ALASKA LEGISLATURE COMMITTEE FILES 1995-1996 8672
8556 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

HB

371

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. HB 371

Revision Date:
Title: An Act relating to the rights of terminally ill persons
Sponsor: Brown, Toohey et al
Requestor: House HES

Dept. Affected: Health and Social Services
BRU: State Health Services
Component: State Medical Examiner
COMPONENT SERIAL NO. 293
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY97	FY98	FY99	FY00	FY01	FY02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	15.0					
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	15.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	15.0					
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	15.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

The Office of the State Medical Examiner will incur the following costs associated with implementation of this bill:
1. Contractual: $15,000 for preparation of regulations to oversee the assisted death process

Prepared by: Peter M. Nakamura, MD, MPH
Division: Public Health
Phone: (907) 465-3090
Date: 01/23/96

Approved by Com: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 1/31/96

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STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. HB 371

Revision Date:
Title: An Act relating to the rights of terminally ill persons
Sponsor: Brown, Toohey et al
Requestor: House HES

Dept. Affected: Health and Social Services
BRU: State Health Services
Component: Bureau of Vital Statistics
COMPONENT SERIAL NO. 961
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY97	FY98	FY99	FY00	FY01	FY02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	4.0					
SUPPLIES	1.0					
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	5.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	5.0					
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	5.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $0.0

POSITIONS:

FULL-TIME	0					
PART-TIME	0					
TEMPORARY	0					

ANALYSIS: (Attach a separate page if necessary)

The Bureau of Vital Statistics will incur the following costs associated with implementation of this bill:
1. Contractual: $4000 to modify Death Certificate computer programs
2. $1000 to modify and print new death certificates

Prepared by: Peter M. Nakamura, MD, MPH
Division: Public Health
Phone: (907) 465-3090
Date: 01/23/96

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SPONSOR STATEMENT
HB 371

An Act relating to the rights of the terminally ill

By Reps. Brown and Toohey, Finkelstein

We are proposing HB 371 because we believe that Alaskans should have a **fundamental right to make their own end-of-life decisions.** The proposed law would allow terminally ill patients to request that their physicians prescribe life-ending medication for self-administration by the patient, subject to a number of safeguards.

HB 371 provides an opportunity for **death with dignity** for someone whose death is inevitable due to terminal illness.

The bill is supported by a statewide coalition of Alaskans, including individuals from all parts of the political spectrum. Supporters all share the belief that end-of-life decisions for terminally ill Alaskans should be a **private matter between physician and patient** and should include the right to request medication to end needless suffering.

Many of HB 371's supporters have watched terminally ill friends and relatives suffer a death wracked with pain and indignity, and have come to believe that the terminally ill should have the option, if they choose, of putting an end to that suffering.

Statutes currently allow dying patients kept alive only by artificial life support to choose to discontinue suffering, but this option is not available to dying patients who are not on artificial life support.

HB 371 would respect a dying patient's constitutional **rights of privacy, autonomy and self-determination.** The opportunity for a terminally ill patient to obtain life-ending medication from a physician should be an alternative to a painful, debilitating death.

The proposed law would ensure the right to make personal end-of-life decisions. It would place **every aspect of the life-ending decision in the exclusive power and control of the patient** and out of the hands of third parties.

The bill would free physicians and pharmacists from the threat of criminal prosecution for prescribing or dispensing medication to a terminally ill patient for self-administration under specific safeguards.

HB 371 encourages patients, but does not require them, to discuss these end-of-life issues with their families.

Safeguards in the proposed law include:

* The patient must be terminally ill in the opinion of a physician.

* The patient must knowingly request life-ending medication in writing.

* A second, consulting physician must then confirm both the diagnosis and the patient's mental competence.

* The request must be witnessed by individuals who have nothing to gain from the patient's death and are not connected with the patient's health care providers.

* The request must be made at least twice and no fewer than 10 days must pass between a first and second request.

* The administration of the life-ending medication is solely in the hands of the patient; the patient may change his or her mind at any time.

* Physicians and hospitals have the absolute and unquestioned right to decline involvement; however, they must refer the patient to persons and institutions who are willing to proceed.

Rep. Kay Brown
December 12, 1995

SECTIONAL ANALYSIS
HB 371

An Act relating to the rights of the terminally ill

Section 1

An agent under a statutory form power of attorney may not make a request for medication for the principal but may be given the power to enforce the principal's such request.

Section 2

The purpose of the chapter, which includes the living will and do-not-resuscitate orders, is set out as a finding that the people have a fundamental right to make their own end-of-life decisions, including an informed request to the medical profession for medication that will make death as humane and dignified as possible. Describes the chapter as permitting expression of wishes, protecting consenting health care professionals and safeguarding against abuse.

Section 3

Describes the general form of a request for medication, requiring two disinterested witnesses, and states the requirements that the requester's doctor and a consulting physician must follow.

Section 4

Adds revocation of the request for medication to the revocation of a living will.

Section 5

Describes the information a treating physician must record in the patient's medical records in regard to the request for medication, including all oral or written requests, the diagnosis, prognosis, finding of terminal condition, competency and voluntary action, the findings of a consulting physician on the same items, the offer to the patient to revoke the request, full description of all required action plus the type of medication prescribed.

Section 6

Provides that the request for medication of a pregnant patient may not be given operative effect if the fetus is viable.

Section 7

Provides for transfer of patients in the event of an unwilling physician or unwilling facility.

Section 8

Requires transfer of the patient's medical records upon transfer of the patient.

Section 9

Permits review of medical records pursuant to this chapter by the Department of Health and Social Services and provides that such information is confidential and not subject to inspecting or copying.

Provides for an annual statistical report.

Section 10

Adds the request for medication to the immunities provided for living wills and do-not-resuscitate orders, protecting a physician or pharmacist under the request for medication.

Section 11

Provides that a person participating or refusing to participate in procedures authorized under the chapter is immune from professional censure or discipline. Good faith compliance under the chapter is not neglect or self-harm nor a basis for appointment of a guardian or conservator for the patient. A contractual provision requiring compliance with a request for medication is void.

Section 12

Adds the request for medication to the existing penalties for failing to comply with a living will or do-not-resuscitate order.

Section 13

Makes it a Class A felony to alter, forge, conceal or coerce a request for medication; does not limit civil damages for other negligence or misconduct nor preclude other criminal penalty for inconsistent conduct.

Section 14

Provides that death resulting from medication prescribed under a request for medication does not constitute a suicide or homicide for any purpose, including civil or criminal liability, if the medication was self-administered by a competent, terminally-ill person who controlled the time, place and manner of death.

Section 15

Adds the request for medication to the living will and do-not-resuscitate orders as not affecting a policy of life insurance.

Section 16

Provides that a request for medication may not be required as a condition for being insured, or receiving health care services.

Section 17

Adds that the absence of a request for medication creates no presumption.

Section 18

Provides for recognition of similar requests authorized in another state.

Section 19

Changes the description of a do-not-resuscitate order from directive to order.

Section 20

Includes a patient who has made a request for medication under the definition of "qualified patient".

Section 21

Adds definitions for "declarant" relating to a maker of a living will, "intentionally" as having the meaning given in the criminal code, Title 11, "requester" as the executor of a request for medication, and "request for medication" as a document executed as above.

Rep. Kay Brown
December 15, 1995

QUESTIONS AND ANSWERS ON THE DEATH WITH DIGNITY BILL

What is the "death with dignity" bill?

It is a proposed law now pending in the Alaska Legislature which, subject to a number of safeguards, would allow terminally ill patients to request that their physicians prescribe life-ending medication for self-administration by the patient.

Who supports the bill?

A statewide coalition of Alaskans including individuals from all parts of the political spectrum. The supporters all share the belief that end-of-life decisions for terminally ill Alaskans should be a private matter between physician and patient and should include the right to request medication to end needless suffering. Many of the bill's supporters have watched terminally ill friends and relatives suffer a prolonged death wracked with pain and indignity and have come to believe that the terminally ill should have the option, if they choose, of hastening an end to that suffering.

What are the safeguards in the bill?

There are many. First, the patient must be terminally ill in the opinion of a physician and knowingly request life ending medication in writing. A consulting physician must then confirm both the diagnosis and the patient's mental competence. Second, the request must be witnessed by individuals who have nothing to gain from the patient's death and are not connected with the patient's health care providers. Third, the request must be made at least twice and no fewer than ten days must pass between a first and second request. Fourth, the administration of the life ending medication is solely in the hands of the patient and the patient may change his or her mind at any time.

How do you know that family members won't pressure a relative with terminal illness to end his or her life?

Nothing is more personal and emotional than the relationship between the terminally ill and their families, and this bill urges patients to discuss these end-of-life issues with their families, but does not require that they do so. In any event, the patient has complete and exclusive control of the situation under this bill and the number of hurdles to the provision of life-ending medicine assures a knowing and voluntary decision.

Can anyone be forced to involve themselves in the procedures set out in this bill against their will?

