ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672

7402 SENATE HEALTH EDUCATION & SOCIAL SERVICES

84-09	LS	Hawaii's Thousand Friends v. Kaiser Development Co., et al. Mediation of a class action lawsuit over maintenance and pollution from a private sewage treatment facility.
87-08	A/R	Naki v. S[illegible]etich. Mediation of a threatened lawsuit over landholdings held in trust for a mentally incompetent individual on Oahu.
87-07	LS	Dole, Del Monte, Velsacol v. State of HI. Mediation of a cluster of lawsuits seeking contribution to a previous settlement arising from heptachlor contamination.
87-06	LS	Hou Hawaiians v. State of HI. Mediation of a lawsuit in the Federal courts over ceded land revenues and other issues related to native Hawaiian entitlements.
87-05	LS	State of HI v. Erkel, et al. and State of HI v. Inryco, et al. Mediation, organization of a mini-trials, and Special Master involvement in two massive litigations over product and construction deficiencies at the State's Aloha Stadium.
87-04	LS	Bishop Trust Co. v. Kiahuna Golf Village. Mediation of a complex business litigation over the financing of a land development on the Island of Kauai and referred by the Circuit Court.
87-03	PM	Special Education Roundtable. Facilitated policy discussions between the State Department of Education and various advocacy groups over the management of I.E.P. disputes.
87-02	LS	Acosta et al. v. Tamashiro, et al. Mediation of a complex litigation matter involving construction defects in a low income housing project built with public funding.
86-01	PM	Water Code Roundtable. Facilitation and mediation of a ten-year policy impasse concerning the management of the State's fresh water resources.

SB

111

Alaska State Legislature

Chair, Resources Committee
Vice-chair, Transportation Committee
Member, Rules Committee
Member, Committee on Committees

District A
Ketchikan, Wrangell, Petersburg,
Hyder, Myers Chuck, Kupreanof

Senator Lloyd Jones

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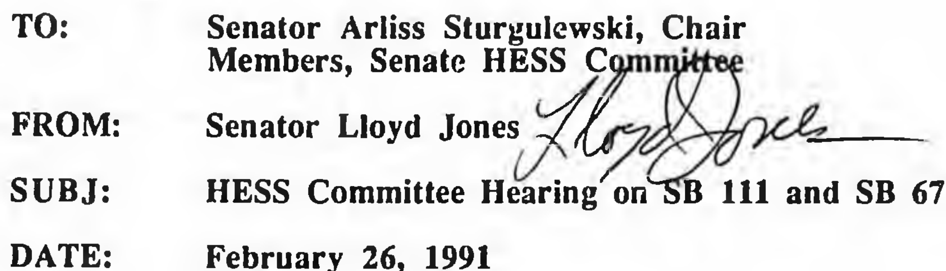
MEMORANDUM



TO: Senator Arliss Sturgulewski, Chair
Members, Senate HESS Committee

FROM: Senator Lloyd Jones

SUBJ: HESS Committee Hearing on SB 111 and SB 67

DATE: February 26, 1991

Thank you for scheduling SB 111 and SB 67 for a HESS Committee hearing this Friday, March 1. As we discussed, I will be unable to attend the hearing as I will be in Washington D.C. However, Glenda Carino of my staff will attend and is able to answer any questions regarding either of these bills.

Since this will be the first time SB 111 will be heard in your committee, I would like to explain my rationale in introducing this bill and its relationship to SB 67. As you know, SB 67 is a mechanism for funding hospital and nursing home capital projects. SB 111 is an appropriation bill which would actually fund three projects ranked in the "Inventory and Evaluation Survey" prepared by the Department of Health and Social Services in 1982.

Historical Perspective

Fifteen hospitals were surveyed in the 1982 study, by a committee made up of the Alaska Medical Facility Authority; the Alaska State Hospital Association; S.E. Alaska Health Systems Agency, Inc; South Central Health Planning and Development, Inc.; the Medical Care Advisory Committee; and the Statewide Health Coordinating Council. The ranking was based on the relative severity of all physical and functional deficiencies found at each facility. It did not consider other factors such as facility utilization or population trends. Kodiak, Seward and Ketchikan General Hospitals were in the top ten.

In 1987, the Hospital and Nursing Home Association of Alaska (formerly the Health Association of Alaska) recommended that Kodiak, Ketchikan and Seward be ranked as the top priority facilities needing construction grants. There have been several attempts to fund those construction grants. Last year, Senator Fred Zharoff and Representative Cliff Davidson introduced bills which authorized the issuance of general obligation bonds to be placed on the 1990 general election ballot. Those bills failed to pass the legislature, however they did bring the issue into the lime light.

As a result, Senator Zharoff was named chair of the Senate Special Committee on Health Care Facilities. I was a member, as was Senator Jay Kertulla. The committee assessed health care facility needs around the state, focusing on renovation and replacement of hospitals and nursing homes. It was also charged with making recommendations regarding the funding of those projects. One proposal is contained in my bill, Senate Bill 67.

Senate Bill 67 - A Long Range Plan

As discussed, Senate Bill 67 is designed to set up a priority ranking system on a statewide basis, to be used by the legislature and the executive branch when making decisions about capital budget priorities. Although it is a good start toward equal and rational distribution of health care facility construction funds, the lag time between getting the program off the ground and getting actual construction dollars to needy projects is too long. Ketchikan, Seward and Kodiak are projects that are ready to go now.

Replacement & Renovation of Ketchikan, Kodiak and Seward Hospitals

As you can see from the most recent figures, inflation costs in just one year have pushed the price tags up on these projects (see attachment: *1990 - 1991 Funding Request Comparison*). In terms of financial prudence, these hospitals have waited too long. But the real issue is health and life safety. For that reason, I ask that you support Senate Bills 67 and 111. The State of Alaska needs direction in prioritizing health care construction grants, but short of this priority list, Ketchikan, Seward and Kodiak General Hospitals need help today.

Enclosures: Backup on Senate Bill 111

- **Title 37, Section 37.05.316**
- **Letter from Ketchikan General Hospital & other backup**
- **Kodiak Island Hospital and Care Center Backup**
- **Seward General Hospital Backup**
- **1990 - 1991 Funding Request Comparison**

FUNDING REQUEST COMPARISON

HOSPITAL PROJECT	1990 REQUEST General Obligation Bond	1991 REQUEST State Grant Request	Local Match	Total Project Costs	C.O.N. REQUEST
Kodiak General Hospital	$14,500,000	$14,250,000	$4,750,000	$19,000,000	$18,167,340
Seward General Hospital	$10,700,000	$8,603,438	$2,867,813	$11,471,251	$9,500,000
Ketchikan General Hospital	$16,200,000	$14,063,678	$4,687,893	$18,751,571	$19,300,000

Note:

The allowable inflation rate under the C.O.N. is 15%

1989 inflation rate 4%

1990 inflation rate 5%

State agencies are using a 10% inflation rate for 1991 & 1992, 7% inflation rate for 1993

**Request under SB 319*

***Request under SB 111 communities must match 25% with a limit of 5% of in-kind funds*

DRAFT

February 25, 1991

BILL BACKGROUND

SENATE BILL 111

S.B. 111 would appropriate $36,917,116 to replace, renovate and/or equip the current general hospitals in Ketchikan, Kodiak and Seward.

In 1982, at the request of the legislature, the Department of Health and Social Services developed a prioritized capital funding plan to meet all non-federal level III hospitals and nursing homes in the state. The plan was based on intensive inventory and condition surveys of each facility. Fifteen separate facilities were surveyed and incorporated into the plan.

Ketchikan General Hospital was ranked 5th of 15; Kodiak Hospital ranked 6th and Seward ranked 8th. To date, all higher ranked facilities have received significant funding. Of the lower ranked facilities, only Weslyn Nursing Home in Seward; St. Ann's Nursing Home in Juneau and Valdez Community Hospital (in a wing of Harborview Developmental Center) have not received significant funding.

Of the three facilities in this bill, all have or have applied for Certificates of Need. Kodiak's requested $18,167,340. It's C.O.N. request is in the final stages of review. Ketchikan received it's C.O.N. June 15, 1990 for $19,300,000 and Seward received it's C.O.N. September 9, 1989 for $9,500,000.

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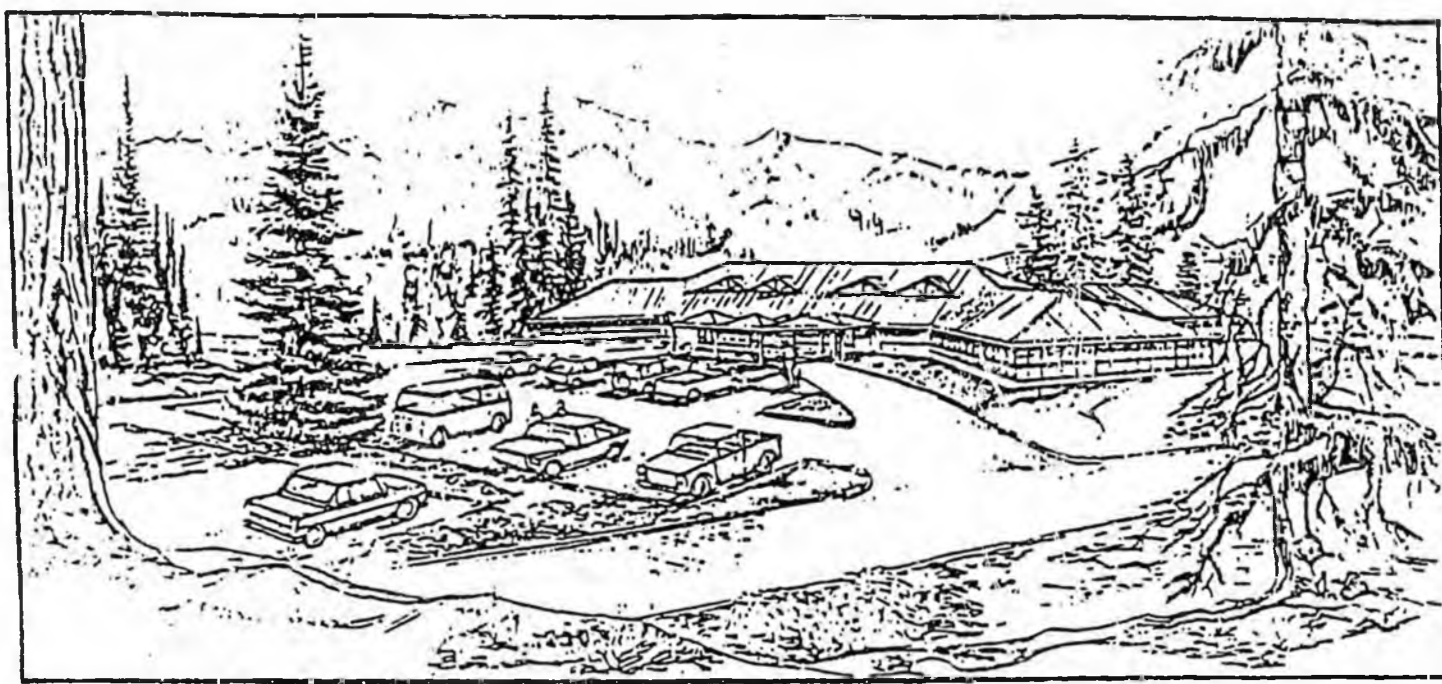
BACKUP
SENATE BILL 111

Kodiak island Hospital and Care Center

JAN 13 [illegible]

KODIAK ISLAND (BOROUGH) HOSPITAL AND CARE CENTER



REPLACEMENT FACILITY PROPOSAL

KODIAK ISLAND (BOROUGH) HOSPITAL AND CARE CENTER

HISTORICAL PERSPECTIVE

Kodiak Island (Borough) Hospital and Care Center has been trying for nine years to achieve funding for a badly needed modern health care facility. The State of Alaska has not funded rural health care facility construction for the past seven years.

During this nine years, several studies have been completed. They have studied the needs of the Borough, the present facilities, the need for either remodeling/additions to the present facility, or a replacement facility; the projected health care needs of Kodiak Island Borough; and the respective costs of remodeling/additions versus a replacement facility.

In 1982, the State of Alaska contracted with ECI-Hyers, Architects and Planners, to study the existing need in the state. Their conclusions were that replacement of the present facility would be the most cost effective methods of providing needed health care.

In 1985, Mills, John & Rigdon Architects determined that the most prudent method of providing the needed health care was a replacement facility. Their findings were that the present facility's problems in the areas of asbestos control, mechanical systems, air handling systems, traffic flow, earthquake protection and multiple code violations made a replacement facility the only choice.

In May of 1986, the Health System Agency came to the conclusion as the two previous studies: replacement is the only cost effective and realistic approach to the problems of health care delivery in Kodiak Island Borough.

The present facility has 66 deficiencies under Federal Codes, 19 deficiencies under the Handicapped Code, 4 major deficiencies under Life Safety Code, and it does not meet the state requirements for earthquake protection.

When the hospital was built in 1968, it met the medical needs of that time. Then, we had 2,300 outpatient visits a year; now, we have over 9,000. Then, we had about 10 patients a day in the hospital; now, we have over 15 a day. Then, we had one x-ray machine; now, we need three machines and our CT Scanner is going to have to be put in a building outside the hospital because there is no room inside. Then, we had three laboratory machines performing 1,500 tests a year; now, we have five state-of-the-art machines performing over 9,000 tests. But we are still in the same building with the same 22-year-old mechanical, ventilation and electrical system.

The State of Alaska appropriated $200,000 to Kodiak Island Borough for planning of a new facility. Kodiak Island Hospital and Care Center has donated over $2,000,000 to the Borough for site acquisition, architect's drawings and specifications, and site preparation. There are currently plans, specifications and documents ready for construction. Due to a lack of funding, the Certificate of Need which was granted, and extended twice in anticipating of funding, has expired. The Certificate of Need has been resubmitted to the State for review.

The Kodiak Island Borough and the City of Kodiak have both made the replacement of the present hospital with a new facility their number one priority again this year.

To date, the Kodiak Island Borough and Hospital have spent $1,813,962.00 in preparation for the new hospital. There is over $1,000,000 in reserves dedicated for the construction of the new hospital. We are currently researching the possibility of a fund developing program to further assist ourselves and the state in providing the necessary health care for our borough.

Over the nine years of waiting, we have spent large sums of money studying the problem and developing the most economical solution and the plans and specifications to implement the replacement facility. The delays have increased the cost of construction, through inflation and increasing technology, from $11,500,000 in 1982 to $19 million in 1991. These are costs that are directly born by the hospital, borough, citizens and State of Alaska.

KODIAK ISLAND HOSPITAL REPLACEMENT

COST ESTIMATE

	Item	Cost
1.	New Construction	$ 14,000,000
2.	Site Work	484,500
3.	Site Acquisition	495,000
4.	Landscaping	250,000
5.	Mechanical Balancing	40,000
6.	Movable Equipment	[illegible]
7.	Architectural/Engineering Fees	1,200,000
8.	Site Survey/Soils & Materials Testing	50,000
9.	Special Inspections	42,000
10.	Administrative Expense	[illegible]
11.	Contingency	[illegible]
	TOTAL PROJECT COST (1991)	$ 19,000,000
	LOCAL FUNDING	$ 4,000,000
	BALANCE REQUESTED FROM STATE OF ALASKA	$ 15,000,000

BACKUP
SENATE BILL 111

Seward General Hospital

CITY OF SEWARD
CAPITAL PROJECT ASSISTANCE 1991

CATEGORY - COMMUNITY DEVELOPMENT CITY PRIORITY 1

PROJECT TITLE: SEWARD GENERAL HOSPITAL REPLACEMENT

PROJECT COST: NEW HOSPITAL REPLACEMENT $10,446,250
REMODEL EXISTING BUILDING $ 1,025,000
TOTAL PROJECT $11,471,250

ANNUAL O & M COST: NO CHANGE

DESCRIPTION:

This project is to construct a new 20-bed hospital facility to provide long term health care services including space for emergency and trauma, obstetrics, operating room, inpatient care, laboratory, imaging (ultra sound and x-ray), intensive care (coronary) and a clinic. The project also includes remodeling the old, existing hospital building to provide for other outpatient health care providers.

JUSTIFICATION:

A new replacement hospital remains the City's highest priority project for state funding. The existing building was inspected in 1981 and deemed to be in violation of numerous federal, state and local life safety and accessibility codes. The extent of the violations should require the facility to be condemned as an acute care facility. It is not feasible and more costly to correct the deficiencies by repairing or remodeling the existing facility.

In 1989 the state re-evaluated and reissued the Certificate of Need. The most recent cost estimate is $10,446,250 for a complete facility. The City proposes to contribute 25% of the hospital construction cost, $2,867,812. The additional cost to remodel the existing hospital for other health services and support activities is $1,025,000.

It is not feasible, nor recommended, to upgrade the existing hospital building for use as an acute care facility; however, it is very suitable for outpatient services, physicians' offices and examination rooms, training and dormitory space for the Community Health Aid Training Program, and similar activities. The net space in the existing hospital is 22,000 square feet; therefore, there is sufficient space for the above-mentioned services. The cost to remodel the building ($1,025,000) is estimated to be less than the cost for a new facility to house these services and activities.

