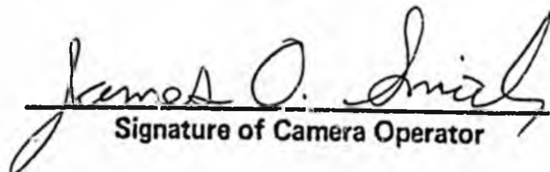
ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

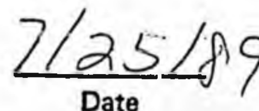
3214.81 HHESS HB 255 - HB 292

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.



Signature of Camera Operator



Date

02-519 (REV 8/78)

HB
255

Alaska State Legislature

House of Representatives

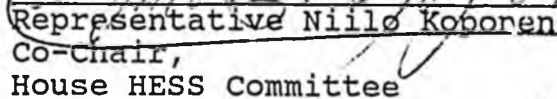
COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

OFFICIAL BUSINESS

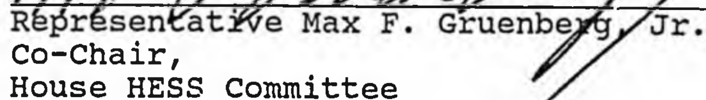
POUCH V
JUNEAU, AK 99811
465-3759

LETTER OF INTENT

It is the intent of the Health, Education and Social Services Committee in passing CS HB 255 (HESS) that this bill would not empower the Department of Health and Social Services to recognize the legal jurisdiction of tribal courts whose authority has not been legally established yet, nor would it permit DHSS to agree to limit the jurisdiction of the state courts. That power is constitutionally vested in the legislature.



Representative Niilo Koponen
Co-Chair,
House HESS Committee



Representative Max F. Gruenberg, Jr.
Co-Chair,
House HESS Committee

proposed CO.

BY WALLIS, ADAMS, TAYLOR,
HURLEY, THOMPSON, KOPONEN
AND HERRMANN

IN THE HOUSE

Committee ~~SPONSOR~~ SUBSTITUTE FOR HOUSE BILL NO. 255 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act authorizing the Department of Health and Social Services to enter into agreements concerning the care and custody of Native children."

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

* Section 1. AS 47.10.230 is amended by adding a new subsection to read:

(g) The department may enter into agreements with Indian tribes under 25 U.S.C. 1919 (Indian Child Welfare Act of 1978) respecting the care and custody of Native children and jurisdiction of Native child custody proceedings.

COMMITTEE REPORT

HOUSE

(7)

FURTHER: FINANCE

3/1/85

Date: March 11, 1986

Mr. Speaker:

The Committee on HEALTH, EDUCATION AND SOCIAL SERVICES has had HB 255

"An Act authorizing Department of Health and Social Services to enter into agreements con the care and custody of Native children."

under consideration and reports it back as follows:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for HB 255 (HESS) [✓] same title [ ] new title

and recommends no rec

[✓] AND attaches a "Letter of Intent" [ ] New Fiscal Note [✓] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the ____________ Committee

MEMBERS SIGNING DO PASS	MEMBERS HAVING OTHER RECOMMENDATIONS:
[signature]	[signature] no rec
Robert Taylor Vice Chair	
[signature]	
[signature]	
[signature]	

[signature]
CHAIRMAN
[signature] Co chair

H 60

BY WALLIS, ADAMS, TAYLOR
HURLEY, THOMPSON, KOPONEN
AND HERRMANN

1 IN THE HOUSE

2 SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 255

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act authorizing the Department of Health a

7 Social Services to enter into agreements concerni

8 the care and custody of Native children."

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15 custody proceedings.

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BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

POUCH K – STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE: (907) 465-3600

March 10, 1986

ANALYSIS OF SSHB 255
by the Alaska Department of Law

The purpose of HB 255 is to authorize the Department of Health and Social Services to enter into agreements with Native villages for implementation of the Indian Child Welfare Act, (ICWA), 25 U.S.C. § 1901 et seq. State-tribal agreements are specifically authorized by 25 U.S.C. § 1919(a). The language of HB 255 is taken directly from 25 U.S.C. § 1919(a).

As background, it should be noted that ICWA is one of the few federal statutes which authorizes Native entities to exercise tribal powers whether or not they exist on reservations. The definition of "Indian tribe" in ICWA explicitly adds Alaska Native Villages: "... including any Alaska Native village as defined in section 1602(c) of Title 43 [the Alaska Native Claims Settlement Act]." ICWA requires state court proceedings involving Native children to meet certain minimal standards, and it also authorizes tribal courts to exercise concurrent jurisdiction with state courts in certain cases involving Native children. HB 255 would authorize the Department of Health and Social Services to enter into agreements with tribes, i.e., Native villages, regarding care and placement of Native children and regarding jurisdiction of Native child custody proceedings.

Agreements on care and placement would include cooperative arrangements for foster care and for developing local provision for child welfare assistance. It could include provisions for cross-licensing of foster homes, for example, or such arrangements regarding contract foster homes or payments for foster care as the parties were able to negotiate.

Agreements on jurisdiction of Native child custody proceedings could deal with the complexities caused by the fact that over 200 Native villages exist in the state and that Native children may have connections to several villages. Methods need to be arrived at for sorting through such complications and deciding what notice and procedures are to be followed in particular cases. We note that this bill would not empower the Department of Health and Social Services to recognize the legal jurisdiction of tribal courts whose authority has not been legally established yet, nor would it permit DHSS to agree to limit the jurisdiction

FEB 2 8 REC'D

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

MEMORANDUM February 28, 1985

SUBJECT: Indian Child Welfare Act
(Work Order No. 14-0618)

TO: Representative Kay Wallis

FROM: Michael F. Ford
Legislative Counsel

The bill draft you requested would authorize the Department of Health and Social Services to enter into agreements with Indian tribes concerning care, custody, and jurisdiction of Native children. This authority is already granted to the States by federal law under the Indian Child Welfare Act (25 U.S.C. 1919). Therefore the bill you have requested would not add to the authority of the State, but would merely mirror the existing federal statute. In this same manner, the use of the term "jurisdiction" in the bill draft does not give the State any more or less authority to act in a childrens' proceeding than exists under present law.

