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STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

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POUCHY - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

May, 1986

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CM 14. In order to save space copies of minutes have not been left in the files.

Jeanie Henry

House Judiciary

4-16-86

1:30 pm

Offered: 3/15/85
Referred: Judiciary

Original sponsors: Eliason, Ziegler
and V.Fischer

1 IN THE SENATE BY THE HEALTH, EDUCATION AND
2 CS FOR SENATE BILL NO. 140 (HESS) am SOCIAL SERVICES COMMITTEE
3 IN THE LEGISLATURE OF THE STATE OF ALASKA
4 FOURTEENTH LEGISLATURE - FIRST SESSION
5 A BILL
6 For an Act entitled: "An Act relating to the rights of the terminally ill;
7 and providing for an effective date."
8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:
9 * Section 1. AS 18 is amended by adding a new chapter to read:
10 CHAPTER 12. RIGHTS OF TERMINALLY ILL.
11 Sec. 18.12.010. DECLARATION RELATING TO USE OF LIFE-SUSTAINING
12 PROCEDURES. (a) Any competent person who is at least 18 years old
13 may execute a declaration at any time directing that life-sustaining
14 procedures be withheld or withdrawn from that person; but the declara-
15 tion is given operative effect only if the declarant's condition is
16 determined to be terminal and the declarant is not able to make treat-
17 ment decisions. The declaration must be signed by the declarant, or
18 another at the declarant's direction, and in either case must be
19 witnessed by two persons. The witnesses must be at least 18 years old
20 and may not be related to the declarant by blood or marriage. A
21 physician or health care provider may presume, in the absence of
22 actual notice to the contrary, that the declaration complies with this
23 Act and is valid.
24 (b) It is the responsibility of the declarant to notify the
25 declarant's physician of the declaration. A physician or other health
26 care provider who is provided a copy of the declaration shall make it
27 a part of the declarant's medical records.
28 (c) A declaration may, but need not, be in the following form:
29 DECLARATION

1 notified of the existence and contents of a declaration determines
2 that the declarant is in a terminal condition, the physician must
3 record that determination and the contents of the declaration in the
4 declarant's medical record.

5 Sec. 18.12.040. TREATMENT OF QUALIFIED PATIENTS. (a) A qual-
6 ified patient has the right to make decisions regarding use of life-
7 sustaining procedures as long as the patient is able to do so. If a
8 qualified patient is not able to make these decisions, the decla-ration
9 governs decisions regarding use of life-sustaining procedures.

10 (b) This chapter does not prohibit the application of any med-
11 ical procedure or intervention, including the provision of nutrition
12 and hydration, considered necessary to provide comfort, care, or
13 alleviation of pain.

14 (c) The declaration of a qualified patient known to the attend-
15 ing physician to be pregnant is given no effect as long as it is
16 probable that the fetus could develop to one point of live birth with
17 continued application of life-sustaining procedures.

18 Sec. 18.12.050. TRANSFER OF PATIENTS. (a) An attending physi-
19 cian who is unwilling to comply with the requirements of AS 18.12.030
20 or who is unwilling to comply with the declaration of a qualified
21 patient under AS 18.12.040 shall withdraw as attending physician but
22 the withdrawal is effective only when the services of another attend-
23 ing physician have been obtained.

24 (b) If the policies of a health care facility preclude compli-
25 ance with the declaration of a qualified patient under this chapter,
26 that facility shall take all reasonable steps to effect the transfer
27 of the patient to a facility in which the provisions of this chapter
28 can be carried out.

29 Sec. 18.12.060. IMMUNITIES. (a) In the absence of actual

1 notice of the revocation of a declaration, the following, while acting
2 in accordance with the requirements of this chapter, are not subject
3 to civil or criminal liability or guilty of unprofessional conduct:

4 (1) a physician who causes the withholding or withdrawal of
5 life-sustaining procedures from a qualified patient;

6 (2) a person who participates in the withholding or with-
7 drawal of life-sustaining procedures under the direction or with the
8 authorization of a physician;

9 (3) the health care facility in which the withholding or
10 withdrawal occurs.

11 (b) A physician, health care provider, or health care facility
12 is not subject to civil or criminal liability for actions under this
13 chapter that are in accord with reasonable medical standards.

14 Sec. 18.12.070. PENALTIES. (a) A physician who wilfully fails
15 to withdraw in accordance with AS 18.12.050 is guilty of a class A
16 misdemeanor.

17 (b) A physician who wilfully fails to record the determination
18 of terminal condition in accordance with AS 18.12.030 is guilty of a
19 class A misdemeanor.

20 (c) A person who wilfully conceals, cancels, defaces, or oblit-
21 erates the declaration of another without the declarant's consent or
22 who falsifies or forges a revocation of the declaration of another is
23 guilty of a class A misdemeanor.

24 (d) A person who falsifies or forges the declaration of another
25 person or wilfully conceals or withholds personal knowledge of a
26 revocation under AS 18.12.020, with the intent to cause a withholding
27 or withdrawal of life-sustaining procedures contrary to the wishes of
28 the other person or declarant, and thereby directly causes
29 life-sustaining procedures to be withheld or withdrawn and death to be

1 hastened violates AS 11.41.100.

2 Sec. 18.12.080. GENERAL PROVISIONS. (a) Except as provided in
3 AS 18.12.070 (d) death resulting from the withholding or withdrawal of
4 life-sustaining procedures under a declaration and in accordance with
5 this chapter does not, for any purpose, constitute a suicide or homi-
6 cide.