The Seward General Hospital is, in effect, a regional health facility, providing services not just to local residents but to outlying areas such as Crown Point, Moose Pass, Bear Creek, the Spring Creek Correctional Facility and the hundreds of seasonal workers and

CAPITAL PROJECT ASSISTANCE 1991

SEWARD GENERAL HOSPITAL
REPLACEMENT PROJECT
REVISED COST ESTIMATE - 1992 CONSTRUCTION

The cost of the 20 bed Seward General Hospital Replacement Project has been revised to incorporate the most recent cost projections and concepts for the project. The estimated cost of 9.5 million dollars by SHPDA was developed prior to August 1989 based on the economic forecast at that time. Since that time inflation has increased the cost of construction by more than 5% per year and this years inflation may exceed this rate. The movable and installed equipment in the existing hospital has continued to age and replacement will be more costly due to greater capability and more costly technology of new equipment. Much of the equipment dates from prior to 1960's through 1970's and is no longer economical to operate, reliable or capable of providing acceptable service by today's standards. It will be necessary to replace the total equipment packages for surgery, radiology, emergency ambulatory care, dietary, kitchen and laundry. The physicians outpatient clinic building (ambulatory care center) must be replaced by including the facility in the hospital, thus increasing the floor space. The existing building is being closed and a temporary office is being set up in a local mall some distance from x-ray and laboratories serving them. The revised project budget is as follows, based on 1992 construction season.

1.	Building Construction		
	Hospital and additional space for ambulatory care center	=	$ 6,941,875
2.	Site Development		
	Site paving, drainage & landscaping	=	$ 452,025
3.	Fixed Equipment	=	$ 300,000
	Total Construction Cost	=	$ 7,693,900
4.	Site Surveying, Soils	=	$ 75,000
5.	Architects & Engr. @ 7% Construction Cost	=	$ 538,573
6.	Other Consultants, @ 2% Construction Cost	=	$ 153,878
7.	Administration @ 1 1/2 Construction Cost	=	$ 115,048
8.	Building Permits	=	$ 28,000
9.	Other Equipment, Movable Equipment	=	[illegible]
10.	Contingency @ 10% Construction Cost	=	$ 769,390
	Total Hospital Project Cost	=	$10,446,250

APPENDIX I - MEMORANDUM TO COUNCIL
1991 LEGISLATIVE PRIORITIES
NOVEMBER 19, 1990

CITY OF SEWARD

P.O. BOX 167
SEWARD, ALASKA 99664

- Main Office (907) 224-3331
- Police (907) 224-3338
- Harbor (907) 224-3138
- Fire (907) 224-3445
- Telecopier (907) 224-3248

MEMORANDUM

TO: HONORABLE MAYOR AND CITY COUNCIL MEMBERS

THRU: DARRYL SCHAEFERMEYER, CITY MANAGER
FROM: E. PAUL DIENER, MGR. ENGINEERING & UTILITIES

SUBJ: 1991 LEGISLATIVE PACKAGE, CAPITAL IMPROVEMENT PROJECTS

DATE: NOVEMBER 19, 1990

The following listed projects are proposed for the legislative CIP package with descriptions and costs as indicated. The list was developed from unfunded projects in last year's legislative CIP list and the City's three year Capital Improvement Plan.

PRIORITY 1   Seward General Hospital   Require $ 9,675,000

This project is the community's **top** priority and is being carried over from previous years. The funding includes $ 9.5 million for a complete new facility including FF&E and $ 1.2 million to remodel the existing facility as a support and out-patient health center. The total project cost is $ 10.7 million less local funding of $ 1,025,000 (land and in-kind contributions), leaving a legislative grant requirement of $ 9,675,000.

PRIORITY 2   School sidewalks/Iditarod bike trail   Require $ 200,000

These items are the city's designated #2 priority and consists of funding for the construction of a multipurpose sidewalk and bike trail. The sidewalk, to be part of the Iditarod National Historic Trail, will provide safe pedestrian passage particularly for school children along a route from the Seward Highway, up Swetmann Avenue to the Junior/Senior High School, and then to create a trail to the Elementary school, thereby providing life safety travelways where no such walks exist. Currently, children are exposed to a tremendous danger walking on roadways made hazardous by snow, ice and darkness. The other portion of this project is to provide funding to complete the asphalting of a hiking/biking trail that follows along the Seward waterfront (9/10th of a

will allow the state and city's hopes to be fulfilled in hopes of developing projects that provide income and employment.

Miscellaneous Projects	Require	$ 185,000

The following projects have been identified frequently by patrons, visitors and local committees:

Item	Amount
Park Improvements	$ 50,000
New ambulance	95,000
Public bath and shower facility, SBH	40,000
Total	$ 185,000

Feasibility Studies Funding	Require	$ 350,000

This request is for funding required for Corps of Engineers studies for the 1991 season only. Additional funds will be needed in future seasons.

A listing of the studies is as follows:

Study	Amount
Seward South Harbor Expansion	$ 150,000
Lowell Canyon Creek Flood Control	100,000
4th of July Creek Flood Control	100,000
Feasibility Studies Total	$ 350,000

Ak. Marine Mammal Center Funding	Require	$ 250,000

The Seward Association for the Advancement of Marine Sciences (SAAMS), with the support of the City of Seward, is actively pursuing the funding for construction of a $10 million science, research, rehabilitation and education center involving marine mammals of the northern regions. The funding requirement is for initial planning and design of the facility and for more thorough research of the project and fund-raising tools.

CIP PROJECTS DESCRIPTIONS

SEWARD GENERAL HOSPITAL - This item calls for the replacement of the Seward General Hospital facility into a twenty (20) bed unit. The existing building has not complied with hospital and building codes, is unsafe and uneconomical to operate. State and Federal agencies may reject SGH's certification at any time leaving the community without an acute-care health facility. With the new facility, it is conceivable that the financial burden of hospital operations may be lessened by an increase in revenues by area residents relying more upon the facility for treatment and care rather than taking their health care dollars to Anchorage or peninsula hospitals. In addition, a new facility would provide additional motivation for new physicians to establish practices in Seward thereby adding to the quality of care and specialties of services. With industries looking at Seward for possible future development, the presence of a quality health facility will make the community appear more attractive to the industries and families considering locating here. This project has been designated as the City's top priority.

SCHOOL SIDEWALK/IDITAROD BIKE TRAIL - The school sidewalk project, not listed on the City CIP plan, has been placed upon this year's legislative list because of the attention caused to this project's need by local groups and families. The project involves the construction of a sidewalk/bike trail along the major street leading to the Seward Junior/Senior High School, from the Seward Highway, along Swetmann Avenue. Currently, students must walk along the roadway as no such sidewalk exists. This presents an extremely hazardous situation to the safety and welfare of the school children who must share the road with vehicle traffic. The hazard is worsened because of snow, ice and darkness and a vehicle/pedestrian accident is inevitable. The sidewalk will be tied in to the Iditarod National Historic Trail project - a project to construct a hiking/biking trail that will run from the city's south beach to the harbor then to the school and then connecting the high school with the elementary school. Not only will the trail (which has been on Seward's legislative list for the past three years) provide a major capital improvement for the city's park lands but will enhance the life safety factors for the thousands of visitors and the local citizens in pedestrian and recreational needs. Monies will be used to build the sidewalks and to asphalt the trail, provide signage and protective barriers such as bollards and to provide bridges and culverts as needed. The City Council has determined these projects to be the City's #2 priority.

LOWELL CANYON CREEK BRIDGE REPLACEMENT - This project is not contained in the CIP. However, Administration wishes to include this in the legislative package because of the notorious nature of the existing bridge and the successful acquisition of state emergency funds for bridge replacement in the amount of $ 340,000 due to damage to the bridge in the 1989 flood. During heavy rains and flooding conditions the bridge, located below the outfall, rapidly fills with water restricted by the narrow width of

fiscal planning though there are a multitude of needs and developments that could be implemented if the monies were available. Park improvement monies have been on the legislative list for the past four years yet have never been funded. Among desired projects are the construction of a bathroom facility at Ballaine & Monroe, replacement of tot lot toys that are of potential high-liability risk, grass planting and more amenities such as picnic tables and grills. Some improvements have been made financed primarily by campground collections profits though more could and needs to be done with additional monies. With Seward experiencing growth in population (caused by more families coming to the community because of the increased employment opportunities) and the boom in tourism, the City is in need of developing these public properties to offer the amenities and facilities expected by the patrons.

SMALL BOAT HARBOR BATHROOM/SHOWER FACILITY - A sanitation facility is desired at the north end of the harbor, near "J" ramp, as permanent facilities are located on the south end of the harbor. This item has been mentioned frequently by harbor users and the Port Advisory Committee as a necessary addition to the harbor.

FEASIBILITY STUDIES FUNDING - Local shares of funding will be required to implement Corps of Engineers' studies on the Small Boat Harbor South Expansion, Lowell Canyon Creek Flood Control and 4th of July Creek Flood Control. If the City wishes to proceed on these projects, monies will need to be made available either through local funds or legislative grants. Because of the importance of the projects, Administration would like to forward these grant requests to the state rather than seek the funding from local funding sources.

MARINE MAMMAL CENTER FUNDING - A local group of citizens, supported by research and rehabilitation professionals in the field of marine mammal studies, have formed an association to pursue the construction of the Alaska Marine Mammal Center to be located in Seward. The City of Seward has provided its support to this project which will provide facilities for research, rehabilitation and education involving marine mammals of northern seas. The plan calls for the construction of a $10 million facility. The request for funding is to acquire funds for design and technical planning for the facility. In addition, the funds will be utilized for other professional services required in the Center's initial development phase.

APPENDIX II - SEWARD GENERAL HOSPITAL CERTIFICATE OF NEED

SHPDA Findings And Recommendation

SEWARD GENERAL HOSPITAL
Application For Modification Certificate of Need

August 30, 1989

State of Alaska
State Health Planning and Development Agency

Planning Section
Division of Administrative Services
Department of Health and Social Services
Post Office Box H-02
Juneau, Alaska 99811
(907) 465-3015

APPENDIX I
CERTIFICATE OF NEED

REVIEW CRITERIA

1. Relationship To Applicable Plans

The original proposal was found to be the product of a thorough planning process and to be consistent with the Health Systems Plan and the State Health Plan. Extension of completion data as requested by this modification application would not appear to be in conflict with this earlier found consistency.

2. Demonstration of Need

The original state agency review found that the deficiencies within the hospital were the primary demonstration of need for the project. Specifically, the hospital does not meet building fire and life safety codes. The problems include use of non-fire treated wood in the interior and ventilating systems that may contribute to the spread of infection. Additionally, the space is insufficient to comply with code requirements.

The service area for Seward General Hospital is defined as the east peninsula portion of the Kenai Peninsula Borough encompassing Seward, Moose Pass, Cooper Landing, Bear Creek and Hope. The 1984 estimated service area population was 3,850. At the time of the original application, the population of Kenai Borough was expected to double within 10 years. The depression has dramatically impacted this projected growth, however, and the State Demographer's most recent estimate shows a 4.4% growth in the Kenai Borough from 1984 to 1988.[1]

The applicant documented and the state agency agreed with an existing need for 9 beds at the time of the original application. The applicant proposed operation of the new facility initially with the ten proposed single rooms, converting to double rooms by adding beds as demand increases. The double bedded rooms appear to be an equitable approach to meeting growth demands as the one time construction cost will provide enough beds for foreseeable increases in demand or changes in service delivery over the economic life of the building. Operating costs will reflect only staffing costs required for the actual utilization.

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[1] "1988 Estimates of Alaska's Population", News Release, Alaska Dept. of Labor, July 10, 1989.

Depreciation of capital funds received through grants is a reimburseable patient care expense under Medicaid regulation. The impact of this project on the Medical Assistance budget will be limited to an increase of the depreciation basis to reflect the $9.5 million capital expenditure. The old building will not be used to support hospital functions and, therefore, no depreciation for that asset will be allowable for rate setting purposes.

5. Relationship To Existing Services

Seward General Hospital has a close working relationship with Wesleyan Nursing Home which is also sited in Seward. The Hospital provides inpatient, outpatient, and ancillary services to Wesleyan and sells meals to the Senior Citizens.

The most important impact that the proposal will have on the health care systems is the assurance that hospital and emergency care will continue to be available in the eastern Kenai peninsula area.

6. Availability of Resources

Fiscal resources are discussed in Section 4 above. Personnel resources are deemed adequate since no increases in personnel are anticipated as a result of this project.

The provision of office space and the up-graded medical care facility resulting from this project should enhance efforts to recruit and retain health care professionals in the Seward area. The revenue expected from rental space was not identified by the applicant.

7. Relationship To Ancillary And Support Services

The use of an adjacent site for patient care facility construction will ease the staging transition to the new structure and allow continuation of core services during the construction period. The new areas provided for ancillary and support services will enhance and facilitate the provision of these services.

8. Methods And Impact Of Proposed Construction

The design of the hospital as originally proposed was reviewed by the Department of Health and Social Services architect and determined to be carefully planned. The architect did find that construction costs were under-estimated. At his recommendation, the Certificate was granted for $10.5 million. This was $2.[illegible] million more than

HEALTH SYSTEMS AGENCY RECOMMENDATION

The South Central Health Planning and Development Agency, Inc., the health systems agency serving the applicant's catchment area, offered no comment or recommendation regarding this application for modification. (This agency has been defunded and no longer maintains an active role in regional health planning activities.)

STATE AGENCY FINDINGS AND RECOMMENDATION

The State Agency finds as follows:

- This application proposes an extension of the completion date for a project originally reviewed and approved in 1985. The circumstances and conditions that led to the original approval of this project remain equally valid when currently reviewed under the Certificate of Need criteria.

- Local funding sources have not been found to provide the capital necessary to complete this project. Efforts during the past four years to obtain a state legislative grant to fund the capital costs of this project have proved unsuccessful.

- The applicant describes a proposed legislative sponsored statewide bond issue in 1990 as a source of funding for this project. However, no assurance can be given that such an issue would be approved by the legislature or accepted by the electorate. The projected completion date for the project under this funding mechanism would be April, 1994.

- The proposal relies entirely on state funding and will require no repayment of principal or interest by the applicant. Depreciation will be increased to reflect the $9.5 million capital expenditure. The old hospital building will not be used for hospital functions.

Based on these findings, the State Agency recommends:

1. A modified Certificate of Need be granted to Seward General Hospital;

2. the completion date for this Certificate be extended until April 30, 1994; and

3. the maximum expenditure authorized for activity conducted under this Certificate be reduced to $9.5 million.

BACKGROUND

The Applicant

The Seward General Hospital is located in Seward, an isolated community of approximately 2,400 population in southeastern Kenai peninsula. The Hospital is owned by the City and is leased for one dollar a year to the Seward General Hospital Association, a local non-profit corporation which operates the facility. Although the City is not directly involved in management of the hospital, City sales taxes are used to defray operational losses at the hospital.

The Proposal

The Seward General Hospital was built in 1958. Although well maintained, the hospital building suffers from deficiencies under the headings of mechanical, electrical, functional, fire prevention, and life safey code violations. In a 1981 state sponsored study of rural health care facilities, Seward ranked third on a priority list of needed hospital projects. In May of 1985, Seward received a Certificate of Need for a $10.5 million project to correct these deficiencies.

The project involves construction of a new building to house patient care and support services on a site adjacent to the current hospital, remodeling of space in the current building to house physician offices, and using the remainder of the current building for other health and social service programs. Bed capacity will decrease from 33 to 20, and equipment will be modernized, but the scope of services offered will be generally unchanged.

The construction plan includes 10 two-bed rooms. However, the actual number of beds licensed will depend on demand. Four of the 20 beds will be dedicated to obstetrics and another four will be equipped for intensive and coronary care. There will be one operating room, one delivery room, and a two-bay trauma room. Patient service areas planned include radiology, physicial therapy, and laboratory, each of which will also have an outpatient component.

The remodeled area of the existing hospital will include physicians' offices, an outpatient clinic, and rental space for other health and social service agencies.

Funding for the project was to be obtained from the State through a legislative grant. However, the oil recession that paralyzed the state's economy since 1985 has

KENAI PENINSULA CAUCUS
AN ORGANIZATION REPRESENTING
MUNICIPAL GOVERNMENTS AND CHAMBERS OF COMMERCE
OF THE KENAI PENINSULA BOROUGH
177 North Birch Street, Soldotna, AK 99669
Phone: 262-9107

January 23, 1991

Alaska Legislators
State of Alaska
P.O. Box V (Mail Stop 3100)
Juneau, AK 99811

Dear Legislators:

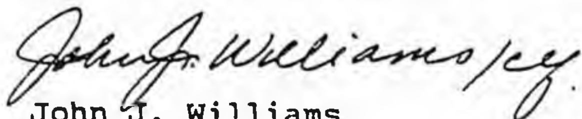
Enclosed please find a copy of the Kenai Peninsula Caucus resolution supporting a legislative grant to fund the replacement of the Seward General Hospital.

The replacement of the Seward General Hospital is the high priority project of the City of Seward for the 1991 legislative session and the Caucus strongly supports the request for funding.

Thank you for your cooperation in this matter.

Sincerely,

KENAI PENINSULA CAUCUS



John J. Williams
Secretary

JJW/clf

KENAI PENINSULA CAUCUS

RESOLUTION 90-12

A RESOLUTION SUPPORTING A LEGISLATIVE GRANT TO FUND REPLACEMENT OF SEWARD GENERAL HOSPITAL.

WHEREAS, Seward General Hospital is one of three acute care hospitals within the Kenai Peninsula Borough; and,

WHEREAS, in 1981 Seward General Hospital was inspected by state and federal regulators and found to be in violation of numerous federal, state and local life safety and accessibility codes; and,

WHEREAS, the State of Alaska, Department of Health and Social Services, pursuant to the provisions of AS 18.07.031-111 and 7AAC 07.010-130, on September 9, 1989, granted Seward General Hospital a Certificate of Need for replacement; and,

WHEREAS, the Certificate of Need authorizes a replacement project of up to ten double-bed, acute-patient-care rooms with a total expenditure authorized for the project of $9,500,000, not including land and in-kind contributions; and,

WHEREAS, the replacement of the Seward General Hospital is the single highest priority project for the City of Seward for funding by the 1991 legislative session.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF THE KENAI PENINSULA CAUCUS:

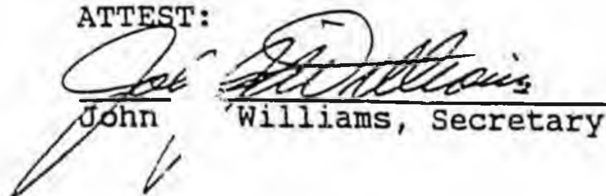
Section 1. The Kenai Peninsula Caucus supports the appropriation of $9.5 million by the 1991 Alaska Legislature for the replacement of Seward General Hospital.