Absolutely not. Patients have the absolute right to change their minds at every stage of the process and certainly have the right not to initiate the process at all. Physicians and hospitals have the absolute and unquestioned right to decline involvement in this process. The only proviso, however, is that if a patient wishes to proceed and a hospital or physician does not, they must refer the patient to persons and institutions who are willing to proceed.

Is this bill likely to lead to other laws which have fewer protections?

No. The supporters of this bill consider its safeguards essential and the patient's complete and exclusive control of the situation vital both as a matter of principle and policy. Any legislation which would attempt to lessen these safeguards or lessen the patient's control will be vigorously opposed by the supporters of this bill.

Why is this bill being proposed now?

At the risk of overusing a cliché, this is an idea whose time has come. Advances in medicine and the ready availability of artificial life support have increased the possibility that the end of life may be a painful and undignified nightmare. The supporters of this bill believe that Alaskans should have the right (which they are free to exercise or not) to avoid ending life in that way.

Rep. Kay Brown
December 12, 1995

CS FOR HOUSE BILL NO. 371(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES BROWN AND TOOHEY, Finkelstein, Davies

A BILL

FOR AN ACT ENTITLED

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

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

* Section 1. AS 13.26.344(l) is amended to read:

(l) In the statutory form power of attorney, the language conferring general authority with respect to health care services shall be construed to mean that, as to the health care of the principal, whether to be provided in the state or elsewhere, the principal authorizes the agent to

(1) have access to and disclose to others medical and related information and records;

(2) consent or refuse to consent to medical care or relief for the principal from pain, but the agent may not authorize the termination of life-sustaining procedures <u>nor originate a request for medication for the purpose of ending the principal's life</u>;

(3) take all steps necessary to enforce a properly executed declaration <u>or a request for medication</u> under AS 18.12;

(4) consent or refuse to consent to the principal's psychiatric care, but the consent does not authorize a voluntary commitment or placement in a mental health treatment facility, convulsive or electric-shock therapy, psychosurgery, sterilization, or an abortion;

(5) arrange for care or lodging of the principal in a hospital, nursing home, or hospice;

(6) grant releases to health care professionals or health care institutions;

(7) hire, discharge, or compensate an attorney, accountant, expert witness, or assistant when the agent considers the action to be desirable for the proper execution of the powers described in this subsection; and

(8) do any other act or acts that the principal can do through an agent and that the agent considers desirable or necessary to provide for the principal's physical or mental well-being.

* Sec. 2. AS 18.12 is amended by adding a new section to read:

Sec. 18.12.005. FINDINGS; PURPOSE. (a) The legislature finds that the people of the state have a fundamental right to make their own end-of-life decisions. The right should include the ability to make a conscious and informed choice to enlist the assistance of the medical profession in prescribing medication that will make death as humane and dignified as possible.

(b) To enable competent adults of this state to exercise this right, this chapter provides a method of

(1) permitting expression of people's wishes;

(2) protecting consenting health care professionals; and

(3) safeguarding against abuse of these procedures.

* Sec. 3. AS 18.12 is amended by adding a new section to read:

Sec. 18.12.015. REQUEST FOR MEDICATION TO END ONE'S LIFE IN A HUMANE AND DIGNIFIED MANNER. (a) A competent person who is at least 18 years old and is a resident of the state may execute a revocable request for medication that can be self-administered for the purpose of ending the person's life in a humane and dignified manner, but the request for medication may be given operative effect only if the condition of the requester is determined to be terminal and other

requirements of this chapter have been met. The request for medication shall be signed by the requester and witnessed by two adults who at the time of witnessing

(1) are not related to the requester by blood, marriage, or adoption;

(2) are not entitled to a portion of the estate of the requester under a will or by operation of law;

(3) do not have a creditor's claim against the requester and do not anticipate making a claim against the estate of the requester; and

(4) are not the requester's attending physician, an employee of the attending physician, a health care provider, or an employee of a health care provider.

(b) It is the responsibility of the requester to give the written request for medication to the requester's physician. A physician or other health care provider shall make it a part of the requester's medical records.

(c) The requester's request for medication may, but need not, be in the following form:

REQUEST FOR MEDICATION
TO END MY LIFE IN A
HUMANE AND DIGNIFIED MANNER

I, _____, over the age of 18 years and of sound mind, do voluntarily make known my desire that I want to end my life in a humane and dignified manner when I have a condition or illness certified to be terminal by my attending physician and at least one consulting physician.

Upon my oral or written request for medication after execution of this document but no sooner than 10 days after execution of this document, and after I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result and irreversible consequences, and the feasible alternatives, including comfort care, hospice care, and pain control, I ask my attending physician to prescribe medication that I can use to end my life in a humane and dignified manner.

Determining the time and place of my death shall be in my sole

discretion and I understand that I must administer the medication to myself.

Initial one of the following:

(1) _____ I have informed my family of my decision and taken their opinions into consideration.

(2) _____ I have decided not to inform my family of my decision.

(3) _____ I have no family to inform of my decision.

I understand that I have the right to rescind this request for medication at any time.

I understand the full import of this request for medication, and I expect to die when I take the medication to be prescribed.

I make this request for medication voluntarily and without reservation, and I accept full moral responsibility for my actions.

Dated: _____ Signed: _____

Requester

Place: _____

STATEMENT OF WITNESSES

I declare under penalty of perjury that the maker of this request for medication

(1) is personally known to me or has provided proof of identity;

(2) signed this request for medication in my presence;

(3) appears to be of sound mind and not under duress, fraud, or undue influence; and

(4) is not a patient for whom either of us is attending physician, health care provider, or an employee of a health provider.

I further declare under penalty of perjury that I am not related to the requester by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the requester

under a will now existing or by operation of law, and have no claim nor do I anticipate making a claim against any portion of the estate of the requester.

Dated: _____

Witness's Signature: _____

Print Name: _____

Residence Address: _____

Dated: _____

Witness's Signature: _____

Print Name: _____

Residence Address: _____

(d) A physician may presume, in the absence of actual notice to the contrary, that a request for medication complies with this chapter and is valid.

(e) Upon a subsequent oral or written request for medication by the maker of the request for medication, the attending physician shall make the initial determination of whether the requester has a terminal disease, is competent, and has made the request for medication voluntarily, and shall inform the requester of the

(1) attending physician's medical diagnosis;

(2) attending physician's prognosis;

(3) potential risks, probable results, and irreversible consequences of taking the medication to be prescribed; and

(4) feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control.

(f) After complying with (e) of this section, the attending physician shall refer the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is competent and acting voluntarily.

(g) The attending physician shall ask the patient to notify next of kin of the request for medication. A patient who declines or is unable to notify next of kin may not have the request for medication denied for that reason.

(h) In order to receive a prescription for medication to end life in a humane and dignified manner, a qualified patient shall have made a written request for

medication under (c) of this section followed by an oral or written request for medication to the attending physician no less than 10 days after making the written request under (c) of this section. A prescription for medication under this chapter may not be written unless the attending physician has verified that the patient is making an informed decision and offered the qualified patient an opportunity to revoke the request for medication.

(i) A prescription written for medication under this chapter must be in writing and must include a notation on the prescription that it is issued at the request of the patient under this chapter.

* **Sec. 4.** AS 18.12.020 is amended to read:

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

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

* **Sec. 5.** AS 18.12.030 is amended to read:

Sec. 18.12.030. RECORDING DETERMINATION OF TERMINAL CONDITION AND CONTENTS OF DECLARATION **OR REQUEST FOR MEDICATION**. When an attending physician who has been provided a copy of a declaration **or request for medication** determines that the declarant **or requester** is in a terminal condition, the physician shall record that determination and the contents of the declaration **or request for medication** in the declarant's **or requester's** medical record. **When recording a request for medication into the requester's medical record under this section, the physician shall also record**

(1) all oral or written requests by a patient for medication to end the patient's life in a humane and dignified manner;

(2) the attending physician's diagnosis and prognosis for the patient and the attending physician's determination that the patient is mentally competent, acting voluntarily, and has made an informed decision;

(3) the consulting physician's diagnosis and prognosis for the patient and the consulting physician's verification that the patient is mentally competent, acting voluntarily, and has made an informed decision;

(4) that the attending physician has made an offer to the patient to let the patient revoke the most recent request for medication;

(5) a note by the attending physician indicating that all requirements under this chapter have been met and describing the steps taken to comply with this chapter; and

(6) the type of medication, if any, prescribed as a result of the patient's request for medication.

* Sec. 6. AS 18.12.040(c) is amended to read:

(c) The declaration or request for medication of a qualified patient known to the attending or consulting physician to be pregnant may not be given operative [IS GIVEN NO] effect as long as it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining procedures.

* Sec. 7. AS 18.12.050 is amended to read:

Sec. 18.12.050. TRANSFER OF PATIENTS. (a) An attending physician who is unwilling to comply with the requirements of AS 18.12.030, [OR WHO IS UNWILLING TO COMPLY WITH] the declaration of a qualified patient under AS 18.12.040, or a request for medication of a qualified patient under AS 18.12.015 shall withdraw as attending physician but the withdrawal is effective only when the services of another attending physician have been obtained.