7 (b) The making of a declaration under AS 18.12.010 does not
8 affect in any manner the sale, procurement, or issuance of a policy of
9 life insurance, nor does it modify the terms of an existing policy of
10 life insurance. A policy of life insurance is not legally impaired or
11 invalidated in any manner by the withholding or withdrawal of life-
12 sustaining procedures from an insured qualified patient, notwithstand-
13 ing any term of the policy to the contrary.

14 (c) A physician, health care facility, or other health care
15 provider, and a health care service plan, insurer issuing disability
16 insurance, self-insured employee welfare benefit plan, or nonprofit
17 hospital plan, may not require a person to execute a declaration as a
18 condition for being insured for, or receiving, health care services.

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

23 (e) Nothing in this chapter increases or decreases the right of
24 a patient to make decisions regarding use of life-sustaining proce-
25 dures as long as the patient is able to do so, nor impairs or super-
26 cedes any right or responsibility that a person has to effect the
27 withholding or withdrawal of medical care in a lawful manner. In that
28 respect, the provisions of this chapter are cumulative.

29 (f) This chapter does not condone, authorize, or approve mercy

1 killing or euthanasia.

2 Sec. 18.12.090. RECOGNITION OF DECLARATIONS EXECUTED IN OTHER
3 STATES. A declaration executed in another state in compliance with
4 the law of that state is effective for purposes of this chapter.

5 Sec. 18.12.100. DEFINITIONS. In this chapter

6 (1) "attending physician" means the physician selected by,
7 or assigned to, the patient who has primary responsibility for the
8 treatment and care of the patient;

9 (2) "declaration" means a document executed in accordance
10 with the requirements of AS 18.12.010;

11 (3) "health care provider" means a person who is licensed,
12 certified, or otherwise authorized by the law of this state to admin-
13 ister health care in the ordinary course of business or practice of a
14 profession;

15 (4) "life-sustaining procedure" means a medical procedure
16 or intervention that, when administered to a qualified patient, will
17 serve only to prolong the dying process;

18 (5) "physician" means a person licensed to practice medi-
19 cine in this state or an officer in the regular medical service of the
20 armed services of the United States or the United States Public Health
21 Service while in the discharge of their official duties, or while
22 volunteering services without pay or other remuneration to a hospital,
23 clinic, medical office, or other medical facility in the state;

24 (6) "qualified patient" means a patient who has executed a
25 declaration in accordance with this chapter and who has been deter-
26 mined by the attending physician to be in a terminal condition;

27 (7) "terminal condition" means an incurable or irreversible
28 condition that, without the administration of life-sustaining proce-
29 dures, will, in the opinion of the attending physician, result in

1 death within a relatively short time.

2 * Sec. 2. This Act takes effect immediately in accordance with AS 01.-
3 10.070(c).

A M E N D M E N T

Offered in the HOUSE

By Clocksin

TO: CSHB 269(HESS)

Page 5, lines 1 - 7 delete all material.

Page 6, line 25, following "state" insert:

"or an officer in the regular medical service of the armed services of the United States or the United States Public Health Service while in the discharge of their official duties, or while volunteering services without pay or other remuneration to a hospital, clinic, medical office, or other medical facility in the state"

cc #11

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: HB 269

Title: Rights of terminally ill

Sponsor: Clocksin 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
600 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
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REVENUE	0	0	0	0	0	0
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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.

Division: Public Health

Phone: 465-3090

Date: _____

Approved by Commissioner: J.R.P.

Agency: Dept. of Health & Social Services

Date: 3/15/85

JCC

Distribution (by Agency preparing fiscal note):

Legislative Finance

Legislative Sponsor

Requestor

Office of Management and Budget

Impacted Agencies

STATE OF ALASKA
THE LEGISLATURE

POUCHY STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

March 22, 1985

SUBJECT: Sectional analysis of House Bill 269

TO: Representative Nillo 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 declarer's 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

OLDER ALASKANS COMMISSION
POSITION PAPER

House Bill No. 269

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

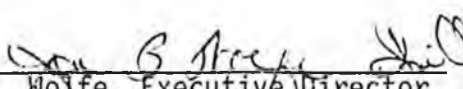
The Older Alaskans Commission urges passage of this legislation to allow terminally ill adults to decline life-sustaining procedures. The legislation would permit an adult to execute a written declaration instructing his physician to withhold or withdraw life-sustaining procedures if he was in a terminal condition and became unable to participate in medical treatment decisions.

In contrast to the acute diseases which were the leading causes of death at the turn of the century, current leading causes of death in this country are heart disease, malignancies, and cerebrovascular diseases. These chronic, progressive diseases often involve lengthy periods of medical treatment and most frequently attack the elderly. The majority of deaths occur in medical institutions where the means exist to prolong life for a substantial period of time, regardless of the irreversibility of the condition or quality of life.

This legislation clearly establishes the means for an adult to decline life prolonging treatment for an irreversible condition; informs his physician on how to proceed should he become unable to participate in medical treatment decisions; authorizes the physician and health care facility to comply with his wishes; and provides immunity to the physician and health care facility from civil or criminal liability for acting in accordance with his wishes.


At least twenty other states have enacted legislation in this area. The language in House Bill 269 is based on a discussion draft of a Rights of the Terminally Ill Act prepared by the drafting committee appointed by the National Conference of Commissioners on Uniform State Laws.

We ask your support of this bill and in making the health and dignity of our elderly a major state priority.



