ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

3928 SHES SB 128 - SB 140

804

1. Costs reflect replacing lost Supplemental Security Income federal payments with increased Old Age Assistance:

		FY Cost
FY86:	750 persons/month =	1,400.0
FY87:	794 persons/month =	1,530.5
FY88:	838 persons/month =	1,669.8
FY89:	884 persons/month =	1,821.6
FY90:	933 persons/month =	1,987.4

2. Old Age Assistance formula need for the Adult Public Assistance component for FY86 to fund the 760.0 or the estimated FY86 cost of preventing bonus-related Old Age Assistance grant reductions:

		FY Cost
FY86:	750 persons/month =	760.0
FY87:	794 persons/month =	830.7
FY88:	838 persons/month =	906.3
FY89:	884 persons/month =	988.8
FY90:	933 persons/month =	1,017.9

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: SB 128

Title: "An Act relating to use of Longevity Bonus in determining APA

Sponsor: Halford, Rodney, Kerttula

Requestor:

Date of Request:

FISCAL DETAIL

Agency Affected: Health & Social Services

Program Category Affected: Soc. & Econ. Assistance for General Pop.

BRU, Program or Subprogram(s) Affected: Medical Assistance

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS		(2,183.2)	(2,480.2)	(2,842.8)	(3,237.4)	(3,702.6)
800 MISCELLANEOUS						
TOTAL OPERATING		(2,183.2)	(2,480.2)	(2,842.8)	(3,237.4)	(3,702.6)
CAPITAL						
REVENUE		(934.9)	(1,062.3)	(1,217.1)	(1,386.0)	(1,584.9)

FUNDING: (Thousands of Dollars)

GENERAL FUND		(1,284.3)	(1,417.9)	91,625.7)	(1,851.4)	(2,117.7)
FEDERAL FUNDS		(934.9)	(1,062.3)	(1,217.1)	(1,386.0)	(1,584.9)
OTHER						
TOTAL		(2,183.2)	(2,480.2)	(2,842.8)	(3,237.4)	(3,702.6)

POSITIONS:

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

ANALYSIS: Attach a separate page if necessary

SB 128 eliminates Medicaid coverage for OAA recipients who because of receipt of ALB/Annuity become ineligible for Medicaid. The attached table projects the reductions in the number of recipients (line f and h) and FFP (line g and i). Table I shows the State General Fund and FFP reductions.

(Federal financial participation)

Prepared By: Rod Betit, Director Phone: 465-3355

Division: Medical Assistance Date: 3/6/85

Approved by Commissioner: Date: 3/8/85

Agency: Health & Social Services

cc

Distribution (by Agency preparing fiscal note):

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

7/1/84

FFP

Table I

This table shows the State general fund match and federal financial participation in the Medicaid program for those expenditures likely to be affected by changes in the current ALB statute. By simply eliminating Medicaid coverage both state and federal expenditures would be reduced. Any change which established an ALB hold harmless provision would result in the loss of FFP. ALB hold harmless program would be funded by transferring the general fund match in the Medicaid program to the ALB hold harmless and adding to it new State general fund in an amount equal to the lost FFP. Because there are a number of legislative proposals seeking to amend the current ALB statute, the following two tables were developed to use in analyzing the impact of these proposals. The comment section on the fiscal note of each bill states whether Medicaid is being eliminated or hold harmless.

Line G. Distribution: Expenditures for non-nursing home clients who may lose Medicaid eligibility.

	FY86	FY87	FY88	FY89	FY90
FED	413,847	471,609	537,173	611,285	697,133
GF	466,678	531,814	605,748	689,321	786,128
TOTAL	880,525	1,003,423	1,142,921	1,300,606	1,483,261

Line I distribution: Expenditures for nursing home clients who may lose Medicaid eligibility.

FED	521,070	590,716	679,971	774,727	887,715
GF	781,605	886,074	1,019,956	1,162,090	1,331,572
TOTAL	1,302,675	1,476,790	1,699,927	1,936,817	2,219,287

Table II

The attached table was prepared to project the offset of various ALB legislative proposals on the Medicaid program. The table represents: a) the nursing home daily rate; b) the nursing home cost for 365 days of services; c) the average cost per non nursing home recipient; d) the recipient share of nursing home costs; e) the number of monthly OAA eligibles; f) the number of ineligible non nursing home OAA due to receipt of ALB; g) the FFP for non nursing home OAA ineligibles; h) the number of ineligible OAA nursing home clients and; i) the FFP for ineligible nursing home clients.

file ~~Sr. Sec.~~ SB 128 (Edie 1-18-85)

EMERGENCY REGULATIONS

The Emergency Regulations were adopted to prevent recipients of the Longevity Bonus from being disqualified from the Medicaid program.

Medicaid coverage depends on what level of Social Security Income (SSI) received per month. Need for more than the minimum SSI supplement is required in order to be eligible for Medicaid.

In many cases this year the Longevity Bonus payments raised the recipient's monthly income to a level where they were receiving (b)te minimum SSI, and therefore becoming ineligible for Medicaid. This is an <u>extremely</u> simplified explanation of the case.

Alaska Legal Services, Inc. of Fairbanks threatened to sue the State, DHSS, if they did not immediately adopt emergency regulations discounting Longevity Bonus as a part of base monthly income in applying the SSI formula.

Rep. Koponen is considering introducing legislation that could rectify this dilemma much in the same way that the Permanent Fund legislation did.

Edie - call + find out why changes necessary; how affect current recipients. Let me know - S.

JAN 11 1985

NOTICE OF ADOPTION OF EMERGENCY REGULATIONS

As required by AS 44.62.250, notice is given that, under authority vested by AS 47.05.010, the Department of Health & Social Services amended on this date, as an emergency regulation, 7 AAC 40.320, relating to income exclusions in determining eligibility for benefits in the Adult Public Assistance program and 7 AAC 43.020, relating to eligibility for Medicaid. 7 AAC 40.320(a)(16) is amended so Adult Public Assistance payments will not be changed when changes occur in SSI eligibility or payment amounts as a result of the receipt of countable Longevity Bonus Payments.

7 AAC 43.020(a) is amended to add that, to be eligible for Medicaid, a person may not have a gross income in excess of 300 percent of the current Supplemental Security Income payment standard.

7 AAC 43.020(a)(2) is amended to clarify that when determining eligibility for Medicaid, no income is excluded in the determination of the 300 percent income limit.

This action is not expected to require an increased appropriation.

Copies of this regulation may be obtained by writing to Gordon Landes, Division of Public Assistance, Pouch H-07, Juneau, Alaska 99811.

Notice is also given that the Department of Health & Social Services intends to make this amendment or other amendments dealing with the treatment of the Alaska Longevity Bonus in determining eligibility for Adult Public Assistance and for Medicaid permanent under AS 44.62.260 and any person interested may present written statements or arguments pursuant to the action proposed at Room 310, Alaska Office Building, 350 Main Street, Juneau, Alaska, or may mail such statements or arguments to the above address to be received no later than 4:30p.m. on February 11, 1985.