(b) If the policies of a health care facility preclude compliance with the declaration or request for medication of a qualified patient under this chapter or a do not resuscitate order issued by an attending physician, or the facility is unwilling to accept DNR identification as evidence of the existence of a declaration or do not resuscitate order, that facility shall take all reasonable steps to notify the patient or, if the patient is not able to make treatment decisions, the patient's guardian or other

person who has the power to make health care decisions for the patient, of the facility's policy and shall take all reasonable steps to effect the transfer of the patient to the patient's home or to a facility where the provisions of this chapter can be carried out.

* Sec. 8. AS 18.12.050 is amended by adding a new subsection to read:

(c) A physician or health care facility that provides for the transfer of a patient under this section shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

* Sec. 9. AS 18.12 is amended by adding a new section to read:

Sec. 18.12.055. REPORTING REQUIREMENTS. (a) The Department of Health and Social Services may review records maintained under this chapter and may issue appropriate regulations to facilitate the collection of information regarding compliance with this chapter. The information collected under this subsection is confidential and not subject to inspection or copying under AS 09.25.110 - 09.25.125.

(b) The Department of Health and Social Services shall prepare and make available to the public an annual statistical report of information collected under (a) of this section.

* Sec. 10. AS 18.12.060(a) is amended to read:

(a) In the absence of actual notice of the revocation of a declaration, request for medication, or do not resuscitate order, as applicable, the following, while acting in accordance with the do not resuscitate protocol adopted under AS 18.12.035 or with the other requirements of this chapter, are not subject to civil or criminal liability or guilty of unprofessional conduct:

(1) a physician who causes the withholding or withdrawal of life-sustaining procedures from a qualified patient or the withholding or withdrawal of cardiopulmonary resuscitation from a patient for whom a do not resuscitate order has been issued or who possesses DNR identification;

(2) a person who participates in the withholding or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures under the direction or with the authorization of a physician or upon discovery of DNR identification upon a person;

(3) persons who cause or participate in providing cardiopulmonary resuscitation or other life-sustaining procedures after an oral or written request communicated to them by a person who possesses DNR identification;

(4) the health care facility in which the providing, withholding, or withdrawal occurs;

(5) a physician or pharmacist who prescribes, prepares, or dispenses medication for a qualified patient to implement a request for medication in accordance with the procedures required by this chapter.

* Sec. 11. AS 18.12.060 is amended by adding new subsections to read:

(c) A professional organization, professional association, or health care provider may not subject to disciplinary measures or other penalty a person based on the person's good faith participation or refusal to participate in procedures authorized under this chapter if the participation or refusal to participate is done in a manner that complies with this chapter.

(d) A request for medication by a patient or the provision by an attending physician of medication in good faith compliance with this chapter does not constitute neglect or self-harm and may not be the basis for the appointment of a guardian or conservator for the patient.

(e) A provision of a contract that requires a health care provider to comply with a request for medication executed under AS 18.12.015 is void.

* Sec. 12. AS 18.12.070 is amended to read:

Sec. 18.12.070. PENALTIES. (a) An attending physician who (1) fails to comply with a do not resuscitate order or the declaration or request for medication of a qualified patient who has complied with the requirements of this chapter; and (2) fails [OR] to make the necessary arrangements to effect a transfer under AS 18.12.050, has no right to compensation for medical services provided to a patient after withholding, [OR] withdrawal, or the requested medication should have been effective or after transfer should have occurred and may be liable to the patient and to the heirs of the patient for a civil penalty not to exceed $1,000 plus the actual costs associated with the failure to comply with the order, [OR] declaration, or request for medication, and this shall be the exclusive remedy at law for damages.

(b) A person who wilfully conceals, cancels, defaces, obliterates, or damages the DNR identification, [OR] declaration, **or request for medication** of another person without the other's consent or who falsifies, **alters,** or forges a revocation of the DNR identification, [OR] declaration, **or request for medication** of another person may be civilly liable to the other person and to the heirs of the other person.

* **Sec. 13.** AS 18.12.070 is amended by adding new subsections to read:

(c) A person who without authorization of the patient intentionally alters or forges a request for medication or conceals a revocation of a request for medication with the intent or effect of causing the patient's death is guilty of a class A felony.

(d) A person who intentionally coerces or exerts undue influence on a patient to request medication that can be used for the purpose of ending the patient's life or to destroy a revocation of a request for medication, is guilty of a class A felony.

(e) This chapter does not limit liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(f) The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct that is inconsistent with the provisions of this chapter.

* **Sec. 14.** AS 18.12.080(a) is amended to read:

(a) Death resulting from the withholding or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures under a do not resuscitate order or protocol, under a declaration, or upon discovery of DNR identification on a person and in accordance with this chapter does not, for any purpose, **including civil or criminal liability,** constitute a suicide or homicide. **Death resulting from medication prescribed under a request for medication in accordance with this chapter does not, for any purpose, including civil or criminal liability, constitute a suicide or homicide if the medication is self-administered by the person who made the request for medication and the person who made the request for medication controlled the time, place, and manner of death.**

* **Sec. 15.** AS 18.12.080(b) is amended to read:

(b) The issuing of a do not resuscitate order, the possession of DNR identification, [OR] the making of a declaration under AS 18.12.010, **or a request for medication under AS 18.12.015** does not affect in any manner the sale, procurement,

or issuance of a policy of life insurance, nor does it modify the terms of an existing policy of life insurance. A policy of life insurance is not legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, [OR] the withholding or withdrawal of cardiopulmonary resuscitation from an insured patient who possesses DNR identification or for whom a do not resuscitate order has been issued, **or the use by an insured qualified patient of medication prescribed in compliance with a request for medication governed by this chapter,** notwithstanding any term of the policy to the contrary.

*** Sec. 16.** AS 18.12.080(c) is amended to read:

(c) A physician, health care facility, or other health care provider, and a health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital plan, may not require a person to execute a declaration **or request for medication**, obtain a do not resuscitate order from a physician, or possess DNR identification as a condition for being insured for, or receiving, health care services.

*** Sec. 17.** AS 18.12.080(d) is amended to read:

(d) This chapter creates no presumption concerning the intention or intended treatment of an individual who does not have DNR identification, has not executed a declaration **or request for medication**, or for whom a do not resuscitate order has not been issued with respect to the use, withholding, or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures.

*** Sec. 18.** AS 18.12.090 is amended to read:

Sec. 18.12.090. RECOGNITION OF DECLARATIONS, **REQUESTS FOR MEDICATION,** AND ORDERS EXECUTED OR ISSUED IN OTHER STATES. A declaration, **request for life-ending medication,** do not resuscitate order, or DNR identification executed, issued, or authorized in another state or a territory or possession of the United States in compliance with the law of that jurisdiction is effective for purposes of this chapter.

*** Sec. 19.** AS 18.12.100(5) is amended to read:

(5) "do not resuscitate order" means **an order** [A DIRECTIVE] from

a licensed physician that emergency cardiopulmonary resuscitation should not be administered to a particular person;

* **Sec. 20.** AS 18.12.100(10) is amended to read:

(10) "qualified patient" means a patient who, **in accordance with this chapter,** has executed a declaration **or a request for medication, as applicable,** [IN ACCORDANCE WITH THIS CHAPTER] and who has been determined by the attending physician to be in a terminal condition;

* **Sec. 21.** AS 18.12.100 is amended by adding new paragraphs to read:

(12) "declarant" means a person who has executed a declaration under AS 18.12.010;

(13) "intentionally" has the meaning given in AS 11.81.900;

(14) "requester" means a person who has executed a request for medication under AS 18.12.015;

(15) "request for medication" means a document executed in accordance with the requirements of AS 18.12.015.

9-LS1354\F.2
Lauterbach
2/16/96

AMENDMENT #1

OFFERED IN THE HOUSE BY REPRESENTATIVE G.DAVIS

TO: HB 371

Page 6, after line 6:

Insert a new subsection to read:

"(i) A prescription written for medication under this chapter must include a notation on the prescription that it is issued at the request of the patient under this chapter. If a prescription for medication governed by this chapter is ordered telephonically, the person communicating the prescription shall orally include a notice that the prescription is being ordered at the request of a patient under this chapter."

FORUM / LETTERS

Allowing death with dignity shows respect for life

By JENNY DICKINSON

I am in total support of the choice of the terminally ill to die in a dignified, painless and legal manner. I lost my loving mother 2 years ago from a hideous disease, that God forbid, could befall any of us. It is a truly mournful experience to watch someone you love dearly suffer the agony of a slow death.

FIRST PERSON

We show more empathy and understanding for our family pets by taking them to the veterinarian for a kind and humane injection when their quality of life loses its meaning. Why can't we muster the courage to treat our loved ones with the same respect and dignity?