Please contact me if you have further questions on this matter.

MFF:ojb
J12/033

POSITION PAPER
HOUSE BILL 255

"An Act Authorizing the Department of Health and Social Services to enter into agreements concerning the care and custody of Native children"

Under Section 1919 of the Federal Indian Child Welfare Act, 25 U.S.C. 1919, "States and Indian Tribes are authorized to enter agreements with each other respecting care and custody of Indian children and jurisdiction over child custody proceedings..."

Despite this federal authorization, the Attorney General has taken the position that the State cannot exercise this power until a State law is passed authorizing a particular State agency to execute agreements on the State's behalf (see March 30, 1983 opinion attached).

HB 255 is the specific authorization which the Attorney General requires. It simply authorizes the Department of Health and Social Services to act for the State in the execution of State-Tribal Native child custody agreements. HB 255 does not add to the State's existing power to enter into such agreements--it merely removes the reluctance the Department has because of the Attorney General's opinion.

Nor would HB 255 violate the Alaska Constitution. Under Federal law, states are empowered to pass laws which implement Federal laws. The sole purpose of HB 255 is to implement the Federal Indian Child Welfare Act. It is therefore consistent with Federal law. Furthermore, under the Federal Supremacy Clause, State laws which are passed to implement Federal laws cannot be successfully challenged on State constitutional grounds.

HBV 255 neither enlarges, diminishes, nor in any way affects the existing power of Alaska Native villages to establish tribal courts and exercise jurisdiction over Native child custody matters. Native governments in Alaska are taking increased interest in exercising their federally guaranteed rights. This bill authorizes DH&SS to do what it ought to do--cooperate with Native governments and Native people to alleviate the problems that led to Congressional passage of the Indian Child Welfare Act.

In passing the Indian Child Welfare Act (ICWA), Congress expressly found:

> ...the States exercising their recognized jurisdiction

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

02-576(2/77)

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LAW

POUCH K – STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE: (907) 465-3600

OFFICE OF THE ATTORNEY GENERAL

March 10, 1986

ANALYSIS OF SSHB 255
by the Alaska Department of Law

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03 – C32LH

of the state courts. That power is constitutionally vested in the legislature. Otherwise DHSS would have fairly broad discretion on which agreements to enter into and which to decline as not in the best interests of the state.

Because DHSS will necessarily be using its discretion in negotiating and deciding whether to enter into specific agreements, we support the bill as now amended. The proposed changes clarify that DHSS must consider the best interests of the state and the public in evaluating a proposed agreement and is not obligated to accept any agreement offered by a village without negotiating its terms.

In our opinion, HB 255, as amended by the sponsor substitute, merits the suppo[illegible] of the Department of Law.

HAROLD M. BROWN
ATTORNEY GENERAL

By:
Douglas K. Mertz
Assistant Attorney General

DKM:dlm

FEB 28 RECD

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

M E M O R A N D U M February 28, 1985

SUBJECT: Indian Child Welfare Act
(Work Order No. 14-0618)

TO: Representative Kay Wallis

FROM: Michael F. Ford
Legislative Counsel

The bill draft you requested would authorize the Department of Health and Social Services to enter into agreements with Indian tribes concerning care, custody, and jurisdiction of Native children. This authority is already granted to the States by federal law under the Indian Child Welfare Act (25 U.S.C. 1919). Therefore the bill you have requested would not add to the authority of the State, but would merely mirror the existing federal statute. In this same manner, the use of the term "jurisdiction" in the bill draft does not give the State any more or less authority to act in a childrens' proceeding than exists under present law.

Please contact me if you have further questions on this matter.

MFF:ojb
J12/033

POSITION PAPER
HOUSE BILL 255

"An Act Authorizing the Department of Health and Social Services to enter into agreements concerning the care and custody of Native children"

Under Section 1919 of the Federal Indian Child Welfare Act, 25 U.S.C. 1919, "States and Indian Tribes are authorized to enter agreements with each other respecting care and custody of Indian children and jurisdiction over child custody proceedings..."

Despite this federal authorization, the Attorney General has taken the position that the State cannot exercise this power until a State law is passed authorizing a particular State agency to execute agreements on the State's behalf (see March 30, 1983 opinion attached).

HB 255 is the specific authorization which the Attorney General requires. It simply authorizes the Department of Health and Social Services to act for the State in the execution of State-Tribal Native child custody agreements. HB 255 does not add to the State's existing power to enter into such agreements--it merely removes the reluctance the Department has because of the Attorney General's opinion.

Nor would HB 255 violate the Alaska Constitution. Under Federal law, states are empowered to pass laws which implement Federal laws. The sole purpose of HB 255 is to implement the Federal Indian Child Welfare Act. It is therefore consistent with Federal law. Furthermore, under the Federal Supremacy Clause, State laws which are passed to implement Federal laws cannot be successfully challenged on State constitutional grounds.

HBV 255 neither enlarges, diminishes, nor in any way affects the existing power of Alaska Native villages to establish tribal courts and exercise jurisdiction over Native child custody matters. Native governments in Alaska are taking increased interest in exercising their federally guaranteed rights. This bill authorizes DH&SS to do what it ought to do--cooperate with Native governments and Native people to alleviate the problems that led to Congressional passage of the Indian Child Welfare Act.