Jon B. Wolfe, Executive Director
Older Alaskans Commission

March 14, 1985
Date



Commissioner Lisa Rudd
Department of Administration

3/27/85
Date

ALASKANS FOR LIFE

Incorporated

P. O. Box 2186

Juneau, Alaska 99803

March 25, 1985

Testimony prepared for presentation by Sidney D. Heidersdorf, Alaskans For Life, Inc. to the Alaska Legislature on SB. 140 and HB 269, acts relating to the right of the terminally ill.

Senate Bill 140 and House Bill 269 gives legal recognition to a declaration signed by a patient that he/she wants life sustaining procedures withheld or withdrawn during an illness judged to be terminal. This is "living will" legislation similar to "death with dignity" and "natural death acts" which have been introduced into State legislatures across the country.

On the surface the living will looks harmless. However, we believe there are serious problems with the concept of this legislation and, therefore, we oppose it.

We do not argue with the implied or stated goals of living will legislation. We support the right of a terminally ill patient to refuse the use of extra-ordinary means to prolong life when death is imminent. Our opposition is based primarily on the method used to obtain its goals. Our reasons for objecting to the concept of the living will are as follows:

1. Living will legislation is unnecessary. Patients already have their rights respected regarding rejection of treatment to avoid the abusive use of technology when terminally ill. At the very best, this is special legislation for a few hard cases and, as such, is bad law. Those who are concerned about being unable to express their wishes due to serious injury or illness are free to do so by writing a personal note. This could be given to a family member, doctor, clergyman, attorney or friend; but the State should be kept out of the transaction.
2. The living will opens the door for potential abuse of the elderly. Subtle coercion to sign the living will could easily be used. The living will could be used as a method of eliminating care for the elderly by those who view them as a burden to society. The Society for the Right to Die is a principal promoter nationwide of the living will. This organization, before it changed its name, was the

Euthanasia Society of America.

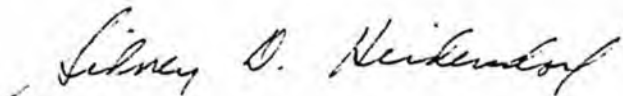
Disclaimers that living wills do not condone euthanasia are meaningless if acts, otherwise unacceptable, are legalized and protected by provisions found elsewhere in the law. To give just one example; In both SB 140 and HB 269 the term "life/sustaining procedure" is defined as "a medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process." Under that definition antibiotics or other routine medication could be considered as a life sustaining medical intervention and, therefore, denied one who is "terminally ill". That is a long way from what has usually been considered required routine medical care.

3. Living will legislation encourages patients to sign a declaration to have their rights to refuse unusual medical life-sustaining procedures respected. It leads to the misconception that the living will confers the right on the patient rather than recognizes it. This is a dangerous precedent. This right is not given to us by the State. Once the right to refuse treatment is construed as conferred by the State the implication is that the State can control this decision relating to death and at some time in the future can make the decision as to when the patient should die.
4. The majority of the people will not sign a living will. They will have their rights undermined by this law. Physicians may feel compelled to over-treat the non-signer since this could be interpreted as saying that the patient wants all efforts made to prolong life. This might be done in spite of the families knowledge of the real wishes of the patient. If this legislation gives something to those who sign, it will necessarily undercut the rights of those who do not sign, regardless of disclaimers made to the contrary.
5. Signing a living will is an uninformed decision and the State should not condone it. A patient cannot make an informed decision regarding the circumstances of his death 5, 10, or 50 years in the future. No one knows in advance the conditions or circumstances that will exist when the declaration is to be implemented. Medical technology changes rapidly. The patient almost certainly will not know how the physician will interpret the phrase "life sustaining procedure". The unknowns are endless, including the risks and problems with interpretation of definitions.

Presumably living will legislation seeks to protect the rights of either the patient or the physician or both. This could be accomplished by legislation acknowledging the fundamental rights of patients to make decisions affecting their care. This legislation could restate the principle that extra-ordinary life sustaining measures may be refused by the patient or withdrawn by the attending physician when done under the usual and customary standards of medical practice following approval of the patient and/or the family. Those who wished to sign a personal declaration could do so, but without the involvement of government.

This approach would avoid the difficulty of definitions. There would be no problem for those who do not sign. Also, there would be no pitfalls or potential for serious abuse that exists in living will legislation.

In conclusion, we believe that legislation in any form which gives legal status to a written declaration in the form of a living will is not in the best interest of our society. Therefore, we ask everyone to think about this issue and request our legislators to reject living will legislation. This is necessary to protect the rights of everyone.



Sidney D. Heidersdorf
Alaskans For Life, Inc.

STATE OF ALASKA
THE LEGISLATURE

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Sec. 18.12.100 defines certain terms used in this chapter.

BGB:ojb
J13/018

HOSPICE OF JUNEAU

PATIENT STATISTICS

January 1, 1984 - December 31, 1984

Males - 11
Females - 7
18

Age of Patient

1-19 year - 1
20-29 - 0
30-39 - 0
40-49 - 2
50-59 - 7
60-69 - 4
70-79 - 3
80+ yrs. - 1

Adult average age - 62

Diagnosis

Cancer - Bone - 1
Breast - 1
Gastrointestinal - 4
Leukemia - 1
Lung - 5
Prostate - 1
Renal - 1
Skin - 1
Thyroid - 1
C.O.P.D. - 1
Congenital & Childhood Diseases - 1

Physicians using the service

Dr. Akiyama - 10 cases
Dr. Brooks - 1 case
Dr. Cole - 1 case
Dr. Franklin - 1 case
Dr. Layman - 1 case
Dr. McCabe - 1 case
Dr. Palmer - 1 case
Dr. Smith - 1 case
Dr. Weist - 1 case

