and state hospital associations.

Open Policies Urged

Calling for "open covenants, openly arrived at" before a forum on "Ethical Issues in Health Care" at the New York Academy of Medicine on September 17, Dr. Axelrod said, "We believe that institutions should adopt procedural guidelines and internal review mechanisms. And we believe that both patient consent and doctors' orders governing DNR decisions should be clearly conveyed in writing."

Citing as his particular concern decision-making for the incompetent patient, Dr. Axelrod said, "There are currently some 10,000 terminally ill individuals in nursing homes in New York State who are incapable of making a decision with respect to their own care. It is in their interest, as well as society's, that we articulate a consensus for dealing with DNR decisions. The framework of a consensus, including the potential for legislative action, on DNR orders is beginning to emerge."

Nation's Living Will Laws Number 23 As Florida and Louisiana Join Roster

In one historic week in May, twin actions of the Florida state legislature and the state's highest court gave legal validity to the Living Will. Floridians won the undisputed right to die with dignity, and a 17 year struggle was finally put to rest. With Governor Bob Graham's signature on the Life Prolonging Procedure Act, which took effect October first, the state that was the nation's very first to consider such legislation finally adopted it. (See page 4 for court action.)



Walter Sackett, Jr., M.D.

Since 1967, when a small forward-looking group of legislators, led by Walter W. Sackett, Jr., M.D., tried unsuccessfully to have a clause inserted in the state constitution guaranteeing the right to control one's medical treatment at the end of life, almost every legislative session in Tallahassee has seen a Living Will bill introduced. And Dr. Sackett was present at the emotional moment when Governor Graham, with whom he entered the legislature in 1967, signed H.B. 127 into law. The bill, which was shepherded through the last session by its sponsor, Rep. Byron Combee, a freshman lawmaker from Clearwater, passed the House 106 to 2, with no debate, and passed the Senate unanimously, 35 to 0. It protects both competent and incompetent patients who have executed a Living Will from the use of extraordinary measures to sustain life, and makes provision as well for decision-making by a family member on behalf of incompetent patients who have not executed a Living Will. Florida is one of five states to provide for designation of a proxy to make treatment decisions.

In a telephone interview with the Society, Representative Combee said he felt the Supreme Court case had been a factor, but more decisive was the softening of traditional Catholic opposition. It had been defused, he said, by negotiation on requests made by spokesmen for the Church: the express inclusion of the right to have life-prolonging treatment provided as
(continued on page 7)



Rep. Byron Combee

BULLETIN

On October 16 the Georgia Supreme Court, in a significant ruling (*In re L.H.R.*), stated that once there has been a diagnosis that either an infant or an adult is terminally ill and in a chronic vegetative state, the decision to terminate life-support measures may be made by parents or other family members. No review of such decisions by either a court or a hospital ethics committee is needed. The court specifically ruled that this applies to patients in Georgia who have not executed Living Wills under the new statute.

On September first, the Society had submitted a brief to the Georgia Supreme Court which stressed that hospital review committees served no useful function under the medical circumstances of this case. The Supreme Court's decision endorsed this point of view.

POLLS SHOW DOCTORS, NURSES AND PUBLIC INCREASINGLY FAVOR LIVING WILL LAWS

Nursinglife Survey

A 1984 survey undertaken by *NursingLife* magazine revealed that most nurses believe a terminally ill patient's wish to be allowed to die should be honored even when the patient's family disagrees. This view was expressed by 97 percent of the 3,504 nurses responding. Seventy percent opposed the use of "extraordinary means" to maintain dying patients "for any reason," while 24 percent had "mixed feelings, slightly against."

A storm of emotional responses on the subject of "Do Not Resuscitate" orders in a 1982 ethics poll led to the magazine's decision to poll its readers in greater depth on issues related to death and dying.

Only 50 percent of the survey's nurses had ever participated in emergency life-sustaining efforts for a dying patient who had begged to be allowed to die. Of these, 49 percent did so in order to protect themselves legally, and 25 percent to avoid conflict with doctor and hospital administration.

When faced with a patient whose death was imminent and for whom no "Do Not Resuscitate" order had been written, 65 percent would question the doctor about the need to prolong the patient's life. Twenty-five percent would initiate discussions with the patient or family about rejecting treatment.