In passing the Indian Child Welfare Act (ICWA), Congress expressly found:

> ...the States exercising their recognized jurisdiction

> over Indian child custody proceedings through administrative and judicial bodies, have often failed to recognize the essential tribal relations of Indian people and the cultural and social standards prevailing in Indian communities and families."
> (25 U.S.C. 1901(5).

By authorizing the Department of Health and Social Services to contract with Native governments, HB 255 will ensure that the State of Alaska recognizes and protects "the cultural and social standards prevailing in Native communities and families" in the administration of Native child welfare proceedings. Agreements have been arrived at in other states. Minnesota, for example, has entered into an agreement with some of its tribes to ensure tribal input and State compliance with the ICWA. H&SS, too, should be free to work with Native people and entities so that these important issues may be dealt with in a spirit of cooperation, rather than confrontation.

HB 255 merely authorizes the Department to enter into such agreements--it does not mandate that they must.

F. Kay Wallis
Representative

March 7, 1986

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

604 BARNETTE ST., RM 228
FAIRBANKS, ALASKA 99701
PHONE: (907) 452-1568

March 30, 1983

Mike Walleri
Tanana Chiefs Conference
Building 201 - First Avenue
Fairbanks, Alaska 99701

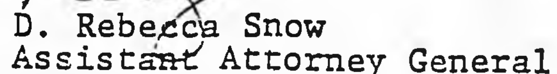
Dear Mike:

Many months ago you sent me a draft of a "109-Agreement" that you have been working on with the villages in your region. Jim Fox responded with some Division of Family and Youth Services' concerns. I have not responded previously because the Department of Law does not have a settled position on negotiation of Section 109 agreements.

At this point, in fact, we recognize that there has been no enabling legislation enacted by the State of Alaska which would authorize any State agency to enter into such an agreement with a village or an entity such as Tanana Chiefs Conference. Until such legislation is enacted setting the limits of any such authority, we feel that it would be impossible to enter into good faith negotiations on the substance of such an agreement. Thus, while I would suggest ordinarily that the proper process for arriving at such an agreement would be for a representative of the villages and/or Tanana Chiefs Conference to sit down with a representative of the Division of Family and Youth Services and a representative of the Department of Law, regretfully at this time I cannot offer to participate in such negotiations. Please be assured that should the necessary enabling legislation be enacted, we would be very willing to sit down with anyone designated by the villages to work on such an agreement.

Very truly yours,

NORMAN C. GORSUCH
ATTORNEY GENERAL

By: 
D. Rebecca Snow
Assistant Attorney General

DRS:bsw

cc: Ron Lorensen
Deputy Attorney General

POSITION PAPER

SPONSOR SUBSTITUTE FOR HOUSE BILL 255

For an Act entitled: "An Act authorizing the Department of Health and Social Services to enter into agreements concerning the care and custody of Native children."

HB 255 would authorize the department to enter into agreements for child protection with Native tribes under 25 U.S.C. 1919 (Indian Child Welfare Act [ICWA]).

The department has and will continue to award monetary grants and contracts to Native nonprofit organizations and to enter into non-monetary social services agreements with Native organizations so that Natives may actively participate in the care and custody of Native children. The department actively supports the Indian Child Welfare Act provisions whereby Native children who must be separated from their families are placed in Native homes and village council authorities must be allowed to recommend the type of placement for Native children.

The Department of Law has informed the department that the Department of Health and Social Services currently has the authority to enter into, and has already entered into, some agreements with Native organizations. Therefore, according to the Attorney General, HB 255 does not add to the department's authority to enter into the agreements. The Attorney General, however, states that the Department of Health and Social Services cannot enter into agreements that would delegate the State's discretionary (police power) duties, and cannot enter into agreements affecting the judicial branch's jurisdiction over Native children.

It is possible for the State to enter into cooperative social services agreements with Native organizations. For example, such agreements were entered into with the Ketchikan Indian Corporation and the United Crow Band. The intent of these agreements is for the parties "to cooperate with each other towards mutual goals of protecting the best interests of Native children, establishing a more effective provision of child protection service, and promoting the stability and security of Native families and villages." (United Crow Band agreement). These social service agreements do not provide state funding directly to the Native villages or organizations for social services.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date : ________

REQUEST

Bill/Resolution No. : HB 255

Title : An Act authorizing the Department of Health & Social Services to enter into agreements concerning Native Children.

Sponsor : ________

Requestor : ________

Date of Request : 2/24/86

FISCAL DETAIL

Agency Affected : Health & Social Services

BRU : Social Services

Components : ________

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		-0-	-0-	-0-	-0-	-0-
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-

CAPITAL		-0-	-0-	-0-	-0-	-0-

REVENUE		-0-	-0-	-0-	-0-	-0-

FUNDING : (Thousands of Dollars)

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

POSITIONS :

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

ANALYSIS : Attach a separate page if necessary

Prepared by : Michael A. Price, Director [signature]

Phone : 465-3170

Division : Family and Youth Services

Date : 2/24/86

Approved by Commissioner : John R. Pugh [signature]

Date : ________

Agency : Department of Health & Social Services

Distribution (by Agency preparing fiscal note) :

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

10/25/85

The Department of Health and Social Services supports this bill.

RECOMMENDED: Michael L. Price
Michael L. Price, Director
Division of Family
and Youth Services

DATE: March 10, 1986

APPROVED: John R. Pugh
John R. Pugh, Commissioner
Department of Health
and Social Services

DATE: 3/10/86

POSITION PAPER/Department of Health & Social Services

MEMORANDUM

TO: HOUSE HESS COMMITTEE MEMBERS

FROM: NANCY BENNETT, COMMITTEE STAFF

DATE: MARCH 10, 1986

RE: TODAY'S AGENDA

We have three bills scheduled for today:

HB 614 - Relating to the Board of Dental Examiners

This bill was introduced by the Committee to continue the board for four years following the Sunset Review hearing conducted in February. There is also a sunset review report in your folder.