Source of the referral

Physicians - 9
Family/Patient - 5
Friend - 1
Clergy - 1
Nurses - 2

Length of service (in days)

Range: 2 to 365 days

1 - 14 - 4
15 - 30 - 4
31 - 60 - 1
61 - 90 - 1
91 - 120 - 0
121 - 150 - 1
151 - 365 - 3

Of the 18 patient/families cared for
12 were new admissions
17 were essentially nursing
1 was more supportive assistance

Average length of stay skilled nursing - 80 days
supportive assistance - 16 days

Total days - 1433
in home - 1335
in hospital - 98

Direct Care

Number of visits
Skilled nursing - 245
Home healthaide - 27
Hospice visit - 51
Hospital - 19
342
Social Workers - 36
Total Staff visits - 378

Volunteer visits - 191

Collateral Consultations

Consulting with individuals regarding death
related issues - 46 consultations

Bereavement Followup

Contacts made - 79

Place of Death

Home - 10 cases
Hospital - 5 cases

Team conferences were held 19 times

HOSPICE OF JUNEAU

PATIENT STATISTICS

Jan. 1, 1983 - Dec. 31, 1983

Males - 13

Females - 12

25

Age of patient

1-19 yrs. - 2

20-29 yrs. - 0

30-39 yrs. - 1

40-49 yrs. - 3

50-59 yrs. - 5

60-69 yrs. - 8

70-79 yrs. -

80+yrs. - 1

Adult Average Age - 61

Diagnosis

Cancer - Breast - 1

Lung - 4

Skin - 2

Lymphoma - 1

Gastrointestinal - 7

Prostate - 1

Head & Neck - 2

C.O.P.D. - 4

Diabetes - 1

Congenital & Childhood Diseases - 2

Physicians using the service

Dr. Akiyama - 8 cases

Dr. Brooks - 1 case

Dr. Cole - 2 cases

Dr. Andrews - 1 case

Dr. Franklin - 3 cases

Dr. Hedges - 1 case

Dr. Hughes - 1 case

Dr. Moss - 1 case

Dr. Palmer - 3 cases

Dr. Thompson - 3 cases

Dr. West - 1 case

Source of the Referral

Physicians - 14

Family/Patient - 7

Friend - 2

Clergy - 1

Nurses - 1

Length of Service (in days)

Range: 6 to 137 days

1 - 14 - 7

15 - 30 - 9

31 - 60 - 2

61 - 90 - 5

91 - 120 - 1

121 - 151 - 1

Of the 25 patient/families cared for

20 were new admissions

16 were essentially skilled nursing

9 were more supportive assistance

Average length of stay skilled nursing - 37 days
supportive assistance - 34 days

Total days - 826

in home - 718

in hospital - 108

Direct Care

Number of visits

Nursing Staff - home - 244

hospital - 44

288 total

Volunteers - 75 total

Social Workers - 6 families

Collateral Consultations

Consulting with individuals regarding death
related issues - 28 consultations

Bereavement Followup

Contacts - 115

Place of Death

Home - 11 cases

Hospital - 9 cases

Nursing Home - 1 case

Hospice of Juneau

Patient Statistics

January 1, 1982 - December 31, 1982

Males - 8
Females - 7
15

Age of patient

30 - 39 yrs. - 1
40 - 49 yrs. - 3
50 - 59 yrs. - 2
60 - 69 yrs. - 5
70 - 79 yrs. - 3
80+ yrs. - 1

Average age - 60 yrs. old

Diagnosis

Cancer - Skin - 2
Lung - 4
Colon - 3
Liver - 1
Brain - 1
Kidney - 1
Pancreas - 1
Breast - 1
Other - Emphysema - 1

Physicians using the service

Dr. Hedges - 3 cases
Dr. Brooks - 1 case
Dr. Thompson - 2 cases
Dr. Akizama - 5 cases
Dr. Cole - 3 cases
Dr. Olsen - 1 case

Source of Referral

Physician - 7
Family Member - 3
Friend - 3
Clergy - 1
Nurses - 1

No. of deaths in hospital-6
No. of deaths in home-8

Length of Service (in days)

Range: 1 - 185

1 - 14 - 4
15 - 30 - 3
31 - 60 - 2
61 - 90 - 4
91 - 120 - 1
121 - 150 - 0
151 - 180 - 0
181 - 210 - 1

Average - 50 Days

Total days - 749
In the home - 598
In the hospital - 151

Direct Care (in hours)

Nursing Staff - Range - 1 - 48 hrs.
Total - 258hrs
Average - 17 hrs.

Volunteers - Range - 2 - 91 hrs.
Total - 279 hrs.
Average - 40 hrs.

Total Hours - 539 hrs.

Coordination with other home care providers

Homemaker Program - 2 cases
Home Health Program - Registered Nurses - 8
Home Health Aide - 6 cases

Collateral Consultations

Consulting with individuals outside of our patients and their families regarding death related issues
14 - individuals
1 - 3 contacts

Regionally

Have assisted 4 families in Southeast Alaska identify resources and consult with local

POSITION PAPER

HOUSE BILL NO. 269

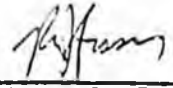
For "An Act relating to the rights of the terminally ill."

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.

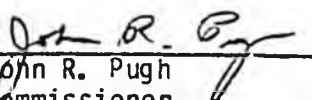
This bill provides a process through which a competent adult can participate in decisions regarding his or her care when afflicted with a terminal condition. "Terminal condition" is an incurable or irreversible condition that, without the administration of life-sustaining procedures, will result in death 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.: up 260
 Title: Rights of terminally ill
 Sponsor: Clocksin 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
600 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. Frazer, M.D. Phone: 465-3090
 Division: Public Health Date: _____

Approved by Commissioner: J.R.P. Date: 3/15/85 JCC
 Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):

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

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.