Section 2. The secretary is hereby directed to send copies of this resolution to The Honorable Walter J. Hickel, Governor, State of Alaska; all members of the 1991 Alaska State Legislature; Theodore Mala, Commissioner, Department of Health and Social Services; and the Alaska Hospital Association.

ADOPTED BY THE KENAI CAUCUS BOARD OF DIRECTORS, this 18th day of January, 1991.

JACK BROWN, President

ATTEST:



John Williams, Secretary

BACKUP
SENATE BILL 111

Ketchikan General Hospital

Ketchikan General Hospital
3100 TONGASS AVE.
KETCHIKAN, ALASKA 99901

January 26, 1990

Senator Lloyd Jones
P.O. Box V
Juneau, AK 99811

Dear Senator Jones:

I am writing to update you on the current status of the Ketchikan General Hospital Remodeling and Expansion project.

Certificate of Need - The Certificate of Need was filed on October 4, 1989. The State Department of Health and Social Services met with the hospital on November 18, 1989 and made a request on December 4, 1989 for additional information.

The Certificate of Need request was for $18,890,000 for the total project. The State Department of Health requested the total project be broken down, if possible, to increase funding potential from the state. After study by the architects, the Certificate of Need was amended on January 25, 1990 to include full funding for the project costing $18,890,000 plus a Phasing Plan that increases the cost by $1,483,457 and increases construction time to 56 months and seriously disrupts the hospital operations. The Phasing Plan is as follows:

Phase I — Cost: $5,505,570 (plus $100,000 hospital equipment, plus contingency of 5%, plus $150,000 project clerk of the works for a total of $6,018,348)

This phase is the infill between the nursing home and hospital for expansion of emergency and outpatient facilities and corrects critical and long standing code deficiencies in the laboratory.

Phase II — Cost: $8,523,167

This phase consists of constructing a new south addition, new service entrance, new boiler plant, new electrical switch gear, new emergency power facilities, and essentially providing new mechanical/electrical infrastructure for the entire hospital complex.

Phase III — Cost $5,228,720

Phase III consists of constructing alteration work on the space vacated and will be the most disruptive to the operations of the daily business of the hospital. The major departments affected will be X-Ray, Food Service and Materials Management.

KGH

The construction plan for the hospital was developed to correct the fire life safety violations, building code violations and space deficiencies that were identified by the state's own assessment in 1982. It is now eight years later and two plans later and our problems have been intensified by increased volumes and new services. I believe the deficiencies have reached a critical level for the hospital to continue to provide high quality services in the future. Ketchikan General Hospital has patiently waited while other hospitals identified in the 1982 reports have been funded by the State of Alaska.

In summary, our request is for the full project or enough to cover Phase I and Phase II. If that is not avilable, any help would be appreciated.

If you need additional information, please call me at 225-5171 ex. 326 or ex. 389.

Sincerely,

Edward Mahn
Administrator

cc: Jack Pearson, City Manager

EMpa

Ketchikan General Hospital

3100 TONGASS AVE.
KETCHIKAN, ALASKA 99901

JAN

January 18, 1991

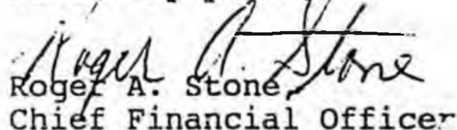
Senator Lloyd Jones
Alaska State Senate
Box V
Juneau, Alaska 99811

Dear Senator Jones:

This letter is to clarify the dollar amount needed to accomplish the planned facility expansion at Ketchikan General Hospital. According to our Certificate of Need dated 5-23-90, we needed $17,774,000 as a lump sum to complete our facilility expansion project all at the same time if construction started during the 1990 construction season. Since construction did not start in the 1990 construction season, our architects, John Rigdon & Mills, estimate our costs have increased approximately 5.5% over last year. Therefore, our current funding need to complete the facility expansion as a single project is estimated to be $[illegible],570[illegible] If our expansion project were to be built in three phases our 1990 Certificate of Need estimated the cost at $19,257,457. Again assuming our costs have increased approximately 5.5%, the [illegible] cost is now estimated to be $[illegible],316,61[illegible].

If you need any additional information or require additional details on the above cost estimates, please contact either Ed Mahn, our Administrator here in Ketchikan, or me if Ed is not available. We sincerely hope the Alaska State Legislature can fund this badly needed project for the Ketchikan Community in the upcoming legislative session.

Sincerely yours,



Roger A. Stone,
Chief Financial Officer

KGH

race on Friday.

Photo by The Associated Press

ing with other agencies in the case.

A troopers vessel visited Seguam

scene, Godfrey said.

A coroner's presumptive death

will attempt to rule whether the two

See 'Investigation' on page 2

Funding would aid cramped hospital

By JANIE DUNWORTH
Daily News Staff Writer

A $14 million appropriation bill for the expansion and renovation of Ketchikan General Hospital was introduced to the Alaska State Senate on Monday.

The bill, sponsored by Sen. Lloyd Jones, R-Ketchikan, is part of a $36.9 million appropriation bill that also seeks funding for hospitals in Seward and Kodiak. The bill calls for Seward to receive about $8.6 million and for Kodiak to receive about $14.2 million.

According to Jones, the three hospitals were identifed for top priority funding in a 1982 Inventory and Evaluation Survey prepared for the legislature by the Department of Health and Social Service.

"There are three hospitals that need help now. Ketchikan, Seward and Kodiak have been identified as top priority for replacement and renovation funds in 1982. It's absolutely critical we fund these projects this year. They were in bad shape then, you can imagine how bad off they are now," said Jones.

Problems outlined

About 250 employees at the hospital don't have to imagine how bad it is. They are the ones who must deal with the lack of space and with bathrooms that are now used as closets and closets that are now used as dressing rooms. They must also deal with radioactive isotopes that have been placed in what used to be a bathroom. The pharmacy department must use a closet to mix its medicine and the blood supply in the laboratory has inadequate storage space. The list goes on and on, according to staff.

"There's no slack left. Currently we are faced with serious life-safety codes and deficiencies," said Ed Mahn, hospital administrator.

Mahn said he is "cautiously optimistic" about funding this year. Other employees were less sure than Mahn. They all continue to play the budget waiting game.

The $18 million expansion and remodeling project has been tagged as the city's number one priority, according to Mahn. In addition, it has been listed as one of the top regional priorities on the Ketchikan Community Legislative Priorities list.

City needs to contribute

If Jones' appropration bill passes this session, the city will need to come up with a $4.6 million match for the funding.

Assistant City Manager Bill Jones said the city is still working on its capital project budget and it is too soon to tell if the hospital project will be included. City Finance Director Howard Ward said the budget should be presented to the Ketchikan City Council in March.

According to Mahn, the need for expansion is illustrated by the increased volume of business at the hospital. He said it has seen a 33 percent increase since 1982. Individual departments are also experiencing increases. While the demand grows, there is no place to accommodate it.

Tim Walker, a medical technologist who has worked in the hospital's lab for four years, said lab activities have doubled. The department reported that it performs between 1,000 and 1,500 tests a week.

A walk through the lab paints a cramped, chaotic picture. Equipment is stacked on desks and the corridor can only accommodate one person in many areas. The blood supply is stacked and another refrigerator is needed. But, Walker said, there isn't room for another refrigerator.

Crowding continues

Dave Smith, director of the radiology and laboratory departments, said there is so little space in the hospital that there isn't any place to put the equipment or to accommodate the technology. He said funding for equipment has been available, but there isn't space.

Smith said he often feels sorry for the patients as they have few if any areas to wait. He said it makes him feel bad when he sees them parading down the hallways in their robes.

Besides the lack of space, other deficiencies have been identified by the State Department of Health. It reported that there are serious life-safety code deficiencies, serious space deficiencies and an asbestos problem.

A lack of parking was identified in the 1982 study as well, but was remedied when the new 60-space parking

See 'Hospital' on page 3

rkers lighten seniors' load

Toni Brend talks with Jean Bliot during a Case Management visit last week.

Staff photo by Janie Dunworth

Allies claim Basra nearly isolated

By FRED BAYLES
Associated Press Writer

DHAHRAN, Saudi Arabia (AP) — Favored by the desert sun, allied jets stepped up the air war Monday with hundreds more bombing runs against Iraqi targets. The city of Basra, nerve center of Iraq's defense, was believed all but cut off.

Iraq fired two Scuds at Israel and launched a missile at Saudi Arabia, causing injuries and damage in both countries.

"We hated to come back, but we ran out of bombs," an exuberant U.S. Air Force pilot told reporters on his return from a bombing run.

As U.S. air commanders pressed this "battlefield preparation phase," President Bush met with his war advisers to consider ordering American troops onto that battlefield — in a decisive ground war for Kuwait.

Emerging from a White House meeting with Defense Secretary Dick Cheney and joint chiefs chairman Gen. Colin Powell, both just back from Saudi

As for a ground offensive, Bush said, "we're not talking about dates."

In Baghdad, the government announced it was reaching still deeper into the Iraqi population — into the schools — for teen-age soldiers to help "destroy the enemies of God and humanity."

Also Monday, Iraq's religious affairs minister, Abdullah Fadel, said "thousands" of civilians have been killed or wounded in allied bombings. It was the first time a senior Iraqi official had spoken of such high civilian losses. The government previously listed 650 civilian dead.

Civilian deaths estimated

Peace activist and former U.S. Attorney General Ramsey Clark, newly returned to New York from a week in Iraq, said the chief of the country's Red Cross affiliate estimated civilian deaths at 6,000 to 7,000.

In the Middle East and elsewhere, the quest for peace continued.

A Soviet envoy, Yevgeny Primakov, ventured into bomb-battered Baghdad

Ketchikan Daily News / Feb 12, 1991

	Tuesday	
Low	5:12 a.m.	4.4 ft.
High	11:15 a.m.	15.2 ft.
Low	5:45 p.m.	-0.2 ft.
High	....	...
	Wednesday	
Low	5:49 a.m.	3.4 ft.
High	0:13 a.m.	14.0 ft.
Low	6:17 p.m.	-0.8 ft.
High	11:51 a.m.	15.0 ft.

Weather Special

Two new records high temperature for the 10th of Feburary was set for Annette Island Sunday.

A new record high to 61 degrees broke the pervious high of 60 degree set in 1970. Also the high minimum temperature of 39 degrees set way back in 1963 was broken with a new high minimum temperature of 45 degrees.

Alaska Summary

By The Associated Press

Two weak low pressure centers located just offshore from the Kuskokwim delta and over the Alaska Peninsula brought precipitation to southern portions of Alaska. The precipitation was mainly in the form of snow over the Aleutians and the Pribilofs.

There was rain over the southeast Alaska panhandle and Kodiak Island, and a mixture of rain and snow over Bristol Bay, the Alaska Peninsula, the Susitna valley and the north gulf coast.

Bethel, in the Yukon Kuskokwim delta, reported periods of freezing rain during the morning.

Otherwise skies were mostly cloudy over the remainder of Alaska today.

Strong northerly winds blew over the Bering Sea, with both Gambell and Saint Paul Island reporting winds gusting over 35 miles per hour. Saint Paul also had a blowing snow advisory in Coast.

It snowed over much of inland New York state and parts of Pennsylvania, Ohio and Michigan. Snow also fell from east central Illinois to southeast Iowa. Snowfall during the six hours ending at 1 p.m. EST included 4 inches at Syracuse, N.Y., and 1 inch at Bradford, Pa. There were no reports of heavy rainfall during the same six hours.

Winds to near 40 mph over parts of New York state and western Pennsylvania brought wind chills of 23 below zero at Massena, N.Y., 19 below at Bradford, Pa., and 15 below at Buffalo, N.Y.

The low for the Lower 48 states Monday morning was minus 10 degrees at Caribou, Maine.

Temperatures around the nation at 3 p.m. ranged from 9 degrees at International Falls, Minn., to 85 at Palm Springs, Calif.

Gulf Summary

By The Associated Press

Tuesday's forecast for Iraq is for quiet weather to continue, according to Accu-Weather Inc.

The private forecast service in State College, Pa., said the sky will be sunny to partly cloudy throught the entire Mideast. Temperatures will be in the low 60s in Iraq and Israel while readings in the upper 60s and low 70s will prevail in Saudi Arabia. Tuesday night will bring patchy clouds and light winds throughout the area.

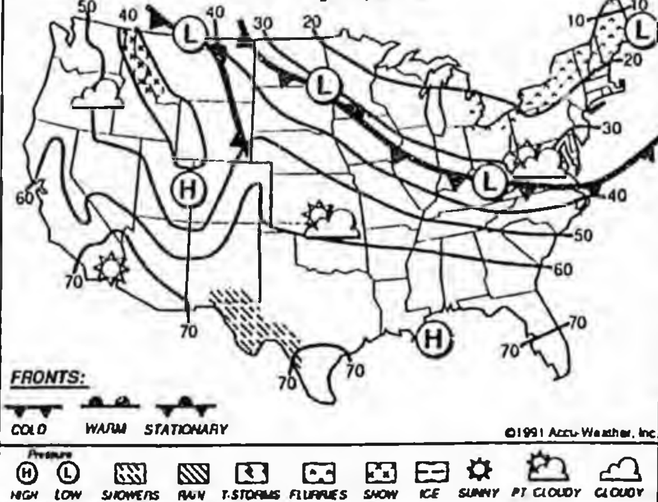
(Some countries in the region, including Iraq, are no longer providing surface observations normally used in forecasting. Accu-Weather bases its predictions on satellite photos, and measurements from the countries still providing weather data.)

Estimated Middle East Temperatures:

Tuesday	Hi	Lo
Amman	62	40
Baghdad	60	32
Cairo	62	42
Damascus	59	30
Dhahran	72	52
Jiddah	78	54
Riyadh	72	49
Tehran	40	25

Lower 48 Weather

The Accu-Weather® forecast for noon, Tuesday, Feb. 12.



Via Associated Press GraphicsNet

nations began considering an Iranian bid to mediate an end to the conflict.

The Soviets and Iranians say Iraq must agree to end its 6-month-old occupation of Kuwait, a condition Saddam has rejected. Before heading to Baghdad, Primakov stopped in Tehran to coordinate his activities with the Iranians.

Since last week, in a buildup to ground war, Operation Desert Storm's air arm has intensified its attacks on Iraqi positions and supply lines, particularly bridges, in the Kuwait Theater of Operations — Kuwait and southern Iraq.

Brightening skies Monday enabled air commanders to mount 2,900 sorties over 24 hours, hundreds more than on any recent day. The U.S command said 750 missions were directed against Iraqi positions in the Kuwait theater, including 200 against the dug-in Republican Guard, the Iraqi army's elite units.

Basra was again hit hard. The southern Iraqi port is both headquarters for the Iraqi defense and a transshipment

Basra .....

A U.S. command spokesman, Marine Brig. Gen. Richard Neal, said bombers have destroyed many of the key links into and out of Basra, which lies in a region crisscrossed by rivers and other waterways.

The Americans reported continuing successful strikes against tanks, artillery and Iraqi bunkers in the Kuwait theater.

Capt. Dewey Gay, the F-16 pilot who "hated to come back," said his flight "pretty much got all the tanks. ... This was one of the best ones in a while."

Launchers reportedly hit

Desert Storm officers also reported likely hits against four Iraqi mobile

...... the Saudi capital. Israeli authorities said the Scud there fell into a deserted area in the central part of the country. U.S.-supplied Patriot missiles destroyed the incoming Scud near Riyadh, but falling debris injured two people, officials said.

Early Tuesday, a missile with a conventional warhead hit a residential area in Israel, officials said. Army spokesman Brig. Gen. Nachman Shai did not say how many people were hurt but that "most of them are only slightly wounded. Perhaps one or two

Iraqi radio announced old male students are bei report to military conscr In January, the Baghdad lowered the age for m tary service in Iraq to 1 exempted 17-year-olds

Iraq will not agree and will never surrend radio said.

Since the early days week-old war, Iraq has silent on the question casualties.

In brief

Hearings scheduled

The House Resources Committee is sponsoring a legislative public hearing on three house bills dealing with the Alaska Mental Health Lands Trust.

House Bill No. 58 calls for appropriations to the Alaska Mental Health Trust Escrow Account while House Bill No. 59 reconstitutes the mental health lands trust under the Alaska Mental Health Enabling Act of 1956.

In addition, House Bill No. 79 will be addressed. It calls for the establishment of a mental health trust authority.

Testimony will be limited to the land/mental health trust issue only and persons interested in testifying or observing may do so at 3 p.m. Wednesday at the Legislative Information Office on Front Street.

In addition, the House Labor and Commerce Committee has planned a public hearing on House Bill No. 78, which relates to employment rights based on pregnancy, childbirth and related conditions, sick leave and family leave.

Testimony will be taken at the teleconference, which starts at 1 p.m. Tuesday at the LIO in Ketchikan.

Hospital

Continued from page 1

berth was completed in June.

Asbestos a problem

The areas of the hospital targeted for renovation and expansion include the emergency and radiology departments, the laboratory, support areas, conference rooms and private patient rooms. Asbestos removal is also slated as part of the project.