"Compassionate Compromise"

"Slow code"—delayed or partial emergency efforts to keep a dying patient alive—had occurred in 61 percent of the respondents' hospitals. Of the 43 percent of nurses who had been involved in this tactic (technically illegal, but seen by some as a "compassionate compromise"), 57 percent considered it morally ethical; 40 percent did not.

Hospitals should have a specially prepared room to help staff care for dying patients, according to 88 percent.

There are no statistics on what nurses would want for themselves, but from the published comments, they would seem to favor a natural death for themselves and their families. Typically, one nurse wrote, "Nurses and doctors here agree we should have 'no code' tattooed over our hearts—in case the doctor is scared to write the order."

Material from *NursingLife* poll from the January/February and March/April 1984 issues of *NursingLife* used with permission. Copyright © 1984, Springhouse Corporation. All rights reserved.

Editors' Conclusions

"*NursingLife* comments in conclusion, "Throughout our respondents' letters three messages were clear:

- The public needs to ask about and fully understand the available options for a dying person.
- There are worse things than dying.
- A hospital may not be the best place for dying.

NursingLife's editors go on to say:

"Right-to-die decisions should be in the hands of the patient, family, and doctor, but nurses play a unique and critical role in them."

Doctors and Nurses in Florida Poll

Another attempt to provide a picture of health professionals' attitudes toward Living Wills was made by faculty members at the University of Florida College of Nursing in Gainesville. Supported by grants from the American Nurses' Foundation and the Florida Division of the

Medicare Reformers Support Living Wills

Estimating that 11 percent of all Medicare expenditures are spent in the last 40 days of life, and the last year of life accounts for 25 percent of the money spent, a government advisory panel of Medicare has endorsed the concept of Living Wills.

Otis Bowen, a physician, a former governor of Indiana, and current chairman of the Advisory Council on Social Security, told the Senate Finance Committee, "The council fully recognizes that this may be a controversial recommendation; however, [it] unanimously endorsed it . . . Living Wills would prevent unnecessarily heroic measures being taken in the terminal days of life."

The group called for a study of the impact of Living Will laws on health care expenditures in the states that have enacted such legislation.

In acknowledging the sensitive nature of the subject, Dr. Bowen emphasized that a decision to forgo life-sustaining treatment in terminal illness should be "totally voluntary."

American Cancer Society, the group surveyed 500 nurses and 500 physicians selected at random from membership lists of the American Medical Association and the American Nurses Association. The following statistics emerged, as detailed in a letter to the *New England Journal of Medicine* (9/6/84):

"Sixty-five percent of the respondents essentially favored Living Wills: 18 percent had either signed a Living Will or made similar arrangements; 31 percent thought they wanted to but needed more information; 13 percent were uncertain and needed more information, and 12 percent were uncertain, even though they were well informed. Nine percent expressed essentially negative positions, but only one person had signed a right-to-life document . . .

"Thus, it is interesting that such a large percentage of nurses and physicians who responded to our questionnaire have already chosen or intend to choose for themselves a more natural process of dying."

N.Y. Times/CBS News Poll

Turning to changing attitudes held by the general public, in June 1984, 1,593 Americans were surveyed at random by the New York Times/CBS News Poll, as follows: "Medical technology now enables doctors to prolong the lives of many people who are terminally ill. Do you believe doctors should stop using these techniques if the patient asks, even if that means the patient will die?"

Seventy-seven percent answered yes, only 15 percent said no, and 8 percent had no opinion.

University of Chicago Poll

The National Opinion Research Center of the University of Chicago has noted a marked change in the response to a related question it has been asking since 1947: "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" In 1947, 37 percent answered yes. In 1973, slightly over 50 percent agreed. By 1983, 63 percent were in favor.

Charleston Woman to Head South Carolina Committee



Lorraine Bate Orr

Mrs. Lorraine Bate Orr of Charleston will head the newly formed South Carolina Citizens Committee for the Right to Die. In announcing the appointment, Evan R. Collins, Jr., president of the Society, said, "We are confident that under the leadership of Mrs. Orr, informed citizen involvement on behalf of right-to-die legislation—first introduced in 1977—will lead to the elimination of needless suffering by terminally ill patients and their families."

Mrs. Orr, who for many years was a public relations executive with the New York advertising firms of Batten, Barton, Durstine & Osborne and Benton & Bowles, has also, in collaboration with her late husband, John D. Orr, written, produced and distributed public service programs for the broadcast media. Her commitment to the right to die stems from her experience during her husband's terminal illness.