Date: January 4, 1985

Connie J. Sipe, Acting Commissioner

Connie J. Sipe, Deputy Commissioner
Department of Health & Social Services

Alaska Legal Services
Judy Bush - Legal Services

EMERGENCY REGULATIONS

Register , 1985 HEALTH & SOCIAL SERVICES 7 AAC 40.320

7 AAC 40.320 (a)(16) is amended as follows:

(16) payments made under AS 47.45; the division will not increase or decrease the amount of any payment made under this chapter to reflect changes in SSi eligibility or payment amounts caused by receipt of countable longevity bonus payments; (Eff. 5/12/82, Reg.82; am 9/30/83, Reg.87, am / / , Register)

Authority: AS 47.05.010
AS 47.25.430
AS 47.25.435
AS 47.25.640
AS 47.25.810

EMERGENCY REGULATIONS

Register, HEALTH AND SOCIAL SERVICES 7 AAC 43.020

7 AAC 43.020 (a) is amended to read:

(a) To be eligible for medicaid coverage, a person must be eligible to receive a cash assistance payment under either the AFDC or APA programs with a gross income that does not exceed 300 percent of the current SSI payment standard. A person need not receive a cash assistance payment, but he or she must be eligible to receive one. Exceptions to this general principle exist as follows: (Eff 8/18/79, Reg. 71; am / / , Register)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.020(a)(2) is amended to read:

(2) For persons in health care facilities on an inpatient basis whose income does not exceed 300 percent of the current SSI payment standard; for purposes of determining the 300 percent limit, no income is excluded; (Eff 8/18/79, Reg. 71; am / / , Register)

Authority: AS 47.05.010
AS 47.07.050

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do here .y 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

10/31/89
Date

02-519 (REV 8/78)

SB
136

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: SB 136 - HB 549

Sponsor: Josephson

Date referred to committee: 2/6

Synopsis completed: 2/6

Fiscal note:

Further referrals: Judiciary, Finance

CONTACTS:

✓ Jerry Reinwand, CHAR 586-8966

✓ Matt Felix, Office of Alcohol 586-6201

Leg. Legal Division - Terry Cramer - 2450

Norma Lang, HSS 3030

ABC Board

✓ won't attend Pat Shattock 277-8638

✓ Dept Revenue, Royce Weller - 2300

✓ MM Miller 4990 - Bob Speed 2/27/86 "OK to use MMiller's language"
HB 549

✓ wanted Jerry Reinwand 586-8966

STATE OF ALASKA
THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

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

Mary Van Nimwegen

HESS 3-6-86 1:34 pm

BOARD: ALCOHOLIC BEVERAGE CONTROL BOARD

TITLE: Alcoholic Beverage Control Board

DEPT: Department of Revenue

AUTHORITY: AS 04.06.010

STATUS: ACTIVE

REQUIREMENTS: LEGISLATIVE CONFIRMATION AND FINANCIAL DISCLOSURE

PROHIBITIONS: No member may hold any other State or federal office, either elective or appointive.

TERM: 3-year - overlapping

DESCRIPTION: 5 members appointed by Governor: 2 from alcoholic beverage industry, but not wholesalers; no three members may be engaged in the same business or profession; Board selects chair from among members; serve at pleasure of Governor; vacancies to be filled within 30 days; Governor also appoints Director.

SPECIAL FACTS: Quorum - 3 members (majority of whole membership must approve applications, renewals, transfers, etc.); regulatory/quasi-judicial agency.

FUNCTION: Controls manufacture, barter, possession, and sale of alcoholic beverages in the state.

COMPENSATION: Standard travel/per diem

MEETINGS: At call of chair; at least once a year in each judicial district; 11 meetings per year; 11-14 days maximum

*FOR FURTHER INFORMATION CONTACT: Director, Alcoholic Beverage Control Board, 201 East Ninth Avenue, Anchorage, AK 99501 - 277-8638

Alcoholic Beverage Control

MEMBER	APPT	REAPPT	TERM
E.L. "Red" Holloway 3441 Douglas Highway Juneau 99801 Public	83/04/11		86/01/31
D n House P.O. Box 575 Wrangell 99929 Industry	82/02/05		85/01/31
James J. McNamee P.O. Box 1308 Fairbanks 99707 Public	84/09/13		85/01/31
Jane C. Perkins P.O. Box 813 Nome 99762 Public	83/10/19	84/01/31	87/01/31
William K. Smith 6002 Acheson Lane Anchorage 99504 Industry - Chair	80/12/12	84/02/16	87/01/31

Alaska State Legislature

Senate

Official Business

Pouch
State Ca
Juneau, Alaska 99811

FOR IMMEDIATE RELEASE
February 6, 1985

JUNEAU, AK -- Three state senators today introduced legislation to enlarge the Alcoholic Beverage Control Board from five to seven members. SB 136 would add one member of the general public, and the coordinator of the State Office of Alcoholism and Drug Abuse to the Board.

Prime sponsor of the measure, SB 136, is Senator Joe Josephson (D-Anchorage). Co-sponsors are Senator Edna DeVries (R-Palmer) and Senator Arliss Sturgulewski (R-Anchorage).

Under existing law, two members of the present five-member Board represent the alcohol beverage industry. "It is fair", Senator Josephson said, "that knowledgeable leaders of the industry should take part in the work of the Board". But he added, "It is also fair that a knowledgeable official who works every day with the problems of teen-age drinking, domestic violence, the physical diseases attributed to alcoholism, and other social and health consequences of alcohol abuse, should also participate. When the Board acts, we want to be assured that health and human perspectives have to be considered."

(more)

"Moreover, Alaska makes significant expenditures to prevent and treat alcohol abuse. We want to be sure that the work of the State Office of Alcoholism and Drug Abuse is not counteracted, or even undermined, by the work of the Board. SB 136 will help assure that when the Board takes action, it will at least be aware of the activities and concerns of the State Office of Alcoholism and Drug Abuse."

For further information contact:
Senator Joe Josephson
465-4525

ABC Board

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majority of the whole membership of the board must approve all applications for new licenses, and all renewals, transfers, suspensions and revocations of existing licenses. If a majority of the board is present and voting, the director, with the consent of the members present, may cast a tie-breaking vote. (§ 1 ch 131 SLA 1980)

Sec. 04.06.070. Appointment and removal of director. The governor shall appoint a director to serve as the executive officer of the board. The board may remove the director at its pleasure, and the governor may remove the director for misconduct, misfeasance or malfeasance in office. The governor may not remove the director unless the director is given a copy of the charges against him and afforded an opportunity to be publicly heard, in person or by counsel, in his own defense upon at least 10 days notice. If the director is removed for cause, the governor shall file with the lieutenant governor a complete statement of all charges made against the director and the findings based on the charges, together with a complete record of any hearing. (§ 1 ch 131 SLA 1980)

Sec. 04.06.075. Authority of director. The director shall enforce this title and regulations adopted by the board. (§ 1 ch 131 SLA 1980)

Sec. 04.06.080. Delegation of authority. The director shall issue, renew, transfer, suspend, or revoke all licenses and permits at the direction of the board. However, notwithstanding AS 04.11.070, the board may delegate authority to the director to temporarily grant or deny the issuance, renewal, or transfer of licenses and permits. The director's temporary grant or denial of the issuance, renewal, or transfer of a license or permit is not binding on the board. The board may delegate to the director any duty imposed by this title except its power to propose and adopt regulations. (§ 1 ch 131 SLA 1980)

Sec. 04.06.090. Powers and duties. (a) The board shall control the manufacture, barter, possession, and sale of alcoholic beverages in the state. The board is vested with the powers, duties, and responsibilities necessary for the control of alcoholic beverages, including the power to propose and adopt regulations and to hear appeals from actions of the director, and from actions of officers and employees charged with enforcing the alcoholic beverage control laws and the regulations of the board.

