SB

140

BILL CONTACT/ACTION

DATE	CONTACT/ACTION
3/15	Bill received in Committee -
	back-up received from sponsor
3/30	Request from sponsor - "please calendar."
3/28	Sheila Peterson notified
	Mail List
	Sid Heidersdorf 789-9858 ✓
	Dr. Thompson - Bartlett - 586-6640 ✓
	Juneau Hospice Rep (Judy Olson?) ✓

Craig, March 6, 1985

Dear Senator Ellsong

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

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

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

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

Had the circumstances been different — no living will, no coming out of the coma -- I know that decisions affecting

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

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

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

Best regards,
Bill and Sunshine Millhorn
Box 335
Craig, Alaska 99921

SB 128 (cont'd)

law or regulation."

Effective July 1, 1985.

Labor Relations (school boards & public employees)

SENATE BILL NO. 129, (see page 216). Reported back to the Senate on March 12 by Labor & Commerce with the committee recommending it do pass. Concurring: Eliason (Vice-Chairman), Bennett and Ray. To HESS.

Rights of the Terminally Ill

SENATE BILL NO. 140, (see page 222). Reported back to the Senate on March 15 by Health, Education & Social Services with the committee recommending it be replaced with a HESS CS and as follows: Fahrenkamp (Chmn.) and Sturgulewski signed "do pass"; Paul Fischer and DeVries signed "no recommendation." To Judiciary.

The HESS CS adds an immediate effective date and clarifies that the bill only applies to persons over the age of 18 (original only said "adult").

Municipal Code Revision

SENATE BILL NO. 142, (see page 223). Reported back to the Senate on March 15 by Community & Regional Affairs with the committee recommending it be replaced with a C&RA substitute and that it do pass. Concurring: DeVries (Chairman), Sturgulewski, Vic Fischer and Coghill. To Judiciary.

The committee attached the following letter of intent:

> It is not the intent of the Legislature through the passage of CSSB 142 to change the taxing provisions for electric and telephone cooperatives as set forth by AS 10.25.540-560; nor is it the intent of the Legislature to change present statute provisions covering public utility access to municipal rights-of-way as set forth by AS 42.05.251.

The bill is a 210-page major rewrite of the Municipal Code. See CSHB 72 (C&RA), page 415. Identical, except CSSB 142(C&RA) includes "Purpose" section in Sec. 1. Outlines the reasons for the municipal code revision. Reads, in part: "... Except as expressly provided, the legislature does not intend by this Act to alter or affect in any way the relationship or balance of authority between the state and home rule or general law municipalities with respect to the timing or manner of resource development ... the legislature does not intend by this Act to increase or reduce the authority of state agencies to carry out their functions under other titles."

State Aid for School Construction (increasing)

SENATE BILL NO. 159, (see page 266). Reported back to the Senate on March 15 by Community & Regional Affairs with the committee recommending as follows: DeVries (Chairman) and Coghill recommended "do pass"; Sturgulewski and Vic Fischer signed "no recommendation." To HESS.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

SENATE BILL No. 140

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 J. Fraser MD

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

Date: 2/15/85

Approved by: John R. Pugh

John R. Pugh
Commissioner
Department of Health &
Social Services

Date: 2/15/85

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: SB 140

Title: Rights of terminally ill

Sponsor: Eliason, et al

Requestor:

Date of Request: 2/8/85

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. Fraser, M.D. Phone: 465-3090

Division: Public Health Date: 2/12/85

Approved by Commissioner: Date: 2/15

Agency: Dept. of Health & Social Services

cc

Distribution (by Agency preparing fiscal note):

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

7/1/84

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

MEMORANDUM February 8, 1985

SUBJECT: Derivation of Senate Bill 140

TO: Senator Richard I. Eliason

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

You have asked me to comment on the derivation of Senate Bill 140, rights of the terminally ill.

The bill is derived from a discussion draft of a Rights of the Terminally Ill Act prepared by a drafting committee appointed by the National Conference of Commissioners on Uniform State Laws. I have furnished you the discussion draft which contains the text and the commentary proposed by the committee.

The NCCUSL is an organization whose purpose is to promote uniformity in state laws in areas where uniformity is desirable and practicable. It is considered a state organization and the major portion of its funds comes from state appropriations.

The National Conference procedure is for the Scope and Program committee to consider proposals for Uniform Laws and recommend to the Executive Committee areas it considers should be addressed. If the Executive Committee agrees it appoints a drafting committee, a review committee and a committee drafting liason. In this instance the drafting committee and review committee are shown on the proposed draft I have furnished you. I am an associate member of the National Conference and was appointed as drafting committee liason.

Following appointment the committee prepares a draft which is reviewed by the review committee. This draft is then presented to the committee of the whole of the National Conference for first reading. At this reading the draft is

read in full and discussed section by section. This draft was before the committee of the Whole at the annual meeting of the National Conference on August 1, 1984. The chair of the committee made an introductory statement explaining the draft and it was then discussed section by section in some detail. I am enclosing the chair's introductory statement.

Following the discussion at the committee of the Whole the draft is then returned to the drafting committee for further action. A draft incorporating the changes from the committee of the Whole and other changes was prepared and distributed to members of the committee. The committee then met in Hartford, Connecticut in September to discuss the revised draft. Representatives from the organization mentioned by Mr. Hite in his introduction were also present.

Based on this meeting professor Bezanson prepared a revised draft which I examined for technical questions. This draft is the draft I used for preparation of the bill adding in the witness requirements you requested.

The draft will now go to the review committee and the National Conference. It will be considered there at second reading where it may be amended and at third reading where it is subject to approval or rejection on a vote of the states. Following that the proposal will be submitted to the American Bar Association at its annual meeting with a request for concurrence. Assuming concurrence the proposal will be submitted to the states with the recommendation it be adopted as a Uniform Law.

Obviously therefore the draft is not at the stage of an approved proposal recommended for adoption by the National Conference. However, in my opinion this draft is technically superior to any of the models available and any of the laws adopted by other states on the subject.

RGB:ojb
J11/073

Enclosures

ENACTED RIGHT-TO-DIE LEGISLATION

Alabama (1981)

Arkansas (1977)

California (1976)

Delaware (1982)

District of Columbia (1982)

Florida (1984)

Georgia (1984)

Idaho (1977)

Illinois (1984)

Kansas (1979)

Louisiana (1984)

Mississippi (1984)

Nevada (1977)

New Mexico (1977)

North Carolina (1977)

Oregon (1977)

Texas (1983)

Vermont (1982)

Virginia (1983)

Washington (1979)

West Virginia (1984)

Wisconsin (1984)

Wyoming (1984)

OLDER ALASKANS COMMISSION
POSITION PAPER

Senate Bill No. 140
"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 Senate Bill 140 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. This draft and Senate Bill 140 appear to be technically superior to any of the models available and any of the laws enacted by other states on this subject.

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 1, 1985
Date

Commissioner Lisa Rudd
Department of Administration

3/6/85
Date

PATRICK RODEY
SENATOR

ALASKA STATE SENATE

POUCH V
JUNEAU, ALASKA 99811
(907) 465-3793
(907) 475-3754

MEMORANDUM

DATE: March 22, 1985

TO : Senator Dick Eliason

Pat

FROM: Senator Patrick Rodey, Chairman Senate Judiciary

RE : SB 140 - An Act relating to the rights of the terminally ill

Thanks for your note requesting that the Judiciary Committee schedule SB 140 as soon as possible.

I have not scheduled the bill yet as I have been busy with the Hairdressers legislation. However, don't worry, I will get to it soon.

ALASKA STATE LEGISLATURE - SENATE

SENATOR RICHARD I. ELIASON

LABOR & COMMERCE COMMITTEE, VICE-CHAIRMAN
LEGISLATIVE COUNCIL VICE-CHAIRMAN
FINANCE COMMITTEE
RESOURCES COMMITTEE

PO BOX 143
SITKA, ALASKA 99835

POUCH V
JUNEAU, ALASKA 99811
(907) 465-4916

MEMORANDUM

TO: Senator Pat Rodey, Chairman
Senate Judiciary Committee

FROM: Senator Dick Eliason

RE: SB 140 - "An Act relating to the rights of the terminally ill"

DATE: March 20, 1985

Senate Bill 140 recognizes the rights of a competent adult to refuse life-prolonging procedures if that adult is terminally ill. The intent behind this legislation is to establish and protect each individual's right to a dignified death without unnecessary medical treatment which serves only to prolong dying.

I would appreciate it if you could schedule this bill for a hearing before the Senate Judiciary Committee as soon as possible.