Within days of her appointment, Mrs. Orr testified before the Joint Legislative Study Committee on Aging, chaired by State Senator Hyman Rubin. "Not being allowed to die with dignity," Mrs. Orr told Committee members, "forces the terminally ill to be robbed of their humanity." She urged lawmakers on the Committee to back right-to-die legislation, so that South Carolina can join nine other Southern states whose residents have such protection.

Mrs. Orr is writing to all Society supporters in South Carolina, and hopes for broad participation in the work of the committee.

NEW IMPETUS SEEN FOR CONNECTICUT LAW

The cause of right-to-die legislation in Connecticut will acquire a new champion in the state legislature, and it is expected to be Rep. Jamie McLaughlin of Woodbury, nominated to succeed Sen. William F. Rogers III. Senator Rogers, who has introduced Living Will bills for five successive years, has retired from political office after one term in the House and two in the Senate, where he was ranking member of the Human Services Committee.

Senator Rogers told the Society in a telephone interview that he is convinced Representative McLaughlin is as committed to this legislation as he has been, and will prove to be an admirable advocate.

Although John J. Paris, S.J., leading Catholic ethicist, has spoken forcefully for the bill, the Catholic Conference of Bishops and the Connecticut Right to Life Corporation continue to be implacable foes. After the bill's approval by the Senate for the fourth straight time (23 to 10), and despite the passionate pleas by proponents which marked the last debate in the House, it lost in 1984—but only by three votes, the narrowest margin so far.

Senator Rogers, in commenting to SRD on the opposition, said, "There is a crying need for this legislation, and we will just have to continue our efforts to bring Connecticut into the 20th century. Though I am retiring from the legislature, I have no intention of retiring from the battle."

Representative McLaughlin is extremely optimistic about the bill's chances this session. Speaking to the Society, he said, "I plan to take up the cudgels for this legislation and go forward to passage. There will be concessions made to longtime opponents so that we can have them join us, not in mere acquiescence but with enthusiasm. As a Catholic, I believe I represent a broad Catholic constituency which feels likeminded. It is my objective to show representatives of the Catholic dioceses that this legislation is necessary, and not contrary to the Church's moral reflections."

In the House, Representative McLaughlin is assured of strong assistance from Rep. Julie Belaga of Westport, who told us, "I care very deeply about this legislation and have extraordinary support for it in my district. A recent questionnaire sent out from my office included the following query: 'Do you support the right to a Living Will which would allow terminally ill patients to refuse life support systems?' Ninety-six percent of the answers were a resounding 'Yes!'"

The legislation is backed by the state's AARP, the Presbyterian and Congregational Churches, the Connecticut Chapter of the ACLU, and editorially in newspapers, radio and TV "from New London to Greenwich," according to Senator Rogers.



Sen. William F. Rogers, III



Rep. Jamie McLaughlin

CASES POINT UP NEED TO UPHOLD PATIENTS' RIGHTS

The "Landy" Case

In a decisive reversal of two lower court decisions, the Florida Supreme Court ruled unanimously that court approval was not necessary for the withdrawal of artificial life support from an incompetent patient, leaving decision-making in the hands of family and physician. (Under the new Florida statute, enacted four days after the court ruling, it is the Living Will, not the physician or family that controls treatment decisions—see page 1.)

The eagerly awaited ruling in *JFK Memorial Hospital v. Bludworth* (SRD Newsletter, Spring '84, page 4), which involved withdrawing life support from the terminally ill comatose patient Francis Landy, stated that when a patient had previously executed a Living Will, as Landy had, it would be "persuasive evidence" of his wishes and should be "given great weight" by those making a decision on his behalf.

Parity for All Terminal Patients

The court also stated that "terminally ill incompetent persons have the same right to refuse to be held on the threshold of death as terminally ill competent persons." It directed family members or guardian to exercise that right in the patient's behalf, if no Living Will had been executed, by substituting their judgment, "in good faith," based on their knowledge of what the patient would have wanted. The ruling stipulated that before a decision to withdraw life support could be implemented, the primary physician and two others with relevant specialties would have to certify that the patient's "existence was being sustained solely through the use of extraordinary life-sustaining measures."

Departing from the 1976 *Quinlan* opinion, the court specifically rejected the involvement of a hospital ethics committee; differing, too, from a ruling in the case of a comatose patient in the state of Washington, it expressly held the official appointment of a guardian was not necessary, although it might be sought if no close family member was available.