(b) The board shall review all applications for licenses made under this title and may order the director to issue, renew, revoke, transfer, or suspend licenses and permits authorized under this title.

(c) When considering an application, the board may reduce the area to be designated the licensed premises below the area applied for when, in the judgment of the board, a reduction in area is necessary to insure control over the sale and consumption of alcoholic beverages on the premises or is otherwise in the best interests of the public.

(d) The board may employ, directly or through contracts with other departments and agencies of the state, enforcement agents and staff it considers necessary to carry out the purposes of this title. The salaries of personnel of the board in the exempt service shall be set by the Department of Administration.

(e) The board shall promptly notify all licensees and municipalities of major changes to this title and to regulations adopted under this title. However, if changes only affect specific classifications of licenses and permits, the board need only notify those licensees and municipalities directly affected by the changes. Current copies of this title and current copies of the regulations adopted under it shall be made available at all offices of the Department of Revenue and the detachment headquarters and posts maintained by the division of Alaska state troopers, Department of Public Safety, in the state. (§ 1 ch 131 SLA 1980)

Cross references. — As to power of board to adopt regulations, see AS 04.06.100. As to procedure for action on license applications, suspensions, and revocations, see AS 04.11.510. As to appeals, see AS 04.11.560.

Editor's note. — The cases cited in the note below were decided under former AS 04.05.010 and 04.05.030.

Discretionary power of board. — The board has the discretionary power to refuse to reissue a license regardless of whether a licensee has been convicted of a liquor law violation or has even been accused of such a violation, provided the evidence showed that it would not have been in the best interests of the public to reissue the license. Alaska Alcoholic Beverage Control Bd. v. Malcolm, Inc., Sup. Ct. Op. No. 208 (File No. 363), 391 P.2d 441 (1964).

Construction of liquor license statutes. — Even if the liquor license statutes were ambiguous, the construction placed upon them by the officers or departments charged with their enforcement and administration is to be considered and given weight in construing the statutes, especially if such construction has been observed, acted upon, and acquiesced in for a considerable period of time. K & L Distribs., Inc. v. Alaska, 184 F. Supp. 496 (D. Alas. 1960), vacated, 318 F.2d 498 (9th Cir. 1963).

Purpose of rule-making power. — The grant of general rule-making power was necessary in order that the legislative objective would not be frustrated. Boehl v. Sabre Jet Room, Inc., Sup. Ct. Op. No. 3 (File No. 17), 349 P.2d 585 (1960).

And validity thereof. — The law-making function has been performed by the legislature to an extent sufficient to resist the challenge that there has been any invalid delegation of legislative power under this section. Boehl v. Sabre Jet Room, Inc., Sup. Ct. Op. No. 3 (File No. 17), 349 P.2d 585 (1960).

Explicit standards of action not required. — The Administrative Procedure Act (AS 44.62) does not require that explicit standards of action be set forth in this chapter. Boehl v. Sabre Jet Room, Inc., Sup. Ct. Op. No. 3 (File No. 17), 349 P.2d 585 (1960).

It is not essential, in order to sustain the grant of authority to promulgate rules and regulations, that the legislature circumscribe administrative discretion by express standards of action in order that the opportunity for capricious exercise of power will not exist. Boehl v. Sabre Jet Room, Inc., Sup. Ct. Op. No. 3 (File No. 17), 349 P.2d 585 (1960).

It would be unreasonable to require that this chapter set forth the details of specific regulation that would be permitted. Boehl v. Sabre Jet Room, Inc., Sup. Ct. Op. No. 3 (File No. 17), 349 P.2d 585 (1960).

As freedom of action is imperative in liquor control. — Where the police power of the state is so vitally involved, as it is in liquor control, it becomes imperative that those who are charged with the duty of regulating the industry have a freedom of action not restricted by limitations that may be required where other types of businesses are involved. Boehl v. Sabre Jet Room, Inc., Sup. Ct. Op. No. 3 (File No. 17), 349 P.2d 585 (1960).

Alaska State Legislature

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

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

Senate

Committee on Health, Education and Social Services

MINUTES

May 2, 1985
1:34 pm

Beltz Room
Room 211, Capitol

MEMBERS PRESENT

Senator Fahrenkamp
Senator Armstrong - De Vries
Senator Josephson
Senator Sturgulewski
Senator Fischer

CALENDAR

SB 136, An Act relating to increasing the membership of Alcoholic Beverage Control Board.

SB 26, An Act relating to notification of community councils of certain state actions.

SB 136

Senator Josephson explained that SB 136 would increase the membership of the Alcoholic Beverage Control Board from five to seven, and declare the coordinator of the Office of Alcoholism and Drug Abuse an ex officio member. This is intended to alleviate an apparent lack of coordination between the Board and the Department of Health and Social Services.

Matt Felix, Director, Office of Alcohol and Drug Abuse, Department of Health and Social Services, spoke in support of the bill and of the department's five year plan to combat alcoholism in the state. He felt that an expanded board would balance the interests of both industry and providers of alcoholism treatment. He also discussed the need for revisions to Title 4.

Patrick Sharrock, Director, Alcoholic Beverage Control Board, discussed the effects of expanding the board and recommended a review of Title 4.

SB 26

Senator Josephson explained that community councils in Anchorage are often not informed of impending state actions. Under SB 26, community councils would receive notification by state agencies of plans for construction of public projects, prison facilities, land disposals, and Alcoholic Beverage Control Board meetings.

Cindy Nelson, Special Assistant to the Commissioner, Department of Corrections, recommended clarifying the definition of "community residential facility" and questioned at what point in the RFP process notice should be given.

Patrick Sharrock, Director, Alcoholic Beverage Control Board, indicated that existing statute requires notification of board meetings to municipalities. He suggested requiring municipalities to notify the community councils.

Dan Malick, Director, Headquarter Plans and Programs, Department of Transportation and Public Facilities, testified that the department's existing planning process includes informing the community of upcoming public projects. He spoke in support of SB 26 as a tool for clarifying that process.

The meeting adjourned at 2:25 pm.

Introduced: 2/6/85
Referred: Health, Education & Social Services, Judiciary and Finance

IN THE SENATE

BY JOSEPHSON, DEVRIES, STURGULEWSKI AND ABOOD

CS SENATE BILL NO. 136 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to increasing the membership of Alcoholic Beverage Control Board."

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

* Section 1. AS 04.06.020 is amended to read:

Sec. 04.06.020. APPOINTMENT AND QUALIFICATIONS. The board consists of seven [FIVE] members appointed by the governor and confirmed by a majority of the members of the legislature in joint session. Except for the coordinator of the office of alcoholism and drug abuse, A member of the board may not hold any other state or federal office, either elective or appointive. Two members of the board shall be persons actively engaged in the alcoholic beverage industry, except that no member may hold a wholesale license or be an officer, agent, or employee of a wholesale alcoholic beverage enterprise. One member shall be the coordinator of the office of alcoholism and drug abuse under AS 47.37.120. No three members of the board may be engaged in the same business, occupation, or profession.