SB 263 - Relating to disqualification for certain state loan programs for failure to pay child support

This bill has been in subcommittee. Representative Taylor has a proposed amendment to offer.

We also have a new memo from Senator Faiks.

HB 255 - Enabling the Department of Health and Social Services to enter into custody agreements regarding indian children

We are having a teleconference on this bill, which would put into state law federal provisions allowing agreements to be entered into regarding the custody of native children.

We also have a bill relating to municipal sales tax and food stamps before us to consider for introduction

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

7/25/89
Date

02-519 (REV 8/78)

HB
264

Alaska State Legislature

House

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

January 24, 1986

Representative Niilo Koponen
Representative Max Gruenberg
Co-Chairmen
Committee on Health, Education
And Social Services
Pouch V
Juneau, Alaska 99811

Dear Representatives Koponen and Gruenberg:

This letter is to request that you, as co-chairmen of the HESS committee, schedule a public hearing for HB 264 - "An Act relating to marijuana, and providing for an effective date."

This bill addresses changes to the statutes which have been identified as top priorities of the Anchorage Crime Commission, and as it was referred to your committee on March sixth of last session, I have hoped it would receive some attention. I spoke with you, as well as your committee aide, in regard to holding hearings on this issue during the last session, as well as during the interim, but that opportunity seems to have passed you by.

I sincerely hope you will consider opening up the discussion on the marijuana issue by scheduling HB 264 for a hearing as soon as possible. The Anchorage Crime Commission, as well as many other experts throughout the state, would sincerely appreciate an opportunity to present to a formal Legislative committee the most recent scientific and sociological findings on the effects of marijuana on the individual, local communities and the state of Alaska. I realize that many Legislators, for various reasons, want to stay as far away as possible from anything to do with the possible recriminalization of marijuana. However, we can no longer ignore our responsibilities to the public as a whole.

Thank you for your attention to this request.

Best regards,

Terry Martin

Rep. Terry Martin

TM/jwm
cc: Harold Heinze, Chairman
Anchorage Crime Commission

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

7/25/89
Date

02-519 (REV 8/78)

HB
269

COMMITTEE REPORT

HOUSE

(7) FURTHER: JUDICIARY

3/6/85

Date: 28 March 1985

Mr. Speaker:

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

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

under consideration and reports it back as follows:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[√] replace with CS for HB 269 (HESS [√] same title [ ] new title

and recommends do pass

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the ____________ Committee

MEMBERS SIGNING DO PASS

[signatures]

MEMBERS HAVING OTHER RECOMMENDATIONS:

[signatures] no rec

[signature] No Rec

[signature]

CHAIRMAN

H 60

MEMORANDUM

TO: Rep. Niilo Koponen

FROM: Connie Jackson

DATE: March 25, 1985

RE: HB 269 - Terminally ill patients

IN YOUR FOLDER -----

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

NOTE:

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

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

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

MEMORANDUM March 22, 1985

SUBJECT: Sectional analysis of House Bill 269

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

FROM: Billy G. Berrier
Director
Division of Legal Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 18.12.100 defines certain terms used in this chapter.

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D R A F T

FOR DISCUSSION ONLY

RIGHTS OF THE TERMINALLY ILL ACT

NATIONAL CONFERENCE OF COMMISSIONERS

ON UNIFORM STATE LAWS

December 18, 1984, Draft

RIGHTS OF THE TERMINALLY ILL ACT

With Prefatory Note and Comments

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

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RIGHTS OF THE TERMINALLY ILL ACT

PREFATORY NOTE

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

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

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

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

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

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

RIGHTS OF THE TERMINALLY ILL ACT

SECTION 1. DEFINITIONS.

As used in this [Act]:

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

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

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

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

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

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

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

COMMENT

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

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

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

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

The Act defines "life-sustaining procedure" in an all-inclusive manner, dealing with those procedures necessary for comfort care or alleviation of pain separately in section 5(b), where it is provided that such procedures need not be withdrawn or withheld pursuant to a declaration. Most existing statutes incorporate "comfort care" as an exclusion from the definition of life-sustaining procedures. Because most such procedures <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, and in either case must be witnessed by two persons. A physician or health-care provider may presume, in the absence of actual notice to the contrary, that the declaration complies with this Act and is valid.

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

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

DECLARATION

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

Signed this ________ day of ________, ____.

Signature ____________________

City, County and State of Residence ____________________

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

Witness ____________________
Address ____________________

Witness ____________________
Address ____________________

COMMENT

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

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

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

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

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

SECTION 3. REVOCATION OF DECLARATION.

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

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

COMMENT

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

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

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

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

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

COMMENT

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

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

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

SECTION 5. TREATMENT OF QUALIFIED PATIENTS.

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

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

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

COMMENT

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

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

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

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

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

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

SECTION 6. TRANSFER OF PATIENTS.

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

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

COMMENT

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

SECTION 7. IMMUNITIES.

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

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

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

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

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

SECTION 8. PENALTIES.

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

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

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

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

COMMENT

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

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

SECTION 9. GENERAL PROVISIONS.

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

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

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

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

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

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

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

SECTION 10. RECOGNITION OF DECLARATIONS EXECUTED IN OTHER STATES.

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

SECTION 11. SEVERABILITY.

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

SECTION 12. TIME OF TAKING EFFECT.

This [Act] takes effect on ________________________________.