Mrs. Gladys Landy, Landy's widow, told the *Miami News*, "I guess I feel good, but not because of Francis. It's too late to help him now. Maybe other people will benefit from this. The horrible thing was seeing him on that lung machine . . . I don't think people understand."

Hospital administrators throughout the state hailed the decision, upheld in their belief that the necessity for court intervention had caused unnecessary trauma for the family, making an already sensitive situation that much harder.

Dr. Maurice Laszlo, former president of the Dade County Medical Association, said, "It's something for the patient and the relatives and the physician to decide. It always has been, and it never should have changed." Dr. Joseph Civetta, head of Miami's Jackson Hospital Surgical Intensive Care Unit told the *Miami Herald*, "This reaffirms the whole idea that death is the end of life, that we can't live forever . . . The goal of medicine is not to make everyone immortal."

California Case Arouses Storm

A striking example of a hospital's reluctance to carry out a patient's instructions is the California case of William Bartling, 70, who suffered from lung cancer, emphysema, coronary artery disease and an aortic aneurysm. Through his counsel, Mr. Bartling applied for an order to prohibit the hospital from continuing him on a respirator. In July, the court refused, finding that the patient was not terminally ill. The court wrongly interpreted current law in holding that the respirator could not be withdrawn because Mr. Bartling was not comatose. The court said that there was "no case in the United States" in which application for legal relief was sought for a patient "who was not in a comatose, vegetative or brain dead state," thereby misreading or ignoring earlier cases. An appeal was planned for Nov. 7; Mr. Bartling died the day before.

As this goes to press, a brief filed by the Society is before the court, and we will urge the court to decide the issues presented by the case even though Mr. Bartling is dead. The brief will emphasize that all patients have a right to refuse treatment, especially when they do not have minor dependents; that allowing the natural process of dying is neither legally nor factually suicide; and that there is absolutely no requirement that patients be comatose or brain dead before life-support can be withdrawn.

Bartling was suing the hospital for money damages, for breach of its contract with him and for committing a bat-

tery on him by continuing to treat without his consent. He also alleged that his constitutional rights to freedom from invasion of his person had been ignored and violated.

Arizona Hospital Rejects Living Will, Durable Power

A recent example of the urgent need for Living Will laws has arisen in Arizona. Harriet Shulan, 83, was admitted to a Phoenix hospital in February 1984, suffering from coronary artery disease. By the time her case came to court she had septicemia, renal failure, a perforated trachea, and was on a respirator. Despite large doses of morphine, she was in great pain. In October 1981 she had executed a Living Will, which specifically referred to "mechanical respiration" as especially abhorrent to her, and had given her daughter a durable power of attorney. Mrs. Shulan, while competent, refused to consent to medical treatment, including the respirator, and when she became incompetent her daughter took up her cause. Because the hospital, unsure of its legal position, insisted on continuing treatment, her daughter applied to the court for relief. The hospital's position—that it could not act without Living Will legislation—forced the daughter to go through an onerous court proceeding. Its misplaced fear of legal liability caused needless suffering.

Possible "Battery" in Ohio

The Ohio Court of Appeal, in one of the most interesting and probably most far-reaching decisions of the last few months, has made it clear that a hospital's or doctor's failure to recognize a patient's right to refuse treatment is not only contrary to the law, but may also result in money damages against hospitals and doctors.

The case of Edna Marie Leach, a comatose patient, came before an Ohio court in 1980. Her husband successfully petitioned the court for authority to remove her respirator. Even after the court order, the treating physician refused. Mrs. Leach's family and lawyer consulted more than 30 physicians before they found one who would comply—18 days after the order was issued and more than five months after Mrs. Leach had been placed on the respirator.

(continued on page 8)

Famed M.D. Defines 'Baby Doe' Issues for SRD Board

Mary Ellen Avery, M.D., Physician in Chief of Children's Hospital, Boston, and Professor of Pediatrics, Harvard Medical School, was guest speaker at an SRD Board of Directors meeting on June 13. In a talk distinguished for its lucidity and candor, she briefly summarized the recent Baby Jane Doe case in New York and its repercussions—specifically the "hot-line" placards posted in all hospitals encouraging reports of any omissions in the care of defective infants. The prominent size and placement of these signs has since been modified, but they will be required if legislation currently in conference committee becomes law. She stated that it is the anti-abortion groups that are now fighting on this issue.