* Sec. 2. AS 04.06.060 is amended to read:

Sec. 04.06.060. QUORUM AND MAJORITY. Four [THREE] members of the board constitute a quorum for the conduct of business, except that a majority of the whole membership of the board must approve all applications for new licenses, and all renewals, transfers, suspensions and revocations of existing licenses. If a majority of the board is present and voting, the director, with the consent of the members present, may cast a tie-breaking vote.

For legislative history of liquor control, see Boehl v. Sabre Jet Room, Inc., Sup. Ct. Op. No. 3 (File No. 17), 349 P.2d 585 (1960), decided under former AS 04.05.010.

Am. Jur. 2d, ALR, and C.J.S. references. — 45 Am. Jur. 2d, Intoxicating Liquors, § 1 et seq.

Federal constitutional and legislative provisions as to intoxicating liquor as affecting state legislation, 10 ALR 1587; 11 ALR 1320; 26 ALR 661; 70 ALR 132.

Test of intoxicating character of bought beverages, 4 ALR 1137; 11 ALR 1233; 19 ALR 512; 36 ALR 725; 91 ALR 513, 528.

48 C.J.S. Intoxicating Liquors § 1 et seq.

Sec. 04.06.020. Appointment and qualifications. The board consists of five members appointed by the governor and confirmed by a majority of the members of the legislature in joint session. A member of the board may not hold any other state or federal office, either elective or appointive. Two members of the board shall be persons actively engaged in the alcoholic beverage industry, except that no member may hold a wholesale license or be an officer, agent, or employee of a wholesale alcoholic beverage enterprise. No three members of the board may be engaged in the same business, occupation, or profession. (§ 1 ch 131 SLA 1980)

Cross reference. — As to appointment, qualifications, and terms of office of members of departmental boards, councils, or commissions, see AS 39.05.060.

Sec. 04.06.030. Terms of office. (a) Members of the board shall be appointed for overlapping terms of three years.

(b) A vacancy occurring in the membership of the board shall be filled within 30 days by appointment of the governor for the unexpired portion of the vacated term.

(c) The board shall select a chairman from among its members. (§ 1 ch 131 SLA 1980)

Cross reference. — As to appointment, qualifications, and terms of office of members of departmental boards, councils, or commissions, see AS 39.05.060.

Editor's note. — Section 14, ch. 131, SLA 1980 provides: "Notwithstanding AS 04.06, members of the Alcoholic Beverage Control Board serving on the board on the effective date of this Act continue in office until the expiration of their terms."

Sec. 04.06.040. Per diem and expenses. Members of the board do not receive a salary, but are entitled to per diem and travel expenses authorized by law for other boards and commissions. (§ 1 ch 131 SLA 1980)

Sec. 04.06.050. Meetings. The board shall meet at the call of the chairman. The board shall also meet at least once each year in each judicial district of the state to study this title and to modify existing board regulations in light of statewide and local problems. (§ 1 ch 131 SLA 1980)

Sec. 04.06.060. Quorum and majority. Three members of the board constitute a quorum for the conduct of business, except that a

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Effect of amendments. — The 1982 amendment deleted "advisory" preceding "board," deleted "on alcoholism" preceding "are not entitled," and made other, minor changes.

Sec. 47.37.110. Duties. The board shall act in an advisory capacity to the commissioner in the following matters:

(1) special problems affecting mental health which alcoholism may present;

(2) educational and research activities conducted by the office in respect to the problems presented by alcoholism;

(3) social problems which affect rehabilitation of alcoholics;

(4) legal processes which affect the treatment and rehabilitation of alcoholics;

(5) a program of public relations concerning the problem of alcoholism conducted by a department of the state government or by an organized group whose purpose is the rehabilitation of alcoholics. (§ 1 ch 207 SLA 1972)

Sec. 47.37.120. Alcoholism program coordinator. The alcoholism program coordinator shall carry out the development and implementation of a comprehensive program dealing with the treatment of, research on and education concerning alcoholic problems as they affect the state. (§ 1 ch 207 SLA 1972)

Sec. 47.37.130. Comprehensive program for treatment; regional facilities. (a) The office shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons. Subject to the approval of the commissioner, the coordinator may divide the state into appropriate regions to conduct the program and establish standards for the development of the program on the regional level. In establishing the regions, consideration shall be given to the city and borough lines and population concentrations and when feasible, programs shall be established with maximum local community involvement.

(b) The program of the office shall include

(1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) inpatient treatment;

(3) intermediate treatment; and

(4) outpatient and follow-up treatment.

(c) The office shall insure that adequate and appropriate treatment is provided to alcoholics and intoxicated persons admitted under AS 47.37.160 — 47.37.190 within the limits of available state and federal funds.

(d) The office shall maintain, supervise and control all facilities operated by it subject to the regulations of the department. The administrator of each facility shall make an annual report of its activities to the coordinator in the form and manner the coordinator specifies.

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness;

(17) submit to the legislature an annual report covering the activities of the office;

(18) develop and implement a training program on alcoholism for employees of state and municipal governments, and private institutions;

(19) develop curriculum materials on drug and alcohol abuse for use in grades kindergarten through 12, as well as a course of instruction for teachers to be charged with presenting the curriculum. (§ 1 ch 207 SLA 1972; am Executive Order No. 39, § 11 (1977); am §§ 2, 4 ch 117 SLA 1978; am E.O. No. 55, § 45 (1984))

Effect of amendments. — The 1984 amendment substituted "Department of Corrections" for "division of corrections" in paragraph (3).

Legislative history reports. — For report on ch. 117, SLA 1978 (SB 542), see 1978 Senate Journal, p. 761.

Sec. 47.37.050. Interdepartmental coordinating committee. (a) An interdepartmental coordinating committee is created, composed of the coordinator, the commissioners of health and social services, education, transportation and public facilities, labor and public safety, and the director of the Alcoholic Beverage Control Board. The committee shall meet at least twice annually at the call of the commissioner of health and social services who is its chairman. The committee shall provide for the coordination and exchange of information on all programs relating to alcoholism and act as a permanent liaison among state departments engaged in activities affecting alcoholics and intoxicated persons. The committee shall assist the commissioner of health and social services and the coordinator in formulating a comprehensive plan for prevention of alcoholism and for treatment of alcoholics and intoxicated persons.

(b) In exercising its coordinating functions, the committee shall assure that the appropriate state agencies

(1) provide all necessary medical, social, treatment, and educational services for alcoholics and intoxicated persons and for the prevention of alcoholism, without unnecessary duplication of services;

(2) cooperate in the use of facilities and in the treatment of alcoholics and intoxicated persons;

(3) adopt approaches for the prevention of alcoholism and the treatment of alcoholics and intoxicated persons consistent with the policy of AS 47.37.010 — 47.37.270. (§ 1 ch 207 SLA 1972; am § 3 ch 150 SLA 1980)

Effect of amendments. — The 1980 amendment deleted "and" preceding "the commissioners of health", substituted "transportation and public facilities" for "highways", and added "and the director of the Alcoholic Beverage Control Board" in the first sentence of subsection (a).