Mahn said the asbestos problem will be contained or "encapsulated" in areas of renovation and removed from areas of remodeling.

In addition, the project calls for the replacement of the mechanical, heating and electrical facilities. Mahn said the hospital does not have the required fire sprinklers, which are included in the project.

Mahn is hoping to receive good news from the Legislature in July. If the appropriation comes through, an 8-month design process will start. He said construction could take between three and four years, depending on the number of project phases.

In addition to the appropriations bill, Jones also introduced Senate Bill No. 67, which would place a systematic, rational procedure for ranking hospital and nursing home projects to help get the worthiest and neediest projects funded.

Rep. Cheri Davis, R-Ketchikan, said it is hard to make the call about the hospital funding. She said it is difficult to know with a new governor and administration.

"I hope it will go well. We're going to fight for it. None of us know what the governor's plan is," she said.

Valentines for T...

Lobster stuffed Filet Mignon

Tender filet stuffed with lobster, green onions, mushrooms and herbs. Broiled to perfection and served with bearnaise sauce.

Halibut & Prawns Vancouve...

A filet of halibut stuffed with peppe... mushrooms and edam cheese. Serve... hollendaise sauce with two bay sh... and three sauteed prawns.

Your Choice for tw...

$60 plus tax & grat...

Includes a rose for the ladies and a bottle of good...

Charley's regular dinner will be available.
Music by 'Hotfoot'

Reservations Recomended 225-5090

Ketchikan's finest Dining and Entertain...

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P.O. Box 2968 • Kodiak, AK 99615 • (907)486-3959

James L. Fisk Jr.
Chief Executive Officer

Diamond Jim's

FAX TRANSMITTAL

DATE: 3-1-91

TO: Senator H. STURGULEWSKI

ATTENTION: Hess Chairman

FAX NUMBER:

COMPANY:

ADDRESS:

FROM:

NUMBER OF PAGES INCLUDING THIS PAGE:

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Our telefax number is:

- [X] (907)486-7099
- [ ] (907)486-4116
- [ ] ______

This FAX was sent by: Jim Fisk Jr.

MESSAGE:

Madam Chairman "Hess"

Here are some facts & Fig.

Saddam is present w/ Republican Guards

For Hearing on SB 111 Let us put it to a

Vote of the people and it will fail

By 95% our facilities is only a Holding

Place Till the Next Jet airplane

Thanks

Jim

"E"

KODIAK ISLAND HOSPITAL AND CARE CENTER
JANUARY STATISTICS

	BUDGETED	ACTUAL	VARIANCE	Decrease
ADMISSIONS:				
MED/SURG	79	70	(19)	
OB/GYN	22	23	1	
SWING BED	3	4	1	
ICU/CCU	10	4	(6)	
NURSERY	21	24	3	
TOTAL ACUTE ADMITS	135	125	(10)	8%
PATIENT/RESIDENT DAYS				
MED/SURG	275	177	(98)	
OB/GYN	47	34	(13)	
ICU/CCU	17	11	(6)	
SWING BEDS	54	63	9	
NURSERY	36	37	1	
TOTAL ACUTE DAYS	429	322	(108)	25%
CARE CENTER DAYS	537	468	(69)	
BIRTHS	21	24	3	
TOTAL OUTPATIENT VISITS	495	325	(170)	35%
SURGICAL SERVICES				
INPATIENT PROCEDURES	15	13	(2)	
OUTPATIENT PROCEDURES	12	5	(7)	
EMERGENCY ROOM VISITS	370	295	(75)	20%

Average 88 / 4 = 22%

F-1-5

Atto: Department Head's 25
Employees 128

EMPLOYEES BY DEPARTMENT LIST

DEPARTMENT 050 (PURCHASING)

01230	*	BARBARA ALLAIN
2410		DONNA BUNNELL
16220		KELLY PHILLIMEANO
19190		JEFFRY SILVA

DEPARTMENT 052 (DIETARY)

2030		NANCY BALORAN
2089	*	BETTY BARNES
2290		DAN BLACKMAN
4143		ELLIZABETH DELOS SANTOS
7054		LADONNA GIL
8032	*	SANDRA HALSEY
1271	*	MITHOSILA LAURIN
13508		DEBRA MULLAN
16071		CORAZION PASION
20053		PATRICIA TILL
23033		ANNIE WAGONER

DEPARTMENT 053 (HOUSEKEEPING)

5082		EGENIO ERIBAL	LOA
7126		CLAUDIA GONZALES	
14035		AURORA NATIVIDAD	
15008		RO-SAL OLAES	
16168	*	MANUAL PENERA	
19000		ROSANEL SABADO	
22046	*	VIRGINIA VALLADOLID	
22053		LALAH VALUZ	

DEPARTMENT 054 (LAUNDRY)

2360		JUANITA BULAONG
7096		NANCY GOCHAN

DEPARTMENT 056 (MAINTENANCE)

1123		PHILLIP AGUIRRE
2121		CHRIS BISHOP
20040		STAN THOMPSONN

5 28

DEPARTMENT 060 (ACCOUNTING)
22160 KEITH VORACHEK
08200 TIMOTHY R. HOCUM
3078 SHARON MAJOR

DEPARTMENT 066 (UNIT SECRETARIES)
6023 * RHONNY FARRELL
7010 * MARIA GARCIA
16154 * FRANCES PENDLEY
18086 * NEDRA ROOKSTOOL
19224 * JENNIFER SMITH
22004 * CYNTHIA VAN REESE
25106 * JESSE YOUMANS

DEPARTMENT 067 (BUSINESS OFFICE)

3319 ALISON CHILDS
8290 JULIE HOWARD
11070 SUSAN KERBY
12098 SHARON LUDVIGSON
13268 KIMBERLY MEAD
15032 DANA OLIVER

DEPARTMENT 068 (DATA PROCESSING)
16055 LETICIA PASCUA

DEPARTMENT 069 (CREDIT & COLLECTIONS)

DEPARTMENT 080 (ADMINISTRATION)
08185 * REBECCA HICKOX HIRED 11/19/90 P/T
18005 DEBRA RAPER
19315 BETH STOHL-REILAND

DEPARTMENT 084 (MEDICAL RECORDS)
5041 RENIE ELLER
7070 MARY GLAMANN
8227 CORLENE HOGG
8326 CYNTHIA HURT
11060 PAMELA KELLY
12054 * SANDRA LAYTON
03300 * DORIS MENSCH
23226 REBECCA WHITE

F-3-5

DEPARTMENT 086 (HUMAN RESOURCES)

DEPARTMENT 101 (NURSING ADMINISTRATION)

6080		KATHLEEN FITZGERALD	
23093	*	CAMI WARNER	

DEPARTMENT 104 (ACUTE NURSING)

1594		SANDRA ANDREWS	
2095	*	LADONNA BENDER	HIRED 11/21/90 ins/chg 12/8
3772		KATHLEEN CROSSEN	
6205	*	ILVA FOX	LOA
6221		NEVA DIANNE FRANKLIN	
07062	*	SHEILA GILPIN	
8052		CINDY HARDY	
8128		MARIAN HEMINGWAY	
10033		LILIA JENKS	
10470		PENELOPE JONES	
11122	*	CHRISTY KINTER	
12013		NANCY LANCE	
12138		ADELAIDA LLAVE	
13029		ALICE MACDONOUGH	
13097	*	ESTRELLA MANGAHAS	
13144		FELICIDAD MARASIGAN	
13151		JANISE MARSHALL	
13185	*	DEBRA MCBRIDE	
13524		LINDA MULLAN	
15040	*	ANDREA OLSEN	
16295	*	JUDY PHILLIPS	
16477		ROBERT PLYER	
16097	*	MAUREEN PROVOST	
18076	*	ALANA ROE	
18101		JOSEFINA ROSALES	
20045		PATRICIA THORN	
22095	*	PAULA VICKSTROM	
23028		BETSY WADE	
23045	*	MARGARET WALKER	HIRE DATE 11/1/90
23058		SUSANA WALLACE	

DEPARTMENT 106 (SURGERY)

02280	*	MIKE BLACK	
07591		JIM GREER	
22030		DONNA VAZQUEZ	

35

DEPARTMENT 120 (ANESTHESIA)

F-4-5

6077	KEITH FALATKO	
DEPARTMENT 122 (LABORATORY)		
1115	MARY AGUIRRE	
3210	RICHARD CARSTENS	
3418	STEPHEN COEN	
13433	DENNIS MOONEY	
DEPARTMENT 126 (RADIOLOGY)		
07665	DENNIS GRUSOLAK	
11200	MEGAN KNAUF	HIRED 11/26/90 F/T
12872	JACK LUA	
19679	FLEURETTE GAGNE	
DEPARTMENT 130 (RESPIRATORY CARE)		
3178	BARBARA CARBERRY	
13227	JEFF MARCH	
23060	WAYNE WALLACE	
DEPARTMENT 132 (PHYSICAL THERAPY)		
8060	CENA HARMON	
DEPARTMENT 133 (SPEECH THERAPY)		
4218	* JEAN DICKSON	
DEPARTMENT 137 (PHARMACY)		
13219	JOHN MCENTEE	
19125	* LUCY PRYOR	
DEPARTMENT 201 (NURSING ADMINISTRATION)		
10462	JUANITA JONES	

7 16

F-5-5

DEPARTMENT 214 (CARE CENTER NURSING)

1032		LILIAN ACUNA	
2006	*	BELINDA BALMES	
2147		SARA BISHOP	
3053		GLORIA CABUDOL	
3582	*	MARLYCE COZART	
4226		EDNA DOMINGO	
11007		MERNA KEENE	
13300		TITA MEDINA	
13359	*	ASUNCION MIRANDA	
16014		ESTHER PAGSOLINGAN	
19140		VICKI SHELTON	
19303		SANDRA STEELMAN	
20008		WILMA TANNER	
20065	*	MARTHA TROTZKE	HIRE DATE 11/1/90
22012		LYNN VARGAS	

DEPARTMENT 234 (ACTIVITIES)

05046	*	SUSAN EMERSON	
03440		ALANNA MONTAGUE	
20125		REBA C. TURNER	HIRE DATE 11/12/90

DEPARTMENT 240 (SOCIAL SERVICES)

6098 MICHELE FITZGERALD-DYER

DEPARTMENT 578 (DR. TSCHERICH BILLING)

10496 EMILIA JOVANOVIC

4

20

A

KODIAK ISLAND HOSPITAL AND CARE CENTER
MEMORANDUM

TO: Jan Blanton, Interim Administrator

FROM: Deb Raper, Administrative Secretary

DATE: February 11, 1991

SUBJECT: New Facility Support

In a phone conversation with Jerome Selby, Borough Mayor, this morning, he indicated that Jim Fiske, a self-appointed community representative and personal friend of Walter Hickel, the new governor, had told Gov. Hickel that Kodiak doesn't need a new hospital. Apparently, Fiske has some influence with Gov. Hickel and Mayor Selby is concerned about Fiske changing the attitude of Gov. Hickel with regard to construction.

Mayor Selby strongly suggested that a letter writing campaign be undertaken, that the letters be addressed to Gov. Hickel and copies sent to Representative Davidson and Senator Zharoff.

Jerome suggested that you work with staff, board and auxiliary and flood Gov. Hickel's office with letters of support for a new hospital. He suggested that staff who wrote letters also indicate their position in the hospital, i.e., Charge Nurse, Janitor, etc. so that a broad cross-section of support is shown.

The Auxiliary is meeting tomorrow night at the home of Anne Kalcic, the co-president, 812 Mission Road. This might be a good opportunity for you to meet with the organization and ask for their support (and the support of their many and influential friends). As an organization, they are pro new facility.

The Board is meeting on Wednesday night and this should be an item on the agenda.

NOTE I would think that the best way to get the word to the staff would be through the daily in-house publication, the "Pulse Beat", which I edit. If you agree, perhaps we can work on the wording?

Post-it™ brand fax transmittal memo 7671	# of pages ▸ 1
To Tom Mingea	From Deb Raper
Co. LHS	Co. KIH
Dept.	Phone #

SB
112

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB 112

Revision Date:

Title: An Act relating to anatomical gifts.

Sponsor: Senator Fahrenkamp

Requestor: Senate HESS

Department Affected: Public Safety

BRU: Alaska State Troopers

Component: Detachments

COMPONENT SERIAL NO. | | 7 | 9 | 9 |

EXPENDITURES/REVENUES: (Thousands of Dollars) (Inflation not Included)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
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						
FEDERAL FUNDS						
OTHER/PROG RCPT						
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

Estimate of current year impact None

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact on Alaska State Troopers.

Prepared by: Gayle A. Horetski
Phone: 465-4322
Division: Commissioner's Office
Date: 3/5/91
Approved by Commissioner: Richard L. Burton
Agency: Department of Public Safety
Date: 3/5/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: SENATE BILL 112
Publish Date: 2/11/91

REQUEST: FISCAL NOTE

Revision Date:
Agency Affected: Health & Social Serivces
Title: Anatomical Gifts
BRU: State Health Serivces
Sponsor: Fahrenkamp
Components: Public Health Administration
Requester: Senate HESS

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants, Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

General Funds	0.0	0.0	0.0	0.0	0.0	0.0
Federal Funds						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS

Full-Time		0				
Part-Time		0				
Temporary		0				

ANALYSIS: (attach a separate page if necessary)

No fiscal impact.

Prepared By: Alfred G. Zangri
Phone: 465-3090
Division: PUBLIC HEALTH
Date: 02/27/91

Approved By Commissioner: Theodore Mala, M.D., MPH
Date: 3-5-91
Agency: HEALTH & SOCIAL SERVICES

Distribution (by preparer):
Legislative Finance, Legislative Sponsor, Requestor,
Office of Management & Budget, Impacted Agency(ies)

Alaska State Legislature

SENATOR BETTYE FAHRENKAMP
CHAIRMAN, LEGISLATIVE COUNCIL
CHAIRMAN, ADMINISTRATIVE REGULATION
REVIEW COMMITTEE
119 N. CUSHMAN STREET, SUITE 201
FAIRBANKS, ALASKA 99701
OFFICE (907) 452-4882
HOME (907) 456-2899

Senate

WHILE IN JUNEAU
P.O. BOX V
JUNEAU, ALASKA 99811
CAPITOL, ROOM 125
OFFICE (907) 465-3834
HOME (907) 780-6027

MEMORANDUM

TO: All Senators

FROM: Senator Bettye Fahrenkamp

DATE: April 15, 1991

SUBJECT: CS SB 112 (Judiciary)
An Act relating to anatomical gifts.

BILL SUMMARY

* Reinforces that an individual's decision to donate body organs does not require the consent or concurrence of any individual after the donor's death.

* Requires that a reasonable search must be made for documentation that identifies the individual as a donor or as someone who has refused to make an anatomical gift. Failure to do so may result in administrative sanctions.

* Law enforcement or medical personnel and hospitals located in areas where hospitals don't have the provisions to accept an organ donation, are exempt from being required to make a reasonable search for documentation. But the hospital is required to make an effort to contact a donor bank if they are aware that the individual is a donor.

FISCAL IMPACT: Zero fiscal notes from HESS and Dept. of Public Safety.

PREVIOUS COMMITTEE ACTION:
HESS: DO PASS Sturgulewski, Cotten and Menard.
JUDICIARY: DO PASS Halford, Collins, Adams and Frank.

DEPARTMENT POSITION: Supported by the Department of Public Safety.

ABOUT THE BILL:
Currently hospitals require the consent of the next of kin before accepting an organ donation. SB 112 requires that hospitals and organ procurement centers comply with the wishes of the individual to make a gift upon their death and not require the consent of any other person. Hospitals that are not equipped to accept a donation are required to make a reasonable effort to contact a donor bank if the individual is an organ donor.

POSITION PAPER / DEPARTMENT OF PUBLIC SAFETY

BILL NO: SB 112

DATE: 3/5/91

TITLE: An Act relating to anatomical gifts.

CONTACT: Gayle A. Horetski
Deputy Commissioner
465-4322

SB 112 modifies the existing anatomical gift statute in the following ways:

1. Unless a gift is revoked before death by the donor, the gift becomes irrevocable and does not require the consent or concurrence of any person after the donor's death.

2. Requires hospital administrators and employees to make a reasonable search for a document or other information, identifying the deceased as a donor, or as a person who has refused to make an anatomical gift.

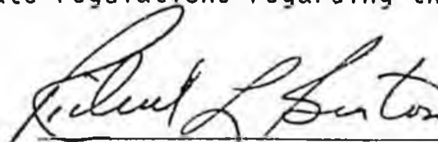
3. Requires law enforcement officers to make a "reasonable search" for a document of gift or other information identifying the bearer as a donor, or as a person who has refused to make an anatomical gift, and to inform hospital personnel of the intended gift.

4. The bill establishes that failure of either hospital administrators or police officers to make a reasonable search may subject the administrator or police office to "appropriate administrative sanctions".

The Department of Public Safety interprets the requirement that law enforcement personnel at the scene of a death make a "reasonable search" for an anatomical gift document to mean that the officer must take an extra moment or two to search the person of the deceased for documents proclaiming him or her as a donor.

The Department of Public Safety supports this bill, as it has the laudable goal of encouraging Alaskans to donate their organs, upon their death, to other persons in dire need of those organs.

The Department proposes one change in the bill. In Section 3, at page 2, line 13, the word "administrative" should be changed to "disciplinary", and a period should be placed after "sanctions", ending the sentence. Line 14 should be omitted entirely. Disciplinary actions against State Troopers are taken under authority of the Department's Operating Procedures Manual (OPM), state personnel rules, bargaining unit contracts, and other applicable provisions. The Department of Public Safety does not have separate regulations regarding this subject.