Remarkable Developments

Dr. Avery reviewed the remarkable developments in medical technology available to the neonate since 1950, when only occasionally fetuses weighing 1 kilo (2.2 pounds) at 28 weeks gestation were kept alive with the help of ventilators. By 1980 about half of all infants under 1 kg and over 0.6 kg survived. Over 90 percent of infants over 1 kg and under 2.5 kg (5.5 lbs.) survive, and 90% of them are normal. At 800 grams (1 lb. 12 oz.) about 70% survive; and it is possible today to maintain fetuses of 400 grams (14 oz., 24 weeks gestation), i.e. less than half the size of the few who could be saved in 1950. (In Europe there is talk of keeping fetuses of 300 grams alive, by use of artificial placentas.)

The cost of these heroic efforts to save fetuses of 400–500 grams is a minimum of \$150,000 for the first 4 months; follow-up is necessary at least until age 2. These infants present a 10% chance of long-term survival, but there has not been enough experience yet to produce information on their long-term condition.

Dr. Avery favors a free and full exchange of information between pediatrician and parents before decisions are made to mobilize intensive care for such very immature infants.

Where to Draw the Line?

Especially provocative were her remarks on where to draw the line. Should Down Syndrome infants with surgically correctable physical defects be treated? What about thalidomide babies with no limbs at all? Is it kinder to end life than to perpetuate it for such babies? Should the parents of infants such as Baby Jane

Doe be liable for any legal or medical costs incurred? What about impaired infants who survive for years as retarded adults? Who is to take care of them when their parents die? (The estimated cost of maintaining such adults is \$50,000 each per year.) There are no categorical answers, Dr. Avery said, and she expressed her belief that decisions are best made on a case-by-case basis rather than through establishing regulatory guidelines. She predicted an increase of government intervention in this area, and observed that even now some hospitals use non-medical criteria in deciding, whether to sustain or not sustain life, i.e. fear of loss of federal funding.



Mary Ellen Avery, M.D.

Dr. Avery concluded by pointing out the necessity to examine the responsibility of society in supporting handicapped individuals as a concomitant of its insistence that severely impaired newborns be kept alive.

Amendment Sets Procedure

Earlier government regulations in "Baby Doe" cases, opposed by several medical organizations as "intrusive," were ameliorated, to some extent, by an amendment to the Child Abuse Prevention and Treatment Act. The amendment, a compromise which was endorsed by a broad spectrum of organizations and bipartisan members of Congress, extended child neglect and abuse to include the "withholding of medically indicated treatment from disabled infants with life threatening conditions." However,

heroic efforts would not have to be made when the infant was chronically and irreversibly comatose, or when treatment would only prolong dying or would be futile and inhumane.

The amendment, signed into law in October, was supported by the Association for Retarded Citizens, the American Hospital Association, and the American Academy of Pediatrics, as well as other groups, including the National Right to Life Committee.

It was opposed by the American Medical Association, which said that the legislation did not give enough weight to the "quality of life" of a severely handicapped baby who did survive treatment.

'84 HANDBOOK OFF PRESS

Handbook of Living Will Laws: 1981–1984, the newest in the series which was started in 1975, is now available for purchase.

A comprehensive view of the right-to-die field up to this moment, it analyzes, comments on, and provides the full text of each of the 13 Living Will laws enacted since 1981. A useful feature is the convenient ready-reference chart, which shows at a glance similarities and differences among the key provisions of all 23 laws.

An introductory section illuminates current thought in the legal, medical and religious communities; in the world of public opinion; and in the findings of a federal commission. Truly an indispensable guide for those who want their information current, complete and authoritative.

Handbook
of
Living Will
Laws
1981-1984

Society for the Right to Die

Standing orders for the *Handbook* have already been filled, and we are making every effort to fill requests in the order they are received.

Staff Attorney Broadens SRD Services

Fenella Rouse, who joined the Society as staff attorney in March, has provided an impressive array of services to many individual SRD supporters and to the Society's ongoing educational activities.

Ms. Rouse has consulted with patients or their attorneys in California, Florida, and in three New York cases, in which she acted as intermediary. She is in active correspondence with hospital administrators and attorneys, and has advised general medical practitioners—uncertain in this field—who have questions on the specifics of court decisions. She has written "friend of the court" briefs in Georgia and California cases. As the new

legislative sessions get under way, she will work with sponsors of right-to-die laws.

Ms. Rouse has drafted a set of *Questions and Answers on the Durable Power of Attorney*, for which a great need was seen, and has written a number of Fact Sheets on recent cases, adding to those the Society already makes available.