Bouvia: Death on the docket

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

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 skill 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. 40:129^a.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 witnesses 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.



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 person 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 pediatricians 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.



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 Mino 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 (Columbia), Frank Dungey (New Zealand), Dr. Saba (Japan) and Mr. Rosoff.

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.



Christine K. Cassel, M.D.



Sia Arnason, M.S.W.

Society for the Right to Die
250 West 57 Street
New York, NY 10107

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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*

SRD Publications

HANDBOOK OF LIVING WILL LAWS 1981-1984

Thirteen New Statutes with Texts, Analysis and Commentary

A companion resource to *Handbook of Enacted Laws (1981)* containing the first ten state right-to-die laws

Each \$5.00

Fact Sheets on Right-to-Die Court Decisions

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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.

The Society for the Right to Die makes available legally recognized advance document forms to residents in the states of Alabama, Arkansas, California, Delaware, Florida, Georgia, Idaho, Illinois, Kansas, Louisiana, Mississippi, Nevada, New Mexico, North Carolina, Oregon, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming and the District of Columbia. For use in states lacking right-to-die laws, SRD supplies Living Will Declaration forms.

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.

ending priorities

effective this July.

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.

HOSPICE OF JUNEAU

PATIENT STATISTICS

January 1, 1984 - December 31, 1984

Males - 11
Females - 7
18

Length of service (in days)
Range: 2 to 365 days

Age of Patient

1-19 years - 1
20-29 - 0
30-39 - 0
40-49 - 2
50-59 - 7
60-69 - 4
70-79 - 3
80+ yrs. - 1

1 - 14 - 4
15 - 30 - 4
31 - 60 - 1
61 - 90 - 1
91 - 120 - 0
121 - 150 - 1
151 - 365 - 3

Of the 18 patient/families cared for
12 were new admissions
17 were essentially nursing
1 was more supportive assistance

Adult average age - 62

Diagnosis

Cancer - Bone - 1
Breast - 1
Gastrointestinal - 4
Leukemia - 1
Lung - 5
Prostate - 1
Renal - 1
Skin - 1
Thyroid - 1
C.O.P.D. - 1
Congenital & Childhood Diseases - 1

Average length of stay skilled nursing - 80 days
supportive assistance - 16 days

Total days - 1433
in home - 1335
in hospital - 98

Direct Care

Number of visits
Skilled nursing - 245
Home healthaide - 27
Hospice visit - 51
Hospital - 19
342
Social Workers - 36
Total Staff visits - 378

Volunteer visits - 191

Physicians using the service

Dr. Akiyama - 10 cases
Dr. Brooks - 1 case
Dr. Cole - 1 case
Dr. Franklin - 1 case
Dr. Layman - 1 case
Dr. McCabe - 1 case
Dr. Palmer - 1 case
Dr. Smith - 1 case
Dr. Weist - 1 case

Collateral Consultations

Consulting with individuals regarding death related issues - 46 consultations

Bereavement Followup

Contacts made - 79

Source of the referral

Physicians - 9
Family/Patient - 5
Friend - 1
Clergy - 1
Nurses - 2

Place of Death

Home - 10 cases
Hospital - 5 cases

Team conferences were held 19 times

Culmonary
Obstructive
Pulmonary
Disease

HOSPICE OF JUNEAU

PATIENT STATISTICS

Jan. 1, 1983 - Dec. 31, 1983

Males- 13
Females-12
25

Age of patient

1-19 yrs. - 2
20-29yrs. - 0
30-39yrs. - 1
40-49yrs. - 3
50-59yrs. - 5
60-69yrs. - 8
70-79yrs. - 5
80+yrs. - 1
Adult Average Age - 61

Diagnosis

Cancer - Breast - 1
Lung - 4
Skin - 2
Lymphoma -1
Gastrointestinal - 7
Prostate - 1
Head & Neck -2
C.O.P.D. - 4
Diabetes - 1
Congenital & Childhood Diseases - 2

Physicians using the service

Dr. Akiyama - 8 cases
Dr. Brooks - 1 case
Dr. Cole - 2 cases
Dr. Andrews - 1 case
Dr. Franklin - 3 cases
Dr. Hedges - 1 case
Dr. Hughes - 1 case
Dr. Moss - 1 case
Dr. Palmer - 3 cases
Dr. Thompson - 3 cases
Dr. Weist - 1 case

Source of the Referral

Physicians - 14
Family/Patient -7
Friend - 2
Clergy - 1
Nurses - 1

Length of Service (in days)

Range: 6 to 137 days

1 -14 - 7
15 - 30 - 9
31 - 60 - 2
61 - 90 - 5
91 - 120 - 1
121 - 151 - 1

Of the 25 patient/families cared for
20 were new admissions
16 were essentially skilled nursing
9 were more supportive assistance

Average length of stay skilled nursing - 37 days
supportive assistance -34 days

Total days - 826
in home - 718
in hospital - 108

Direct Care

Number of visits
Nursing Staff - home -244
hospital 44
288 total
Volunteers - 75 total

Social Workers - 6 families

Collateral Consultations

Consulting with individuals regarding death related issues - 28 consultations

Bereavement Followup

Contacts - 115

Place of Death

Home - 11 cases
Hospital - 9 cases
Nursing Home - 1 case

Hospice of Juneau

Patient Statistics

January 1, 1982 - December 31, 1982

Males - 8
Females - 7
15

Age of patient

30 - 39 yrs. - 1
40 - 49 yrs. - 3
50 - 59 yrs. - 2
60 - 69 yrs. - 5
70 - 79 yrs. - 3
80+ yrs. - 1