LIVING WILL/NATURAL DEATH ACTS

Statutory Citations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Arguing the Right to Die

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

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

In simpler times, William Bartling would have died at home, far from the ethical questions a bivalve respirator brings to life. Now, however, thanks to stunning advances in emergency medicine, hospitals have become the nation's charnel houses: roughly 80 percent of Americans who die each year die in hospitals or nursing homes. That dramatic change has led to problems that the law isn't quite ready to sort out and a growing right-to-die movement which vigorously insists that sick people should have the last word about their own lives.

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

Both legislatures and courts have the death issues on their dockets. The District of Columbia and 22 states have adopted "living will" laws that permit mentally competent adults to declare—before they get sick—that they don't want their lives prolonged artificially. A court in New York has also embraced this notion. More than 35 states now have "brain death" laws that allow respirators to be withdrawn when a patient no longer shows any sign of brain activity. New York doesn't have that statute, but last week a state judge essentially followed it by ordering a suburban hospital to unplug a comatose man from his life-support system.

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

Bouvia: Death on the docket

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

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

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

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

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 269

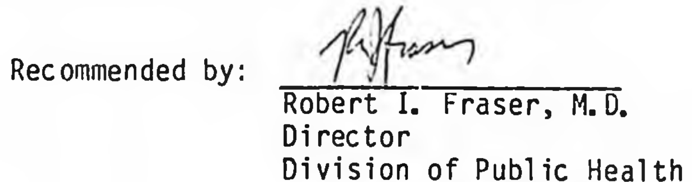
For "An Act relating to the rights of the terminally ill."

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

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

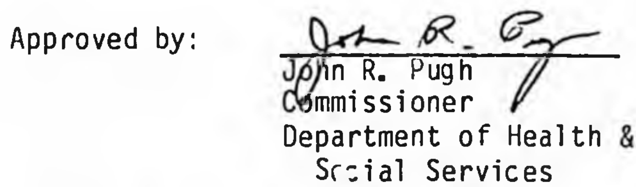
According to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 13 states and the District of Columbia have adopted so-called natural death legislation. The proposed legislation appears to be generally similar to the major provisions in other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

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



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

Date: 12 MAR 85



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

Date: 3/15/85

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

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

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
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)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
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:

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: Attach a separate page if necessary

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

Approved by Commissioner: [signature]
Date: 3/5/85 JCC
Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

7/1/84

…ending priorities. … effective this July.

DN 2-11-85

Measure would give terminally ill patients the right to die

The Associated Press

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

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

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

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

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

The bill also would free physicians and other health care professionals from any liability for honoring a patient's written request.

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

Society For The Right To Die

NEWSLETTER FALL 1984

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

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

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

Open Policies Urged

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

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

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

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

Walter Sackett, Jr., M.D.

Since 1967, when a small forward-looking group of legislators, led by Walter W. Sackett, Jr., M.D., tried unsuccessfully to have a clause inserted in the state constitution guaranteeing the right to control one's medical treatment at the end of life, almost every legislative session in Tallahassee has seen a Living Will bill introduced. And Dr. Sackett was present at the emotional moment when Governor Graham, with whom he entered the legislature in 1967, signed H.B. 127 into law.

The bill, which was shepherded through the last session by its sponsor, Rep. Byron Combee, a freshman lawmaker from Clearwater, passed the House 106 to 2, with no debate, and passed the Senate unanimously, 35 to 0. It protects both competent and incompetent patients who have executed a Living Will from the use of extraordinary measures to sustain life, and makes provision as well for decision-making by a family member on behalf of incompetent patients who have not executed a Living Will. Florida is one of five states to provide for designation of a proxy to make treatment decisions.

Rep. Byron Combee

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

BULLETIN

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

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

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

Nursinglife Survey

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

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

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

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

"Compassionate Compromise"

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

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

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

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

Editors' Conclusions

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

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

Nursinglife's editors go on to say:

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

Doctors and Nurses in Florida Poll

Another attempt to provide a picture of health professionals' attitudes toward Living Wills was made by faculty members at the University of Florida College of Nursing in Gainesville. Supported by grants from the American Nurses' Foundation and the Florida Division of the American Cancer Society, the group surveyed 500 nurses and 500 physicians selected at random from membership lists of the American Medical Association and the American Nurses Association. The following statistics emerged, as detailed in a letter to the *New England Journal of Medicine* (9/6/84):

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

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

Medicare Reformers Support Living Wills

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

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

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

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

N.Y. Times/CBS News Poll

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

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

University of Chicago Poll

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

Lorraine Bate Orr

Charleston Woman to Head South Carolina Committee

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

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

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

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

NEW IMPETUS SEEN FOR CONNECTICUT LAW

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

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

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

Sen. William F. Rogers, III

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

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

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

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

Rep. Jamie McLaughlin

CASES POINT UP NEED TO UPHOLD PATIENTS' RIGHTS

The "Landy" Case

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

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

Parity for All Terminal Patients

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

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

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

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

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

California Case Arouses Storm

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

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

Bartling was suing the hospital for money damages, for breach of its contract with him and for committing a battery on him by continuing to treat without his consent. He also alleged that his constitutional rights to freedom from invasion of his person had been ignored and violated.

Arizona Hospital Rejects Living Will, Durable Power

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

Possible "Battery" in Ohio

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

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

(continued on page 8)

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

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

Remarkable Developments

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

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

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

Where to Draw the Line?

Especially provocative were her remarks on where to draw the line. Should Down Syndrome infants with surgically correctable physical defects be treated? What about thalidomide babies with no limbs at all? Is it kinder to end life than to perpetuate it for such babies? Should the parents of infants such as Baby Jane Doe be liable for any legal or medical costs incurred? What about impaired infants who survive for years as retarded adults? Who is to take care of them when their parents die? (The estimated cost of maintaining such adults is $50,000 each per year.) There are no categorical answers, Dr. Avery said, and she expressed her belief that decisions are best made on a case-by-case basis rather than through establishing regulatory guidelines. She predicted an increase of government intervention in this area, and observed that even now some hospitals use non-medical criteria in deciding whether to sustain or not sustain life, i.e. fear of loss of federal funding.