A graduate of the University of Exeter in England, Ms. Rouse has a law degree from Columbia University in New York, where she practiced law for several years. She is married to an attorney and has an 18-month-old son. She appears frequently on radio and television.

WORLD FEDERATION MEETS IN NICE

Delegates from 26 member organizations and some 500 members of the public gathered at the Palais des Congrès in Nice for the fifth international conference of right-to-die societies, and heard Dr. Christiaan Barnard, pioneer in life-extending heart transplant surgery, voice his views on "good death."

"I believe that often death is good medical treatment because it can achieve what all the medical advances and technology cannot achieve today, and that is to stop the suffering of the patient," he said. Dr. Barnard was firm in his stated conviction that it is solely up to the physician to determine when it is appropriate to humanely help a patient to die, despite objections from the audience that the patient should have a major role in such decisions.

Physicians, in general, held the spotlight. On the eve of the conference, five French physicians issued a startling statement that they had "helped patients in a terminal stage of illness to end their lives in the least painful way possible." Medical viewpoints on "The Right to Choose Death" were later debated on a conference panel composed of doctors from France, Belgium and the Netherlands.

Panels Open to Public

A wide range of topics were covered by conference speakers, including Dr. George Saba of Japan who presented an historical overview of hara-kiri, stating that this practice had never been suicide at all but actually a form of military execution ordered by feudal lords.

The Association Pour Le Droit De Mourir Dans La Dignité (A.D.M.D.) hosted the conference and organized the legal, medical and ethical panels that were open to the public. The business meetings of conference delegates were chaired by Sidney D. Rosoff, chairman of the Society for the Right to Die (U.S.) and first president of the World Federation. Newly elected officers of the World Federation are Minoo Masani (India), president; Patrick Nowell-Smith (Canada), vice-president; Paula Caucanas-Pisier (France), secretary-treasurer; and Jean Davies (England), newsletter editor. Other Board members are Beatriz Gomez (Colombia), Frank Dungey (New Zealand), Dr. Saba (Japan) and Mr. Rosoff.



Christine K. Cassel, M.D.

News From SRD Board

Christine K. Cassel, M.D., Assistant Professor of Geriatrics and Adult Medicine at Mt. Sinai Medical Center (N.Y.), was appointed to the Board in May. She has been named president-elect of the Society for Health and Human Values. In September, Dr. Cassel was a panelist on an hourlong discussion of medical ethics relating to the right-to-die issue on National Public Radio station KQED in San Francisco, and was interviewed on WABC-TV's "Eyewitness News."

Sia Arnason, M.S.W., has been appointed to the Association of the Bar of the City of New York's committee on "Legal Aspects of Aging," as one of only three non-lawyers on the committee. During the Conference of the National Council on Aging held in September in Washington, D.C., Ms. Arnason led two workshops on "Legal and Financial Issues Important to Caregivers."

An article by Evan R. Collins, Jr., Board president, entitled "The Right to Choose Between Life and Death," has been published in the November issue of *USA Today* magazine.

Kurt Borchardt, Esq., was one of the speakers at a forum on "The Rights of a Dying Patient, with Emphasis on the Living Will," at Hilton Head Island, S.C.

Joseph Fletcher, S.T.D., D.D., President Emeritus of SRD, was granted an honorary Doctor of Laws degree from the University of West Virginia.



Sia Arnason, M.S.W.

Society for the Right to Die
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Old Quotes Never Die. . .

"In the old days there was no plug. No life-supporting premortem umbilical cord silently proclaimed the presence of a fellow human being surviving only by grace of the physician's technological defiance of nature. Doctors knew their place: their allegiance to life was nearly absolute, but they understood when death had won."

—from *Medical World News*, 5/29/78

"Living Will legislation is a result of a generation searching for ways to rehumanize the dying process, and the product of a generation which views with horror the confrontation between modern technology and the human needs of the dying."

—Senator Barry Keene, sponsor of the California Natural Death Act (1976)

What They're Saying Now. . .

"I don't want to be surrounded by technology and kept alive just breathing like a vegetable for six months . . . I'd rather be surrounded by my brother and my children and my sister when I die than by a bunch of machines and some doctors and nurses I hardly know . . . and let God make his decision without a respirator."

—Joseph Califano, former Secretary of Health, Education & Welfare

"When a doctor won't order a 'no code' for a terminal patient, I want to scream, 'Why? What are you bringing him back to?'"