AARP

ALASKA STATE LEGISLATIVE COMMITTEE

CHAIRMAN
Mrs Jane Windsor
319 E Bentley Drive
Fairbanks, AK 99701
(907) 456-5035

VICE CHAIRMAN
Mr. John E. Dapcevich
Box 1081
Sitka, AK 99835
(907) 747-8383

SECRETARY
Ms. Lee McAnerney
P.O Box 406
Seward, AK 99664
(907) 224-3080

March 27, 1985

Chairman Pat Rodey
Senate Judiciary Committee
Pouch V
Juneau, AK 99811

Dear Senator Rodey:

At its meeting in Juneau March 7-8, 1985, the AARP State Legislative Committee voted to endorse the living will legislation, HB 269.

On behalf of our 16,000 members in Alaska, we urge passage of HB 269 this session. We feel it is important that this legislation become part of Alaska's statutes to clarify living will requests and to provide appropriate legal authority for doctors, medical care providers, family members, and the individuals who choose to use a living will.

We would point out that the legislation itself does not require financial support from the state; it basically places in statute appropriate recognition of living wills for those who choose to have them. Where living wills are used, the savings in medical costs can be a significant amount to insurance providers, medical care providers and individuals, as well as to the State of Alaska.

We urge your support of and passage of HB 269 this session.

Sincerely yours,

Jane Windsor

Mrs. Jane Windsor, Chairman

Sen Porter: These are my thoughts about SB 140. If you have any questions I can be reached at 789-9856. Sid Heidersdorf

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 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 overtreat 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

Sidney D. Heidersdorf
Alaskans For Life, Inc.

Changes: p. 1, line 12
p. 4, line 10
p. 6, line 23

Introduced: 2/7/85
Referred: Health, Education and Social Services and Judiciary

BY ELIASON, ZIEGLER, V. FISCHER, SACKETT, ABOOD AND STURGULEWSKI

IN THE SENATE

CS SENATE BILL NO. 140 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

* Section 1. AS 18 is amended by adding a new chapter to read:

CHAPTER 12. RIGHTS OF TERMINALLY ILL.

Sec. 18.12.010. DECLARATION RELATING TO USE OF LIFE-SUSTAINING PROCEDURES. (a) Any competent [adult] person, 18 years or older, may execute a declaration at any time directing that life-sustaining procedures be withheld or withdrawn from that adult; but the declaration is given operative effect only if the declarant's condition is determined to be terminal and the declarant is not able to make treatment decisions. The declaration must be signed by the declarant, or another at the declarant's direction, and in either case must be witnessed by two persons. The witnesses must be at least 18 years old and may not be related to the declarant by blood or marriage. A physician or health care provider may presume, in the absence of actual notice to the contrary, that the declaration complies with this Act and is valid.

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

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

DECLARATION

If I should have an incurable or irreversible condition that will

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

Signed this_____day of_____, _____.

Signature_____

City, County and State of Residence_____

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

Witness_____

Address_____

Witness_____

Address_____

Sec. 18.12.020. REVOCATION OF DECLARATION. (a) A declaration may be revoked at any time and in any manner by which the declarant is able to communicate an intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending physician or any health care provider acting under the guidance of that physician upon communication to the physician or health care provider by the declarant or by another to whom the revocation was communicated.

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

Sec. 18.12.030. RECORDING DETERMINATION OF TERMINAL CONDITION AND CONTENTS OF DECLARATION. When an attending physician who has been notified of the existence and contents of a declaration determines

that the declarant is in a terminal condition, the physician must record that determination and the contents of the declaration in the declarant's medical record.

Sec. 18.12.040. TREATMENT OF QUALIFIED PATIENTS. (a) A qualified patient has the right to make decisions regarding use of life-sustaining procedures as long as the patient is able to do so. If a qualified patient is not able to make these decisions, the declaration governs decisions regarding use of life-sustaining procedures.

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

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

Sec. 18.12.050. TRANSFER OF PATIENTS. (a) An attending physician who is unwilling to comply with the requirements of AS 18.12.030 or who is unwilling to comply with the declaration of a qualified patient under AS 18.12.040 shall take all reasonable steps to effect the transfer of the declarant to another physician.

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

Sec. 18.12.060. IMMUNITIES. (a) In the absence of actual notice of the revocation of a declaration, the following, while acting

in accordance with the requirements of this chapter, are not subject to civil or criminal liability or guilty of unprofessional conduct:

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

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

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

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

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

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

(c) A person who wilfully conceals, cancels, defaces, or obliterates the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another is guilty of a class A misdemeanor.

(d) A person who falsifies or forges the declaration of another, or wilfully conceals or withholds personal knowledge of a revocation as provided in AS 18.12.020, with the intent to cause a withholding or withdrawal of life-sustaining procedures, is guilty of a class A misdemeanor.

Sec. 18.12.080. GENERAL PROVISIONS. (a) Death resulting from the withholding or withdrawal of life-sustaining procedures under a

declaration and in accordance with this chapter does not, for any purpose, constitute a suicide or homicide.

(b) The making of a declaration under AS 18.12.020 does not affect in any manner the sale, procurement, or issuance of a policy of life insurance, nor does it modify the terms of an existing policy of life insurance. A policy of life insurance is not legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

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

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

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

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

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

Sec. 18.12.100. DEFINITIONS. In this chapter

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

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

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

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

(5) "physician" means a person licensed to practice medicine in this state;

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

(7) "terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a relatively short time.

Section 2. Immediate effective date.

SB 63, Special appropriation for remodeling and construction of an addition to the Wrangell General Hospital.

SB 63 would appropriate $6,000,000 for a payment to the City of Wrangell to correct functional and physical deficiencies in the existing Wrangell General Hospital facility. Much of the proposed remodeling is needed to meet fire, safety and sanitation regulations. In 1981, the project was granted a Certificate of Need permitting an expenditure of $6.9 million. Last year the State granted $400,000 for the design phase of the project, all of which is presently encumbered. The Alaska State Hospital Association has indentified the Wrangell project as the priority for FY 86.

The Wrangell General Hospital serves approximately 3,000 people in the Wrangell area.

Senator Zharoff has proposed an amendment (attached) to SB 63 which would appropriate $2,114,000 to the Kodiak Island Borough for architecture and engineering costs of either remodeling or reconstructing the Kodiak Island Borough Hospital.

SB 140, Rights of the terminally ill.

Under the authority granted in SB 140, a competent adult would be allowed to execute a declaration that life-sustaining procedures be withheld or withdrawn from that adult. The bill specifies that the declaration would take effect only if the adult's condition is terminal and the adult is unable to make treatment decisions. A declaration would be revocable at any time.

The bill requires witnessing of the signing of the declaration and proper recording of the decision on the patient's chart. It provides for immunity from liability for honoring a declaration and penalties for disregarding one.

According to the Society for the Right to Die, similar legislation has been enacted in 20 other states and the District of Columbia.

Senate HESS committee memo

3/1/85

Alaska State Legislature

BETTYE FAHRENKAMP, Chairman
ARLISS STURGULEWSKI, Vice Chairman
JOE JOSEPHSON
PAUL FISCHER
EDNA ARMSTRONG-DE VRIES

POUCH V
STATE CAPITAL
JUNEAU, ALASKA 99811
(907) 465-3834
(907) 465-3835

Senate

Committee on Health, Education and Social Services

MINUTES

March 5, 1985
1:37 pm

Beltz Room
Room 211, Capitol

MEMBERS PRESENT

Senator Fahrenkamp, Chairman
Senator Armstrong - De Vries
Senator Paul Fischer
Senator Josephson
Senator Sturgulewski

CALENDAR

SB 45, Hospital inspections and investigations by the Department of Health and Social Services.

SB 140, Rights of the terminally ill.

SB 45

Dennis Dewitt, President, Alaska State Hospital Association, spoke in support of proposed CSSB 45 which would allow the Department of Health and Social Services to accept accreditation inspections by the Joint Commission of the Accreditation of Hospitals in lieu of its own inspections. He stated that this action could result in significant cost savings to both hospitals and the state.

Bob Ogden, Assistant Director, Division of Medical Assistance, Department of Health and Social Services, spoke in support of the proposed committee substitute as it would allow the department flexibility in scheduling hospital inspections. He answered questions on when inspections of smaller facilities would be conducted.

Senator Faiks, sponsor, spoke in support of the proposed committee substitute and of including additional language that would ensure annual inspections of smaller hospitals.

SB 140

Senator Eliason, sponsor, explained that under SB 140, a competent adult would be allowed to execute a declaration that life-sustaining procedures be withheld or withdrawn if that adult develops a terminal condition and is unable to make treatment decisions.

Mary Tonsmeire, Clinical Coordinator, Hospice of Juneau, spoke in support of SB 140, and offered specific comments from the Hospice of Anchorage, and the comments of a visiting lecturer, Dr. James Speer, Lawyer and Doctor of Medical Ethics, on earlier "living will" legislation in other states.