I believe in God and respect the sanctity of all life, including the unborn. I have great empathy for those who are depressed or who are experiencing marital or financial problems. I, in no way, advocate that the solution to these problems is suicide.

What we are talking about here are the terminally ill. People who, in many cases, are suffering excruciating pain and despair. People who are forced to remain in a basically lifeless shell, called their body, that is no longer functional.

We show more empathy and understanding for our family pets by taking them to the veterinarian for a kind and humane injection when their quality of life loses its meaning. Why can't we muster the courage to treat our loved ones with the same respect and dignity?

My mother was my best friend and I miss her terribly, but I was relieved for her when she finally slipped into a coma and died.

You can't imagine the helpless feeling of watching someone you love suffer day after endless day. Someone who was extremely proud, relegated to using a bedpan, auxiliary oxygen to breath and a myriad of pills too numerous to count. Her cries in the night were the worst, something that will haunt my family forever. The only more horrible experience I could imagine would be to watch your own child suffer this agony. My brother-in-law, a police officer, went to visit mother during one of her many emergency hospital stays. She asked him to shoot her. He raced out of her room and cried.

I have given the suicide aid bill much thought and consideration. I want to commend Rep. Kay Brown for her courage to stand up to the criticism of the people who have no concept of what true pain and suffering are all about. I know very little of the premise of the Hemlock Society. I am not a member, but if they support assisted suicide for the terminally ill, then God bless them.

I will fight for the right to life with everything that is in me. I also will fight for the right to die with dignity, with equal conviction, for the right to die for the terminally ill, in reality, is their truest blessing of all.

□ Jenny Dickinson lives in Anchorage.

Survey finds hospitals inept at handling death

By DON COLBURN
The Washington Post

The largest study ever of how hospitalized patients die reports that American doctors and hospitals, even under the best of circumstances, do not manage death well.

Many patients die a prolonged, painful death, with doctors giving "heroic" treatments such as mechanical ventilation or cardiopulmonary resuscitation (CPR) even when patients have asked that they be withheld, the study found.

The five-year study of more than 9,000 acutely ill patients in five teaching hospitals describes a pattern of depersonalized care near the end of life and poor communication among patients, families and doctors.

The study found that even giving doctors computer-generated statistics on a patient's prognosis and making known the patient's wishes about treatment did not change the way patients died.

Researchers said they were stunned by the findings, which are published

Please see Back Page, DEATH

DEATH: Sometimes hospitals, doctors make it worse

Continued from Page A-1

in today's Journal of the American Medical Association. Among them:

- In nearly half the cases, doctors were not aware that the patient had asked not to undergo CPR in the event of cardiac arrest.
- Half the dying patients spent at least eight days in the intensive care unit (ICU), in a coma, or on a mechanical ventilator.
- Half the patients who died were reported by their families to be in moderate or severe pain most of the time during their final three days of life.

"I was shocked," said William Knaus, co-leader of the study and former director of the Intensive Care Research Unit at George Washington University Medical Center, now at the University of Virginia Health Sciences Center. "It was a fundamental belief that if you gave people the opportunity and the information to do things right, they would take that opportunity. But nothing really has changed over the five years we've been studying these things. We're stuck on this one."

"We underestimated the weight of habit," said Joanne Lynn, director of the Center to Improve Care of the Dying at George Washington University Medical Center, the study's co-leader. She said doctors and patients alike have to learn to talk more openly about pain, death and the risks as well as benefits of medical technology.

Living wills and other advance directives on what kinds of treatment a person wants in the event of an incapacitating illness "aren't enough on their own," Lynn said. "We need a vision of what it would be to live well in the shadow of death."

BILL ROTH / Anchorage Daily News

Kent Lee Woodman, shown with his dog, Newman, has been diagnosed with Lou Gehrig's disease.

Gehrig's disease has man walking fine line with time

By STAN JONES
Daily News reporter

Most of the questions in Kent Lee Woodman's life these days have to do with timing.

Take his hair. He has only enough arm strength left for 50 or so strokes of the blow dryer and brush. So, after a shower, he has to let his hair air-dry just long enough.

■ **LEGISLATURE:** Hemlock Society helps offer assisted-suicide bill. **C-1**

Wait too long, and there's no point in blow-drying at all. Act too soon, and he's out of muscle with a wet head.

It's more or less the same thing with killing himself.

If he waits too long, he'll be so sick with Lou Gehrig's disease he might foul up the suicide and make things worse.

Please see Back Page, **ALS**

ALS: Anchorage man with Lou Gehrig's disease walks fine line with time

Continued from Page A-1

But if he acts too soon, he'll needlessly write off weeks or months of life, maybe even years.

"The prospect of me lying in a hospital bed on a ventilator with tubes poked in me, not able to even go to the bathroom by myself — that's not the me that I want my friends and my relatives to remember," Woodman said. "It's clear to me that I'm going to leave before that happens and it doesn't scare me at all. The question is, how do I determine when that happens?"

As he waits, it's possible things will break his way.

The drug companies might find something to cure or at least slow his disease, which kills people by attacking the nerves that carry signals from the brain to the muscles. In just the past few months, two new drugs have been announced for people with amyotrophic lateral sclerosis, as Lou Gehrig's disease is officially known. Woodman has already signed up to take one of them, riluzole, though he realizes it's a long shot.

Or, the Legislature might pass a bill that Woodman and his fellow members of the Hemlock Society of Alaska are pushing.

The bill would make it legal for a doctor to prescribe a lethal dose of drugs for a terminally ill patient, as long as the patient requested it and a second doctor agreed the case was hopeless. No doctor would administer the drug — that would be up to the patient. But at least those in the condition Woodman expects to reach someday could get professional help in the tricky business of killing themselves.

At present, helping someone commit suicide is manslaughter — a felony — in Alaska.

"The whole idea is to allow humane assistance without taking the family or the doctor and making a shambles out of their career and the rest of their life," Woodman said.

Woodman was born in Washington, D.C., 56 years ago. The family moved to Anchorage in the early 1950s when his father, Lyman Woodman, was assigned to Elmendorf Air Force Base. Lyman still lives in Anchorage.

Kent Lee's mother, Betzi Woodman, was a longtime Alaska journalist and a founder of Alaska Press Women. She was killed five years ago in a car crash.

The family moved back and forth between Anchorage and California as Woodman was growing up, but he returned here to live and work after college. He served as pilot and civil engineer with the Alaska Air National Guard. In the 1970s and 1980s, he worked in a series of private engineering jobs, then in 1992 founded a consulting business to help architects and owners make sure their buildings satisfy the Americans with Disabilities Act.

He came down with amyotrophic lateral sclerosis — or ALS — in December 1988, though he didn't realize it at the time and a firm diagnosis was years off.

"I noticed a weakness in my left foot while I was skiing," Woodman said. "I couldn't keep my skis straight in the track. I didn't pay too much attention. I just thought 'I'm getting old.'"

When spring came, however, he noticed something else: If he stepped on a stone, even a small one, he would go sprawling. He went to a doctor and started the five-year process of finding out what was going on in his body.

The answer came after a trip to a University of California neurological clinic in San Francisco in September 1994. A couple weeks later, Woodman went to his Anchorage doctor's office for the results.

"He said, 'You got something really bad.'"

Lou Gehrig's disease is named after one of its most famous victims, the legendary New York Yankees first baseman of the 1920s and 1930s. Besides weakness and loss of muscle mass, its symptoms can include impaired speech, difficulty chewing and swallowing, difficulty breathing, and choking and drooling. Most victims die within five years or so of getting it.

To sit and talk with Woodman, you wouldn't know he's sick at all. He's trim and seems fit, looking perhaps 10 years younger than his actual age. His speech is loud, fast and confident. The only obvious sign he's ill is the limp that now marks his stride.

Divorced and childless, he lives alone with his mongrel dog Newman in the Hillside home he built in 1969. He runs his consulting business and a host of personal projects out of a computer-stuffed office on the second floor. When a reporter visited last month, he was wrestling with problems caused by installation of the new Windows 95 operating system.

If he's not at home, he answers the phone with a complex voice-mail system — regrettably unaffected by Windows 95 — that would do credit to the Internal Revenue Service or another major government bureaucracy.

He gets information about his disease off the Internet and communicates constantly by electronic mail. In fact, many of his comments in this story were drawn from a two-month exchange of e-mail messages between the reporter and Woodman.

His personal projects include being president of a nonprofit group devoted to Russian-American relations and vice president of the Hemlock Society.

He oversees the care of his father, who, at 82, still lives in his own home but is suffering memory loss and other symptoms of advanced age. A few weeks ago, they traveled to Massachusetts together and located the home where the family lived more than 50 years ago.

And then there's "Portal," the potboiler novel Woodman is writing. It's about an East Coast electrical engineer who steals his company's plans for a device that can transmit matter electronically and flees to Alaska.

Besides doing all the usual things a 56-year-old divorced guy with a high energy level would do, Woodman fights a running battle — a series of adaptations, really — with the disease.