Mary Ellen Avery, M.D.

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

Amendment Sets Procedure

Earlier government regulations in "Baby Doe" cases, opposed by several medical organizations as "intrusive," were ameliorated, to some extent, by an amendment to the Child Abuse Prevention and Treatment Act. The amendment, a compromise which was endorsed by a broad spectrum of organizations and bipartisan members of Congress, extended child neglect and abuse to include the "withholding of medically indicated treatment from disabled infants with life threatening conditions." However, heroic efforts would not have to be made when the infant was chronically and irreversibly comatose, or when treatment would only prolong dying or would be futile and inhumane.

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

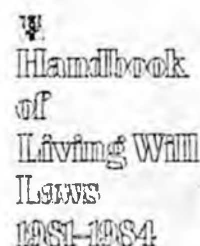
It was opposed by the American Medical Association, which said that the legislation did not give enough weight to the "quality of life" of a severely handicapped baby who did survive treatment.

'84 HANDBOOK OFF PRESS

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

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

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



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

Staff Attorney Broadens SRD Services

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

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

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

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

Christine K. Cassel, M.D.

Sia Arnason, M.S.W.

News From SRD Board

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

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

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

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

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

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

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WORLD FEDERATION MEETS IN NICE

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

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

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

Panels Open to Public

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

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

Old Quotes Never Die...

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

—from *Medical World News*, 5/29/78

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

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

What They're Saying Now...

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

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

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

—Unidentified nurse, *Nursinglife*

SRD Publications

HANDBOOK OF LIVING WILL LAWS 1981–1984
Thirteen New Statutes with Texts, Analysis and Commentary

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

Each $5.00

Fact Sheets on Right-to-Die Court Decisions

Binder Set $3.00

Order From:

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

FLORIDA AND LOUISIANA LAWS *(continued from page 1)*

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

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

Professionals Pleased

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

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

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

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

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

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

HEMLOCK SOCIETY CONFERENCE

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

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

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

Living Will Legislation in the United States

Enacted Law:

1984 Bill:

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

PATIENTS' RIGHTS AT ISSUE IN THE COURTS

(continued from page 4)

In July 1982, Mrs. Leach's estate sued both doctor and hospital, seeking damages for the 5-month period. A lower court dismissed the suit, finding it without legal basis. Mrs. Leach's estate appealed, and the Ohio Court of Appeal, in a very strongly worded opinion, stated that a) treatment without consent constitutes battery, b) not only consent, but informed consent, is required before treatment (with the usual exception of medical emergency) and c) if Mrs. Leach's estate could prove that she had been placed on a respirator without proper consent, when there was no medical emergency, such action would be a battery, remediable in damages. The court saw the danger that a physician "could circumvent the express wishes of a terminal patient by waiting to act until the patient was comatose and critical." On the other hand, it recognized that "the prospect of refusing to act in an emergency because the patient at some time voiced vague wishes not to be kept alive on machines is equally unacceptable."

Before an assessment can be made of whether damages can be awarded, a trial must be held to determine, on the facts, whether the doctor and the hospital did in fact act improperly, without consent. If Mrs. Leach's estate is successful at trial level, Living Wills as clear expressions of intent may well be accorded great respect in Ohio in the future.

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 PROGRESSES

On October 12–13, the Drafting Committee for the Rights of the Terminally Ill Act, a committee of the National Conference of Commissioners on Uniform State Laws, met in Hartford, Connecticut. They reviewed the numerous suggestions for revisions to the proposed Act which followed the first reading held in Keystone, Colorado, in August. These suggestions were offered by the commissioners and the several participating organizations, which included the Society for the Right to Die, represented by Sidney D. Rosoff, Esq., chairman of the Board. (SRD Newsletter, Spring '84, page 8.)

As a result of the Hartford meeting, a version incorporating these changes is being prepared for consideration by the committee at a March 1985 meeting to be held in Chicago. It is expected that there will be a second and final reading of the proposed text at the August 1985 National Conference, at which time it is hoped that a Uniform Act will be adopted.

Craig, March 6, 1985

Dear Senator Elison,

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

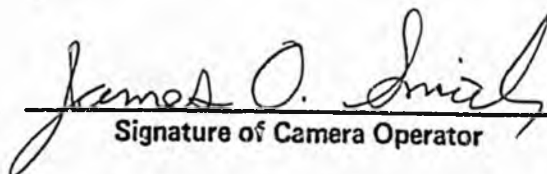
her welfare would have been much more difficult to resolve. "Second-guessing" what the dying person might wish done on his/her behalf and cooperatively agreeing to a course of action (family members, physicians) leaves a lingering doubt and the potential for possible guilt.

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.

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.



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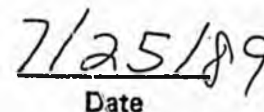


Date

02-519 (REV 8/78)

HB
292

Alaska Public
Employees Association APEA
~~State Headquarters: 310 N. Franklin, Juneau, AK 99801 (907) 586-2334~~
210 Ferry Way, Suite 20?, Juneau, AK 99801
(907)586-2334

MEMORANDUM

TO: Representative Niilo Koponen and
Representative Max Gruenberg, Co-Chairmen
Health, Education and Social Services Committee

FROM: Cherie Shelley
Executive Director

SUBJECT: HB 292 - Credited Service for Noncertifcated School Employees

DATE: March 4, 1986

The Alaska Public Employees Association supports House Bill 292. This bill corrects an inequity in the retirement system which unfairly discriminates against the classified employees of school districts. This group includes teachers aides, secretaries and custodians: traditionally the lowest paid public employees in Alaska.