Dr. Robert Fraser, Director, Division of Public Health, Department of Health and Social Services, spoke in support of the bill, explaining that currently these decisions are made by the physician and the patient's family. This bill offers the individual the ability to make this decision.

Dennis Dewitt, President, Alaska State Hospital Association, spoke in support of SB 140 and offered an amendment that would expand the immunities section to include health facilities.

Sid Heidersdorf, Alaskans for Life, Juneau, spoke in opposition to SB 140, indicating that patients already have this right. He felt the bill would not promote good medical care.

Mary Riggen-Ver, Older Alaskans Commission, Department of Administration, spoke in support of SB 140.

The meeting adjourned at 3:23 pm.

Alaska State Legislature

BETTYE FAHRENKAMP, Chairman
ARLISS STURGULEWSKI, Vice Chairman
JOE JOSEPHSON
PAUL FISCHER
EDNA ARMSTRONG-DE VRIES

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Senate

Committee on Health, Education and Social Services

M I N U T E S

March 14, 1985
1:35 pm

Beltz Room
Room 211, Capitol

MEMBERS PRESENT

Senator Fahrenkamp, Chairman
Senator Armstrong - De Vries
Senator Paul Fischer
Senator Sturgulewski

CALENDAR

SB 117, Alzheimer's disease and related disorders.

SB 140, Rights of the terminally ill.

SB 128, Relating to the use of longevity bonus payments in determining adult public assistance.

SCR 10, Requesting the State Board of Education to require the study of Alaska history and government in the schools of the state.

SB 117

Senator Fahrenkamp indicated that the committee was working on establishing priorities for funding those services proposed in the bill.

SB 140

Sandra Schubert, Senate HESS Committee Aide, reviewed the changes in the proposed committee substitute that would clarify that 1) any any competent person 18 years or older may execute a declaration, 2) expand the immunity section to include health care professionals and facilities, and 3) provide for an immediate effective date.

Senator Sturgulewski moved to adopt CS SB 140 (HESS) and move it from committee with individual recommendations. There was no objection.

SB 128

Sandra Schubert, Senate HESS Committee Aide, explained that the proposed committee substitute was drafted at the request of the sponsor.

Rod Betit, Director, Division of Medical Assistance, Department of Health and Social Services, spoke in support of the proposed committee substitute for SB 128, which would require the state to make up for federal SSI payments lost due to receipt of the longevity bonus and place recipients who have lost Medicaid eligibility under the state's General Relief Medical program. He proposed an amendment that would exempt nursing home residents from eligibility for the bonus. and urged that the committee define "public assistance". Betit reviewed the costs involved in enacting different "hold harmless" options.

Senator Halford, Sponsor, spoke in support of the bill and the proposed amendment, discussed the cost figures supplied by the Department, and recommended the committee pass the bill to the Senate Finance Committee so it could be considered in conjunction with other pending longevity bonus legislation.

Deborah Vogt, Assistant Attorney General, discussed the constitutionality of exempting nursing home residents from eligibility for the longevity bonus.

Debra Neidermeyer, Aide to Representative Koponen, reviewed the committee substitute passed by the House HESS Committee that would require the state to make up for benefits lost from any federal needs-based program.

Senator Sturgulewski moved to adopt the nursing home exemption amendment and to move CS SB 128 with the amendment from committee with individua_ recommendations. There was no objection.

SCR 10

Steve Hole, Special Assistant to the Commissioner, Department of Education, testified that the Board of Education agrees that each school district should offer courses in Alaska history and government, and explained that the Board encourages school districts to provide this instruction through its Model Curriculum. Hole stated that decisions on specific course requirements of school districts are best made by locally elected school officials.

Don McKinnon, Alaska Council of School Administrators, supported the concept that Alaska history and government be taught in the schools, but recommended amending the resolution to request the

Board to "encourage", rather than "require" local school districts to offer such courses.

Gayle Pierce, President, National Education Association-Alaska, spoke in support of retaining the language that would "require" local school districts to offer courses. She also recommended specifying that Alaska Native Land Claims Settlement instruction be included.

Senator Paul Fischer questioned the availability of curriculum materials as referenced in lines 15-20.

The meeting adjourned at 2:45 pm.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

SENATE BILL No. 140

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 J. Fraser MD

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

Date: 2/15/85

Approved by: John R. Pugh

John R. Pugh
Commissioner
Department of Health & Social Services

Date: 2/15/85

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: SB 140

Title: Rights of terminally ill

Sponsor: Eliason, et al

Requestor:

Date of Request: 2/8/85

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. Fraser, M.D. Phone: 465-3090

Division: Public Health Date: 2/12/85

Approved by Commissioner: Date: 2/15

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)

7/1/84

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM February 8, 1985

SUBJECT: Derivation of Senate Bill 140

TO: Senator Richard I. Eliason

FROM: Billy G. Berrier
Director
Division of Legal Services

You have asked me to comment on the derivation of Senate Bill 140, rights of the terminally ill.

The bill is derived from a discussion draft of a Rights of the Terminally Ill Act prepared by a drafting committee appointed by the National Conference of Commissioners on Uniform State Laws. I have furnished you the discussion draft which contains the text and the commentary proposed by the committee.

The NCCUSL is an organization whose purpose is to promote uniformity in state laws in areas where uniformity is desirable and practicable. It is considered a state organization and the major portion of its funds comes from state appropriations.

The National Conference procedure is for the Scope and Program committee to consider proposals for Uniform Laws and recommend to the Executive Committee areas it considers should be addressed. If the Executive Committee agrees it appoints a drafting committee, a review committee and a committee drafting liason. In this instance the drafting committee and review committee are shown on the proposed draft I have furnished you. I am an associate member of the National Conference and was appointed as drafting committee liason.

Following appointment the committee prepares a draft which is reviewed by the review committee. This draft is then presented to the committee of the whole of the National Conference for first reading. At this reading the draft is

read in full and discussed section by section. This draft was before the committee of the Whole at the annual meeting of the National Conference on August 1, 1984. The chair of the committee made an introductory statement explaining the draft and it was then discussed section by section in some detail. I am enclosing the chair's introductory statement.

Following the discussion at the committee of the Whole the draft is then returned to the drafting committee for further action. A draft incorporating the changes from the committee of the Whole and other changes was prepared and distributed to members of the committee. The committee then met in Hartford, Connecticut in September to discuss the revised draft. Representatives from the organization mentioned by Mr. Hite in his introduction were also present.

Based on this meeting professor Bezanson prepared a revised draft which I examined for technical questions. This draft is the draft I used for preparation of the bill adding in the witness requirements you requested.

The draft will now go to the review committee and the National Conference. It will be considered there at second reading where it may be amended and at third reading where it is subject to approval or rejection on a vote of the states. Following that the proposal will be submitted to the American Bar Association at its annual meeting with a request for concurrence. Assuming concurrence the proposal will be submitted to the states with the recommendation it be adopted as a Uniform Law.

Obviously therefore the draft is not at the stage of an approved proposal recommended for adoption by the National Conference. However, in my opinion this draft is technically superior to any of the models available and any of the laws adopted by other states on the subject.

RGB:ojb
J11/073

Enclosures

alaska state hospital association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

February 25, 1985

Senator Richard Eliason
Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Senator Eliason:

Subject: SB 140

I appreciate the help your staff has given on responding to our initial questions on SB 140.

We believe that Section 18.12.060(b) ought to be amended to include health care facilities and other persons participating in actions under this chapter. We are concerned that the exemption, if limited to physicians, implies that facilities and other personnel could be held to a higher standard than the physician who directs the activity. Because of the greater amounts of liability insurance carried by hospitals and nursing homes, we believe that such an implied difference in immunity protection would significantly increase the probability that litigants would file claims against the hospital. We believe this immunity is necessary but should be broadened to include other probable targets of litigation.

Thank you for your consideration.

Sincerely,

Dennis L. DeWitt
President

DLD/agk

cc: Steve Berkshire

Society For The Right To Die

NEWSLETTER SPRING 1984

HOSPITAL SURVEY: AN INTERIM REPORT

The grass roots survey initiated by the Society last year, in which members were asked to write their hospitals to inquire about their policies toward the Living Will, is proving so effective that it is being continued through 1984.

Hospitals in 49 states have responded so far, with lengthy and thoughtful letters—often formulated with legal counsel—indicating great sensitivity to their patients' concerns. Significantly, there is evidence that a number of hospitals have been stimulated to action by these Society-generated inquiries.

"We are in the process of developing a formal policy and procedure because we have had so many letters like yours," wrote Freehold (N.J.) Area Hospital. "We have even gone so far as to develop a short form of our own to be utilized in the event that the patient has not had the foresight or opportunity to prepare a Living Will in advance such as you have."

Discuss with Physician

Hospitals in states both with and without laws giving legal recognition to these advance directives emphasize the importance of discussing your Living Will with your physician. Letter after letter states that hospitals do not initiate services but produce them on doctors' orders.