Average age - 60 yrs. old

Diagnosis

Cancer - Skin - 2
Lung - 4
Colon - 3
Liver - 1
Brain - 1
Kidney - 1
Pancreas - 1
Breast - 1
Other - Emphysema - 1

Physicians using the service

Dr. Hedges - 3 cases
Dr. Brooks - 1 case
Dr. Thompson - 2 cases
Dr. Williams - 5 cases
Dr. ... - 3 cases
Dr. ... - 1 case

Source of Referral

Physician - 7
Family Member - 3
Friend - 3
Clergy - 1
Nurses - 1

No. of deaths in hospital - 6
No. of deaths in home - 8

Length of Service (in days)

Range: 1 - 185

1 - 14 - 4
15 - 30 - 3
31 - 60 - 2
61 - 90 - 4
91 - 120 - 1
121 - 150 - 0
151 - 180 - 0
181 - 210 - 1

Average - 50 Days

Total days - 749
In the home - 598
In the hospital - 151

Direct Care (in hours)

Nursing Staff - Range - 1 - 48 hrs.
Total - 258 hrs.
Average - 17 hrs.

Volunteers - Range - 2 - 91 hrs.
Total - 279 hrs.
Average - 40 hrs.

Total Hours - 539 hrs.

Coordination with other home care providers

Homemaker Program - 2 cases
Home Health Program - Registered Nurses - 8
Home Health Aide - 6 cases

Collateral Consultations

Consulting with individuals outside of our patients and their families regarding death related issues
14 - individuals
1 - 3 contacts

Regionally

Have assisted 4 families in Southeast Alaska identify resources and consult with local

Eight in 10 Americans Back Terminally Ill Patients' Right to Die

Eight in 10 Americans believe terminally ill patients should have the right to die by asking doctors to stop life-supporting medical treatment, according to recent Gallup and Harris surveys.

Over the past decade, the public has become much more likely to accept euthanasia in such circumstances. The latest surveys found strong support for the concept in all major demographic groups and in every region of the country.

The Gallup Poll asked this question:

"The New Jersey Supreme Court has recently ruled that all life-sustaining medical treatment may be withheld or withdrawn from terminally ill patients, provided that is what the patients want or would want if they were able to express their wishes. Would you like to see such a ruling in the state in which you live, or not?"

Overall, 81 percent were in favor and 13 percent opposed; 6 percent were undecided. A similar question by the Harris Poll found an 82-to-16 percent majority endorsing the New Jersey ruling, with 2 percent undecided.

According to the New Jersey ruling, a mentally competent patient can stop medical treatment on request. Treatment for a terminally ill patient who is not mentally competent can be ended if that was requested when the patient was competent.

The New Jersey ruling was the first in which a state high court decided that a patient has the right to stop medical treatment, including feeding.

Both surveys found a large majority of old-

Men and women hold similar views on the issue

er people in favor of the ruling, with younger and middle-aged people backing it even more strongly. For example, Gallup found support at 68 to 20 percent among those aged 65 and older; at 82 to 12 percent among those 50 to 64 years old; at 86 to 9 percent among those 30 to 49; and at 80 to 16 percent among those 18 to 29 years old.

Protestants and Catholics held similar views on the matter, as did men and women, according to Gallup.

Gallup did not present trend data, as Harris did. Here are the questions asked by Harris that dealt broadly with euthanasia:

"All doctors take an oath saying they will maintain, restore and prolong human life in their treatment of patients. It is now argued by some people that in many cases people with terminal diseases, those which can only end in death, have their lives prolonged unnecessarily, making them endure much pain and suffering for no real reason. Do you think a patient with a terminal disease ought to be able to tell his doctor to let him die rather than to extend his life when no cure is in sight, or do you think this is wrong?"

This year's survey found 85 percent who said people should be allowed to die when they request it, up from 78 percent in 1981, the last previous survey on the subject. In 1973, when the question was first asked, 62 percent were in favor.

Harris then asked: "Do you think the patient who is terminally ill, with no cure in

sight, ought to have the right to tell his doctor to put him out of his misery, or do you think this is wrong?"

This year, 61 percent said the patient should have the right to die in those circumstances and 36 percent said that was wrong; 3 percent were undecided. In contrast, a 53-to-37 percent majority were opposed in 1973, with 10 percent undecided.

The Gallup Poll was based on personal interviews with 1,528 adults from Jan. 25 to 28. The Harris Poll was based on phone interviews with 1,254 adults from Jan. 24 to 27. The margin of sampling error in both surveys was plus or minus 3 percentage points.

Campaign Contributions

A plurality of Californians think campaign contributions by both liberal and conservative interest groups have a "bad influence" on politics and government, California Poll found.

At the same time, however, a majority said that contributions by environmental groups, consumer groups, teachers' organizations, women's political groups and organizations that favor farm workers have a good influence.

The poll, conducted last fall and recently released, found that 45 percent said "politically liberal interest groups" have a bad influence, while 29 percent said they have a good influence; 26 percent expressed qualified views or none at all. A narrower 41-to-36 percent plurality said that contributions by "po-

litically conservative interest groups" have a bad influence.

The most popular interests were environmental groups (63 percent said their contributions have a good influence), consumer groups (63 percent), organizations representing teachers (58 percent), women's political groups (58 percent) and groups that favor farm workers (50 percent).