Early this month, he slipped and fell on his way to the mailbox with Newman. An e-mail he sent the next day captured both the incident and his attitude toward ALS:

"I did the splits and went down heavy on the asphalt, landing first on my left knee then hip and shoulder. I missed a large rock with my head by inches. My leg went so far back that I pulled all the skin off the top of my left foot. I was jolted and out of breath, and for about 10 minutes I simply could not even roll over to find a tree to pull myself up.

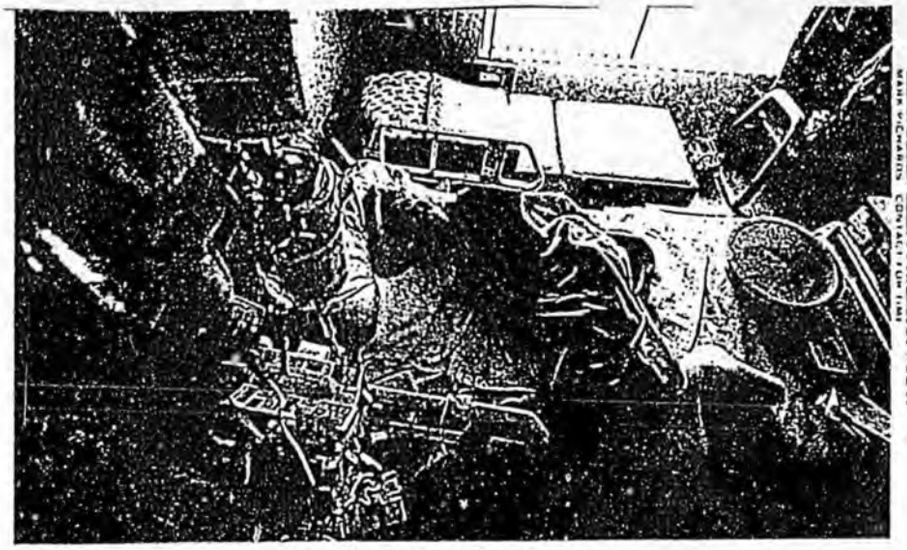
"About 10 cars zoomed by, no interest at all. Newman was concerned and licked my face. At one point I told him, 'Newman ... sometimes it's very, very hard ... this is one of them.'

"Well, I finally got up and hobbled in and had my mocha espresso. My doctor saw me hobbling and insisted on X-rays of knee. No permanent damage, but I lost a lot of time, spent $105 at the hospital, slept like hell and I certainly promised myself no more 'Help, I've fallen and I can't get up' jokes! I plan to carry my cell phone in my pocket from now on, in case I just cannot get up.

"Hell, I could freeze to death!"

The Hemlock Society is a nationwide group that advocates what it calls "voluntary aid-in-dying." Woodman is as interested as any other member in making assisted suicide legal in Alaska — that was much of his motive for going public about his own illness. But he's not wildly optimistic anything will happen in time for him to get expert help with what he describes as "ending a death."

"I don't want anybody to think that this is a cry from me to the public that they've got to do something for me," he said. "All I want them to do is think about it and talk about it. ... If I didn't think this was important in getting the discussion started and I didn't think that was valuable for our community, I wouldn't do this."



TERMINALLY ILL: Most patients prefer to die in peace, surrounded by their loved ones

HEALTH

Knowing When to Stop

Doctors go to heroic lengths to keep terminally ill patients alive—often against their wishes

By LEON JAROFF

IN HOSPITALS ACROSS THE U.S., DOCTORS ignore, or are unaware of, the last wishes of dying patients, needlessly prolonging their pain and suffering. That is the disturbing conclusion of a massive study published last week in the *Journal of the American Medical Association*. "There is a tragic mismatch between the health care many seriously ill people want and what they get," says the University of Virginia's Dr. William Knaus, co-director of the study. "We don't know when or how to stop."

In the initial phase of the study, which was conducted with a $28 million grant from the Robert Wood Johnson Foundation, hundreds of doctors and nurses in five major teaching hospitals cooperated in observing 4,301 desperately ill patients. Among their findings:

► While a third of the patients had asked not to be revived with cardiopulmonary resuscitation, half the time DO NOT RESUSCITATE was never written on their charts.

► Nearly 40% of patients spent at least 10 days in intensive care, kept alive only by breathing machines.

► Half the patients able to communicate in their last three days of life reported that they were in severe pain.

"We don't decide to let patients die in peace until almost the last moment," says George Washington University's Dr. Joanne Lynn, the study's co-director. "This is hard on patients, their families and the health professionals who care for them."

Convinced that the problem was caused largely by a lack of communication, the researchers launched the second phase of the study, involving 4,804 different terminally ill patients. This time half the group received traditional hospital care, while the others were monitored by specially trained nurses who consulted with patients and their families, forced them to confront the realities of dying and kept doctors informed about their patients' conditions and wishes.

"We were stunned to find that it didn't make a bit of difference," says Knaus. "The tools that experts thought would work didn't." The reasons, suggests Lynn, are ingrained in our society. "Physicians are taught to save lives, that death is failure," she says. "Patients and families have come to expect miracles in every case. No one wants to give up too soon."

They may have to, if health-care reform is to succeed. The U.S. currently spends around $62 billion of its total expenditure of $884 billion on intensive care; nearly 30% of all Medicare payments go to patients in their last year of life. What is needed to bring about change, some experts now suggest, is something more fundamental than improved communication: a hard look at a medical culture in which doctors have access to splendid life-saving technology and feel obligated both morally and legally to use it. "We have to recognize that there are alternatives to extending life hooked up to high-tech machines," concludes Knaus. "And we have to think creatively to help patients craft the best way for them to live their last days." *–Reported by Alice Park/New York*

DEATH with DIGNITY

Doctor talks about Oregon's right-to-die measure and what it may mean for Alaska

By Jay Bluchor / Daily News reporter

In 40-plus years of practicing family medicine in Oregon and Washington, death has remained the enemy of Dr. Peter Goodwin, just as it has for physicians since the advent of the Hippocratic oath.

But there have been instances when all Goodwin's experience and medical training left him feeling helpless when confronting death — never more so than when terminally ill patients have asked for his aid in dying.

It first happened 25 years ago in Oregon. A man he knew well from years of office visits came to see him with unmanageable pain from incurable bone cancer. According to Goodwin, the man said, "Doctor, I want you to help me die." The patient's wife accompanied him and told Goodwin that if he would prescribe the necessary pills, she would help her husband take them.

Goodwin could not grant his patient's wish. He might have faced a felony charge of manslaughter.

Worse, Goodwin found he could not even talk about his ethical predicament with medical colleagues.

"It was as if somebody was presenting themselves to me with a disease that I had never heard of, and no resources existed which could help me make my decision — I look back on that experience to this day with absolute desolation and regret," he said. "I could do nothing."

Last year, Goodwin decided to do something. He became the architect and national spokesman for Oregon's Death With Dignity Act, which voters there approved in a November ballot measure,

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SUICIDE THE WRONG TERM FOR GRAVELY ILL WHO WANT TO DIE

comment

The ethics and wisdom of physician-assisted suicide are a formidable legal and moral dilemma for Americans. The issues are so complex and emotion-laden that clarification and consensus on the part of the public are not likely.

One of the sources of our collective confusion is the use of the term "suicide" in the law and the literature.

Suicide is a word loaded with negative and frightening connotations. It suggests the self-destruction of a person because of insanity.

Please see Page C-2, SUICIDE

By Richard T. Penman

DEATH: Doctor wants legal right to help end suffering

Continued from Page C-1

making Oregon the only state that allows physicians to hasten death for the terminally ill.

The initiative, also known as Measure 16, passed 52 percent to 48 percent. It allows a patient with six months to live to ask a doctor to prescribe a lethal dose of drugs to end unbearable suffering. A second doctor must agree that the patient's condition is terminal.

Among other safeguards, the patient must request the drugs at least three times, with the third request in writing. The measure also leaves it up to the patient to administer the drugs. Physicians are not allowed to. (Similar ballot measures were defeated in Washington in 1991 and California in 1992 in part because physicians would have been able to administer the lethal drugs.)

Last year, lawmakers in the Netherlands approved guidelines allowing doctors to assist in the suicide of a terminally ill patient. It was the first country in the world to allow the practice.

But the Oregon measure was quickly challenged in state court on constitutional grounds and now sits in legal limbo. It was opposed by the American Medical Association, the Catholic Church and the National Right to Life movement, Goodwin said.

In Alaska, members of the Hemlock Society are proposing that state law pertaining to living wills be amended to allow people to ask their doctor to prescribe medication to end terminal illness, according to Al Sundquist, president of the Hemlock Society of Alaska board of directors. No bill has been introduced in the state legislature. Currently in Alaska, assisted suicide can bring a felony manslaughter charge.