This excerpt from a letter from The Fairfax Hospital in Virginia is representative of letters from hospitals in states with laws: "The Fairfax Hospital, of course, fully complies with the provisions of [the Virginia Natural Death Act] . . . a declaration such as the one that you attached to your letter can be of great assistance . . . If it is properly executed and presented to us at the time of treatment, it would document your directions/instructions as required by State law."

In states without laws, hospitals have written that they consider the Living Will

(continued on page 8)

LEGISLATION IN NEW SURGE: LAWS NOW TOTAL 21

Legislators who have long been committed to the cause of "living will" legislation, and have for years fought an uphill battle, are experiencing a change in the weather. Increasing acceptance by much of the medical profession and a groundswell of public support have sharpened the national perception that such laws are indeed necessary.

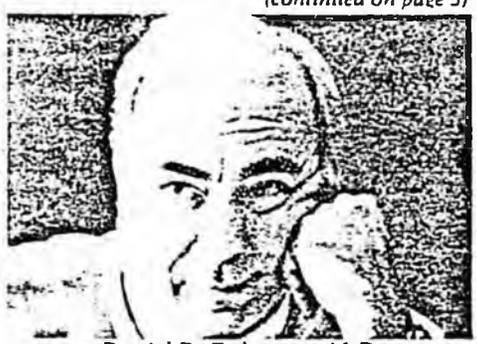
Concerted efforts by organizations devoted to the welfare of the elderly—AARP, Gray Panthers, Senior Citizens, and the like—have lent heightened visibility to the issue. Typical of their no-nonsense stand is the recent statement by Maggie Kuhn, Gray Panthers founder, as quoted in the *Litchfield* (CT) *County Times:* "It's on ethical and moral grounds that we take this position. When you're hooked up to a machine, it's an affront. Most people in their right minds would want to die quietly."

The enactment of five laws in approximately one month—in **Georgia, Mississippi, West Virginia, Wisconsin, Wyoming**—and a statute in **Illinois**, which passed last year and took effect January 1, demonstrates the momentum which right-to-die legislation is currently enjoying, and brings the number of jurisdictions with "living will" laws up to 21, including the **District of Columbia.**

Legislation in the Midwest got a significant boost with the passage of Illinois's Living Will Act. It is particularly fitting that it should finally have been passed in the home state of Luis Kutner, the Chicago attorney who originated the concept of the

(continued on page 3)

Sidney H. Wanzer, M.D., Primary Author



Daniel D. Federman, M.D., Conference Chairman

New England Journal of Medicine Publishes Physician Guidelines

Ten of the nation's most distinguished physicians, representing various medical disciplines, and brought together by the Society for the Right to Die to clarify the physician's responsibility toward hopelessly ill patients (Spring '83 Newsletter, page 2), have published their conclusions in a Special Article in the April 12 issue of *The New England Journal of Medicine.*

Headlined by the *Washington Post* as a "Bill of Rights for Terminal Patients," the article spells out in detail the medical care the physicians consider ethically correct,

(continued on page 2)

GRAND JURY CALLS FOR NY HOSPITAL GUIDELINES

A call for the New York State Legislature and the Commissioner of Health to establish formal procedures to govern the withholding of emergency resuscitation from terminally ill patients was made by a special grand-jury, which found what it called "shocking procedural abuses" during its year-long investigation of "Do Not Resuscitate" procedures at a Queens County (N.Y.) hospital.

The investigation arose out of the death in 1981 of a 78-year-old woman who went into cardiac and respiratory arrest after her respirator was unaccountably disconnected. No alarm calling for resuscitation was sounded.

Although it handed down no indictment, the grand jury found that DNR decisions were made at the hospital without properly documenting them on the patient's chart and without consulting the patient's family. According to testimony, a purple dot affixed to the patient's nursing card was used to indicate "no code," and when the patient died, the card was thrown away—all in order, the grand jury report stated, "to avoid legal responsibility." This "purple dot" system, it went on to say, "eliminated professional accountability, invited clerical error and discouraged physicians from obtaining informed consent."

Specific Recommendations

Acknowledging that it may be appropriate to withhold resuscitation when it would only prolong the dying process and cause needless suffering, the grand jury made specific recommendations for officially recognized "no code" procedures, as well as safeguards against abuse. These included verification that the patient's condition was irreversible, with death "imminent and inevitable"; consultation with patient and family; joint agreement not to resuscitate; and proper recording of the decision on the patient's chart. "Responsible physicians should not have to ignore their own best medical judgments or the wishes of their suffering and terminally ill patients out of an unjustified fear of legal consequences," the jury's report stated.

A spokesman for State Health Commissioner Dr. David Axelrod said that Governor Mario Cuomo had ordered a review of issues involving medical ethics, including DNR orders.

The New York State Medical Society, the New York State Hospital Association, and the Greater New York Hospital Association all testified before the grand jury in support of express DNR guidelines, including a strict ban on verbal orders. There is a growing awareness throughout the country of the need for such regulations. (SRD Newsletter, Spring '83, page 3.)

VA Offers New DNR Option

The grand jury's recommendations resemble new guidelines adopted by the Veterans Administration for its 172 hospitals, which, in a major reversal of policy, afford a DNR option to terminally ill patients who do not wish to be kept alive when there is no hope of recovery.

The VA guidelines, prepared by physicians, nurses and attorneys, took a year and a half to write, and replace an earlier policy which prohibited doctors from denying resuscitation to hopeless patients.

New England Journal of Medicine *(continued from page 1)*

permissible and desirable in various stages of illness, for both competent and incompetent patients. These range from emergency resuscitation and intensive care to the administering of comfort measures solely, and specifically include the withholding or withdrawing of artificial feeding when that would only perpetuate nonmeaningful life. (see page 4.)

Society Sponsorship

Society sponsorship of the meeting was undertaken in recognition of the need for such guidelines at a time when the technological capacity to sustain life indefinitely has led to widespread uncertainty on the part of physicians as to how best to discharge their responsibility toward the dying patient and his or her family.

Two major precepts are basic to the guidelines: The role of the patient in making treatment decisions is primary; and a decrease in aggressive treatment is advisable if continuing it would only prolong the process of dying. "Senseless perpetuation of the status quo is decision by default," the authors state.

The dying patient's prior attitude is crucial to such decision-making, because pain, drugs, or other influences on mental states may render even the competent patient incapable of directing his or her treatment. In such cases, the authors point out, a Living Will or a proxy appointment in advance "can be helpful in indicating the patient's preference with respect to terminal treatment."

Physician's Role

Clear communication between doctor and patient is essential. The authors stress the physician's role as a source of comfort to patients and their families, especially when the decision has been made to withhold life-sustaining treatment.

In recommending how, and how much, to tell the patient who is faced with a life-threatening illness, the authors in general advocate honesty, saying: "A decision not to tell the patient the truth because of fear of his or her emotional inability to handle it is rarely, if ever, justified. . . . The anxiety of dealing with the unknown can be far more upsetting than the grief of dealing with a known, albeit tragic, truth."

Influences on physicians that may prevent them from accepting the idea that often "less" can be "more" are cited frankly: training and tradition that emphasize aggressive treatment; the temptation to use today's sophisticated medical technology; fear of legal liability; personal values and unconscious motivations; equating a patient's death with professional failure; and unreasonable insistence on impossibly absolute prognostic certainty.

Medical professionals who have commented on the article have observed that the prestige of the authors and *The New England Journal* will have considerable influence, and will free physicians in many cases to do what in the past they might have hesitated to do.

Media Response

The response of the media to publication of the article has been gratifying. *Good Morning, America*, the *CBS Morning News*, the *Freeman Report* on Cable Network News, and a number of radio interviewers have made it a subject for discussion, and syndicated stories by the Associated Press and the *Washington Post* have appeared nationwide. Other media articles are in progress—a clear indication that the subject is of overriding interest to the public as well as the medical community.

Reprints of the *NEJM* article, "The Physician's Responsibility Toward Hopelessly Ill Patients," by Sidney H. Wanzer, M.D., et al., are available for $1.00 each from the Society.

John D. Rockefeller IV, Governor of West Virginia.

MS Victim Forms Living Will Society

Sarah Caldwell, of Epsom, N.H., 37, has joined the six-year battle of State Representative Eugene S. Daniell to enact "living will" legislation in that state.

A wheelchair victim of multiple sclerosis, Miss Caldwell offers vivid testimony to the urgent need for legislation. She fears that she will lapse into a coma, and in the absence of a law, will have no protection against the life-sustaining treatment she does not want.

Although muscular control comes at great cost, she has embarked on a series of speaking engagements to law centers and other groups throughout the state.