Richard L. Burton
Commissioner

Alaska State Legislature

SENATOR BETTYE FAHRENKAMP
CHAIRMAN, LEGISLATIVE COUNCIL
CHAIRMAN, ADMINISTRATIVE REGULATION
REVIEW COMMITTEE
119 N. CUSHMAN STREET, SUITE 201
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HOME (907) 456-2899

Senate

WHILE IN JUNEAU
P.O. BOX V
JUNEAU, ALASKA 99811
CAPITOL, ROOM 125
OFFICE (907) 465-3834
HOME (907) 780-6027

TO: Senator Arliss Sturgulewski, Chair
Senate Health, Education and Social Services Committee

FROM: Senator Bettye Fahrenkamp

DATE: February 22, 1991

SUBJECT: Senate Bill 112
"An act relating to anatomical gifts."

A constituent of mine, upon renewing his driver's license this summer, decided to become an organ donor. He was then advised that hospital policy still required the consent of next of kin or they would not accept the donation.

By accepting next of kin's refusal to honor an organ donor's wishes, hospitals and organ procurement centers may be witholding medical care from transplant recipients. This would hold particularly true in the instance where a recipient is on hand and the next of kin cannot be reached to ask for consent. **No one should interfere with an individual's right to make the final decision on organ donation.**

BILL SUMMARY:

SB 112 clarifies that an individual's decision not revoked by the donor before death does not require the consent or concurrence of any person after the donor's death.

SB 112 also requires that a reasonable search must be made for documentation that identifies the person as either a donor or someone who has declined to donate. Failure to make a reasonable search may be the basis for appropriate sanctions under regulations of the Department of Health and Social Services, the State Medical Board or private hospital accrediting organizations. Any hospital or person acting in good faith or attempting to do so in accordance with this chapter could not be held liable for any damages.

SB 112 is an attempt to put the decision about organ donation back into the donor's hands, while clearly defining the protection against liability to hospital officials and physicians who act on the basis of signed donor cards.

As Joel Swerdlow of the Annenberg Washington Program wrote in **Matching Needs, Saving Lives**, "By letting donors themselves decide, we protect two basic values: First, we protect our right to decide, which is already granted by law. Second, we can save lives: when health-care institutions accept the next of kin's refusal to honor an organ donor's wishes, they may be withholding medical care from transplant candidates."

I urge your early scheduling and favorable consideration of this measure. I would be happy to answer any questions you may have and provide further information upon request.

PUBLIC OPINION MESSAGE

DEAR: SENATOR STURGULEWSKI

NAME: DONALD STEIN/CMTE MEMBER
TITLE: ALASKA LEGISLATIVE AFFAIRS WATCH
ADDRESS: PO BOX 10904
CITY: FAIRBANKS ZIP: 99710
PHONE: 455-6208
BILL NO: SB 112
SUBJECT: ANATOMICAL GIFTS
MESSAGE: ALASKA LEGISLATIVE AFFAIRS WATCH OPPOSES SB 121. THANK YOU. EOM/CLS

POMID: 07124217
DATE: 91/03/15
TIME: 12:42:17
LIONAME: FAIRBANKS LIO

COPIES:

REPRESENTATIVES	SENATORS
BOYER	FAHRENKAMP
KOPONEN	FRANK
M.W.MILLER	SHULTZ
MOYER	ZHAROFF
SHARP	HOFFMAN
	PEARCE
	KERTTULA
	POURCHOT
	DUNCAN
	ADAMS
	UEHLING

MATCHING NEEDS, SAVING LIVES

BUILDING A COMPREHENSIVE NETWORK FOR TRANSPLANTATION AND BIOMEDICAL RESEARCH

A REPORT ON POLICY OPTIONS

BY JOEL L. SWERDLOW

THE ANNENBERG WASHINGTON PROGRAM
Communications Policy Studies
Northwestern University

DEDICATION

About a year ago I read a newspaper story about how a 49-year-old woman in Wisconsin had saved the life of a six-year-old girl in Raleigh, N.C., who was dying of leukemia. The girl needed a bone marrow transplant and had no siblings whose antigens matched hers. But the woman in Wisconsin was a perfect match—a computer search that cost pennies brought the two of them together.

The story made me think of my brother, Paul H. Swerdlow. He was full of life and love, a Ph.D. in nuclear physics and a board-certified radiologist—a man with much to give. In late 1984 he lay dying of leukemia.

Paul's hope for life was that either our sister or I would be a match. Technicians took our blood. We all tried to keep busy with other things while we waited for the results. When the telephone rang, however, the lab reported that neither of us matched Paul. Seven months later, at the age of 42, he died.

Paul lived in Boston. In just that area, according to medical experts, there were about 100 people who might have saved him. In all of America, as many as 25,000 people might have saved my brother's life—if society had set up the necessary communications system. It could have been so simple, but ultimately it was impossible. And, as this report shows, the need goes far beyond my brother's particular illness.

My brother lived in the world of medicine and science; my work involves politics and public policy. "We should write something together," he often said. "The people in your world have to better understand the great advances in mine."

During the past six months I've visited in Paul's world. I've interviewed hundreds of health care providers, read medical journals and transcripts of congressional hearings, and attended conventions of transplant specialists. Although I was sometimes the only nonmedical person at the meetings, few participants seemed surprised to see me. The transplantation community knows the outside world will eventually pay more attention. Some expect the attention to come in the form of scandal, bred by the lack of regulation in tissue recovery and the huge dollar flow in the processing and distribution of organs and tissues. Others expect that the public will some day demand to know why more sick and injured people don't benefit from transplants.

I repeatedly heard one message from professionals who work long hours, receive little recognition and make miracles: To accept the status quo, given today's capabilities, is inexcusable.

This report is dedicated to all the people who would have helped my brother if given the chance, to all who now suffer for lack of a transplant and to those who will make possible the happy endings yet to come.

JOEL L. SWERDLOW

CONTENTS

DEDICATION 3

FROM THE DIRECTOR 6

INTRODUCTION 7

EXECUTIVE SUMMARY 8

LIFESAVING CONNECTIONS 10

THE SITUATION TODAY: SHORTAGES 13

OPTIONS: TO INCREASE DONATION 16

THE SITUATION TODAY: RECOVERY AND DISTRIBUTION 21

OPTIONS: TO COORDINATE RECOVERY AND DISTRIBUTION 28

THE NEXT STEPS 31

COMMENTARIES 35
By Richard L. Fuller and Thomas J. Moore, Eye Bank Association of America;
William E. Grizzle, University of Alabama at Birmingham;
Dale Hatfield, communications consultant;
Nancy Holland, American Council on Transplantation;
William V. Miller, American Red Cross;
John M. Newmann, health policy consultant;
Luke Skelley, American Association of Organ Procurement Organizations;
Rodney A. Smolla, law professor, College of William and Mary;
William W. Tomford, American Association of Tissue Banks;
Pamela Weinberg, National Marrow Donor Program;
Steven S. Wildman, communications professor, Northwestern University.

APPENDIX
Laws and Regulations Relating to the Procurement
and Use of Human Organs and Tissues

By Fred H. Cate, Debevoise & Plimpton 46

ACKNOWLEDGMENTS 61

ENDNOTES 63

INTRODUCTION

This report is worthy of attention for its fresh, comprehensive look at the issues in the critical field of human organ and tissue transplantation, and, in particular, for its emphasis on improving communications within the field and coordination of efforts to increase organ and tissue availability.

The shortage of organs and tissues is often the factor that most severely limits physicians' ability to treat patients who need a transplant. The patients' life-or-death situation and the present scarcity of available organs demand the most efficient use of present resources and intensification of efforts to increase supply.

We are making progress in increasing supply through such measures as state required-request laws for organ donation, the Uniform Anatomical Gift Act and federal requirements that hospitals develop written protocols for identification of potential organ donors. Despite these important steps, however, we are still unable to provide lifesaving organs to even a majority of individuals who need transplants.

Innovative means of increasing supply should be both encouraged and subjected to thoughtful scrutiny by patients, physicians and other health care personnel, ethicists, legal experts, hospital administrators and those involved in organ procurement and distribution. Improvements in supply are likely to be achieved by involving all parties concerned with improving patient care.

M. ROY SCHWARZ, M.D.
Assistant Executive Vice President,
Medical Education and Science
American Medical Association

The proposals advanced in this document do not necessarily reflect the policies and positions of the American Medical Association.

propose a comprehensive National Human Organ and Tissue Policy. The task force would both initiate and coordinate demonstration projects in the medical community and propose legislation. It would consider and recommend plans for initiatives such as these, built on existing institutions:

- a comprehensive national computer-based communications network to coordinate the recovery and allocation of donated tissues as well as organs under consistent, equitable ground rules,
- a continuous, intensive public education campaign to promote donation and family discussion of donation options,
- experimentation with a statewide electronic donor registry and other mechanisms that would let donors themselves (instead of their next of kin) make the final decision to donate,
- training and incentives for hospital personnel to increase the recognition of potential donors and improve requests for donation,
- streamlined systems on the local level for more extensive recovery of donated organs and tissues,
- an expanded computer registry of living Americans who volunteer to donate lifesaving bone marrow,
- a 24-hour database of medical literature and a telephone hotline to make available the latest techniques and data to health care providers,
- a coordinated system of national databases, linked with all tissue and organ transplantation centers and procurement organizations, to collect data on treatment, cost and outcomes for evaluation,
- assessment of public attitudes about and the desirability of expanding "presumed-consent" laws, which would increase donation by declaring that everyone has given consent to donation unless they explicitly withhold it (registering their refusal with a national databank), and
- a medical consensus conference on the desirability of beginning kidney recovery from non-heart-beating donors, which would greatly increase the supply of the most frequently transplanted organ.

Many people still think of transplantation as a high-technology luxury. In fact, investing in the measures described above would save money for taxpayers and society as a whole, because transplantation is often less costly than alternative treatments.

More importantly, the lives saved and suffering ended give us tens of thousands of human reasons for action.

OPTIONS: TO INCREASE DONATION

In the Dan Smith scenario, Dan was able to donate because he and his wife had talked about donation long before his fatal accident and because hospital personnel were prepared to respond to his wish. These things seem simple, but they are not the norm in the United States today. As long as patients are waiting for organ transplants, the failure to recover a single suitable donated organ is tantamount to withholding medical care. A concerted effort is needed, including any or all of the following policy options, before we can expect more people to give or receive "the gift of life."

FULLY IMPLEMENT THE "REQUIRED-REQUEST" LAWS

In the mid- to late 1980s, public policymakers took what they hoped would be a major step to increase donation: federal regulations and "required-request" laws in 41 states and the District of Columbia obligate hospitals to ask next of kin whether they wish to donate the organs and tissues of a recently deceased family member.[33]

In practice, however, state agencies make little effort (or have little authority) to enforce required-request laws, and many hospitals—including major transplant centers—have done nothing to implement them, according to hospital officials. Short-staffed hospitals frequently lack the resources to perform the time-consuming, demanding tasks necessary to acquire donated tissue and organs.

The first task is for physicians to identify medically eligible donors and alert the appropriate hospital personnel. This is not so likely to be done as one might expect. A recent sample of 195 physicians and nurses found that only 35 percent "correctly identified the legal and medical criteria for determining" brain-death.[34] The leader of one of the nation's most successful organ procurement organizations says the hospitals in his area often do not call when they have potential donors because they do not properly identify them. "We sit around and wait far more than we should," he says.

Second, a hospital or organ procurement worker must approach the family to request donation—a delicate task. When the health-care worker assigned to request donation doesn't want to do it or doesn't know how, says University of Minnesota ethicist Arthur Caplan, "the consent rate is . . . zero."[35] In some states, furthermore, the required-request laws do not apply to tissue donation and do nothing to encourage donation of human material for medical research.[36]

It is too soon to know how well required-request laws work. Caplan, their principal proponent, remains optimistic that "the supply of organs and tissues will significantly increase once all protocols are in place and people are more comfortable with required request."[37] However, evidence about the effects of the laws is conflicting. Tissue bank officials indicate that tissue donations have increased, perhaps by as much as 300 percent.[38] The Eye Bank Association of America reports only a 4 percent increase in 1988.[39] A recent UNOS study reveals "a marked upturn trend for the 15-month period ending in December 1988,"[40] although some transplant surgeons question this finding.

Experience indicates that donations surge in hospitals where trained professionals have adequate time to communicate with donor families.[41] At the

same time, reports from some localities, including a statewide Ohio survey, show no change in the donation rate after passage of required-request laws.[42] Whatever the success of required-request laws, experts agree that there is little reason to believe that these laws alone will produce an adequate supply.

INCENTIVES AND TRAINING TO PROMOTE REQUIRED-REQUEST

Requesting donations is a difficult, labor-intensive task that demands sensitivity and special skills. Yet it often falls upon hospital personnel who are already overworked and underpaid. Thus, money for training and incentives is needed: public/private-sector mechanisms could pay for training of personnel to implement required-request. Hospitals could be motivated by more consistent enforcement of existing required-request statutes and by linking their accreditation or tax-exempt status to effective donor-recruitment efforts.

When the House of Representatives was considering transplantation legislation in 1984, then-Congressman Albert Gore predicted that the bill would inspire "educational and training programs in every hospital and medical community throughout this country in order to greatly increase the rate of organ donation."[43] But no organization received the mandate or the money necessary to conduct such an effective nationwide training program. Training has been sporadic, and varies significantly from hospital to hospital.

BUILD A CONTINUING PUBLIC EDUCATION CAMPAIGN

Despite extraordinary dedication of the OPOs and voluntary organizations, current efforts to spread the word about donation have been underfunded.[44] For various reasons the health community has not yet fully enlisted the communications media in this cause as effectively as it has put out messages about smoking, seat belts, drunk driving, illegal drugs and AIDS.

By not volunteering to donate their own or their relatives' organs and tissues, too many people opt to permit avoidable suffering and death without knowing they are making the choice.

Today, the major effort to educate the donation decision-maker occurs immediately after the death of a relative, when a health-care worker sits down with the grieving next of kin. It is not the ideal time for either one. A concerted public education program would at least lay the groundwork for such sensitive discussions.

Teaching people about donation when they are in a learning setting can be very effective; therefore, donor-awareness programs could well be expanded in schools, churches, synagogues and civic organizations. Other mechanisms, some already in use, are also appropriate—among them, public service advertisements and dramatizations of the donation theme in popular television programs.[45]

Other health-related campaigns have shown that sustained effort can change behavior, particularly when the message taps into preexisting public support. According to public opinion polls, transplantation has such support. If campaigns are to promote complex changes in behavior, however, they must be continuous. Sporadic campaigns yield sporadic results.

The ideal campaign would encourage people to consider universal donation—all tissues and organs for medical research as well as transplantation. As a complement to in-depth efforts, it would also offer a 24-hour "800" Human Organ and Tissue (HOT) hotline, similar to the service the OPTN now operates (dial 800-24-DONOR), that anyone could call to ask questions.

In-depth research on Americans' current knowledge and attitudes about donation would help in fine-tuning the donor-options message, perhaps building on the familiar "Give the Gift of Life" theme now employed. Surveys and anecdotal evidence suggest, for instance, that many fear that organ and tissue donation disfigures the body before burial and in the afterlife. (Polls show that a vast majority of the American people believes in an afterlife.[46]) Outreach could reassure people that the major religions in this country encourage donation and could clarify the poorly understood concept of brain-death.

LET DONORS DECIDE FOR THEMSELVES

Federal and state laws give adults the right to decide whether to donate their tissues and organs.

Indeed, many people carry signed consent forms or fill in pledges on their drivers' licenses. Many assume that their wishes will be automatically respected, but often they are wrong. Hospitals contend that family values must be protected and fear negative publicity and legal challenges by displeased survivors. Therefore, they almost always let the next of kin make the final decision, regardless of the wishes of the deceased.

ONLY ABOUT 5% OF ELIGIBLE ADULTS DONATE BLOOD. IF THE SAME PERCENTAGE DONATED TISSUE, THE NATION'S TISSUE NEEDS COULD BE MET.

By letting donors themselves decide, we protect two basic values: First, we protect our right to decide, which is already granted by law. Second, we can save lives: when health-care institutions accept the next of kin's refusal to honor an organ donor's wishes, they may be withholding medical care from transplant candidates. This is particularly true in cases when a potential organ donor has just died, a recipient is at hand and the next of kin cannot be reached to be asked for consent.

Letting the donor decide would also clarify in the public mind who is making the decision and give donors a measure of personal satisfaction while they are still living.

Various kinds of legislation could put the decision back in donors' own hands. New laws could, for example, strengthen and more clearly define the protection against liability afforded hospital officials and physicians who act on the basis of signed donor cards. States could obligate hospitals and OPOs to recover organs and tissues for which there is a donor card and a demonstrated need. States could also more diligently enforce existing administrative penalties or allow civil liability to be imposed against institutions that fail to act on the basis of donor cards.

A DONOR REGISTRY

A communications option that would help return the donation decision to the donor is a computerized donor registry,[47] which medical personnel would consult shortly before or after the death of a person medically eligible to donate. With information from the registry, personnel could act promptly to recover organs and tissues during the brief period of time in which they are most useful for transplantation and research. For people who register as donors and then change their minds, the registry would permit easy updates.

In 1984, the Senate committee responsible for the National Organ Transplant Act reported its belief "that one important and appropriate new activity to include in the national computer registry is to provide a centralized list of individuals who have voluntarily agreed to donate organs. . . . "[48]

To avoid pitting the health care community against the family, donor registries (and nonelectronic alternatives such as consent forms and living wills) could include certification that the donor had discussed the decision with family members and, as appropriate, that the family had endorsed the decision. The registry could also bring in medical history data vital for screening for AIDS, hepatitis and other infectious diseases (and helpful in locating particular types of diseased tissues needed for research).