TO: BETTYE

FROM: SANDRA

RE: MEMBERSHIP OF ALCOHOL BEVERAGE CONTROL BOARD (JOSEPHSON)
SB 136

DATE: MAY 2, 1985

EARLY IN THE SESSION THE DEPT. H&SS PRESENTED AN OVERVIEW OF THE DEPT. TO THE COMMITTEE. THIS INCLUDED A PRESENTATION BY MATT FELIX, DIRECTOR OF THE OFFICE OF ALCOHOL, WHO EXPRESSED FRUSTRATION THAT HIS EFFORTS TO PREVENT ALCOHOLISM OFTEN SEEM DEFEATED BY THE PROLIFERATION OF LICENSED ESTABLISHMENTS BY THE BOARD.

THE BILL WOULD INCREASE THE MEMBERSHIP OF THE BOARD FROM 5 TO 7, AND APPOINT THE ALCOHOL OFFICE DIRECTOR AS A PERMANENT MEMBER ON THE BOARD. THE INTENT IS TO PROVIDE A FORMAL OPPORTUNITY FOR INPUT AND FEEDBACK; THE CONCERN IS THAT THE DIRECTOR MAY SIMPLY OPPOSE ALL LICENSING TRANSACTIONS, WHICH IN ITSELF WOULD SERVE NO USEFUL PURPOSE.

CURRENT STATUTE ESTABLISHES AN INTERDEPARTMENTAL COORDINATING COMMITTEE TO PROVIDE FOR COORDINATION AND EXCHANGE OF INFORMATION ON ALL PROGRAMS RELATING TO ALCOHOLISM. (MEMBERSHIP: COMMISSIONERS OF HEALTH AND SOCIAL SERVICES, D.O.T., EDUCATION, LABOR, PUBLIC SAFETY, AND DIRECTOR OF A.B.C. BOARD.) TO MY KNOWLEDGE, THE COMMITTEE HAS NEVER MET; IF IMPLEMENTED, IT MAY BE A WORKABLE ALTERNATIVE.

FEB 19 1985

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: SB 136

Title: increasing membership of Alcoholic Beverage Control Board

Sponsor: Sen. Joe Josephson et. al.

Requestor: Sen. Hess Committee

Date of Request: February 7, 1985

FISCAL DETAIL

Agency Affected: Department of Revenue

Program Category Affected: public protection

BRU, Program or Subprogram(s) Affected: Alcoholic Beverage Control Board

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL		13.6	13.6	13.6	13.6	13.6
300 CONTRACTUAL		.1	.1	.1	.1	.1
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING		13.7	13.7	13.7	13.7	13.7
CAPITAL						
REVENUE		-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND		13.7	13.7	13.7	13.7	13.7
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

Prepared By: Patrick L. Sharrock, Director Phone: 277-8638

Division: Alcoholic Beverage Control Board Date: 2/11/85

Approved by Commissioner: Mary Alice Nordale Date: 2/15/85

Agency: Department of Revenue

Distribution (by Agency preparing fiscal note):

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

7/1/84

Alaska State Legislature

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

POUCH V
STATE CAPITAL
JUNEAU ALASKA 99811
(907) 465-3834
(907) 465-3836

Senate

Committee on Health, Education and Social Services

Sandra

M E M O R A N D U M

TO: Members, Senate Committee on Health, Education and Social Services

FROM: Committee Staff

RE: Committee Meeting, May 2, 1985

DATE: May 1, 1985

Sharrock - prefer look at Title 4. Doesn't think specific board expansion of the Board will necessarily solve the licensure concerns.

On Thursday, May 2, at 1:30 pm in the Beltz Room, the Senate Committee on Health, Education and Social Services will hear the following bills:

SB 136, Relating to the membership of the Alcoholic Beverage Control Board.

SB 136 would increase the membership of the Alcoholic Beverage Control(ABC) Board from five to seven, and declare the coordinator of the Office of Alcoholism and Drug Abuse an ex officio member.

The ABC Board was established under the Department of Revenue in 1980 to control the manufacture, possession and sale of alcoholic beverages in the state, and to review applications for licensure for the same. The Office of Alcoholism and Drug Abuse was established in the Department of Health and Social Services in 1972 to develop and encourage programs for the prevention and treatment of alcoholism.

A committee substitute has been prepared which clarifies that SB 136 would make an exception to the provision that prohibits a holder of state office from serving on the ABC Board.

Office of alcohol has an advisory board.

Rev "professional life involved in alcohol abuse" - doesn't necessarily need to be office of alcohol. (Fischer suggest "Comm H+SS or designee")

file SB 136

Cramer
3/21/86

Original sponsors: Josephson, DeVries, Sturgulewski and Abood

not adopted

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 136 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to membership and quorum requirements of the Alcoholic Beverage Control Board."

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

* Section 1. AS 04.06.020 is amended to read:

Sec. 04.06.020. APPOINTMENT AND QUALIFICATIONS. The board consists of <u>seven</u> [FIVE] members appointed by the governor and confirmed by a majority of the members of the legislature in joint session. A member of the board may not hold any other state or federal office, either elective or appointive. Two members of the board shall be persons actively engaged in the alcoholic beverage industry, except that no member may hold a wholesale license or be an officer, agent, or employee of a wholesale alcoholic beverage enterprise. <u>One member shall have experience in the field of alcohol abuse treatment or prevention. Two members shall be public members</u> [NO THREE MEMBERS OF THE BOARD MAY BE ENGAGED IN THE SAME BUSINESS, OCCUPATION, OR PROFESSION].

* Sec. 2. AS 04.06.060 is amended to read:

Sec. 04.06.060. QUORUM AND MAJORITY. <u>Four</u> [THREE] members of the board constitute a quorum for the conduct of business, except that a majority of the whole membership of the board must approve all applications for new licenses, and all renewals, transfers, suspensions and revocations of existing licenses. If a majority of the board is present and voting, the director, with the consent of the

members present, may cast a tie-breaking vote.

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER

P.O. BOX S
JUNEAU, ALASKA 99811-0400
PHONE: (907) 465-2300

March 13, 1986

The Honorable Joe Josephson
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Senator Josephson:

Enclosed is language which we suggest be substituted for Section 1 of your bill or for Section 1 of HB 549. You will note that in addition to expertise in the treatment of alcohol abuse, we suggest also that qualification in the area of alcohol abuse prevention also be available to the board.

I understood your concerns to arise from three principal areas:

1. Public concern for greater sensitivity to the location of alcohol sales points, especially retail sales.

2. Public concern for greater sensitivity in the board's actions affecting alcohol abuse and the prevention of abuse.

3. Public concern for compliance with conditions of licensure.

As I indicated to the committee, a change in qualifications for board members was not of great concern to this department. What is of concern is that applicants for licensure be properly dealt with and that community concerns as to location be appropriately addressed. The participation of community councils, pursuant to the 1985 amendments, has been actively sought. We would like to see their participation commence at the time the local governing body deliberates the question of approval of the license. Because we have less than a year's experience, we are as yet uncertain of the most effective means of insuring such participation.

Although the board has an admirable record of accommodation to community concerns, the system does not guarantee that everyone's concerns will be fully alleviated. However, with changing views relating to sales of alcohol and with the dynamic growth of some communities, the board's responsibilities become more complex and dealing with community

concerns more imperative. We believe that alcohol abuse prevention is of great and wide interest among the public and would encourage your adoption of that qualification.