In October 1983 Caldwell formed a Living Will Society, which by now has garnered more than 3,000 signatures in support of Representative Daniell's bill. Her determination to secure its enactment goes beyond her concern for her own welfare. The time she has spent in hospitals has let her view at first hand the anguish that families suffer when the life of someone they love is artificially prolonged.

Representative Daniell, now approaching the age of 80, remains undaunted by the New Hampshire governor's veto in 1983 of his legislation. With so many state residents now energized by the newly formed Living Will Society, he is hopeful of passage in the 1985 session. Commenting that since 1976 the bill has passed the House three times and the Senate twice, and has been vetoed twice—once by a Democratic governor and once by a Republican—he adds: "I only hope I'm successful in time to do *me* some good!"

New Living Will Laws *(continued from page 1)*

Living Will. The act, initiated by the Greater Springfield Interfaith Association, and introduced by Representative Michael Curran, is the successor to bills introduced in that state starting in 1976.

Georgia's Living Will Law, which came into effect July 1, became the nation's seventeenth, culminating efforts which began in 1976. Abigail Van Buren ("Dear Abby"), who has recommended the Living Will to her readers (see page 5), visited the State Capitol at the request of Senator Richard L. Greene. The legislation had already passed both houses, but lacked Governor Joe Frank Harris's signature. The governor had not indicated whether or not he would sign it, but he did so directly after meeting with "Abby."

West Virginia's Natural Death Act, which in the first week of March passed the House by 100 to 0 and the Senate with only four dissenting votes, will become effective June 4. Senator Stephen L. Cook, its sponsor, received support from the state Nurses Association, as part of their legislative program.

In Mississippi, "An Act to Allow Persons to Authorize the Withdrawal of Life-Sustaining Mechanisms . . ." sponsored by Senator Bob Usey, was enacted in April, to take effect July 1. It was supported by the Council on Aging and various church groups, including one of the state's two Catholic dioceses. Mississippi is the first state to require the filing of a "living will" declaration (and any subsequent revocation) with a government agency, in this case, the Bureau of Vital Statistics of the State Board of Health.

Wisconsin's "living will" law was signed by the governor in April. Introduced by Representative Walter J. Kunicki and 19 co-sponsors, it was backed by the state medical society, the state hospital association, the AARP, and the Wisconsin Retired Teachers Association.

In Wyoming, a "living will" law, which passed and was signed in March, becomes effective July 1. Senator Russell W. Zimmer, the prime sponsor, introduced the bill on behalf of the Commission on the Aging. He received bipartisan support in the legislature as well as strong backing from Governor Ed Herchler. The Silver-Haired Legislature and the Wyoming Medical Association were also active in the bill's passage. The law contains a provision for a proxy appointment.

The Society will provide residents with appropriate declaration forms on request.

In addition to the five states that have enacted "living will" laws in 1984, 19 legislatures had such bills under consideration: Alaska, Arizona, Colorado, Connecticut, Florida, Hawaii, Indiana, Iowa, Maine, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, and Utah.

Photo: Courtesy of Rochester (N.H.) Courier

Sarah Caldwell

RAPID GAINS FOR BAY STATE BILL

After ten years of struggle, "living will" legislation in 1983 achieved the necessary support for passage in the Massachusetts legislature, only to fail when the "special rules" requiring unanimous consent which govern the close of the Senate session were invoked.

Encouraged by the remarkable progress made in the 1983 session, the bill's supporters, led by Representative Richard A. Voke, have re-introduced it. It was reported favorably by the Judiciary Committee after only one day of consideration, and moved rapidly to the third "reading" in the House. At this writing, all legislation has been deferred until debate on the budget is concluded.

The bill is actively supported by the Massachusetts Committee for the Living Will and the Massachusetts Council of Churches.

ARTIFICIAL FEEDING BECOMES PIVOTAL ISSUE

The first case in the country in which a state's highest court will specifically address the issue of terminating artificial feeding of an incompetent patient will be decided in New Jersey. The state Supreme Court has heard arguments in the case of Claire C. Conroy, a semi-comatose 84-year-old nursing home patient who had been fed through a nasogastric tube.

In ruling on a suit to discontinue feeding, brought by Conroy's nephew, Superior Court Judge Reginald Stanton had held in a 1983 opinion that feeding could be terminated, saying, "The patient is functioning at a virtually zero intellectual level" and "when a person has been permanently reduced to a very primitive intellectual level or is . . . suffering from unbearable and unrelievable pain, there is no valid human purpose to be served by employing active treatment designed to prolong life."

Paul Armstrong, Karen Quinlan's attorney, called Judge Stanton's ruling the "logical extension" of the same court's 1976 decision that his comatose client could be disconnected from her respirator.

Disagreement on Condition

Although Conroy died during a stay of this ruling, her court-appointed guardian *ad litem*, John J. DeLaney, Jr., appealed. The Appellate Division sharply disagreed with the lower court's interpretation of the patient's condition, and with its decision, stating that the withdrawal of feeding, even on a person who lacked intellectual capacity, "authorized euthanasia [and] would have frightening implications." The court held that the testimony in the Conroy case drew a very different picture from that in *Quinlan*. The *Quinlan* ruling, Judge Herman P. Michels said, "applies only to noncognitive, vegetative patients," whereas Conroy was "awake, but confused."

The New Jersey Hospital Association, in its *amicus curiae* brief, argues that any difference between withdrawing a respirator and a feeding tube is an "artificial distinction," and that Judge Stanton's decision should be upheld. Briefs have also been submitted by the American Geriatric Association, the New Jersey Catholic Conference, individual members of the President's Commission for the Study of Ethical Problems in Medicine, and others.

In October 1983, the California Court of Appeals dismissed murder and conspiracy charges against surgeon Robert J. Nejdl and internist Neil L. Barber (SRD Newsletter, Spring '83, page 4), stating that to withdraw artificially administered food and water is no different, legally, from withdrawing respirator support.

While the California case involved criminal charges, the Conroy case is the first civil action in which the withholding of nourishment has been at issue. As such, observers on both sides await with particular interest the New Jersey Supreme Court's decision.

Physicians' and Ethicists' Views

While lawyers and the courts continue to debate, physicians and ethicists have expressed their views in recent articles. The ten physicians who co-authored the *New England Journal of Medicine* article (see page 1) concluded that for patients in a persistent vegetative state "it is morally justifiable to withhold antibiotics and artificial nutrition and hydration, as well as other forms of life-sustaining treatment. In the case of severely and irreversibly demented patients, if food and water are rejected by mouth, it is ethically permissible to withhold artificial nutrition and hydration by vein or gastric tube."

Joanne Lynn and James F. Childress, writing in the October 1983 issue of *The Hastings Center Report*, state: "Medical nutrition and hydration do not appear to be distinguishable in any morally relevant way from other life-sustaining medical treatments that may on occasion be withheld or withdrawn." Dr. Lynn, Professor at George Washington University, Division of Geriatrics, was Assistant Director of the President's Commission. Dr. Childress is Professor of Religion at the University of Virginia.

In the October 1983 issue of *Law, Medicine and Health Care*, Dr. Anne Fletcher, director of the intensive care nursery at Children's Hospital in Washington, D.C., and John J. Paris, a Jesuit priest who teaches ethics at Holy Cross University, co-authored an article in which they noted that in certain limited circumstances artificially administered nourishment may be futile treatment.

Now that termination of respirator support has been permitted by many courts, it appears that the moral dilemma caused by the decision to withhold or withdraw artificial feeding is destined to become the issue of the '80s.

Ruling Awaited on Florida Court Role

Florida's Supreme Court will shortly rule on whether court approval must be obtained before life-support systems can be withheld or withdrawn from a terminally ill comatose patient who has executed a Living Will. The case under review, *JFK Memorial Hospital v. Bludworth*, concerns Francis Landy, 79, who had signed a Living Will in 1975 and died at the Lake Worth hospital in 1981.

When Landy's condition was deemed irreversible, his wife asked the hospital to honor his Living Will and disconnect his respirator. The hospital petitioned the circuit court for permission to act on her request, and, although Landy died before the first decision was handed down, the hospital pursued the matter in the courts, hoping for guidance in the treatment of other comatose patients.

Court Approval Needed

Acknowledging the value of the Living Will as evidence of a patient's intent, County Circuit Judge Timothy Poulton ruled nevertheless that court approval was necessary before life support systems could be terminated. The Fourth District Court of Appeals upheld that decision, but asked the Florida Supreme Court to review the case because of the importance of the issue.

A brief filed in the Supreme Court by the Florida Hospital Association argued that the requirement for court approval places hospitals in an untenable position: it hampers implementation of difficult choices as to allocations of limited medical equipment such as respirators, "removes the sensitive decision from physician and family members" and will be expensive and time-consuming.