Great Britain briefly tested in-hospital donor registries with some success in the mid-1980s.[49] Twenty-one hospitals were connected in a system listing more than a quarter-million donation volunteers. Britain is now considering a system that would allow people to sign up as donors through a computer network with terminals in every physician's office. This would have the dual advantage of placing the discussion of donation in the context of the patient-physician relationship and removing it from the family's time of grief.

Georgetown University bioethicist Robert Veatch suggests that the government could increase the percentage of Americans making the donation decision themselves, and encourage family discussion of the decision, by adding donation questions to income tax forms.[50] For example, the forms could

ask the taxpayer, "Do you wish to be an organ/ tissue donor? With any limitations?" If a central registry were created, those who consented would have their names entered.

Opponents argue that donor registries are too expensive and difficult to keep up to date, that registries cannot guarantee confidentiality,[51] and that reliance on a registry might inadvertently contradict family wishes. Furthermore, critics say, hospitals might still leave the actual decision to next of kin, disregarding a donor registry just as they now ignore notations on donor drivers' licenses.

A MEDICAL ARGUMENT FOR LETTING DONORS DECIDE

Changing medical practice may increase the number of cases when doctors must determine quickly whether they have consent for donation. Kidneys recovered as late as one hour after coronary death can be transplanted, if certain medical steps are taken.[52] American transplant teams now almost always take kidneys only from brain-dead donors whose hearts are beating with support from ventilators, but recovering from non-heart-beating donors in addition would greatly increase the supply of kidneys—by far the most frequently transplanted organ. By the end of the century, says transplant surgeon David Anaise of the State University of New York at Stony Brook, livers and other organs may also be recovered from non-heart-beating donors.

Anaise estimates this the practice would increase the supply of kidneys tenfold if proper medical procedures are followed. It is, he says, "the only solution to the supply problem."[53]

Although the practice arouses opposition from parts of the medical community, many surgeons argue that "non-heart-beating donors can be a reasonable approach to help alleviate the shortage of kidneys."[54] Animal studies and advances in drugs that inhibit tissue death also suggest the practice may be productive.[55]

Each year, tens of thousands of Americans medically eligible to donate organs suffer coronary death from some form of heart attack or trauma.[56] Use of a donor registry, for rapid identification of those patients who have already consented to donate, would enable hospitals to coordinate rescue squads, emergency room personnel and organ recovery teams to recover the kidneys without delay.

States could adopt laws making it unnecessary to seek permission from next of kin before taking medical steps to protect the transplantability of organs from the deceased, thereby keeping their options open for later donation.[57] (Hospitals already perform a number of routine nondeforming procedures on cadavers for which permission is not requested.[58])

EXAMINE THE DESIRABILITY OF EXPANDING PRESUMED-CONSENT

More than a dozen countries—including France, Israel and Italy—have adopted "presumed-consent" laws, under which everyone is designated a donor unless they register their refusal.[59] These laws may not have had much effect, however, because most physicians still seek family permission.

The prevailing view among U.S. health care professionals is that presumed consent would never attract public support. However, given the new capability of computer/communications systems to register declinations, presumed-consent laws may be consistent with our basic values.[60]

Such a suggestion may seem startling, but limited presumed-consent laws are already on the books. Twenty-one states—double the number of only a few years ago—have such laws for corneas obtained from bodies under the jurisdiction of a medical examiner; unless the next of kin object, the medical examiner may remove the corneas of the deceased during autopsy. Seventeen states have similar provisions for pituitary glands.[61] Various states also have presumed-consent laws for unclaimed bodies. These laws could be expanded to provide tissues for research.

Presumed consent seems to be attracting support within the medical community for use in areas other than transplantation. Medical leaders, for example, are discussing mandatory autopsies and application of presumed consent to "intubation training" for physicians, which does not disfigure the corpse and is necessary for sound medical training.[62]

In Britain, furthermore, there is reportedly substantial public support for laws under which "doctors [can] remove organs from dead people for transplant unless they had specifically 'opted out' before death."[63]

SB
123

Comm.   Rm 427

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: SENATE BILL 123
Publish Date: 2/13/91

REQUEST: FISCAL NOTE

Revision Date:		Agency Affected:	Health & Social Scrivces
Title:	Informed Consent for Dental Fillings	BRU:	State Health Scrivces
Sponsor:	Rodey	Components:	Public Health Administration
Requester:	Senate HESS		

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants, Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
General Funds	0.0	0.0	0.0	0.0	0.0	0.0
Federal Funds						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Full-Time		0				
Part-Time		0				
Temporary		0				

ANALYSIS: (attach a separate page if necessary)

No fiscal impact.

Prepared By: Alfred G. Zangri   Phone: 465-3090
Division: PUBLIC HEALTH   Date: 02/27/91

Approved By Commissioner: Theodore Mala, M.D., MPH   Date: 3-5-91
Agency: HEALTH & SOCIAL SERVICES

Distribution (by preparer):
Legislative Finance, Legislative Sponsor, Requestor,
Office of Management & Budget, Impacted Agency(ies)

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB 123

Revision Date: ______

Department Affected: Commerce & Economic Dev.

Title: An Act requiring a dentist to obtain informed consent for dental fillings

BRU: Occupational Licensing

Component: Administration

Sponsor: Senator Rodey

Requestor: Senate HES

COMPONENT SERIAL NO. 0 3 5 6

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.)

New funds are not required to implement SB 123.

Prepared By: Jennifer Strickler, Admin. Officer

Phone: 465-2144

Division: Occupational Licensing

Date: May 2, 1991

Approved by Commissioner: Glenn A. Olds

Agency: Commerce and Economic Development

Date: 5-2-91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

STATE OF ALASKA

1992 LEGISLATIVE SESSION

FISCAL NOTE

BILL NO. SB 123

Revision Date. 02/26/92

Department Affected: Commerce & Economic Development

Title: An Act requiring a dentist to obtain informed consent for dental fillings.

BRU: Occupational Licensing

Component: Administration

Sponsor: Senator Rodey

Requestor: Senate HES

COMPONENT SERIAL NO. 0 3 5 6

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
GENERAL FUND	0.0	0.0	0.0	0.0	0.0	0.0
FEDERAL FUNDS	0.0	0.0	0.0	0.0	0.0	0.0
OTHER	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary)

New funds are not required to implement SB 123.

Prepared By: Jennifer Strickler

Phone: 465-2144

Division: Occupational Licensing

Date: 02/25/92

Approved by Commissioner: Glenn A. Olds

Agency: Commerce & Economic Development

Date: 2-25-92

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

Patrick M. Rodey
Senator

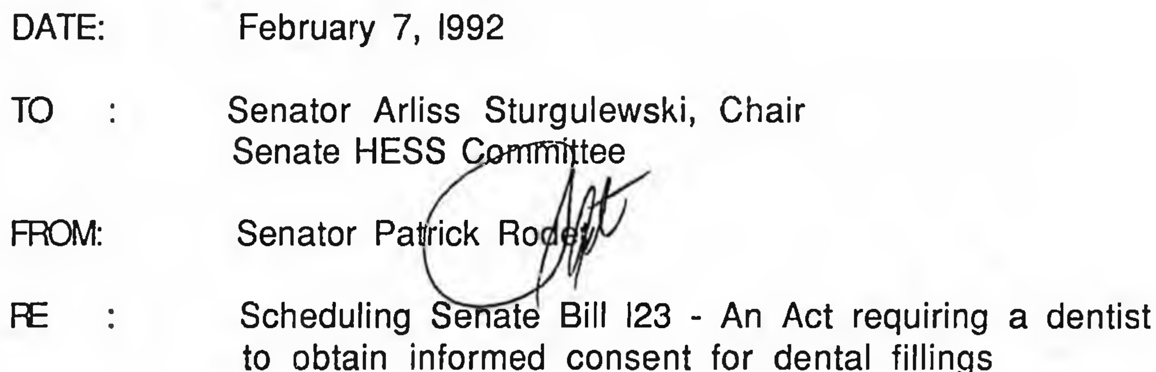
Alaska State Legislature

3111 C. St., Suite 510
Anchorage, Alaska 99503
(907) 561-7618

During Session:
P.O. Box V
Juneau, Alaska 99811
(907) 465-3793

Senate

MEMORANDUM



DATE: February 7, 1992

TO : Senator Arliss Sturgulewski, Chair
Senate HESS Committee

FROM: Senator Patrick Rodey

RE : Scheduling Senate Bill 123 - An Act requiring a dentist to obtain informed consent for dental fillings

I respectfully request that the Committee schedule SB 123 for a hearing.

As you know, the proposal establishes a statutory requirement for informed consent regarding dental fillings. I have provided the members material relating to this issue and believe there are sufficient consumer concerns which warrant establishing a responsible state policy on certain dental procedures.

I would appreciate your consideration of this request.

Patrick M. Rodey
Senator

Alaska State Legislature

311 C. St., Suite 510
Anchorage, Alaska 99503
(907) 561-7618

During Session:
P.O. Box V
Juneau, Alaska 99811
(907) 465-3793

rec'd 4-12-91

Senate

MEMORANDUM

DATE : April 9, 1991

TO : Senator Arliss Sturgulewski, Chair
Senate HESS Committee

FROM : Senator Pat Rodey *Pat*

RE : Senate Bill 123 - An Act requiring a dentist to obtain informed consent for dental fillings

I respectfully request that the Senate HESS Committee consider scheduling Senate Bill 123 for consideration in the near future.

The proposal establishes a statutory requirement for informed consent relating to dental fillings.

The legislation is an outgrowth of increasing concern nationwide as well as internationally concerning the use of mercury in amalgam fillings. While some dispute the alleged health problems associated with the use of mercury in amalgam, I believe there have been sufficient concerns raised nationwide which justify establishing a basic "right-to-know" policy regarding the use/alternatives/effects of certain dental treatment on clients.

Since the biological safety of silver amalgam remains a subject of controversy within the dental profession and the general public, **I believe this is a step in the right direction to provide a prudent and responsible state policy as well as being a good piece of consumer protection legislation.**

Offered: 2/13/90 6-1387E
Referred: Rules

Original sponsor(s): SEN. RODEY

1 IN THE SENATE BY THE HESS COMMITTEE

2 CS FOR SENATE RESOLUTION NO. 12 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 Relating to the use of informed consent
6 by dentists when they insert dental
7 fillings.

8 BE IT RESOLVED BY THE SENATE:

9 WHEREAS it is a common dental practice in the state to use a variety
10 of materials for dental fillings; and

11 WHEREAS some components of the fillings may infrequently cause
12 allergic or adverse reactions in some persons; and

13 WHEREAS dental patients should have the right to choose which mate-
14 rials are used for their dental fillings; and

15 WHEREAS they often lack basic information that would help them make an
16 informed choice;

17 BE IT RESOLVED that the Senate respectfully requests the Governor to
18 direct the Board of Dental Examiners to report to the legislature by the
19 10th day of the First Session of the Seventeenth Alaska State Legislature
20 its recommendations on whether dentists should inform their patients

21 (1) about the materials that are used for dental fillings;

22 (2) that there is a variety of materials that could be used for
23 dental fillings; and

24 (3) that it is possible that alternative material can be used.

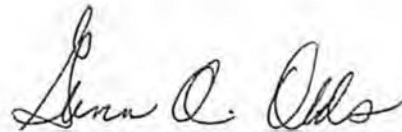
POSITION PAPER

Department of Commerce & Economic Development

SB 123: An act requiring a Dentist to obtain informed consent for dental fillings.

If there exists a wide spread problem with dentist's failing to inform patients of their options in regards to the types of filling materials available and the possible harmful effects on health by specific materials, then the department supports the intent of this bill.

The department agrees with holding Dentists to a reasonable standard of care for their patients. If, however, there are only isolated incidents of a Dentist failing to explain all of the above, we question the need for an extra layer of red tape. We question how the Department or the Board of Dental Examiners can effectively enforce this statute.



Glenn A. Olds, Commissioner

4-2-91

Date

Good morning Senator Sturgeluski and esteemed members of the HESS committee.

My name is Dr. Burton A. Miller, a practicing dentist of 16 years in Anchorage, Alaska.

Thank you for this opportunity to share this information with you and to voice my opinion on Senate Bill 123.

Dental amalgam consists of 48 to 52% mercury. Mercury is a poisonous metal that has been utilized in dentistry for over 160 years. During that entire time the dental establishment has not produced one scientific experiment that proves the safety of dental amalgam.

As of May of 1991 there has been 8 scientific studies actually measuring the amount of mercury vapor being released from dental amalgam fillings under various conditions. The most recent evaluation of all existing data from around the world is contained in the World Health Organizations 1991 document titled "Environmental Health Criteria 118 - Inorganic Mercury". The W.H.O. task group, comprised of the worlds class mercury toxicologists and scientists, concluded that dental amalgams were the greatest source of mercury vapor exposure to humans causing the daily intake and retention of 3 to 17 micrograms of mercury. This far exceeds the amounts attributable to seafood of 2.3 micrograms per day of methyl mercury and derived from food other than fish of 0.3 micrograms per day of inorganic mercury.

There are thousands of case histories testifying efficacy of amalgam replacement with non-mercury containing fillings. At present, there have been almost 500 Amalgam Adverse Reaction Reports filed with the FDA during the last 6 months. Of this number, approximately 96% are indicating some degree (10-100%) of improvement of pre-existing health conditions after dental amalgam replacement.

The entire medical profession has reacted to the potential of lead poisoning in children based, essentially, on one large scale study demonstrating learning deficits in children exposed to lead. Mercury has been shown to cause similar learning deficiencies in children. Mercury and lead work synergisticly in the human body, the effect being greater when both are present.

The medical profession stopped using mercury therapeutically over 25 years ago because of adverse side effects. The EPA has banned the use of mercury in paint. The FDA is proposing that mercury be banned in all over-the-counter, non-prescription anticeptic products.

Our rivers and our lakes have become polluted with mercury to the point the EPA wants to impose strict regulations on the amount of mercury from dental offices permitted in waste water effluent.

In conclusion, any prudent person presented with this information must seriously question the validity of the dental establishments position regarding the safety of dental amalgam fillings. This same prudent person is entitled to all relative information to arrive at an informed decision and allow him freedom of choice based on knowledge.

There are published scientific reports documenting periodontal disease in humans as a direct result of dental mercury amalgam fillings. Animal studies (both sheep and monkey) document kidney disease resulting from mercury from amalgam fillings. There is published documentation of mercury from amalgam fillings that induced anaphylactic reaction to exercise. Published clinical evidence demonstrated theraputic efficacy of amalgam filling removal in 22 patients with multiple severe sensitivities. Additionally, studies from all over the world confirm alarming rates of allergies to mercury and other components of amalgam fillings.

Exciting research in progress at the University of Kentucky on the causes of Alzheimer's Disease has documented mercury as a probably cause and has noted dental amalgams as the most likely source of mercury in the A.D. brain tissue.

Research in progress in Sweden is showing a positive correlation between the presence of dental amalgam fillings and suppression of immune function.

Research in progress in Norway is investigating a relationship from dental amalgam fillings and mental disease.

Research in Sweden with patients having Crohn's Disease have demonstrated high levels of mercury in the gut lining.

Research from the University of Georgia at Athens, GA demonstrated that dental amalgam fillings provoked an increase in mercury and antibiotic resistant bacteria in the mouth and intestinal normal flora.

It is the function of established dentistry to serve the public and not to dictate to it.

Honorable Senators -- I want to go on record in support of Senate Bill 123. Thank you again.

SB123

Sheila [illegible]
strongly urges
you to move this
bill. Very important

14 May 1105 | LEFT MSG W JOANN

De Paine

561-2475

SB123

1120 14 May

4x phone ring once 1x hold 5min

Rowen
344-7778

Payne 561-2475

272-1029

Walsh Miller 258-1390

Omni Medical Center

ALASKA DENTAL Society
State 277 4675

South Central District
277 9144

Carrie & [illegible] 30 Aug
Testimony [illegible]

OMNI MEDICAL CENTER

Robert Jay Rowen, M.D.
Diplomate, American Boards of
Family Practice, Emergency
Medicine, Chelation Therapy

"Biologic Alternatives to
Drugs and Surgery"
907-344-7775

Sandra Denton, M.D.
Diplomate, American Boards of
Emergency Medicine &
Chelation Therapy

May 6, 1991

Madam Chairperson and Members of the HESS Committee:

I waited patiently, as did others, to testify on SB123, but, alas, you ran out of time. I hope that I will be available to testify when the bill next comes up, but I wanted to give you some information that you will find useful.

The only opposition you will have from this bill is from mainstream dentistry. For years they have been telling us that the mercury in the fillings is inert and does not come out. After years of promulgating these falsehoods, they had acknowledged that the mercury does come out but refuse to acknowledge there could be any harm in it. In fact, as part of my supporting materials I am sending you a copy of an ad that appeared in the Anchorage Daily News "Straight Talk About Dental Amalgam". In it the dental establishment declared to the public that the fillings were safe.

Neither the American Dental Association nor any other dental establishment has been able to provide any original scientific research on the safety of mercury amalgam. In fact, there is none. All of it is propaganda and hearsay based on the fact that they have used it for 100 years. Well, I can say that for hundreds of years Europeans thought the earth was flat. For scores of years, it was felt that radiation did not hurt people, and the government lied to us about the hazards of that. We have been using pesticides for years only to find out that it was, and is, hazardous. That type of logic just doesn't hold.