Sincerely,

Mary A. Nordale
Commissioner of Revenue

MAN:mll
86-69

Enclosure

Sec. 04.06.020. Appointment and qualifications. The board consists of five members appointed by the governor and confirmed by a majority of the members of the legislature in joint session. A member of the board may not hold any other state or federal office, either elective or appointive. Two members of the board shall be persons actively engaged in the alcoholic beverage industry, except that no member may hold a wholesale license or be an officer, agent, or employee of a wholesale alcoholic beverage enterprise. <u>One member shall have experience in the fields of alcohol abuse treatment or prevention. Two members shall represent the public interest.</u> [NO THREE MEMBERS OF THE BOARD MAY BE ENGAGED IN THE SAME BUSINESS, OCCUPATION, OR PROFESSION.]

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

10/31/89
Date

02-519 (REV 8/78)

SB

140

hearing Tues, Mar 5

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: SB 140

Sponsor: ELIASON

Date referred to committee: 2/7/85

Synopsis completed: 2/8

Fiscal note:

Further referrals: JUDICIARY

CONTACTS:

✓ Eliason 4711 (Sheila) Linda Leer

✓ Dept Law - [redacted] Elizabeth Shaw 3603

✓ Dept H+SS, Norma Lang 3030 - Public Health 3090 Tirador, Dean

* Dr Frazier testify

✓ Hospice - Juneau, Ancer 5750 Glacier Hwy.

& Mary Townsmeire 780-6530

✓ Rick Urion - [redacted] Medical Association 364-2315 [redacted]

✓ AARP - Dove Kull 586-2670

✓ Dennis DeWitt 586-1790

✓ Billy Bennie, Legal 2450

Sylvia Short, Athny. (Arch; per Sturgulewski)

Sid Heidersdorf, PO Box 658, Jnu 789-9858
Alaskans for Life

Mary Riggen-Ver, Older AK Commission, DOA 465-3250

Offered: 2/5/86
Referred: Rules

Original sponsors: Eliason, Ziegler,
V.Fischer, et al

IN THE SENATE BY THE JUDICIARY COMMITTEE

HOUSE CS FOR CS FOR SENATE BILL NO. 140 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the rights of the terminally ill; and providing for an effective date."

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

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

CHAPTER 12. RIGHTS OF TERMINALLY ILL.

Sec. 18.12.010. DECLARATION RELATING TO USE OF LIFE-SUSTAINING PROCEDURES. (a) A competent person who is at least 18 years old may execute a declaration at any time directing that life-sustaining procedures be withheld or withdrawn from that person; but the declaration is given operative effect only if the declarant's condition is determined to be terminal and the declarant is not able to make treatment decisions. The declarant shall subscribe to the declaration in the presence of a judge or magistrate. The judge or magistrate shall inquire on the record whether the declarant understands the importance and effect of the declaration. A judicial officer may not charge a fee for witnessing a declaration. A person may not charge a fee for preparing a declaration.

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

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

DECLARATION

If I should have an incurable or irreversible condition that will

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

Signed this_____day of_____, _____.

Signature_____

Place_____

Subscribed and sworn to or affirmed before me

at_____ on _____.

(Date)

_____

Signature of Officer

_____

Title of Officer

(d) A physician or health care provider may presume, in the absence of actual notice to the contrary, that the declaration complies with this chapter and is valid.

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

(b) The attending physician or health care provider shall make

the revocation a part of the declarant's medical record.

Sec. 18.12.030. RECORDING DETERMINATION OF TERMINAL CONDITION AND CONTENTS OF DECLARATION. When an attending physician who has been notified of the existence and contents of a declaration determines that the declarant is in a terminal condition, the physician shall record that determination and the contents of the declaration in the declarant's medical record.

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

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

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

Sec. 18.12.050. TRANSFER OF PATIENTS. (a) An attending physician who is unwilling to comply with the requirements of AS 18.12.030 or who is unwilling to comply with the declaration of a qualified patient under AS 18.12.040 shall withdraw as attending physician but the withdrawal is effective only when the services of another attending physician have been obtained.

(b) If the policies of a health care facility preclude compliance with the declaration of a qualified patient under this chapter, that facility shall take all reasonable steps to effect the transfer

of the patient to a facility in which the provisions of this chapter can be carried out.

Sec. 18.12.060. IMMUNITIES. (a) In the absence of actual notice of the revocation of a declaration, the following, while acting in accordance with the requirements of this chapter, are not subject to civil or criminal liability or guilty of unprofessional conduct:

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

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

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

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

Sec. 18.12.070. PENALTIES. (a) An attending physician who fails to comply with the declaration of a qualified patient or to make the necessary arrangements to effect a transfer under AS 18.12.050 may be civilly liable to the qualified patient and to the heirs of the qualified patient.

(b) A person who wilfully conceals, cancels, defaces, obliterates, or damages the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another may be civilly liable to the qualified patient and to the heirs of the qualified patient.

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

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

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

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

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

(e) Nothing in this chapter increases or decreases the right of a patient to make decisions regarding use of life-sustaining procedures as long as the patient is able to do so, or impairs or supercedes any right or responsibility that a person has to effect the withholding or withdrawal of medical care in a lawful manner. In that respect, the provisions of this chapter are cumulative.

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

Sec. 18.12.090. RECOGNITION OF DECLARATIONS EXECUTED IN OTHER STATES. A declaration executed in another state or a territory or possession of the United States in compliance with the law of that

jurisdiction is effective for purposes of this chapter.

Sec. 18.12.100. DEFINITIONS. In this chapter

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

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

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

(4) "life-sustaining procedure" means a medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process; "life-sustaining procedure" does not include nutrition or hydration;

added in House

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

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

(7) "terminal condition" means a progressive 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.

* Sec. 2. This Act takes effect immediately in accordance with

1 AS 01.10.070(c).

COMMITTEE REPORT

SENATE

FURTHER: JUDICIARY

2/7/85

Date 2/7/85

Mr. President

The Committee on HESS considered SB 140

relating to the rights of the terminally ill.

and (a majority of the committee) (the committee) reports it back with the following recommendations:

[ ] do pass

[ ] do pass with attached amendment(s)

[ ] replace with/or adopt CS for SB 140
[ ] new title
[ ] same title and recommends _____

[ ] and attached a "LETTER OF INTENT" [ ] NEW FISCAL NOTE

[ ] reports it back without recommendation

[ ] recommends referral to _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS

Paul Fisher

Bill Yockey

Chairman

Do Pass

Chairman recommendation

MAR 7 1985

OLDER ALASKANS COMMISSION
POSITION PAPER

Senate Bill No. 140
"An Act relating to the rights of the terminally ill"

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

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

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

At least twenty other states have enacted legislation in this area. The language in Senate Bill 140 is based on a discussion draft of a Rights of the Terminally Ill Act prepared by the drafting committee appointed by the National Conference of Commissioners on Uniform State Laws. This draft and Senate Bill 140 appear to be technically superior to any of the models available and any of the laws enacted by other states on this subject.