Dr. Goodwin visited Anchorage recently to testify as an expert medical witness in an Anchorage court case and to give an update on the Oregon measure to the Hemlock Society of Alaska. We caught up with him last weekend to learn more about the Oregon experience, and what it might mean for Alaska:

Daily News: How is it that you got involved with the Death with Dignity movement?

Goodwin: Traditional medicine simply doesn't prepare physicians for this — we were not taught to deal with patients as persons. Patients die all the time. But for somebody to confront me and say, "Doctor, I want you to do something to help me die," it's an unsettling experience for a physician. And that happened to me several times. Doctors usually say we are going to do what we think is best for the patient, and we do what we want to do. And we don't even consult the patient much of the time. That's all changing now, and I say it's long past due.

Why do you say you couldn't talk about this with any of your medical colleagues?

Because it has always been a taboo subject among doctors. You can't say, "Hey, this woman wants to die. Should I let her die?" The other doctors would say you are crazy. What sort of a doctor are you, anyway?

So, you got to thinking about it, and just decided you had to do something?

Yes, this was just crazy. So I joined the Hemlock Society in 1990 and got involved, first on the board and then gradually after that until we started hatching plans to launch this initiative.

Who were your strongest opponents?

It was strongly opposed by the Catholic Church because they said it would lead to all sorts of abuse, that people would die inappropriately, that they were going to be abused by their families.

What do your critics mean when they say it will cause the disadvantaged to suffer?

They fear it will lead to abuse of the elderly, because they can't be trusted to make their own decisions. That the physically disabled will be abused. It's ridiculous.

The measure has been halted in court. What's next?

We don't have a time scale. The next hearing is on Feb. 14. I think everyone agrees this is ultimately headed to the U.S. Supreme Court. That seems inevitable now.

In simplest terms, what does the measure do?

It makes it legal for the first time for a physician to respond to a constant and abiding request from a terminally ill, dying patient for aid in dying.

What if I just put that request in writing in my living will? Won't that take care of it?

You can, but the doctor won't necessarily have to abide by it. Sure, if you're (medically) incompetent. But if you're competent and want aid in dying, there's nothing legal a doctor can currently do for you. No physician in America can help you.

But doctors withdraw life support all the time from patients. What's the difference?

They can withdraw life support, but then many terminally ill people are not on life support. But I believe there is no difference between withdrawing life support and helping somebody to die because both ways, you are helping somebody die with compassion.

What is the AMA's position on this measure?

Their position has been that it is ethically improper. So they absolutely oppose this. But my reaction to them is that their ethics are not better than mine. Who is the AMA to decide this? Is this an organization of physicians who look after dying patients every day? What right does an ophthalmologist or a radiologist have to talk about the proper care of a dying patient? None.

Given the role of the medical profession in dealing with dying patients, won't this measure give physicians even more power? Perhaps too much power — the power to kill?

That's rubbish. We are giving patients the power to interact in a realistic and powerful way with physicians. Physicians have all the power now; patients have very little. It's another bargaining chip for the patient. Physicians are so poor at looking after the dying patient now precisely because they have no incentive to get any better. So who needs to change? When we give patients the right to say, "Hey, Doctor, I want a say here in how things are going to end for me," you see, that's very threatening to a lot of doctors. Then the physician has to say, "OK, let me think about this."

Didn't the living-will laws change all this and give patients the right to do precisely that?

No, not really. The living-will law only gives patients the opportunity to tell the physician that this is the way they want things to go. But many physicians still ignore the living wills. They stuff it in the charts without even reading it. Or they will tell the patient, "I'll know what to do for you when the time comes."

Don't you dare let them tell you that. Make your doctor read your living will. Make him say he understands your wishes. Most patients don't have the gumption to do that with their doctors, and they should.

This aid-in-dying measure is an extension of the living will. It gives patients more power and an additional choice.

Essentially, this measure is limited to a prescription bill. Why?

When all of the safeguards have been met, all the physician can do is hand a written prescription to the patient. The patient has to administer it themselves, so that a tremendous amount of responsibility remains with the patient.

What prescription would you use?

A short-acting barbiturate. Death is quick and trouble-free.

What has been the reaction of your colleagues?

Many physicians are uncomfortable looking after dying patients. And what makes them most uncomfortable is the intimacy this process demands. You are forced to see this patient as a person, not some clinical disease. All their professional lives, doctors are taught to keep the patient alive as long as possible, at all costs. Well, what if the patient does not want to be kept alive as long as possible?

Some doctors obviously regard your measure as killing. Isn't it the same as suicide?

Yes, in a narrow sense, it is suicide, and yet it is so very different from the average suicide. We are talking about somebody who has been gathered in by society, gathered in by a circle of friends in a true spirit of compassion.

How can you call it compassionate when you are aiding people in killing themselves?

I say to you, "How can you call it mercy when you allow someone to suffer, and watch their life unravel?" When all their life's savings, and their children's savings, are spent on doctors' bills.

But don't doctors already aid patients in dying anyway?

Not officially, but yes, it happens. Physicians help patients to die, but without any safeguards or guidelines. We just increase the dose of morphine to decrease the patient's suffering, but knowing full well it will shorten their lives. The morphine will depress their respiration if you give them enough. But because our intent is to relieve suffering and not to shorten their life, that's OK, which is rubbish. You know them with morphine. I've done it. Nobody tells anybody and that's fine. But there's no real difference between that and our proposal.

❑ **FOR MORE INFORMATION** about the Death With Dignity Movement, contact The Hemlock Society of Alaska Inc., P.O. Box 91613, Anchorage AK 99509-1613, or the Hemlock Society U.S.A., P.O. Box 11830, Eugene OR 97440-4030 Phone: 1-800-247-7421.

SUICIDE: Not the right word

Continued from Page C-1

deep mental depression or a fear of being exposed.

Every state has now abolished any penalty for the suicidal person or those left behind. The moral stigma embodied in the ecclesiastical law of some denominations that a person who commits suicide cannot receive a Christian burial has essentially been abolished.

The debate about the moral and legal issues that arise when a terminally ill patient wants to shorten the period of suffering should not be confused with suicide. Perhaps the more appropriate term is "expedited death."

The very concept of suicide means that a person who is healthy, in no danger of death, seeks to terminate life because for subjective reasons it is no longer satisfying.

This should not apply to the person who, with the aid of family and professional counsel, deliberately and solemnly concludes to hasten his or her inevitable demise.

But a new terminology and a new way of thinking about those who desire to shorten their lives will not come quickly.

Deep in our religious instincts is a profound conviction that human life belongs to God alone and that we should bear with patience the sickness that will bring an end to our lives. But these days, most religious traditions allow terminally ill patients to forgo any extraordinary measures that cannot cure, but can only prolong the inevitable.

There is a sharp debate among Catholics and other religious communities as to whether care-givers may, with the consent of the patient, withdraw food and water. Some feel that the failure to give hydration can be equivalent to "mercy murder."

But other voices quietly suggest that the moral issue is not clear. They argue that physicians and care-givers should be allowed to follow a course of conduct with which they feel comfortable in their consciences.

That approach is persuasive and pervasive in many difficult situations. But some legislators, pressured by special-interest groups, will continue to feel obliged to fashion guidelines for hospitals, physicians and jurists presented with very sick patients who want to avoid pain and a loss of dignity as death approaches.

As legislators, courts and ethicists continue their struggle to develop moral guidelines for the right to die, those who cherish the sanctity of human life at every stage of its existence should avoid extreme positions and the hard rhetoric that make this intractable problem even more difficult to resolve.

❑ **Robert F. Drinan, a former member of Congress, is a professor of law at Georgetown University, a legal ethicist and a Jesuit priest.**

The American way of dying

Hospital culture is at war with patients' wishes about how they're treated in their final days

Most people hold in their hearts a special dread of a hospitalized, medicalized death. Yet about half of all Americans die in hospitals, in a tangle of tubes, surrounded by anxiety-producing technology. They suffer alone in the glare of a comfortless ward, their last hours guided by the training and instincts of highly specialized strangers. No one seems to know when to finally give in to death's certainty, and relentless procedures rob people of a death with comfort and dignity.

Many of those who dread that kind of death think they're doing something about it by signing living wills or otherwise making their wishes very explicit. But a large-scale study of terminal patients by the *Journal of the American Medical Association* showed last week just how futile those efforts are. While patients say they want peace, comfort, the sanctity of home and freedom from pain in their last hours, shockingly few of them actually had their wishes honored even at the five top medical centers that were featured in the *JAMA* study. Even more distressing, the study's authors found that when they tried to take steps using specially trained nurses to encourage communication between patients, their families and doctors, none of the interventions mattered.