HB 292 amends the provisions of the Public Employee's Retirement System (PERS) to make the calculation of credited service for noncertificated school employees similar to that provided for certificated employees in the Teachers Retirement System and for Legislative staffers in PERS. The special circumstances of school district employment make this change appropriate.

Fairbanks Field Office
825-D College Road
Fairbanks, AK 99701
Telephone: (907) 456-5412

Anchorage Field Office
833 Gambell Street, Suite A
Anchorage, AK 99501
Telephone: (907) 274-1688

Juneau Field Office
227 4th Street
Juneau, AK 99801
Telephone: (907) 586-6305

COMMITTEE REPORT

HOUSE

3/14

(7)

4/30/85

FURTHER: FINANCE

Date: 3/11/86

The Committee on HEALTH, EDUCATION AND SOCIAL SERVICES has had HB 292

"An Act relating to credited service for noncertificated school employees who are members of the public employees' retirement system; and providing for an effective date."

under consideration and recommends:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for ______ [ ] same title [ ] new title

and recommends ______

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[✓] reports it back without recommendation [✓] Zero Fiscal Note Attached w/ analysis new (1986) see Supplement #97

[ ] referred to the ______ Committee

MEMBERS SIGNING DO PASS	MEMBERS HAVING OTHER RECOMMENDATIONS:
[signature]	[signature] - Do Not Pass
	[signature] NO Rec
	[signature] / no rec
	[signature] No Rec
	[signature] - NO REC
	[signature] do not pass

[signature] Co-ch

CHAIRMAN

[signature] / Co-Chair

4/30

COMMITTEE REPORT

HOUSE

HEALTH, EDUCATION AND SOCIAL SERVICES

(7)

FURTHER: FINANCE

3/15/85

Date: 4/29/85

The Committee on STATE AFFAIRS has had HB 292

"An Act relating to credited service for noncertificated school employees who are members of the public employees' retirement system; and providing for an effective date."

under consideration and recommends:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for ______________ [ ] same title [ ] new title

and recommends ______________

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[L] ~~Zero~~ Fiscal Note Attached zero with Analysis

[X] reports it back without recommendation

[ ] referred to the ______________ Committee Sup 60

MEMBERS SIGNING DO PASS		MEMBERS HAVING OTHER RECOMMENDATIONS:
~~[signature]~~	M.M.Miller	[signature] - NO REC
	Jenkins	[signature] No-Rec.
Cato: Bette Cato	Collins	[signature] DO NOT PASS
	Navarre	Mike Navarre ~~[struck]~~ NO REC
	Hurley	Katie Hurley no-rec.
	Boucher	[signature] no-rec

Katie Hurley

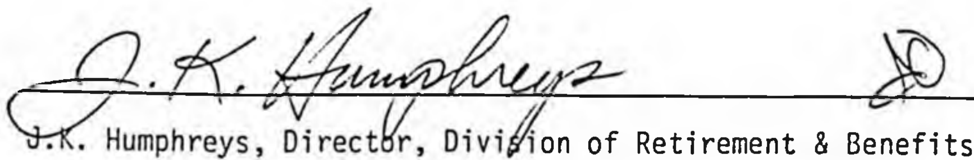
CHAIRMAN

Position Paper

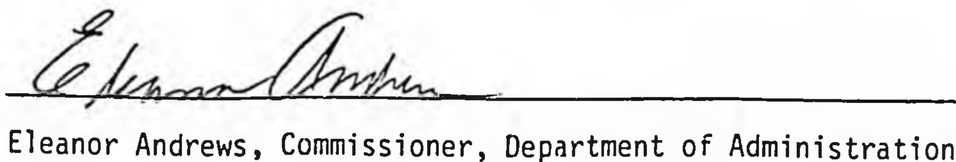
House Bill 292

This bill would allow non-teaching employees of school districts to accrue credit in the Public Employees' Retirement System (PERS) for the period of time during summer breaks when they are not working. No public purpose is served by giving PERS members retirement credit for periods of time when they are not working or contributing to the system. The argument can be that teachers receive a full years credit for nine months work, but teachers belong to a different retirement system with many differing provisions. Many other public employees could make a case for receiving service credit on some basis other than day-for-day; such exceptions would not improve equity in the system and would foster additional problems.

The Department is opposed to this bill.



J.K. Humphreys, Director, Division of Retirement & Benefits — 3/11/86 Date



Eleanor Andrews, Commissioner, Department of Administration — 3/11/86 Date

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: 3/11/86

REQUEST	FISCAL DETAIL
Bill/Resolution No.: HB 292	Agency Affected: None
Title: "An Act relating to credited service for non-certificated ..."	BRU: None
Sponsor: Koponen	Components: None
Requestor:	
Date of Request:	

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
RTMNT & BNFTS						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
TRS MATCH						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:	-0-	-0-	-0-	-0-	-0-	-0-
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

See attached

Prepared By: J.K. Humphreys, Director
Phone: 465-4470
Division: Retirement & Benefits
Date: 3/11/86

Approved by Commissioner: Eleanor Andrews
Date: 3/11/86
Agency: Department of Administration

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

 Rev. 11/15/85

House Bill 292
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

March 11, 1986

Analysis:

The cost of this bill will be borne entirely by the Public Employees Retirement System (PERS) school district employers. It is estimated that 35 percent of school district employees would be affected by earning, in essence, one fourth of a year of service free.

The estimated increase in employer contribution rates for those affected employers would be 1.7% of their PERS payroll. The estimated PERS school district payroll in FY 87 is $202,389,595.00.