I am enclosing for you a copy of the warnings about mercury from the American Dental Association itself. It is entitled "Hazards Communication Program" sponsored by the ADA and reprinted from ADA News April 25 and September 19, 1988. It explains hazards of various compounds including mercury. Examples include bulk mercury, precapsulated alloy, and scrap amalgam. The latter is most significant since scrap amalgam is the same thing as amalgam mixed by the dentist and not implanted in the person's mouth, or amalgam that is drilled out of a person's mouth.

The dentist is to store this scrap amalgam under a photographic fixer solution in a closed container. All such scraps are to be disposed of in a proper manner. The Environmental Protection Agency has recently declared that scrap amalgam is a hazardous waste substance and cannot be buried in a common landfill but must be handled by a toxic disposal site. The dentist is warned to avoid direct skin contact with mercury. Somehow, however, when the dentist places it in our mouths, it suddenly becomes safe. The ADA's guidelines and how it promulgates the usage of mercury are inconsistent. If the dentist is warned by the ADA about the hazards of scrap amalgam, then a patient needs to be warned about the hazards of the non-scrap amalgam that is deliberated implanted within his body.

615 E. 82nd Street, Suite 300 • Anchorage, Alaska 99518
Members, American Academy of Advancement in Medicine, American Academy of Environmental Medicine, American Society of Bariatric Physicians

I am also enclosing for you a copy of an article written by my former associate, Dr. Sandra Denton, M.D., who departed to Colorado to lend more study to the mercury issue with a principal researcher, Dr. Hal Huggins. Her article about the hazards of mercury is well referenced .

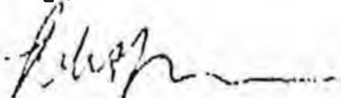
My only disagreement with this bill is that it is not adequate. I feel there should be a ban on mercury without any hesitation. Under the assumption that the HESS committee will not allow that through, then at the very least, informed consent should be obtained from the patient. Throughout the other testimony I heard on Friday morning, everyone was concerned about protecting the public. This bill has no fiscal consequence. It is merely a public protection measure and does not take away anybody's rights. If the dentists had nothing to hide about mercury, then there should not be any objection to this bill. If they do object to it, then they simply wish to keep the public in the dark and not give their patients the same warnings the ADA has given them with regard to the hazards of amalgam.

That mercury escapes and escapes in toxic amounts is no longer questioned. There are ample reference~ in the literature showing that the more amalgam someone wears, the more mercury shows up in the brain and other tissues. Mercury crosses the placental barrier and is actively concentrated in the fetus compared to maternal blood. There is a epidemic of anxiety and depression in this country. It has clearly paralleled the rise of amalgam implantation in people.

The public has a right to know what the dentist is placing in their mouths. In my opinion, any dentist who does not give duly informed consent is negligent, and I have let it be known that I would testify to that in court. Most of my patients had no idea that what was going in their mouths was mercury. They seemed to know more about the hazards of the substance than the dentist themselves. It is time that the dental profession was forced to come out of the dark.

If you have any further questions of me, please to do hesitate to contact me.

Sincerely,



Robert Jay Rowen, M.D.

RJR/fdl

Enclosures

Bio-Sketch — Sandra Denton, M.D.

KUP'S KOMMENT:

I had the indeed pleasure of being with Sandra Denton, M.D. at the World Congress on Alternative Medicines in Athens, Greece this spring. I asked Sandy if she would honor HC by being on the cover and writing a feature story for you. Her most beautiful photo appears on the cover and her most dynamic, high impact writing *The Mercury Cover-Up* appears here!!!

There is an aura of love, calmness, caring, compassion, and balance about Sandy that is immediately perceived. She is also a very powerful, effective, truthful and well documented speaker and writer; and from the feedback that I have received from HC readers and patients of hers, a superb physician. What a treat you have in this issue of HC with Sandra Denton, M.D.

The Mercury Cover-Up is a paper to be read by all the members of the health profession as well as the medical/allopathic profession and as many lay people as possible. Extra issues will be available for a while and I am planning on having printed reprints of this article. Thanks, Sandy! God bless you!

Dr. Denton received her medical degree from the University of Tennessee in 1971 and completed an internal medicine internship at St. Luke's Episcopal Hospital in Houston, Texas. She then specialized in emergency medicine for almost 14 years, becoming board certified in 1981. Serving as director of two hospital emergency medical services in Louisville, Kentucky for five years, Dr. Denton gave many lectures in her field of expertise, "poisoning and toxicology."

Dr. Denton made a career change in 1985 when she became convinced of the benefit of nutritional and preventive medicine. By learning many of the therapies taught by the American College of Advancement in Medicine, she felt she could prolong and improve the quality of life of her patients — and yes, keep them out of the emergency room.

She became board certified by the American Board of Chelation Therapy. Chelation therapy is an accepted therapy for the treatment of heavy metal poisoning and recognized by some for its efficacy in improving arterial circulation throughout the body.

Keeping in line with her interest in toxicology, Dr. Denton became aware of the presence of mercury in dental fillings and immediately recognized the potential health problems. Having majored in chemistry in college, she saw that anything having such a strong affinity for sulfhydryl groups could cause major disruption of normal cellular functions in the body. It occurred to her that many of those people who used to frequent the emergency room with strange, bizarre, unexplained, undiagnosed symptoms, finally being labeled as "crazy", could instead be suffering from chronic mercury toxicity. She began to investigate this possibility and has collected numerous articles (almost 3000) and several books on the subject of mercury toxicity. She spent four months at Huggins Diagnostic Center reviewing patient charts, answering phone calls from patients worldwide, going through the files adding to her documentation, and doing research.

Dr. Denton has since treated hundreds of patients whose health problems have definitely improved when toxic dental materials were properly removed and detoxification procedures followed. She, of course, works closely with dentists trained in this area.

Realizing that most physicians are not aware of even the presence of mercury in the dental fillings, much less its effects, Dr. Denton lectures to interested professional organizations. In fact, she recently had the privilege of lecturing at the World Congress of Complementary Medicine in Athens, Greece, to physicians from 44 countries. Dr. Denton also gave two lectures at the International Conference on Biocompatible Materials, November 1988: 1) Clinical Pointers on Detoxification of Mercury 2) Infertility and Birth Defects — the Mercury Connection. The proceedings are being published by Life Sciences Press in Tacoma, Washington (206 / 272-0530) and tapes are available through Huggins Diagnostic Center (800 / 331-2303). Dr. Denton also lectured at the International Academy of Oral Medicine and Toxicology meeting September 1988.

Dr. Denton has studied the various treatment modalities for mercury toxicity extensively. While raising awareness of the problem both at the public and professional level, she endeavors to teach the solution as well. She is a frequent radio and television guest.

Dr. Denton has become involved with dental personnel, treating their health problems and fighting their battles for disability from their occupational exposure to a known poison.

Her professional memberships include:

American College Advancement in Medicine — chelation therapy and nutritional medicine

American Academy of Environmental Medicine — allergies and toxic substances in the environment

International Bio-Oxidative Medicine Foundation

International Ozone Association

Consultant for Toxic Element Research Foundation

Board of Directors for International Academy of Oral Medicine and Toxicology

Fellow, American College Emergency Physicians

Dr. Denton and her dental colleague, Dr. Paul Rubin of Seattle, Washington, made a professional cassette tape "Mercury Detoxification — Patient Instructions" which has been of great assistance in outlining general procedures for the patient to speed the healing process. To order call 206 / 328-0221.

Dr. Denton is in private practice with Dr. Robert Rowen at *Omni Medical Center,* which is a total holistic health center. Chelation therapy, oxygen therapies, applied clinical nutrition, acupuncture, neural therapy, sclerotherapy, counseling, a weight loss program, and mercury toxicity evaluation and treatment are only a few of the services offered at OMNI. For further information write Dr. Denton at:

Omni Medical Center
615 E 82nd Ave., Suite 300
Anchorage, AK 99518

. In 1988, scrap dental amalgam was declared a hazardous waste material by the Environmental Protection Agency . . . Once a doctor removes an amalgam filling from your mouth and places it on the tray, it once again becomes a hazardous waste material . . . I ask the reader — what is it about the mouth that makes this same item non-toxic?

The Mercury Cover-Up

By SANDRA DENTON, M.D.

Sandra Denton, M.D.

Absolutely Amazing ! ! ! ! !

In just a few minutes I can present the "facts" to most lay people, and they can immediately grasp the significance that a poison has been implanted in their mouth without their knowledge or consent. Naturally, they are unhappy about this and would like to see the practice stopped.

Why is it then, that trained, educated professionals still ignore and discount these "facts" and even go so far as to place paid advertisements in the newspapers to assure the public of the safety of this poison??? The legal opinions right now seem to be indicating that this is frank negligent misrepresentation, possibly consumer fraud, and this action may have serious consequences.

What are some of the "facts" I tell my patients?

- Mercury comprises over 50% of the "silver" dental filling.
- Researchers from all over the world have measured mercury vapor coming off the filling, particularly after stimulation through chewing, bruxism, hot and/or acidic food and tooth brushing.[1,2,3,4] (For many years the American Dental Association maintained that once mercury was placed with the other ingredients of the dental filling — silver, tin, zinc, copper — it was tightly bound and did not escape.) In the face of voluminous research they were forced to change their position and admitted that although mercury does come out of the filling, the amount is "insignificant."
- Everyone knows that mercury is a poison. It is in fact, as Sharma and Obersteiner stated, ". . . a strong protoplasmic poison that penetrates all living cells of the human body. Mercury is a powerful biological poison with no necessary biological function."[5]
- Mercury is extremely toxic. Sharma and Obersteiner at Utah State University discovered mercury is the single most toxic metal that they investigated (even in such minute concentrations as 3.47×10^{-7} moles). Mercury is even more toxic than lead, cadmium and arsenic![5] It has been stated by world regulatory agencies that the smallest amount of mercury that will not cause damage is UNKNOWN! How then can we be so certain that the amount coming out of our dental fillings is insignificant?
- The world's foremost researchers on mercury toxicity, Drs. Thomas Clarkson and John Hursh of the University of Rochester School of Medicine, Department of Toxicology and Drs. Magnus Nylander and Lars Friberg of Karolinska Institute in Stockholm, Sweden, concluded from their research[6] that "the release of mercury from dental amalgams makes the predominant contribution to human exposure to inorganic mercury including mercury vapor in the general population."[6]
- The International Conference on Biocompatibility of Materials was held in November 1988 in Colorado Springs, Colorado. Many of the world authorities on mercury met to discuss the issue of dental amalgam and other materials commonly used in dentistry. (The proceedings of this meeting are being published by Life Sciences Press in Tacoma, Washington (206/272-0530) and audio-visual tapes are available through Huggins Diagnostic Center, Colorado

Springs, Colorado (1-800 / 331-2303). On the last day of the meeting, the doctors in attendance drafted and signed their official conclusion, which read: "Based on the known toxic potentials of mercury and its documented release from dental amalgams, usage of mercury-containing amalgam increases the health risk of the patients, the dentists, and dental personnel."[7]

- Autopsy studies show a positive correlation between the number of occlusal surfaces of dental amalgam and mercury levels in the brain[8] and kidney cortex.[9]
- Research has shown mercury dental amalgam to have an adverse effect on the T-lymphocyte count (a very important part of our immune system). In one patient, Dr. David Eggleston of the University of California, found a T-lymphocyte count of 47% (ideal levels are between 70-80%). After removal of the amalgams the T-lymphocyte count rose to 73%. Reinsertion of four amalgam restorations on top of the composite fillings, not even in direct contact with the teeth, resulted in a decrease to 55%. The amalgams were removed and the T-lymphocyte count measured 72%.[10] Dr. Eggleston's important research is ongoing and even more startling results are being published now. With all the concern about the immune system diseases of today, does it make sense to continue using a dental material that might have such a drastic effect on one's defense system?
- Multiple Sclerosis patients have been found to have 8 times higher levels of mercury in the cerebrospinal fluid compared to neurologically healthy controls.[11] Inorganic mercury is capable of producing symptoms which are indistinguishable from those of multiple sclerosis.
- In 1988 scrap dental amalgam was declared a hazardous waste material by the Environmental Protection Agency.[12] Scrap amalgam, the portion that remains, after placing a filling in your mouth, must be handled with great care. According to the Materials Safety Data Sheet for mercury, which OSHA mandates be present in every dental office, the dentist is told to handle scrap amalgam in the following manner:

1. Store in unbreakable, tightly sealed containers, away from heat.

2. Use a no touch technique for handling amalgam.

3. Store under liquid, preferably glycerin or photographic fixer solution.

Prior to the use of mercury fillings, lead fillings had been customary for many years and had been considered safe. For years radiation was considered safe. Does the routine use of pesticides for many years reduce their toxicity?

Once a doctor removes an amalgam filling from your mouth and places it on the tray, it once again becomes a hazardous waste material and must be handled in the same manner described above. If this scrap amalgam should find its way into the ground, one may be fined a sizable amount.[12] I ask the reader — what is it about the mouth that makes this same item non-toxic? Or is it possible that the mouths of some 80% of Americans with amalgam fillings are in actuality "toxic waste dumps."

In Alaska, during April and May, 1989, the state dental association appropriated money for a paid advertisement titled "Straight Talk About Dental Amalgam." Let's compare facts.

"FACT": <u>The fillings in your teeth are safe.</u> For more than 100 years dentists have used, observed and tested amalgam filling materials, and we have found them to be both safe and effective. No other material has been so thoroughly tested, nor found to be as cost effective as dental amalgams.

This statement is very misleading. Amalgam fillings have been tested for their strength but not for their safety. Although asked several times to do so, the ADA cannot produce these "studies" showing safety. On the other hand the research pointing out its toxicity is voluminous. Prior to the use of mercury fillings, lead fillings had been customary for many years and had been considered safe. For years radiation was considered safe. Remember the days of shoe fluoroscopy? Does the routine use of pesticides for many years reduce their toxicity?

"FACT": <u>The dental profession has complete confidence in the safety of dental amalgam.</u> The members of the dental team, who work with amalgam everyday, are as healthy as their peers in the general population. And most of us have — and would accept — amalgam fillings in our own mouths. Over 100 million Americans have amalgam fillings.

If this statement is true, as the Alaska Dental Association would have us believe, then why do dentists have the highest suicide and divorce rate among professionals? Why was neuropsychological dysfunction present in 90% of dentists tested by Joel Butler, Ph.D., professor of psychology, University of North Texas? This information was presented at the ICBM conference November 1988. His abstract reads "Areas of suboptimal function were evident in shifting tasks - attention span, ability to concentrate - recent memory deficits - visual recall, control dyspraxia - tremor and perceptual accuracy in judgment.

Psychological problems were concentrated in the areas of irritability, impatience, tension, frustration and conflict. Notably absent was calmness. Observation of data suggest that the longer a dentist practices, the less ability he has to pass the entrance exams into dental school. Dr. Butler is alarmed at the implications of his studies and wants to inform dentists of the damage that is undermining their personalities and motor skills."[7]

If the above "FACT" is true, why then do female dental personnel have a higher spontaneous abortion rate, a raised incidence of premature labor, and an elevated perinatal mortality?[13] This has been substantiated by the Environmental Protection Agency to be characteristic of women chronically exposed to mercury vapor.[14] Recent studies in pregnant women indicate that elemental mercury does cross the placenta and incorporate into the fetus. ". . .the placenta, the chorioallantoic membrane, the amniotic membrane, and the neonatal blood of women who were exposed to

Why . . . do female dental personnel have a higher spontaneous abortion rate, a raised incidence of premature labor, and an elevated perinatal mortality?

mercury while working in dental offices were found to contain significantly higher mercury levels than in control women with no occupational exposure to mercury."[15] Sikorsky's work in Poland studied 81 females (45 dentists and 36 dental assistants). Sikorsky found hair mercury levels much greater than in 34 non-exposed controls. There was significant positive correlation between total mercury levels and reproductive failures and also with a prevalence of menstrual cycle disorders.[15] This is a very recent and significant study. There was a high incidence of spina bifida births that occurred in the Sikorsky study population (5 out of 117 pregnancies). The normal ratio of occurrence is 1 in 1000 births. Folic acid deficiency has been associated with spina bifida and mercury is known to block the function of folic acid in the body. Other articles with similar information abound in the literature.[17, 18, 19, 20, 21] I also encourage the reader to get Sam and Michael Ziff's book Infertility and Birth Defects - Is Mercury From Silver Dental Fillings An Unsuspected Cause?[21]

If dentists and dental personnel are so "healthy", why do dentists, according to the insurance industry, have one of the highest utilization rates of medical insurance? Another reason to consider why more dental personnel are not diagnosed as mercury toxic may be explained by an incident reported by Macdonald[22] who stated "Since symptoms vary greatly, improper diagnosis may result. Failure to consider mercury as a causative factor in digital numbness resulted in two exploratory surgical procedures for a 40 year old dentist. He was treated in several prestigious medical facilities for 16 years before a 'long shot' test for urine mercury was taken." One must also remember that the diagnosis of mercury intoxication is extremely difficult because of the insidious nature of the onset and because of most physicians' unfamiliarity with proper testing techniques.