JAMA's grim conclusions: The culture of major hospitals is at war with dying patients' desires. The culture emphasizes technological attacks on diseases and keeping lives going. Doctors don't listen to what patients want; they aren't honest with bad news; they manage pain poorly, and their decisions leave an alarming number of families broke or near broke. Some experts are cynical that things will ever change. "Doctors are the last to accept [with dying patients] that there is nothing left that medicine has to offer," says medical ethicist George Annas of Boston University. "If you want control over your death, you have to stay out of the hospital." To understand that argument and the pain embodied in the *JAMA* findings, *U.S. News* sought out stories that illustrate *JAMA*'s basic points:

■ **Patients' desires don't get attention.** Perry Elfmont hovers in an unknowable place that is not yet death but bears little resemblance to the life he knew. A recent autumn day is like every other since a day 18 months ago when, his wife, Sabina, believes, he was kept from his appointment with death. Elfmont, 90, lies in bed, stares at the ceiling and works a spoonful of strawberry Jell-O around his mouth. Sabina has put on a jolly demeanor, leaving her rage and her tears at the dining room table when she enters their bedroom. She tells him what a lovely day it is, playfully squeezing his toes through a plaid blanket.

He has not responded significantly for months, and her smile melts to searing sadness as she turns away from him to leave the room. He cannot communicate, but she says everything in his life before May 5, 1994, indicates that he would not want to live like this—unable to speak, understand or enjoy. On that day, his wife says, doctors at Mount Sinai Medical Center in Manhattan ignored the instructions he had recorded in a living will that he wanted no cardi-

DOCTORS DON'T LISTEN. Two thirds of doctors who received reports on patients' wishes about life-sustaining care did not even look at the reports.

INFORMATION IN THE CAPTIONS COMES FROM THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

ac resuscitation, nor any life-sustaining treatment, including feeding tubes and respirators. "It was so important to him to have that living will filed. At his 85th birthday, he said, 'Whatever happens, I am protected,' " recalled Sabina.

But he was not. In the spring of his 88th year, suspecting a stroke, Sabina brought him to Mount Sinai. They spent a grueling 12 hours in the emergency room before he was admitted. Sabina, 78 at the time, gave in to her exhaustion and went home, but only, she says, after hearing assurances that her husband's wishes were known and would be respected. "It was midnight. I said, 'Do you have the living will?' They told me everything was under control. They told me not to worry, to go home," she says.

When she returned, she found her husband on oxygen and receiving intravenous antibiotics—two interventions she contends were against his written and expressed wishes. She found him in restraints because of his attempts to pull out the tubes. She says a resident told her that her husband was gone, and they brought him back. The hospital denies there was a cardiac resuscitation but will not discuss its other interventions, citing patient confidentiality. Following Elfmont's complaints, Mount Sinai initiated an educational program for staff members on advance directives, according to a hospital statement.

Perry Elfmont lives on with irreversible brain damage. Once, he was a family physician, a man fluent in five languages who loved Russian art and literature. He spent 25 years practicing family medicine in Long Island, N.Y., and another 23 years working for the Greater New York Blood Bank. He knew what a slow, agonizing death could do and tried to protect himself and his wife from the ordeal.

But now, Sabina Elfmont cannot grieve and cannot move on. She pretends cheer for his unknown feelings. She refuses to clear the clutter from his unused desk, fearing it would insult him to see his work put away forever. His reading glasses gather dust.

■ **Doctors shy away from grim news.** Marie Fifer never heard beforehand the hard reality of what her mother's life would be like after a feeding tube was inserted. Her mother had made her wishes known in a living will written 15 years before she suffered a stroke last May. But the wishes were seen by doctors as ambiguous. She wrote, "I direct that I be allowed to die and not be kept alive by medications, artificial means or heroic measures." There was no mention of feeding tubes. Still, her daughter knew that she would not have wanted one. "I'm her only child. I understood

her desires. We had discussed it talking to each other across the table, but never in detail," said Fifer.

So following the stroke, when Fifer's mother could no longer swallow, her doctor wrote up an order for a surgically implanted permanent feeding tube. "He never really talked to me about it. He never talked to my mother either. I know because I was there for all his visits," she claims. When Fifer voiced an initial objection to the feeding tube, based on what she knew to be her mother's wishes, she felt the doctor implied that she was asking him to kill her mother. "And a nurse said, 'You don't want her to starve to death, do you?' " recalls Fifer. "It was too much for me to deal with. It was a weak moment, and I agreed."

Without thorough discussions in advance of urgent care, such weak moments commonly lead to care that is unwanted or poorly understood. The *JAMA* study found that about 60 percent of patients or their family members did not discuss their preferences about heroic resuscitation, or the likely consequences of such treatment, with a physician. Alfred Connors, head of critical-care medicine at Cleveland MetroHealth Medical Center and a principal investigator in the study, does not know Fifer or her mother. But his work often means hooking people up to high-technology care. "I work in an ICU. We don't put people on machines unless we feel we can get them off," he says. "We focus on a disease, not a person." Connors acknowledges that the full picture of a human life ebbing can be overlooked. "When death becomes imminent," he says, "we have trouble deciding to stop using technology."

Fifer's mother, whose name her daughter does not want published, will live the rest of her life in a nursing home, unable to swallow or speak, to tell aides if she's comfortable, or whether she needs her pink sweater. She's 86, and likely to survive for a long time. Fifer visits daily and watches her mother weep. "I think when she had the stroke, she wanted to die. Sometimes when I visit her, I can only stay for half an hour, and then I break down and I have to go home. It's not because she's in a nursing home. It's because she's hooked up to this thing," says Fifer. Had she had a more realistic picture of her mother's misery—and the duration of her joyless life—she says she would have stood firm and rejected a feeding tube.

■ **Too many patients suffer in pain.** Laurie Pross watched as her mother, Irene Pross, screamed and cried for two hours while doctors went about the business of keeping her alive. On hemodialysis because of kidney failure, the elder Pross had a shunt implanted in her body to accommodate the flow of her blood to and from the life-saving artificial-kidney machine. But clots would clog the shunt and needed to be cleaned out. The procedure normally required sedation, but eventually the elder Pross, who had a complex series of bad interactions between the many drugs she needed, could no longer tolerate any anesthesia, and the clots were cleared while she was fully awake.

Her daughter, Laurie, who was making decisions for her mother, reluctantly agreed to the agonizing procedures, just as she had sweated over dozens of similar decisions during her mother's two-year course of heart and renal failure, confusion and depression. The pain she witnessed as doctors cleared the shunt was the final straw. "That's when I said, no more," said Pross.

Without dialysis, Irene Pross's death was inevitable. Her daughter took her back to a nursing home and camped there. The toxins gathering in her mother's body provided a kind of sedation, and death, a week later, was peaceful.

The *JAMA* study's authors are the first to concede that pain is a complicated issue. They know that enduring pain is sometimes an essential price for a patient to pay for beneficial treatments. But they are convinced that hospital culture is weighted heavily toward focusing on treatments even if they are excruciat-

DOCTORS DON'T TALK ABOUT BAD NEWS. Fully 60 percent of dying patients said they had not discussed dying or diminished living with doctors. Of those, 40 percent would have liked such a discussion.

ing. The Pross case is typical in that respect. There was no medical way out of the pain, and technological procedures were paramount. Still, her doctor, Elizabeth Cobbs, was acutely aware of her suffering. "We never were successful in making her symptom-free in any of the procedures," says Cobbs, director of the Division for Aging Studies and Services at George Washington University Medical Center in Washington, D.C.

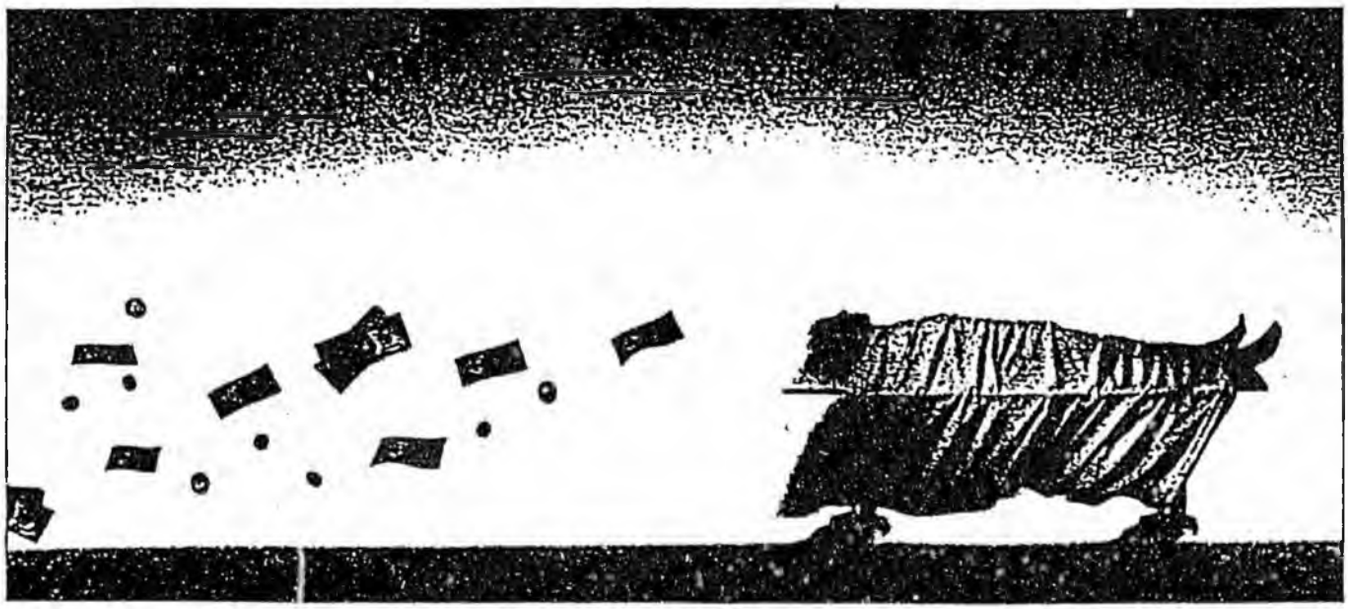
But other times, patients are stoic, reluctant to complain of pain, perhaps for fear of angering or insulting doctors. And sometimes doctors and nurses simply do not ask about pain. Dr. Humberto Vidaillet, a cardiologist in Marshfield, Wis., and an investigator in the study, said he knew cancer patients suffered, but was surprised that so many cardiac patients were among those experiencing pain in their final days.