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

Jon B. Wolfe, Executive Director
Older Alaskans Commission

March 1, 1985
Date

Commissioner Lisa Rudd
Department of Administration

3/6/85
Date

SB 140

ENACTED RIGHT-TO-DIE LEGISLATION

Alabama (1981)

Arkansas (1977)

California (1976)

Delaware (1982)

District of Columbia (1982)

Florida (1984)

Georgia (1984)

Idaho (1977)

Illinois (1984)

Kansas (1979)

Louisiana (1984)

Mississippi (1984)

Nevada (1977)

New Mexico (1977)

North Carolina (1977)

Oregon (1977)

Texas (1983)

Vermont (1982)

Virginia (1983)

Washir ı (1979)

West Virginia (1984)

Wisconsin (1984)

Wyoming (1984)

SB 140 RIGHTS OF THE TERMINALLY ILL (ELLASON)

SENATE H.E.S.S. COMMITTEE SUBSTITUTE --- TITLE CHANGE

UNDER THE AUTHORITY GRANTED IN SB 140, A COMPETENT ADULT WOULD BE ALLOWED TO EXECUTE A DECLARATION THAT LIFE-SUSTAINING PROCEDURES BE WITHHELD OR WITHDRAWN FROM THAT ADULT.

1. DECLARATION WOULD TAKE EFFECT ONLY IF ADULT CONDITION IS TERMINAL AND ADULT IS UNABLE TO MAKE TREATMENT DECISIONS.
2. DECLARATION WOULD BE REVOCABLE AT ANY TIME.
3. SIGNING MUST BE WITNESSED BY 2 ADULTS NOT RELATED TO PATIENT.
4. DECISION MUST BE RECORDED ON THE PATIENT'S MEDICAL CHART.
5. PHYSICIANS WHO HONOR DECLARATION ARE IMMUNE FROM LIABILITY.
6. IMPOSES PENALTIES (CLASS A MISDEMEANOR) FOR FAILURE TO HONOR A DECLARATION.

HESS C.S.:

PAGE 1, LINE 12 - SPECIFIES THAT ADULT DECLARANT MUST BE A PERSON 18 YEARS OR OLDER

PAGE 4, LINE 10 - CLARIFIES THAT HEALTH CARE PROFESSIONALS AND HEALTH CARE FACILITIES, IN ADDITION TO THE PHYSICIAN HIMSELF, ARE IMMUNE FROM LIABILITY FOR HONORING A DECLARATION.

PAGE 6, LINE 23 - IMMEDIATE EFFECTIVE DATE. (NECESSITATES A TITLE CHANGE.)

SB 140 RIGHTS OF THE TERMINALLY ILL (ELIASON)

SENATE H.E.S.S. COMMITTEE SUBSTITUTE --- TITLE CHANGE

UNDER THE AUTHORITY GRANTED IN SB 140, A COMPETENT ADULT WOULD BE ALLOWED TO EXECUTE A DECLARATION THAT LIFE-SUSTAINING PROCEDURES BE WITHHELD OR WITHDRAWN FROM THAT ADULT.

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PAGE 6, LINE 23 - IMMEDIATE EFFECTIVE DATE. (NECESSITATES A TITLE CHANGE.)

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

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

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

IN THE SENATE

CS SENATE BILL NO. 140 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

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

CHAPTER 12. RIGHTS OF TERMINALLY ILL.

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

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

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

DECLARATION

If I should have an incurable or irreversible condition that will

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

Signed this_____day of_____, _____.

Signature_____

City, County and State of Residence_____

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

Witness_____

Address_____

Witness_____

Address_____

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

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

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

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

Signed this_____day of_____, _____.

Signature_____

City, County and State of Residence_____

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

Witness_____

Address_____

Witness_____

Address_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 18.12.100. DEFINITIONS. In this chapter

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

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

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

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

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

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

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

Section 2. Immediate effective date.

Sec. 18.12.100. DEFINITIONS. In this chapter

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

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

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

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

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

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

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

(23) Section 2. Immediate effective date.

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

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

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

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

SB 140, Rights of the terminally ill.

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

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

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

Senate HESS committee memo
3/1/85

Alaska State Legislature

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

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

Senate

Committee on Health, Education and Social Services

MINUTES

March 5, 1985
1:37 pm

Beltz Room
Room 211, Capitol

MEMBERS PRESENT

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

CALENDAR

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

SB 140, Rights of the terminally ill.

SB 45

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

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

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

SB 140

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

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

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

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

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

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

The meeting adjourned at 3:23 pm.

Alaska State Legislature

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

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

Senate
Committee on
Health, Education and Social Services

M I N U T E S

March 14, 1985
1:35 pm

Beltz Room
Room 211, Capitol

MEMBERS PRESENT

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

CALENDAR

SB 117, Alzheimer's disease and related disorders.

SB 140, Rights of the terminally ill.

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

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

SB 117

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

SB 140

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

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

SB 128

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

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

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

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

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

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

SCR 10

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

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

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

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

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

The meeting adjourned at 2:45 pm.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

SENATE BILL No. 140

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

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

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

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

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

Recommended by: Robert J. Fraser MD

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

Date: 2/15/85

Approved by: John R. Pugh

John R. Pugh
Commissioner
Department of Health &
Social Services

Date: 2/15/85

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: SB 140

Title: Rights of terminally ill

Sponsor: Eliason, et al

Requestor:

Date of Request: 2/8/85

FISCAL DETAIL

Agency Affected: Health & Social Services

Program Category Affected: Public Health

BRU, Program or Subprogram(s) Affected: State Health Services

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: Attach a separate page if necessary

Prepared By: Robert I. Fraser, M.D. Phone: 465-3090

Division: Public Health Date: 2/12/85

Approved by Commissioner: Date: 2/15/85

Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):

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

7/1/84

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

MEMORANDUM February 8, 1985

SUBJECT: Derivation of Senate Bill 140

TO: Senator Richard I. Eliason

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

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

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

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

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

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

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

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

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

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

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

BGB:ojb
J11/073

Enclosures

alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

February 25, 1985

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

Dear Senator Eliason:

Subject: SB 140

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

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

Thank you for your consideration.

Sincerely,

Dennis L. DeWitt
President

DLD/agk

cc: Steve Berkshire

Society For The Right To Die

NEWSLETTER SPRING 1984

HOSPITAL SURVEY: AN INTERIM REPORT

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

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

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

Discuss with Physician

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

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

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

(continued on page 8)

LEGISLATION IN NEW SURGE: LAWS NOW TOTAL 21

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

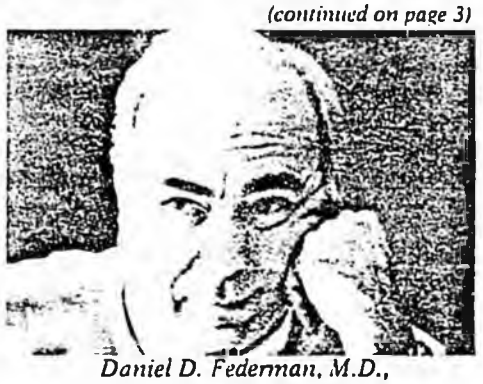
Concerted efforts by organizations devoted to the welfare of the elderly—AARP, Gray Panthers, Senior Citizens, and the like—have lent heightened visibility to the issue. Typical of their no-nonsense stand is the recent statement by Maggie Kuhn, Gray Panthers founder, as quoted in the *Litchfield* (CT)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

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

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

(continued on page 3)

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



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

New England Journal of Medicine Publishes Physician Guidelines

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

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

(continued on page 2)

GRAND JURY CALLS FOR NY HOSPITAL GUIDELINES

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

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

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

Specific Recommendations

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

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

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

VA Offers New DNR Option

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

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

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

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

Society Sponsorship

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

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

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

Physician's Role

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

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

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

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

Media Response

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

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

John D. Rockefeller IV, Governor of West Virginia.