Earlier Patient's Wish Granted

The only other right-to-die case to reach the Florida Supreme Court involved a competent patient, Abraham Perlmutter, whose request to be disconnected from his respirator was approved by the Fourth District Court of Appeals and upheld unanimously by the Supreme Court 15 months after Perlmutter's death in 1977. Although the Court emphasized that its decision was limited to the case of a competent, terminally ill adult with no minor dependents, whose family was in full agreement with his request, it did clearly address the need for legislative guidelines, stating that the issue was more suited to the legislative forum than to the courts.

SRD HONORS "DEAR ABBY"

Abigail Van Buren, who writes the widely syndicated "Dear Abby" column, was honored by the Society for the Right to Die at a luncheon held on November 11, 1983, to thank her formally for continuing to emphasize the need for Living Wills. Two columns last year resulted in a flood of nearly 100,000 requests to the Society for these documents—impressive testimony to the influence she has on her readers and to the public's ever-increasing interest in the subject.

"Abby" was presented with a Living Will plaque by Sidney D. Rosoff, past president and currently chairman of the SRD Board. In responding to the presentation, she said, "Every time the Living Will is mentioned in my column the response from readers is overwhelming. My mail triples from 10,000 letters a week to 30,000! In fact, this is by far the most popular issue in my column to date and keeps gathering momentum. . . . The Living Will is simply a document that a person signs saying that he or she does not want to be kept alive by artificial means after all hope for recovery is gone. It is not a way of 'getting rid' of a relative (but) an expression of what one wants for himself! I have signed one, and I can only wish that every citizen in the U.S. had the peace of mind it has given me."

Abigail Van Buren and Sidney D. Rosoff

California, Oregon Strengthen Rights

California and Oregon, which were among the earliest states to adopt right-to-die laws, have recently enacted legislation aimed at overcoming a major restriction imposed by both statutes. California legislators have accomplished this indirectly, by amending the state's Uniform Durable Power of Attorney statute. Oregon has amended the Natural Death Act itself.

As enacted in 1976 and 1977 respectively, both Natural Death acts stipulated that to be binding, a person's Directive to Physicians must be executed, or reexecuted, 14 or more days after confirmed diagnosis of a terminal condition—frequently impossible for a critically ill or injured patient.

In California, the expansion of the Uniform Durable Power of Attorney statute to cover health care gives state residents a means of appointing a proxy (attorney-in-fact) to make medical decisions in case of lack of capacity, whether temporary or permanent, including the decision to discontinue life-sustaining treatment.

This device is a potentially useful supplement to the Directive to Physicians. Used in conjunction with the Directive, the Durable Power provides the advantage of having a decision maker who is familiar with the patient's wishes and can select from treatment options on the basis of specific information about the patient's condition.

Oregon amended its 1977 law last year to remove the same difficult 14-day requirement contained in the California statute, and to eliminate the five-year limit on the Directive's term of effectiveness.

MS SUFFERER ALLOWED TO DIE

A Hartford, Connecticut Superior Court judge ruled in March that Sandra Z. Foody, 42, a comatose terminally ill victim of multiple sclerosis who had been cared for at home for 24 years before being hospitalized, could, because of "narrow and extreme circumstances," be disconnected from her respirator "without undermining the state's interest in the preservation of life."

Foody's parents filed the lawsuit to insure that there would be no civil or criminal reprisals against any person or institutions if their daughter's life support system were disconnected.

During the years of home care the Foodys had spoon-fed, cleaned and dressed Sandra—tasks she was unable to do for herself. Mr. Foody was quoted in the *Hartford Courant* as saying, "In all the years we weren't out of the house ten times" except to go to church on Sundays. The decision to hospitalize Sandra was made only when complete paralysis made home care no longer possible.

Judge Mary R. Hennessey, in a thoughtful and humane opinion, found that "withdrawal of treatment should be ethically permissible where it no longer offers hope of benefit to the patient." She listed conditions that should be met in future cases: permanent and irreversible illness and no reasonable probability that the patient will ever return to a cognitive state; agreement of the attending physician and at least two others; and the good-faith wish of the family to exercise through substitute decision-making the patient's right to discontinue artificial life support systems.

No Appeal Sought

Although Connecticut attorney general Joseph I. Lieberman felt that the state had an interest in arguing for Sandra Foody's life, he decided not to appeal, saying, "I do not want to extend any further the suffering of the Foody family or delay what now appears to be inevitable."

In a 1981 case, Angela Garvais had petitioned the same court on behalf of her 23-year-old sister, Melanie Bacchiochi, who went into a coma after suffering cardiac and respiratory arrest while having her wisdom teeth removed. Although she was diagnosed as brain dead, it took more than a month before the court ruled that respirator support could be stopped.

Isn't It Enough?

In commenting on the Foodys' sad victory, Garvais deplored the public airing of situations that should remain private. "What happened to my sister was a horrible thing. I hoped the next person wouldn't have to go through this. Isn't it enough already?"

Proxy Provision Added To SRD Model Bill

Provision for the optional appointment of a proxy to make treatment decisions on behalf of an incapacitated individual has been added to the Society's Model Bill. Although "personalized instructions" were permitted in the bill as originally drafted, the Society believes that spelling out the right to designate a proxy strengthens the bill and enhances the patient's potential right of self-determination. The appointment of a proxy is entirely discretionary, and failure to make such an appointment in no way affects the authority of the Declaration.

THE NEW YORK TIMES, WEDNESDAY, APRIL 4, 1984

To Die or Not to Die

By Evan R. Collins Jr.

The Governor of Colorado, Richard D. Lamm, had his heart in the right place when he warned that "we really should be very careful in terms of our technological miracles that we don't impose life on people who, in fact, are suffering beyond the ability for us to help."

Speaking at a meeting of the Colorado Health Lawyers Association, Governor Lamm stirred widespread public criticism, apparently based on a misunderstanding of his remarks, when he said that "we've got a duty to die, to get out of the way with our machines and our artificial hearts." Later, Governor Lamm said that he simply was urging that economically sound and sensible allocation of limited medical resources should preclude fruitless treatment of the terminally ill.

An essential principle of life is the fundamental right of self-determination. From time to time, misguided people say that it is the "duty" of a patient to die — a duty to himself or herself, or to the family. Of course, it is abhorrent for anyone to argue that one should die for social, economic or any other reasons. To philosophically advocate death as a public responsibility — a position that might well lead to public imposition of death for political ends — evokes chilling echoes of other times in history, especially Nazi Germany.

It is also abhorrent to impose on a dying patient a horrifying array of respirators, tracheal tubes, feeding tubes through the nose and repeated violent cardio-pulmonary resuscitations — all futile, and in almost all cases contrary to the wishes of the patient and his or her family.

Because of our society's remarkable technological successes, we find ourselves crossing the line from prolonging life to prolonging dying. At what point do we stop?

Dr. Joseph Fletcher, professor emeritus of Christian ethics and pastoral theology at the Episcopal Divinity School, in Cambridge, Mass., (and former president of the Society for the Right to Die), has written: "Ethical questions jump out at us from every laboratory and clinic ... The crucial question is not whether the end justifies the means, but *what justifies the end?*"

The elderly are frightened — legitimately so. They see a lifetime of control over their own lives eroded at the end by a battery of medical decision-makers who are intent on keeping them alive without thought to their dignity or desires.

A physician's training impels him to try to sustain life, and in the present climate that training is reinforced by the real danger of civil, even criminal, lawsuits. To minimize this legal liability, even humane and sensitive physicians, aware that the quality of life that they are perpetuating does not merit heroic measures, are loath to obey their instincts and let nature take its course. The terminally ill elderly are caught in this tragic conflict. How can they protect themselves?

Aware of this problem facing the elderly, 15 states — New York, New Jersey and Connecticut are not among them — and the District of Columbia now have "living will" laws that offer protection against dehumanized dying and confer immunity upon physicians and hospital personnel who comply with a patient's wishes.

To avail themselves of the right to a dignified death, individuals can execute legal declarations that direct their physicians to withhold or withdraw artificial life support when an illness is medically certified as terminal. As an indication of the widespread demand for this protection, thousands of such directives, different in some respects in each state, have been executed. Also, there is a trend toward recognizing an individual's advance appointment of a proxy to make decisions on treatment in the event of incompetency.

Residents of states that have not yet enacted these laws have signed "living wills" by the hundreds of thousands, thereby expressing a morally potent, if not legally binding, wish not to have their lives prolonged artificially.

With artificial measures rejected, what constitutes appropriate treatment for elderly dying patients? What are they entitled to? Ease of pain, certainly, and, insofar as possible, relief from emotional discomfort. But beyond these considerations, it is the assurance that they will be permitted to die with, to quote Dr. Fletcher again, "that quality of humanness, the preservation of which is what the concepts of loving concern and social justice are built upon."

As he wrote: "Good dying must at last find its place in our scheme of things, along with good birthing, good living and good loving. After all, it makes perfectly sound sense to strive for quality straight across the board, as much in our dying as in our living."