Pluralities said contributions by groups that favor large farming interests, state employe organizations and nuclear freeze proponents have a beneficial effect.

The least popular interest groups included real estate interests (63 percent said their contributions are a bad influence), bankers and insurance interests (56 percent), large companies (54 percent) and trial lawyers (50 percent). Pluralities said contributions by religious groups and labor unions have a negative effect.

People were evenly divided over the effect of political contributions by doctors and dentists.

The poll also found six in 10 Californians endorsing contributions by political candidates to their own campaigns. But more than six in 10 criticized contributions by legislative leaders to candidates in other districts, and a majority were critical of contributions by interest groups that are "outside" a state legislator's district.

Findings were based on about 500 telephone interviews conducted last fall. The margin of sampling error was plus or minus 4.5 percentage points. ■

Compiled by Kenneth E. John

The Washington Post-Nat'l. Weekly Edition

April 1, 1985

*
* DELIVER TO: JPOH
*
* ORIGINAL
* SENT: 04/02/85 TIME: 14:40
* FROM: ANNIE NEUBAUER
* SUBJECT: POM/FAIRBANKS
* PRINT DATE: 04/02/85 TIME: 14:40
*

5

TO: REPS. M. M. MILLER AND SUND

SENATORS RODEY AND KELLY

FROM: JANE WINDSOR, CHAIRPERSON OF ALASKA STATE LEGISLATIVE
COMMITTEE, AMERICAN ASSOCIATION OF RETIRED
PERSONS, 319 EAST BENTLEY DRIVE, FAIRBANKS 99701

PHONE: 456-6035

RE: SB140 AND HB269 RIGHTS OF TERMINALLY ILL/LIVING WILL

APPROVE...NO FISCAL NOTE...IMPORTANT OPTION FOR OUR CITIZENS NO
MATTER WHAT CIRCUMSTANCES SURROUND A TERMINAL CONDITION.

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.

11

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. 31-22-1-12 (1984).

Written declaration signed in presence of two disinterested witnesses. Form prescribed in statute if declaration made while patient in hospital or skill 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 witnesses 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.

Alaska State Legislature



House of Representatives House Judiciary Committee

Pouch V
State Capitol
Juneau, Alaska 99811
(907) 465-4990

April 10, 1985

Ms. Irene Hedstrom
1521 "N" Street
Anchorage, AK 99501

Dear Ms. Hedstrom:

This is to notify you that the House Judiciary Committee has scheduled a hearing on HB 269, Right of the Terminally Ill, for Tuesday, April 16 at 1:30 p.m. This hearing will be a teleconference with Anchorage.

Very truly yours,

A handwritten signature in cursive script that reads "Kaylene Svendsen".

Kaylene Svendsen
Committee Secretary

State of Alaska

COMMITTEES

HOUSE HEALTH, EDUCATION
AND SOCIAL SERVICES
(Co-Chairman)
HOUSE JUDICIARY
HOUSE COMMUNITY AND
REGIONAL AFFAIRS



POUCH V
JUNEAU, ALASKA 99811
(907) 465-4968

914 CLAY COURT
ANCHORAGE, ALASKA 99503
(907) 276-6844

Representative Max F. Gruenberg, Jr.
District 11
Spenard, Upper Midtown Anchorage

April 8, 1985

Ms. Irene Hedstrom
1521 "N" Street
Anchorage, AK 99501

Thank you very much for your public opinion message on House Bill 269. This bill was passed out of the House HESS Committee on April 1, and is now referred to the House Judiciary Committee. I am sorry that not everyone who wanted to testify was able to do so at the HESS Committee hearing. I am sending a copy of your POM to Chairman M. Mike Miller of the Judiciary Committee, with a specific request that they hold a teleconference on the bill, and that they notify you so that you will have a chance to testify.

Cordially,


Max F. Gruenberg, Jr.

MFG/ke
cc: Rep. M. Mike Miller

*
* DELIVER TO: JPOM *
* *
* *
* ORIGINAL *
* SENT: 03/29/85 TIME: 12:37 *
* FROM: BARBARA NORRELL *
* SUBJECT: POM *
* PRINT DATE: 03/29/85 TIME: 12:37 *
* *

9

TO: HOUSE HESS
REFS. GRUENBERG, KOPONEN, TAYLOR, HANLEY, HURLEY,
PETTYJOHN, THOMPSON,
AND
REF. CLOCKSIN
FROM: IRENE HEDSTROM, 1521 N STREET, ANCHORAGE, AK 99501
277-6001
SUBJECT: HB 269, RIGHT OF THE TERMINALLY ILL

PEGGY BERGEN , DR. RODMAN WILSON AND OTHERS CAME TO TESTIFY TO
YOUR HB 269. HEARING WERE CANCELLED AT 6:30 PM. WHEN WILL WE
HAVE THE OPPORTUNITY TO TESTIFY IN SUPPORT OF THIS BILL?

PRIMARY DISTRIBUTION
JPOM
L10A

DATE/TIME SENT
03/29/85 12:37
03/29/85 12:37

State of Alaska

COMMITTEES

HOUSE HEALTH, EDUCATION
AND SOCIAL SERVICES
(Co-Chairman)
HOUSE JUDICIARY
HOUSE COMMUNITY AND
REGIONAL AFFAIRS

POUCH V
JUNEAU, ALASKA 99811
(907) 465-4968

914 CLAY COURT
ANCHORAGE, ALASKA 99503
(907) 276-6844

Representative Max F. Gruenberg, Jr.
District 11
Spennard, Upper Midtown Anchorage

April 8, 1985


David T. Walker, Esq.
326 Fourth St., Suite B
Juneau, AK 99801

Dear Mr. ^{Walker} Walker:

Thank you much for your letter of March 6, regarding House Bill 269. I very much regret that your letter was misplaced and you were therefore not notified of the HESS Committee hearing on House Bill 269. Please accept my apologies for this oversight. As you may be aware, the bill passed out of the House HESS Committee on April 1, 1985.