The total cost to school districts who are participating in PERS is expected to be as follows:

FY 87	FY 88	FY 89	FY 90	FY 91
$3,440.6	$3,715.9	$4,013.1	$4,334.2	$4,680.9

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: 3/11/86

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Requestor:
Date of Request:

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POSITIONS:	-0-	-0-	-0-	-0-	-0-	-0-
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

See attached

Prepared By: J.K. Humphreys, Director
Division: Retirement & Benefits
Phone: 465-4470
Date: 3/11/86

Approved by Commissioner: Eleanor Andrews
Agency: Department of Administration
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Distribution (by Agency preparing fiscal note):
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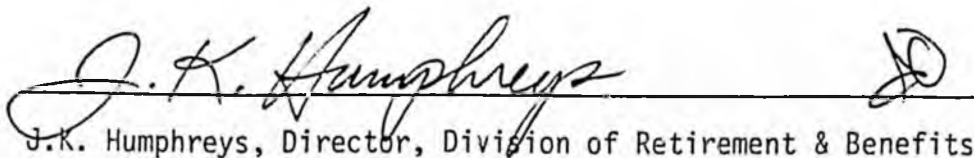
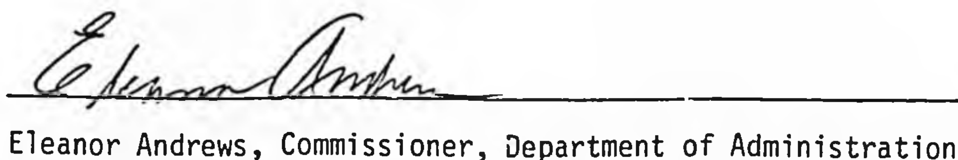


3/11/86

J.K. Humphreys, Director, Division of Retirement & Benefits — Date



3/11/86

Eleanor Andrews, Commissioner, Department of Administration — Date

CLASSIFIED PERSONNEL ORGANIZATION

Testimony Supporting H.B. 292

"An Act relating to credited service for noncertificated school employees who are members of the public employees' retirement system; and providing for an effective date."

Submitted: March 4, 1986

Education support personnel who are employed for less than twelve months are adversely affected by the PERS statute and the administrative regulations implementing same.

These school district employees have their yearly duration of employment determined by the length of the school year which in turn is mandated by state statute. Their services are not required when school is not in session. Other public employees receive a full year's retirement credit for their services, including teachers and legislators whose employment, theoretically, is also less than a year in duration. Equity demands that these school district employees also be afforded a full year's retirement because their duration of employment is also contingent upon the school year which is mandated by state statute.

Educational support staff have been overlooked in nearly every aspect of their employment conditions. For example, there is no statutory recognition of these employees for collective bargaining purposes, no unemployment compensation for many of these employees, and no procedure for dispersing of accumulated unused sick leave at termination or retirement. With no recognition for collective bargaining purposes these employees are powerless in attempting to address the issues.

There is a contradiction that must be addressed. Education support staff employed in positions such as teachers aides, bilingual/bicultural aides, Title I reading Assistants, in general staff in any position that deals with the instructional setting, are excluded from the provisions covering unemployment during the periods of time that school is not in session. On the other hand, nurses, custodians, secretaries, library assistants, and so on, are eligible for unemployment benefits as long as the state continues to fund the program. All noncertificated education support staff should be eligible for unemployment benefits. However the major contradiction that must be addressed is that these employees are denied a year's credit in their retirement system by the state of Alaska, while the state continually attempts to remove these employees from eligibility for unemployment benefits maintaining that these employees are ineligible because they are continuing employees. As we previously mentioned, not all of these education support personnel are now eligible for unemployment benefits.

The bottom line is that some educational support staff are neither eligible for unemployment benefits nor are they given credit for retirement purposes on par with teachers, although they are considered instructional employees. The situation of these employees is tenuous at best because:

1) Some of these employees <u>are not</u> now eligible for unemployment benefits;
2) The funding of unemployment benefits is from year to year;
3) These employees do not get a full year's retirement credit and yet their employment is determined by the length of time the principals and teachers are working.

The Department of Administration is opposing H.B. 292 for essentially two reasons. Namely that

1) The Employer would bear full financial responsibility if this bill were enacted, and
2) No public purpose is served by giving PERS members retirement credit for periods of time when they are not working.

We take issue with both reasons. First, a reasonable compromise could be reached in determining the financial obligation of the parties. Secondly, public purpose IS served when the state recognizes inequities and moves to correct those situations. Those recognized inequities can be corrected without jeopardizing the equity of the system. PERS addresses many different groups of employees, i.e. judges, police and fire personnel, legislators, etc. Correcting an inequity for education support staff of school districts is no different than changing the conditions for any of the other groups of employees covered by PERS.

It now takes from seven to nine years of actual employment for these employees to even become vested in the system and consequently they have to work for 37 or more years in order to retire from the system with 30 years of credited service. In a time when accelerated retirements are becoming popular the plight of education support staff is certainly contradictory to this growing popular opinion.

Currently a public employee who is vested in the Teachers Retirement System and has at least two years paid up PERS or has at least 60 days of paid-up credited service as a temporary employee of the legislature during each of five legislative sessions may be able to retire at age 55 or age 50 (early retirement) under the conditional service provision of PERS. The above provision also works the other way. Teachers credited retirement service is based on less than twelve months employment and yet they can transfer that credit into PERS. We see no reason why provisions cannot be devised to accommodate education support staff of school districts while maintaining the actuarial soundness of the system.

The passage of H.B. 292 would correct a very inequitable situation which now exists.

1) It would provide credited retirement service on a par with other public employees.

2) It would make it necessary to revise regulations governing unemployment benefits.

3) It would provide internal equity among education support staff themselves.

Submitted by:

H. Frank Belts, Business Manager

Classified Personnel Organization
2118 Cushman Street
Fairbanks, Alaska 99701