Evan R. Collins Jr. is president of the Society for the Right to Die, a national, nonprofit, educational organization that is based in New York City.

Dr. Joseph Fletcher

Dr. Helen B. Taussig

News From SRD Board

Joseph Fletcher, S.T.D., D.D., President Emeritus of SRD, was elected to the National Council of Alpha Omega Alpha, an honorary medical society—one of only eleven non-physicians accorded this honor. Recently he was officially made a full-fledged brave in the Clan of the Turtle of the Mohawk Indians, a distinction of which he is particularly proud.

The new Helen B. Taussig Children's Heart Center—the pediatric section of the regional Heart Center of Maryland at Johns Hopkins University Hospital—was officially dedicated on December 8, 1983. Dr. Taussig, originator of the "blue baby" blood transfer operation, and the person who more than anyone else alerted the U.S. to the dangers of thalidomide in 1962, has been a Director of the Society since 1976.

Sia Arnason, M.S.W., has been elected to the Board. Ms. Arnason is an expert on problems of the aging, and is Social Work Coordinator at the Institute on Law and Rights of Older Adults, Brookdale Center on Aging of Hunter College.

Anthony Reynolds Smith has joined the Board. Mr. Smith, who has occupied high positions in New York's municipal government, is the Assistant Commissioner of the Metropolitan Transportation Authority.

A MESSAGE FROM OUR PRESIDENT

The right-to-die movement is moving forward rapidly. What was not too long ago the dream of a few—the legal recognition of Living Wills—has become a reality in twenty-one jurisdictions. With five new laws enacted in one month this year, and a promising outlook for legislation in other states, 1984 may prove to be another watershed year, much like 1977, which saw seven bills signed into law.

Elsewhere in this Newsletter you can read about the highlights of our program: the Physicians' Conference we sponsored, the nationwide hospital survey which is proving so fruitful, and the deluge of requests for Living Wills that resulted from "Dear Abby" columns and kept our office working almost around the clock.

But quite aside from the highlights, we must continue the day to day work of just "being there." Due in large part to our efforts, individuals' awareness of their rights is growing. The many court cases in states without laws demonstrate this, even as they demonstrate the need for legislation. As right-to-die activities have intensified, so, inevitably, have the demands on our staff.

To help meet these demands, and to expand our direct services, we have retained a staff attorney. She will give advice on executing Living Wills and Durable Powers of Attorney, act as a central legal information source, and work with legislators in drafting bills to insure that they are inclusive and effective.

Because laws have little value unless citizens are aware of them, we have also added to our staff a public information specialist, to reinforce our presence at the leading edge of the patients' rights movement.

Most of all, we need your awareness, your voice, and your support to help us continue to defend the principle of the individual's right of self-determination at the end of life, which is what the Society is all about.

Evan R. Collins Jr.

Evan R. Collins, Jr., new President of the Board of Directors of the Society, took office in December 1983. A vice president of the New York investment banking firm of Kidder, Peabody & Company, Mr. Collins is past president of United Way of Westchester (N.Y.)

SRD Publications

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

The Society for the Right to Die makes available legally recognized advance document forms to residents in the states of Alabama, Arkansas, California, Delaware, Georgia, Idaho, Illinois, Kansas, 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.

We deeply appreciate your past contribution.
Your continued support will help us make new gains in behalf of your right to die with dignity.
Please be generous.

Enclosed is my contribution in support of the Society's work: ☐ $25 ☐ $50 ☐ $100 **Other $**_____

(Contributions of $10 or more receive a wallet-size Living Will/Annual Membership Card and Society Newsletters. All contributions are tax deductible.)

Please send me:

_____ Reprint(s) of *NEJM* Physicians' Article @ $1
_____ 1984 Handbook(s) of Living Will Laws @ $5
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_____ Hospital Survey sample letter
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_____ Reprints of *N.Y. Times* article, "To Die or Not to Die"

Name _____

Address _____

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

_____ I can no longer be helpful. Please remove my name from your mailing list.

WORLD CONFERENCE MEETS IN NICE

The World Federation of Right-to-Die Societies will hold its Fifth International Conference in Nice, France, September 20–23. An eleven-member delegation from SRD's Board of Directors will join with their colleagues from countries all over the world to share experiences and discuss issues of mutual concern.

Two roundtable panel discussions will be open to the public—one on legal concerns, and one on ethics. Dr. Joseph Fletcher, President Emeritus of the Society, will be a panelist on the latter. The major address will be delivered by Dr. Christiaan Barnard, cardiologist and pioneer in the heart transplant operation, who will speak on "Good Life — Good Death," also the title of his celebrated book.

Society members who are interested in attending can write for more information directly to Mme. Paula Caucanas Pisier, A.D.M.D./Congres International, 103, rue La Fayette, 75010, Paris.

Hospital Survey

(continued from page 1)

morally persuasive as a document of intent which will carry weight, even if not legally binding. They report their frustration at the failure of their legislatures to act, as the following quote from the Ft. Myers Community Hospital in Florida illustrates: "It is unfortunate that the State of Florida does not recognize the popular Living Will as a legal document. . . . You have brought up an issue that is important . . . It will eventually be resolved with guidelines provided by the legislature and reinforced by the courts. Until then it is imperative that we protect ourselves from the potential of civil and/or criminal liability . . ."

The personal nature of the survey is apparently having a far greater impact than would have been achieved by a more institutional approach, and is alerting hospitals in the most direct way to the increasing importance prospective patients attach to their rights.

Thanks to all of you who have written your hospitals and sent us copies of the responses you have received. If you have not already written, we urge you to do so. A sample letter on which you can base your own is available from the Society on request.

A final report on the survey will be provided in the Newsletter early in 1985.

HELP WANTED . . . to build SRD files of right-to-die news stories, editorials and magazine articles. You are our "clipping service," so please continue to send all relevant material to the Society for the Right to Die, 250 West 57 Street, New York, NY 10107. Warm thanks to those of you who have done so.

Uniform Law Promoted

The National Conference of Commissioners on Uniform State Laws, an organization composed of commissioners from each state who seek to promote uniformity in state laws where appropriate, is now considering such a law in the right-to-die field.

The first meeting of the drafting committee was held in Alexandria, Virginia, in January, to analyze laws which had been enacted or were presently pending before state legislatures. Preliminary policy decisions were made on the text of a Uniform Law at a second meeting in Chicago in April. A first draft was circulated for consideration, and a second is now in preparation for presentation to the Commissioners at their annual conference, to be held in Colorado in July.

Before recommending any law for adoption by the states, the National Conference must approve it at two successive annual meetings.

"The fact that 19 states and the District of Columbia have already enacted 'living will' laws points up the significance of the Commission's work," says Sidney D. Rosoff, SRD board chairman, who attended both conferences. "It is important to have a well-drafted Uniform Law adopted throughout the country, since Americans move easily from state to state and illness or accident may occur in any jurisdiction. The existence of a Uniform Law with a Living Will which will be recognized in all states, irrespective of the state in which it was signed, is imperative."

Society for the Right to Die
250 West 57 Street
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DRAFT

FOR DISCUSSION ONLY

RIGHTS OF THE TERMINALLY ILL ACT

NATIONAL CONFERENCE OF COMMISSIONERS

ON UNIFORM STATE LAWS

MEETING IN ITS NINETY-THIRD YEAR
KEYSTONE, COLORADO

JULY 27 - AUGUST 3, 1984

RIGHTS OF THE TERMINALLY ILL ACT

With Prefatory Note and Comments

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RIGHTS OF THE TERMINALLY ILL ACT

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NATIONAL CONFERENCE OF COMMISSIONERS
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RIGHTS OF THE TERMINALLY ILL ACT

PREFATORY NOTE

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

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

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

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

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

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

SECTION 1. DEFINITIONS.

As used in this [Act]:

(1) "Physician" [means a person licensed to practice medicine in this State.]

(2) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(3) "Health-care provider" means a person who is licensed, certified or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

(4) "Declaration" means a document executed in accordance with the requirements of Section 2.

(5) "Qualified patient" means a patient who has executed a declaration in accordance with this [Act] and who has been determined by the attending physician to be in a terminal condition.

(6) "Life-sustaining procedure" means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process.

(7) "Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a relatively short time.

COMMENT

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

RIGHT TO DECLINE LIFE-SUSTAINING PROCEDURES ACT

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COMMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DECLARATION

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

Signed this _____ day of _____, ____.

Signature _____

City, County and State of Residence _____

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

Witness _____
Address _____

Witness _____
Address _____

COMMENT

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

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

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

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

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

SECTION 3. REVOCATION OF DECLARATION.

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

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

COMMENT

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

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

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

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

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

COMMENT

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

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

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

SECTION 5. TREATMENT OF QUALIFIED PATIENTS.