I am sending a copy of your letter to Chairman M. Mike Miller of the House Judiciary Committee, with the request that it be included in the official committee file on the bill. I am also requesting that the Judiciary Committee staff notify you of the Judiciary Committee hearing date on House Bill 269, so that you can testify at that time.

Cordially,


Max F. Gruenberg, Jr.

MFG/ke

cc: Rep. M. Mike Miller
Rep. Don Clocksin

Sorry about the misprop.

DAVID T. WALKER
ATTORNEY AT LAW
MENDENHALL BUILDING
326 FOURTH STREET, SUITE B
JUNEAU, ALASKA 99801
(907) 586-3537

March 6, 1985

The Honorable Max F. Gruenberg, Jr.
Co-Chairman
House Health, Education and Social
Services Committee
Pouch V
Juneau, Alaska 99811

Re: House Bill 269

Dear Representative Gruenberg:

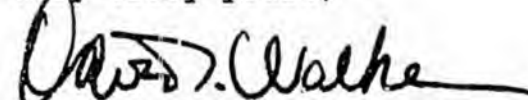
I am the registered lobbyist for the Alaska Nurses Association.

The Association supports HB 269 "An Act relating to the rights of the terminally ill." Quite a few of my clients have requested instruments similar to the instrument proposed to be authorized by House Bill 269. Generally speaking, my clients do not fear death itself as much as the indignity of deterioration, dependency and hopeless pain. An individual with a sound mind has a perfect right to make carefully considered decisions impacting and controlling his medical treatment. Those decisions should, upon the request of the individual, be controlling if the individual's physical condition becomes terminal and he is no longer able to participate in decisions regarding medical treatment.

I would appreciate it very much if you would have your staff notify me of the hearing schedule on this bill. It may be that the Association will want to present testimony.

Please do not hesitate to contact me if you have a question about the Association's position regarding House Bill 269 or any other matter.

Very truly yours,


David T. Walker

DTW/cah

cc: Margaret Bixby, R.N.
Janet Bunes, R.N.

My dear Mr. Nick Miller

April 15, 1985

Page 7
Jensen, Ak 99801

APR 25 1985

Dear Sir,
 Bill #269, the rights
 of the terminally ill is presently
 before your committee.
 I am concerned about
 some aspects of this bill.
 I do not regard a "right" for
 'competent persons 18 years old'
 not to happen to the 'right'
 of the minor child, or the
 or mentally ill adult, or the
 mentally retarded adult? Or the
 joining of many people, a right
 should that have to be claimed
 by signing a declaration, but
 instead should be available
 to all persons whenever needed.
 2) No definition has been given



to competent. This allows for subjective application of this law based on an interruption by the judiciary branch of government.

3) This bill does not require a declaration to be signed, thereby allowing for the status quo to exist. My physician informed me that the wishes of the family are honored without a signed declaration.

4) Senator Claiborne's office told me twice there is no real need for the legislation, its purpose is to provide comfort to those who wish to make a declaration.

5) The Society for the Right-to-Die, formerly the Euthanasia Society of America supports this bill. Their goal is to get legislation on the books that can be changed 5, 10, or 20 years from now to allow for active euthanasia of the elderly, handicapped, mentally retarded & perhaps groups of people who think differently than they. That really disturbs me.

I would like to see the
bill completely withdrawn.

If the Legislature feels a
need to state "The Rights" of the
terminally ill, may I suggest a
State Bill of Rights in which the
Right to die without life sus-
taining systems can be a part.

Please make this letter
a part of the permanent
record or provide copies for
your Committee members.

Respectfully submitted,
Betty Bengtson

9449 Patricia Pl.
Juneau, Ak. 99801



Opinion

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Bill provides compassion for terminally ill

A bill now before the Legislature would guarantee adults the right to decide for themselves, while capable of deciding, whether life-sustaining measures should be used to prolong life when death is imminent.

Under the proposal, an adult at any time—whether ill or not—could sign a form saying:

"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 administrative or 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."

The bill forces no one to sign such a declaration and does not affect those who choose not to sign one. It also allows a person to revoke a declaration at any time, as long as he or she can make decisions and communicate them.

The bill does not, and specifically states it does not, "condone, authorize or approve mercy killing or euthanasia."

What the bill provides is compassion and the right to choose for one's self while the choice can still be made. It would apply only in those cases where there is no hope for recovery.

How much emotional pain would have been eased if a signed declaration had been available to some families and physicians. How many people would prefer—and should have the right to prefer—to make the decision for themselves, and for their families, and for those caring for them.

It's hard to imagine a more essentially personal question than whether one's life, and what one defines as living, should be extended by artificial means when all hope is gone. Given advances in medical technology, the question now arises more frequently, but when does an individual have the chance to provide the answer?

Sen. Dick Eliason (R-Sitka) is chief sponsor of the bill in the Senate. A companion measure was recently introduced in the House. The proposal has received support from hospice officials, who work with terminally ill patients and their families, and the Alaska State Hospital Association, in addition to numerous individuals.

Laws similar to Eliason's proposal have already been enacted in 23 states, including California, Oregon, Washington and Idaho.

For the sake of compassion and individual choice, Alaska should add itself to the list.