—Unidentified nurse, *Nursinglife*

FLORIDA AND LOUISIANA LAWS (continued from page 1)

well as withdrawn or withheld; the exclusion of sustenance from the category of extraordinary life-support measures; the emphasis on family involvement in decision-making; the elimination of pregnant women from the definition of "qualified" patients; and the change of the bill's title from "Natural Death Act" to "Life Prolonging Procedure Act." Catholic spokesmen were also responsive, Combee said, to "the generally changing times."

Thomas A. Horkan, Jr., executive director of the Florida Catholic Conference, praised the law, stating that it "recognizes well-established rights of society [and] is very carefully drawn to avoid abuses which are inherent in legislation that has been adopted in other states. . . . It is not death-oriented; rather, it is concerned with providing life-prolonging procedures, as well as withdrawing or withholding such procedures."

Professionals Pleased

Supported by 91 percent of his constituents, according to an informal poll, Combee was strongly backed by the Florida Hospital Association and the Florida Nurses Association. The latter lobbied actively for the bill, and Virginia Haggerty, R.N., executive director, commented, "We are extremely pleased. Most frequently in a code situation it is a nurse who is on the front line making the initial decision about whether to start resuscitation. We've been torn between our cau-

tion and concern over malpractice liability and the human need of the patients and their families for a dignified death."

A footnote to the passage of legislation in Florida was provided by the *Miami Herald* in a recent editorial, which noted that "by the year 2000, the percentage of Floridians 80 to 85 will grow by 120 percent, with those 85 and older growing by an astounding 178 percent."

Louisiana's right-to-die law became the nation's 23rd, after seven successive tries. The bill, a collaborative effort of Reps. Raymond Laborde and Manuel Fernandez and Sen. William MacLeod, was the result of a yearlong study at Loyola University in New Orleans. It passed the Senate 35-2 and the House 88-8 on the same day, was signed into law by Gov. Edwin W. Edwards on July 6, and took effect September 3.

Representative Laborde successfully fought efforts by the House Civil Law Committee to eliminate the bill's provision for surrogate decision-making, which he felt strongly was an advance for patients' rights.

Louisiana's Catholic bishops did not oppose the bill, as they have in years past, according to Church spokesman Emile Comar, who said, "While the Church has always supported life, it does not favor 'artificially supporting life' merely to prolong it without hope of recovery." The state's Catholic Hospital Association also supported the bill.

SRD Publications

HANDBOOK OF LIVING WILL LAWS 1981-1984

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HEMLOCK SOCIETY CONFERENCE

The Hemlock Society is sponsoring its second conference, "Good Life, Good Death Through Control and Choice," in Santa Monica, California, on February 8-9, 1985, at the Miramar-Sheraton Hotel.

Dr. Joseph Fletcher, theologian and ethicist, will be a panelist in a group discussion of "Ethics and Euthanasia." Other panel discussions on such topics as law, medicine, and practical ways of dealing with dying will be led by noted figures in each field. There will also be workshops on Grieving and Alzheimer's disease.

Details are available from Hemlock Society, P.O. Box 66218, Los Angeles, CA 90066. (213) 391-1871.

Craig, March 6, 1985

Dear Senator Ellison,

In watching your presentation on legislation to adopt a living will provision in our state statutes, my husband, Bill, and I were very favorably impressed.

Prior to Bill's mother's death this winter in Spokane, she had signed a living will. Cancer had spread from her lungs to her brain and her condition was diagnosed as terminal. She was 82 years old at the time.

Her written directive, made about two years before her death, provided a structure in which her family and her physicians could carry out her wishes in a coordinated effort.

Unlike many patients who relapse into a coma and never regain consciousness, my mother-in-law did regain her faculties shortly before her death and was able to talk to four of her five children, expressing her good-byes and wishes for their well being.

Had the circumstances been different — no living will, no coming out of the coma — I know that decision's affecting

her welfare would have been much more difficult to resolve. "Second-guessing" what the dying person might wish done on his/her behalf and cooperatively agreeing to a course of action (family members, physicians) leaves a lingering doubt and the potential for possible suit.

Long before Bill's mother's death, Bill and I had made inquiries about Alas. law in regard to the "right to die" principle, and we were very disappointed and concerned that no provision exists at this time.

We hope you will be able to gain the needed support for this legislation, and we would like to personally thank you for introducing this bill to the Senate.