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

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

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

COMMENT

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

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

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

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

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

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

SECTION 6. TRANSFER OF PATIENTS.

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

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

COMMENT

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

SECTION 7. IMMUNITIES.

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

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

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

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

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

SECTION 8. PENALTIES.

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

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

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

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

COMMENT

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

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

SECTION 9. GENERAL PROVISIONS.

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

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

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

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

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

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

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

SECTION 10. RECOGNITION OF DECLARATIONS EXECUTED IN OTHER STATES.

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

SECTION 11. SEVERABILITY.

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

SECTION 12. TIME OF TAKING EFFECT.

This [Act] takes effect on _____.

PROCEEDINGS IN COMMITTEE OF THE WHOLE

RIGHTS OF THE TERMINALLY ILL ACT

of the

NATIONAL CONFERENCE OF COMMISSIONERS

ON UNIFORM STATE LAWS

August 1, 1984
Keystone Lodge
Keystone, Colorado

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REPRESENTATIVES IN PRINCIPAL CITIES

Proceedings in Committee of the Whole

Rights of the Terminally Ill Act

Wednesday Morning, August 1, 1977

Ms. Acie L. Ward of North Carolina presiding; Mr. Richard C. Hite of Kansas presenting the Act.

CHAIRMAN WARD: Good morning, everyone! Before we begin our debate on the Rights of the Terminally Ill Act, I would like to remind you, as other Chairmen of the Committee of the Whole have, to please bring forward in writing any changes that are simply matters of style to the Chairman of the Committee, and they will consider those.

Also, I'd like to ask each of you, although all of you feel your names are known, for various reasons--maybe even for reasons that we wouldn't like to be known--but when you do approach the mike, please state your name, for identification purposes for the record, and the state which you represent.

And if motions do arise, my memory is very good and I can hear very well, but I want to make sure that the Committee has the exact language of the motion, so I would request that you bring up those motions in writing and submit them to me, so that I will make sure that we are passing exactly what you would like to have passed, as far as your suggestions are concerned to the Committee.

We will proceed now by allowing Commissioner Richard Hite, Chairman of the Committee on the Right of the Terminally Ill Act, to begin with an introductory statement.

MR. HITE: Thank you, Madam Chairman.

First of all, I would like to introduce John Lombard, of Philadelphia, who has been an Advisor from the ABA Section of Real Property and Trust Law. And, Madam Chairman, I believe under the prior blanket motion that Mr. Lombard has the rights of the floor for the purpose of discussing this Act. Mr. Lombard is at the far left of the platform.

Secondly, I'd like to make a brief comment on the title of our Act. You can see from the blue book that it's referred to both as the Rights of the Terminally Ill Act and the Right to Decline Life-Sustaining Procedures Act. The Committee has suggested the latter name, not being entirely satisfied with Rights of the Terminally Ill. The Executive Committee, for the time being, has rejected the suggestion of the Drafting Committee, and I believe there is an agreement that further consideration as to the exact title will be given at the next meeting of the Drafting Committee this fall, and there will be further work on that at some time in the future.

We are advised by President Ring that we have only limited time for the first reading of this Act, and therefore

The Committee believes it might be helpful to make a few remarks about the work of the Committee, the scopy of the Act, the history of the facts and events giving rise to our reasoning, hoping this will help us to sharpen the focus of the discussion and debate.

At the turn of this century, the leading causes of death were influenza, pneumonia, tuberculosis, and something referred to in the statistics as gastritis. It will be noted that all of these leading causes of death were acute diseases which might attack anyone, regardless of the age group.

At the turn of the century, most deaths in this country occurred in the home, rather than in the hospital or any other type of medical institution. There is some question as to what obligation, if any, physicians had to prolong life at the beginning of this century. In a treatise entitled The Art in Hippocratic Corpus, three goals of medicine were defined. The first of those was doing away with the suffering of the patient; the second was lessening the violence of the disease; and the third, and the one that is at work here, refers to "those overmastered by their disease".

This, of course, provides a great contrast to the situation in recent years. At this time approximately 2 million people per year die in this country. The leading causes of

death are heart disease, which accounts for more than one-third of the deaths, malignancies, which account for approximately 23% of the deaths, and cerebrovascular diseases, which account for about 7% of all deaths. In one recent year, chronic, progressive disease accounted for more than 81% of all of the deaths in this country. This is, of course, in great contrast to what was going on at the turn of the century; and since we are considering deaths resulting from chronic and progressive diseases, it's necessary to keep in mind that those situations frequently involve lengthy periods of medical treatment.

Also, these diseases are more inclined to attack the elderly than the young. At this time it's probably well known that a vast majority of all deaths occur either at hospitals or some other medical institution. It's also obvious that tremendous advances in biomedical sciences have created the means to prolong life for substantial periods of time. In addition, the medical profession has a clear commitment to prolong human life.

From this combination of circumstances, many profound questions have arisen about prolonging life when the quality of life is either nonexistent or very, very doubtful. The entire subject has received the attention of many groups in this country--certainly, too numerous to mention--but the groups include

a Precidential Commission which has published a very comprehensive report entitled "Deciding to Forego Life-Sustaining Treatments", which has been a very valuable resource for this Committee.

The circumstances cutlined have alsc prompted the legislatures of twenty-three states in this country to adopt so-called Natural Death Acts or Living Will Statutes. That has occurred since 1975, and in the last two or three years there has been a rush of the state legislatures to adopt such legislation. Six of those acts have been adopted since January 1, 1984.

The Committee believes that there is a great variance in the quality of these acts. We also believe that if there was ever any question about the propriety of legislation in the field with which we are dealing, it has been laid to rest by the fact that twenty-three legislatures have acted in this area.

The Committee also believes that there is a clear and pressing need for a quality act, and for the promotion of uniformity.

In assigning the drafting task to this Committee, the Executive Committee placed certain limitations upon the purpose of the Act. Our exact charge was to draft an act providing the means for competent adults to direct that life-sustaining procedures either not be instituted or, if they have been previous-

ly instituted, be withdrawn if the person involved is in a terminal condition and no longer able to participate in decisions concerning medical treatment.

Stated a little bit differently, our Act does not deal with minors, including newborns, with serious illnesses. It does not deal with persons who have not executed a directive, or declaration. And it does not deal with the use of proxies, or substituted judgments, in making medical decisions--medical treatment decisions.

However, having noted those limitations, I would ask you to keep in mind that, because of the fact that chronic and progressive diseases constitute the leading cause of death, this Act, even with those limitations, would have possible application in a great majority of situations in which there is concern that life will be prolonged after all quality has forever disappeared.

In facing up to our drafting responsibilities, we have been guided by certain basic considerations. The first is that competent adults have the fundamental right to make important decisions concerning their own lives, including the right to decline medical treatment; secondly, that this Act should simply be a means whereby the fundamental right to decline medical treatment is extended to decisions which will be of no ef-

fect until after the person involved is no longer able to make such decisions. Thirdly, we have been guided by the principle that in case of doubt there should be a presumption in favor of continuing life.

We have tried to draft this Act with simple language which is both understandable to lay persons and meaningful to physicians. And we have tried to draft this Act in a convenient way, so that strictly medical decisions and judgments regarding particular cases are referred to the attending physician. And let me state that in the converse: We believe it is impossible to draft an act which speaks to specific factual situations.

As structured, as now before you, this Act basically does three things. First of all, it authorizes competent adults to execute a declaration stating that the person does not want life-sustaining procedures, as defined, utilized when he is in a terminal condition, as defined. Secondly, it provides, or notes. or acknowledges the right of the individual to make his own decisions regarding use of life-sustaining procedures, as long as he is able to do so. And thirdly, it provides that the declaration shall govern the use of life-sustaining procedures when the individual is no longer able to do so.

Before turning to the line-by-line reading, I would like for the Committee of the Whole to know that this Committee

has received valuable inputs from the ABA Section of Real Property, Probate and Trust Law through Mr. Lombard, from the ABA Commission on Legal Problems of the Elderly, the United States Catholic Conference, the American Hospital Association, the American Society of Law and Medicine, the Society for the Right to Die, the Catholic Health Association, and we have given both the American Medical Association and the Joint Commission on Accreditation of Hospitals opportunities to comment about the drafts of this Act.

In addition, I would like to acknowledge the very valuable contribution made by Commissioner Randy Bezanson, who has acted as our unofficial Reporter, and Nancy Belcit, of the University of Iowa Law School, who has given Randy a substantial amount of support.

With that, Madam Chairman, I believe we are ready to turn to a line-by-line reading of the Act.

CHAIRMAN WARD: If there are no comments at this point, we will begin by reading Section 1, Definitions, of the Act.

MR. HITE: Again, to try to sharpen the focus of the issues, in Section 1 the first, fifth, and sixth definitions really are the operative provisions, or provide the operative basis, of this Act. And before I read the entire thing, I