Most physicians would like to be able to diagnose mercury toxicity by finding a high urinary level of mercury. High levels may be found in acute exposures (macromercurialism). However, they are rarely present in the chronic low-dose exposures (micromercurialism). The chapter on mercury of the fifth edition of Clinical Toxicology of Commercial Products by Robert Gosselin, M.D., Ph.D.; Roger Smith, Ph.D.; and Harold Hodge, Ph.D., D.Sc., makes this clear. "Urinary mercury levels are characteristically low in chronic exposure suggesting a hypersensitivity reaction." Another article by L.J. Goldwater, "The Toxicology of Inorganic Mercury"[23] says that urinary mercury levels may give some indication of the degree of exposure. However, they are of limited value

Why do dentists, according to the insurance industry, have one of the highest utilization rates of medical insurance?

in the diagnosis of poisoning. High levels can be found in human subjects who are symptom free, and low levels in those exhibiting marked evidence of micromercurialism. It has been suggested that, in some cases, failure to excrete mercury is a factor in the development of poisoning. T.W. Clarkson in Biological Monitoring of Toxic Metals,[8] discusses the significance of urine mercury values. "Urinary excretion of mercury is used widely in monitoring workers exposed to mercury vapor (see U.S. EPA, 1984). However, the relationship between urinary excretion and absorbed dose is not well understood; urinary excretion may be directly related to the kidney burden of mercury unless renal damage has occurred." This point was also made by Lamm and Pratt in their 1985 study when they discovered a clear, negative and significant correlation between time on the job and the level of mercury in the urine. These researchers found that the longer a worker was on the job, the less mercury is excreted in his urine.

Blood levels are not helpful in the diagnosis of mercury poisoning since mercury only remains in the blood for a

One must also remember that the diagnosis of mercury intoxication is extremely difficult because of the insidious nature of the onset and because of most physicians' unfamiliarity with proper testing techniques.

few minutes. Mercury quickly finds its way into the various tissues of the body, depositing in the brain, adrenals, thyroid, and other organ systems. Only at high levels of exposure will this parameter be of any value.

Another point to be considered is Dr. Magnus Nylander's report which appeared in Lancet describing the increased uptake of mercury in the pituitary gland of dentists.[17]

There are not enough words to describe the dentists and dental assistants I have seen whose lives have been devastated by the effects of chronic mercury exposure. It is truly heartbreaking - and preventable!

The last part of the above "FACT" indicates that since over 100 million people have mercury fillings in their mouth, it must be right. The majority is not always right. Reports indicate that every one of us has measurable residual amounts of pesticides in our body. Does that reduce the degree of toxicity?

"FACT": Any dentist who encourages you to remove amalgam fillings in order to "remove toxic substances from the body" is guilty of a breach of ethics. In addition to the ADA, the United States Public Health Services, the National Institute of Dental Research and the Consumers Union have all investigated the allegations about amalgam — and have found them to be useless.

Remember, the ADA formerly maintained that mercury did not come out of the filling. It may interest you to know that the same dentist subject to breach of ethics for suggesting toxicity may remove the fillings for cosmetic reasons without threat of disapproval, censure, or removal of his license. If it is unethical to remove a documented biological known poison from the mouth, are we to assume that it is ethical to place this poison in the mouth? Is it

proper ethics to be allowed to replace an amalgam for cosmetic reasons, but to be reprimanded because replacement of amalgam for any other purpose may jeopardize the health of the tooth? Is it considered proper ethics to withhold the information that mercury is present in the restoration and to use amalgam indiscriminately? In the American legal system the judge always directs the jury that it can not return a verdict of guilty if there is any reasonable doubt.

Alaska State Senate majority leader Pat Rodey, has recently stated "there is enough evidence to establish REASONABLE DOUBT as to the safety of dental amalgams in any prudent person's mind. Senator Rodey followed his words with action by introducing a senate resolution which will be voted on in the next session. It reads thus:

"SENATE RESOLUTION NO. 12
IN THE LEGISLATURE OF THE
STATE OF ALASKA
SIXTEENTH LEGISLATURE
FIRST SESSION

Relating to the use of informed consent by dentists when they insert dental fillings that contain mercury.

BE IT RESOLVED BY THE SENATE:

WHEREAS it is a common dental practice in the state to use an amalgam of materials for dental fillings; and

WHEREAS this dental amalgam is thought by most persons to be made only of silver, but its composition is actually 50 percent mercury; and

WHEREAS some studies have shown that toxic mercury vapors can leak from the fillings into a patient's blood system and lead to mercury poisoning, particularly in chemically sensitive or allergic persons; and

WHEREAS dental patients should have the right to choose which materials are used for their dental fillings, but they often lack basic information from the dentist that would help them make an informed choice;

BE IT RESOLVED that the Senate respectfully requests the Governor to direct the Board of Dental Examiners to report to the legislature by the 10th day of the Second Session of the Sixteenth Alaska State Legislature its recommendations on the manner in which dentists should inform their patients that

(1)mercury is contained in most dental filling material;

(2)mercury in fillings can have toxic effects on some persons;

(3)there are alternative materials that could be used for dental fillings that could have other effects on the person; and

(4)they have the right to insist that an alternative material be used."

It is hoped that other states will follow this recommendation in passing similar legislation.

In a "Concept Paper" the Alaska Department of Health and Social Services on January 17, 1989 stated: "Those persons who have had a large number of amalgam fillings, who have experienced symptoms commensurate with chronic low level mercury exposure and who have tried traditional treatments may wish to consider replacement therapy". The Alaska Public Interest Research Group investigated information presented in this paper and is now supporting efforts to introduce legislation that will mandate the provision of full information about these potential health effects from mercury amalgams. The group is also supporting additional legislation to "hold harmless" dentists who provide this information (in rejection of ADA guidelines which prohibit even telling patients about these concerns).

"FACT": The Board of Dental Examiners of the State of Alaska supports the position of the American Dental Association that "there is no scientifically documented evidence of a cure or improvement of a specific disease due to the removal of (silver) amalgam restorations from a non-allergenic patient."

There are not enough words to describe the dentists and dental assistants I have seen whose lives have been devastated by the effects of chronic mercury exposure. It is truly heartbreaking — and preventable!

This is true because poisoning is not a specific disease. Nonetheless, I have documented cases of seizure disorders, chronic fatigue, memory loss, menstrual disturbances, depression, neurological symptoms, various eye problems, headaches, muscle tremors, joint pains, intestinal problems, irregular heart beats and/or unexplained chest pains, agitation and irritability, suicidal thoughts, and many many more conditions disappearing after amalgam removal.

The Alaska paid advertisement goes on to say "Decisions about fillings, like all decisions about your dental health, should be made in your dentist's office within the bounds of the doctor/patient relationship." This may be somewhat difficult if the reader experiences what many of my patients tell me happens when they either inquire as to what material is being placed in their mouth or if they should request non-mercury fillings be placed in their mouths or that of their children. In many cases the dentist has gone into an absolute rage and stormed out of the office. In several other documented instances, the dentist, despite the request for non-mercury fillings, deliberately placed mercury amalgam fillings. What does that do for the doctor/patient trust and relationship????

If the dentists of Alaska, or any dentist, care about our health, as the advertisement claims, they would give serious consideration to the evidence that is mounting at an alarming rate proving mercury is detrimental to our health and well being. When the report appeared in a Swedish newspaper May of 1987 stating that the Swedish government health board declares amalgam toxic and unsuitable as a dental filling material it was quickly disregarded. Headlines in the ADA literature read "Amalgam ban reports are bogus." I think it is quite significant that public hearings occurred in Sweden toward the end of 1988 and the previous ruling was upheld and reinforced.

Fortunately, there are dentists who have seriously questioned the information being propagated by the establishment. They can no longer, with a clear conscience, continue placing a poison in unsuspecting patients who trust their dentist. Especially now that we have suitable alternatives which, according to pro-amalgam dentist Dr. George Freedman, may be stronger than amalgam. (*Dentistry Today, Feb. 1989*). These concerned dentists are attending meetings

to learn more about the materials they are using and how to properly remove unsuitable ones. There are two such meetings in the near future. The International Academy of Oral Medicine and Toxicology will hold its annual meeting September 15-17, 1989, in Detroit, Michigan. For information call 313 / 627-4934. Huggins Diagnostic Center will host an intensive five day course October 18-23, 1989, on Biocompatible Materials and treatment protocols. Call 1-800 / 331-2303.

Clinical observation seems to indicate that serum biocompatibility testing through Huggins Diagnostic Center is very valuable. Immunologic reactions to various dental materials are identified and quantified, providing guidance in determining the need for removal and replacement with appropriate materials. For information about this test call (1-800 / 331-2303). Some patients who have not had the benefit of this test have had to replace their dental materials a second or third time before finding compatible restorations.

An excellent reference text for the health professional and victim interested in learning more about mercury toxicity is Chronic Mercury Toxicity — New Hope Against an Endemic Disease, Doctor's Guide for Lifestyle Counseling by H.L. Queen (1988). For your copy call 1-800 / 2 HEART 2. The book describes the insidiousness of the problem and, more importantly, outlines protocols for proper use of intravenous vitamin C and other treatment modalities.

In subsequent issues of *Health Consciousness* I will discuss patient instructions for someone going through detoxification and helpful clinical pointers for both physicians and dentists.

I trust this article has caused some to have "second thoughts" about the safety of amalgam, and others to stand up and end what was referred to by Dr. Alfred Stock in 1926 as a "terrible sin against humanity."

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What does public think of amalgam?

By Daniel McCann

Chicago—Overall, American adults are basically divided when asked if they're concerned about dental amalgam, water fluoridation or the chance of contracting the AIDS virus from a dentist.

"Over 40 percent [of those polled] express individual concerns about all three issues," says the executive summary of the survey, "National Attitudes Toward Dental Issues," conducted last month by KRC/Communications Research.

The ADA-commissioned study, which has a margin of error of plus or minus 3 percent, involved telephone interviews of 1,083 adults (543 men and 540 women) across the country.

Taking as its focus three issues that have received wide media attention lately—amalgam, fluoridation and HIV infection control—the survey will serve as the foundation of an extensive ADA consumer education campaign.

"What the survey indicates," said Lorna Mitchell, director of the ADA's division of communications, "is that in an era of negative media publicity on each of these issues, we really need to be aggressive and proactive in trying to get our messages and our positions out there to the media and the public."

The prime sources of health care information for those questioned were: television, 26 percent; magazines, 21 percent; newspapers, 16 percent; physicians and dentists, 14 percent; family and friends, 12 percent; other, 7 percent; and the remaining 2 percent either couldn't cite a source or refused to answer.

Some of the more striking results of the survey were: 80 percent of those surveyed were aware that dentists should wear a mask, surgical gloves and protective eyewear while treating patients; 63 percent said they would say something to dentists if they were treating without gloves, masks and eyewear; 83 percent knew that a patient may have contracted AIDS from a dentist; 88 percent said that if a dentist had the AIDS virus, the dentist should inform the patient; and 83 percent said they would inform the dentist if they had the AIDS virus.

Other survey questions and responses included:

- Does the drinking water in your community contain fluoride?

Yes, 48 percent; no, 27 percent; and don't know, 25 percent.

- Do you want your drinking water to contain fluoride?

Yes, 52 percent; no, 28 percent; and don't know, 20 percent.

- Do you think people should have any concerns at all that they might develop health problems from fluoride in drinking water?

Yes, 45 percent; no, 40 percent; and don't know, 15 percent.

- Have you ever heard anything about people possibly developing health problems caused by silver fillings in their teeth?

Yes, 48 percent; no, 51 percent; and don't know, 1 percent.

- Do you think people should have any concerns at all that they might develop any health problems from silver fillings in their teeth?

Yes, 48 percent; no, 37 percent; and don't know, 15 percent.

- Have you had your fillings removed or have you ever considered such a procedure?

No, haven't considered it, 53 percent; no, because I have no fillings, 25 percent; yes, had them removed, 4 percent; yes, considered having them removed, 16 percent; and don't know, 2 percent.

- Are you aware that a dentist should wear a mask, surgical gloves and protective eyewear while treating patients?

Yes, I am aware, 80 percent; not aware, 19 percent; don't know, 1 percent.

- Have you read or heard anything about the possibility that a dental patient may have contracted the AIDS virus from a dentist?

Yes, I have, 83 percent; no, I haven't, 16 percent; and don't know, 1 percent.

- With regard to contracting the AIDS virus from a dentist, would you say that you are concerned that this is something that could happen to you?

Yes, I'm concerned, 43 percent; not very concerned, 52 percent; somewhere in between, 3 percent; and don't know, 2 percent.

- If a dentist had the AIDS virus and you were the patient, how important would it be to you that you were told about the dentist's condition?

Very important, 88 percent; somewhat important, 8 percent; not very important, 4 percent; don't know or refused to answer, 2 percent.

- If you had the AIDS virus, do you think you would tell your dentist?

Yes, I would, 83 percent; probably wouldn't, 8 percent; depends on the circumstances, 4 percent; don't know, 4 percent; and refused, 1 percent.

Survey respondents were drawn from a range of adult age groups: 18-29, 22 percent; 40-49, 24 percent; 30-39, 19 percent; 50-64, 19 percent; 65 and over, 16 percent; and 1 percent refused to state their age.

New!

TRIAL PKG.

Paid Advertisement ADN + A.T. 1989

STRAIGHT TALK ABOUT DENTAL AMALGAM

The people of Alaska are too wise to buy the mercury poison scare some people are trying to sell.

But just for the record, we, the dentists of the Alaska Dental Society and our peers in the American Dental Association, want you, our patients, friends and neighbors, to hear the facts.

FACT: The fillings in your teeth are safe. For more than 100 years dentists have used, observed and tested amalgam filling materials, and we have found them to be both safe and effective. No other material has been so thoroughly tested, nor found to be as cost effective as dental amalgams.

FACT: The dental profession has complete confidence in the safety of dental amalgam. The members of the dental team, who work with amalgam everyday, are as healthy as their peers in the general population. And most of us have -- and would accept -- amalgam fillings in our own mouths. Over 100 million Americans have amalgam fillings.

FACT: Any dentist who encourages you to remove amalgam fillings in order to "remove toxic substances from the body" is guilty of a breach of ethics. In addition to the ADA, the United States Public Health Service, the National Institute of Dental Research and the Consumers Union have all investigated the allegations about amalgam -- and have found them to be baseless.

FACT: The Board of Dental Examiners of the State of Alaska "supports the position of the American Dental Association that "there is no scientifically documented evidence of a cure or improvement of a specific disease due to the removal of (silver) amalgam restorations from a non-allergenic patient."

Decisions about fillings, like all decisions about your dental health, should be made in your dentist's office within the bounds of the doctor/patient relationship.

If you don't have a dentist and would like to speak to one, please feel free to call the Alaska Dental Society at 277-4675.

Because we're the dentists of the Alaska Dental Society and we care about your health.

Paid Advertisement

Flammable Gases

Examples: Nitrous oxide and oxygen, liquified petroleum gas (LPG).

Hazards: Fire

DO:
- o Test periodically for leaks.
- o Avoid contact between compressed oxygen gas and lubricants or grease.
- o Avoid having sparks or flames near flammable gases

Flammable Liquids

Examples: Solvents such as acetone and alcohol.

Hazards: Fire or explosion.

DO:
- o Store flammable liquids in tightly covered containers.
- o Provide adequate ventilation.
- o Have fire extinguishers available at locations where these liquids are used.
- o Avoid sparks or flames in areas where flammable liquids are used.

METALS

Beryllium

Examples: Beryllium dust and fumes arise from the melting, grinding and milling of some base-metal alloys.

Hazards: Contact dermatitis, corneal burns, inflammation and scarring of respiratory tissues.

DO:
- o Wear gloves, eye protection and NIOSH-approved mask when casting, polishing or grinding these alloys.
- o Provide adequate local exhaust ventilation for all operations in casting areas.
- o Use power suction methods rather than air hoses to remove dust from clothing and to clean machinery.
- o Dispose of wastes, storage materials or contaminated clothing in sealed bags.

Mercury

Examples: Bulk mercury; precapsulated alloy; scrap amalgam.

Hazards: Fine tremors, nausea, loss of appetite, diarrhea, depression, fatigue, increased irritability, allergic manifestations, contact dermatitis, pneumonitis, nephritis, headache, insomnia, dark pigmentation of marginal gingiva, loosening of teeth.

DO:
- o Work in well-ventilated spaces.
- o Avoid direct skin contact with mercury.
- o Store mercury in unbreakable, tightly sealed containers away from any source of heat.

- Salvage amalgam scrap; store under photographic fixer solution in a closed container.
- Clean up spilled mercury using appropriate procedures and equipment; do not use a household vacuum cleaner.
- Place contaminated disposable materials in polyethylene bags and seal.

Nickel

Examples: Nickel-containing dental alloys, gold alloys, solders.
Particles released during fabrication and grinding of nickel-containing alloys.

Hazards: Allergic manifestations Irritation to eyes and respiratory systems.

DO:
- Use protective eyewear and NIOSH-approved mask when grinding nickel-containing alloys.
- Use high-velocity evacuation systems.

Nitrous Oxide

Hazards: Based on laboratory animal studies, high exposure may cause adverse health effects.

DO:
- Steps should be taken to minimize the vapor concentration of nitrous oxide in the dental suite.
- Use a scavenging system.
- Check nitrous oxide machines, lines, hoses and masks for leakage.
- Maintain adequate ventilation.

Other Metals

Examples: Casting alloys and alloys for amalgam.

Hazards: Metal dusts and fumes may irritate eyes and respiratory systems. Contact dermatitis

DO:
- Wear protective eyewear and NIOSH-approved mask while grinding metal prostheses.

Organic Chemicals

Examples: Alcohols, ketones, esters, solvents, and, monomers such as methyl methacrylate and dimethacrylates. The halogen-containing organic liquids used in dental offices primarily include chloroform and carbon tetrachloride and some solvents and cleaners.

Hazards: Fire, allergic manifestations, contact dermatitis, irritation to mucous membranes, respiratory problems, central nervous system depression, headache, drowsiness, loss of consciousness, nausea, liver and kidney damage, possible mutagenesis.

DO:
- Avoid skin contact.
- Avoid excessive inhalation of vapors.
- Work in well-ventilated areas.
- Use forceps or gloves when handling contaminated gauze or brushes.

Hazards Communication Program

American Dental Association

Handle With Care — A Hazards Communication Program for Dentistry

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