MS Victim Forms Living Will Society

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sarah Caldwell

RAPID GAINS FOR BAY STATE BILL

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

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

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

ARTIFICIAL FEEDING BECOMES PIVOTAL ISSUE

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

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

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

Disagreement on Condition

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

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

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

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

Physicians' and Ethicists' Views

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

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

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

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

Ruling Awaited on Florida Court Role

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

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

Court Approval Needed

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

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

Earlier Patient's Wish Granted

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

SRD HONORS "DEAR ABBY"

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

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

Abigail Van Buren and Sidney D. Rosoff

California, Oregon Strengthen Rights

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

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

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

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

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

MS SUFFERER ALLOWED TO DIE

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

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

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

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

No Appeal Sought

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

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

Isn't It Enough?

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

Proxy Provision Added To SRD Model Bill

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

THE NEW YORK TIMES, WEDNESDAY, APRIL 4, 1984

To Die or Not to Die

By Evan R. Collins Jr.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Joseph Fletcher

Dr. Helen B. Taussig

News From SRD Board

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

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

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

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

A MESSAGE FROM OUR PRESIDENT

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

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

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

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

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

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

Evan R. Collins Jr.

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

SRD Publications

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

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

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

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

Please send me:

____ Reprint(s) of *NEJM* Physicians' Article @ $1
____ 1984 Handbook(s) of Living Will Laws @ $5
____ Set(s) of Right-to-Die Fact Sheets in binder @ $3
____ Hospital Survey sample letter
____ Living Will Document(s) for my state
____ Reprints of *N.Y. Times* article, "To Die or Not to Die"

Name _____

Address _____

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

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

WORLD CONFERENCE MEETS IN NICE

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

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

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

Hospital Survey

(continued from page 1)

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

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

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

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

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

Uniform Law Promoted

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

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

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

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

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

Mary M. Levan
Box 86
Angoon AK 99820

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

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

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

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

SB 140, Rights of the terminally ill.

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

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

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

SB 140

ALASKA STATE LEGISLATURE - SENATE

SENATOR RICHARD I. ELIASON

LABOR AND COMMERCE COMMITTEE, CHAIRMAN
RESOURCES COMMITTEE
JUDICIARY COMMITTEE
FISHERIES SUB-COMMITTEE

P.O. BOX 143
SITKA, ALASKA 99835

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

MEMORANDUM

TO: Senator Bettye Fahrenkamp, Chair
Senate HESS Committee

FROM: Senator Dick Eliason

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

DATE: February 18, 1985

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

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

Clocksin last yr - HB 107

presumption that person competent at time fills out form. Not in this yr's leg.

Barbara ANRN
Support
spoke to him
3/7/85

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

March 5, 1985

Honorable Bettye Fahrenkamp
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Re: Senate Bill 140

Dear Senator Fahrenkamp:

I am the registered lobbyist for the Alaska Nurses Association.

The Association supports SB 140 "An Act relating to the rights of the terminally ill." Quite a few of my clients have requested instruments similar to the instrument proposed to be authorized by Senate Bill 140. Generally speaking, my clients do not fear death itself as much as the indignity of deterioration, dependency and hopeless pain. An individual with a sound mind has a perfect right to make carefully considered decisions impacting and controlling his medical treatment. Those decisions should, upon the request of the individual, be controlling if the individual's physical condition becomes terminal and he is no longer able to participate in decisions regarding medical treatment.

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

Please do not hesitate to contact me if you have a question about the Association's position regarding Senate Bill 140 or any other matter.

Very truly yours,

David T. Walker

DTW/rnt
cc: Margaret Bixby
Janet Buness

Taking Charge of the End of Your Life

Proceedings of a Forum on Living Wills and Other Advance Directives

"Given the new medical technology that can sustain life even when the brain is gone, we must think about the right to die and the need for dignity in departing life. We owe it to ourselves and the ones we love to make provision for that moment."

Jacob K. Javits

"Staying in control of your own death takes planning and conviction. It is easier said than done. Yet there are dangers. Already public policy tends toward the cheapest way to keep an old person alive."

Tish Sommers, President
Older Women's League

Taking Charge of the End of Your Life

Proceedings of a Forum
on Living Wills and
Other Advance Directives

Washington, D.C.
1985

Contents

Part 4. Bringing the Problem Out of the Shadows: What Organizations Can Do

Foreword

On July 9, 1985, the Older Women's League (OWL) sponsored a forum in Washington, DC entitled "Taking Charge of the End of Your Life: A Forum on Living Wills and Other Advance Directives." The forum, which took place in the Dirksen Senate Auditorium and was attended by about 250 persons, was sponsored by OWL in cooperation with the American Bar Association's Commission on Legal Problems of the Elderly, and the Congressional offices of Representative Sid Morrison, Senator John Heinz, Senator John Glenn and Representative Edward Roybal.

The forum was the culmination of almost one year of planning that was initiated by Representative Morrison. In the fall of 1984, in response to his own and constituent interest, Morrison began to research the issue of advance directives for health care decisions at the end of life. He concluded after several months that federal legislation would not help this issue to develop -- that Congress is not equipped to answer these difficult and sometimes emotional questions that are shaped by regional values and concerns. But Mr. Morrison recognized the need for Congress, federal agencies and national organizations to dialogue on this issue and to help make advance directives more visible and more widely recognized by the public.

Knowing of OWL's strong concern with this issue, Mr. Morrison approached the League and asked if they would like to take the lead in planning a forum on Capitol Hill on this topic, with his support. Tish Sommers, president and co-founder of OWL, and a terminal cancer patient, has had a longstanding personal interest in promoting better understanding of ways to preserve autonomy in the final stages of a terminal illness. OWL had in fact already planned a major new initiative for their 14,000 members on the topic of planning for death and dying that would include information on living wills and durable powers of attorney for health care decisions and a new report in their series of Gray Papers. OWL readily accepted Morrison's invitation, and Sommers went about seeking funding and the involvement of other organizations.

One especially bright note in the planning came when Jacob Javits, former Senator from New York, learned about the Forum and expressed an interest in participating. He was quickly added to the list of speakers and his poignant personal remarks along with Sommers' personal perspective, provided an intensity and depth of vision that propelled the discussions through the complexities that followed.

The success of the Forum is well reflected in these Proceedings, published through the generosity of the ABA's Commission on the Legal Problems of the Elderly. The Commission's willingness to make the contents of the Forum available to thousands of persons who did not attend means that this critical issue may more fully receive the kind of national attention it deserves, and that ultimately more of our citizens will begin to make careful advance plans to take charge of the end of their lives.

Acknowledgements

The Forum "Taking Charge of tne End of Your Life"

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and

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Thanks are due for the creativity and hard work

of the Forum's planning committee:

Alice Quinlan	Forum Coordinator, Older Women's League
Janet Warren	Office of Representative Sid Morrison
Nancy Coleman	American Bar Association
Charles Sabatino	American Bar Association
Bill Benson	Senate Special Committee on Aging
Linda Josephson	Senate Special Committee on Aging

Part 1

Framing the Issues