■ **The cost of dying can crush survivors.** In the parlance of the hospital, "no code" or "DNR" means do not resuscitate. It means if a heart fails, if a life flickers, let it go. Edward Winter had a DNR order in his medical file at St. Francis–St. George Hospital in Cincinnati, according to a lawsuit filed by Winter's daughters against the hospital. "I saw the 'no code' in my father's chart. That's the only way he would consent to stay in the hospital," says Lynn Kroger, one of his three daughters. After seeing his wife die a slow, confused death, Winter was adamant about not wanting heroic efforts to save his life.

That was in 1988. His heart did indeed fail during that hospitalization, but Kroger and her sisters contend that hospital personnel ignored Winter's wishes and his primary physician's orders. A nurse used defibrillators to restore a steady heartbeat. Two days later, Winter suffered a paralyzing stroke. He lived about two more years, scarcely able to speak, incontinent, unable to walk or even roll over in bed. "It was his worst nightmare. He was enraged and depressed," says Kroger.

The extended life he did not want depleted his life's savings. About $100,000

POOR PAIN MANAGEMENT. Half the patients who died in the hospital had moderate to severe pain at least half the time during their last few days.



FINANCIAL DRAIN. Thirty-one percent of families lost most or all of their savings while caring for dying relatives.

that he had hoped to leave to his children went instead for nursing-home care. His daughters are suing the hospital for medical expenses and damages for pain and suffering. The case is likely to be heard by the Ohio Supreme Court next year. Hospital officials declined comment.

The suit is not about money, says Kroger. It's about following through on her father's wishes. The day after he was resuscitated against his will, he asked for an attorney and began the process of suing the hospital. He died in 1990, but his children fight on for him. "It's difficult to watch a parent's dreams for his children dissipate in that way," says Kroger. "But the most important thing was the amount of suffering he endured. Every day that he would wake up, he would cry—he would cry *because* he woke up." A handful of similar lawsuits are being litigated, but *JAMA* reports that most families simply foot the bills and watch their savings evaporate.

Epilogue. Surgeon Sherwin Nuland, who spent his career overseeing countless last-ditch efforts to rescue fading lives, is not surprised by the study results. The author of the bestselling book *How We Die*, Nuland argues, "We forget that death is something that belongs to the dying person."

The doctors and nurses most intimately involved in the study are more optimistic, and they are eloquent in speaking of what they've learned. "I believe in my heart of hearts that, at least anecdotally, communication was improved during the course of the study," says William Fulkerson Jr., director of the medical intensive care unit at Duke University Medical Center in Durham, N.C., and one of the study's principal investigators. He knows that learning to talk directly about dying will take a long time. But he believes that at his hospital, the effort has begun.

Others involved in the study look for meaning in the disappointing results. A geriatrics physician says he is now teaching the medical students he trains to start discussions of death planning when elderly patients are still vigorous and healthy. A nurse talks about the difficulty of giving patients bad news without destroying hope and suggests changing the focus from hope for a longer life to hope for a peaceful death. An ICU director says that since reviewing the study results, the first thing he does upon walking into the unit is ask if the patient is hurting. All of them hope the lessons learned from the study grow into a chorus of open talk about how to grant dying people their dignity. ■

BY SUSAN BRINK

THE FINAL STEPS

Having your wishes honored

While most people shy away from talking about death, it's very clear that engaging the issues directly can be an enduring comfort to people left behind. Listen to Marie Bassett: "When I read his words, it all came down to me what it meant."

When her husband, Chet, was diagnosed with cancer in 1990, he wrote that if he were permanently ill, with no chance of survival, he did not want his family to prolong the process. His wife, Marie, was with him when he talked about his wishes and put them into a living will, but during his struggle against disease, she had forgotten. So a nurse named Susan Kronenwetter who was working with the family found the document in his medical records and brought it before them two years later when family members convened in a hospital waiting room.

Last aid. *Kronenwetter (left) helped Bassetts decide.*

Indecision. Kronenwetter had seen the family agonizing in indecision—wanting so much for their husband and father to live to see the youngest of his four children, Christie, graduate from high school in six months. But they were torn by his deteriorating condition and knew a decision on whether to resuscitate him, if necessary, was imminent. In that waiting room, Kronenwetter recalls: "The family was stymied. They were all at different points." To help them, she brought out the living will so they could reread Chet Bassett's own wishes.

"These were their father's words and you could just see the impact," the nurse remembers. "As it went around, each person nodded agreement. They knew that it was finally time to let him go." In January 1993, Bassett, 55, died surrounded by his family, each one having said goodbye.

Many families face this conflict. About 75 percent of people surveyed thought it was a good idea to have a living will or advance directives to set down wishes regarding medical treatment. But fewer than a third of people actually have one, according to a survey by the American Medical Association. To help people think through and write down their wishes, the American Association of Retired Persons and the American Bar Association have a free publication, *Shaping Your Health Care Future with Health Care Advance Directives*. Write to AARP Fulfillment (EE0940), 601 E Street, N.W., Washington, DC 20049.

But writing the words down is just the first step, says Karen Orloff Kaplan, executive director of Choice in Dying (phone: 800-989-9455), which helps families with personal and legal advice. She says it's important not only to talk about wishes with doctors and family members but to give each interested party a written copy. Designate one person—someone in tune with your desires—to carry out your wishes if you are no longer able to. Update your documents every few years.

Experts also suggest choosing a doctor who will stay involved, even if your care is transferred to a specialist. "Ask your doctor specifically if he'll honor your wishes," says Kaplan, "and if he'll continue to be your advocate even if another doctor will be treating you."

Post-it™ Fax Note 7671	Date 2/20	# of pages ▶ 2
To Rep. Toohey	From FBX LIO	
Co./Dept. Hess Co-Chair	Co.	
Phone # WRITTEN TESTIMONY	Phone # re HB 371	
Fax #	Fax #	

ALA URE

PLEASE ENTER INTO THE RECORD MY TESTIMONY TO THE HESS
COMMITTEE NAME

COMMITTEE ON HB 371 DATED 2-20-96
BILL/SUBJECT

I strongly oppose this "Assisted Suicide" Bill.
We do not have the right to end our lives or
ask others as we don't have the right to kill
any human being. God gives us life
& we have the right to life and death. This
Bill is another movement meditation of Society
that has no dignity & honor.
There are many groups that give loving
care and help families and the suffering ones
Vote

SIGNED Sandra K Boyle
TESTIFIER

REPRESENTING (OPTIONAL)

PO Box 81183 Fairbanks AK 99708 (116 Kelsall Way 99709) 479951
ADDRESS/PHONE NUMBER

(7)

HOUSE COMMITTEE REPORT

Date Referred to Committee: January 8, 1996 FURTHER REFERRALS: State Affairs
Judiciary

Date of Committee Action: 2/20/96

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 371

HOUSE BILL NO. 371 RIGHTS OF TERMINALLY ILL PERSONS

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

recommends it be replaced with the following committee substitute CS HB 371(HES) [X] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

(2) [X] fiscal note(s) (2) H+SS [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [ ] zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Lonnie Hamm		✓	✓	
Nancy Kelly		✓		
Jan Brewer			✓	
[illegible]	✓			
Eileen Russell			✓	
Tom Brice			✓	

CHAIR'S SIGNATURE [illegible] _____

It's Not Your Choice

Who are you to condemn someones life
You have never been given that choice
Murder someone for not being (OK)
Is that what was said with your voice

The old who are sick
The young yet unborn
The ones who have done
Evil crime

Are we telling ourselves
It's OK not to care
That these people are not
worth our time

God only knows
When our time here is done
Then he calls us to be by
His side

What really happens
To those that we kill
Are their souls lost
Forever in time

To murder someone
And justify it by law
That's not what Jesus
Has taught

For the people who believe
They've been given this power
Will someday be judged
Before God

So before you agree
To end someones life
Don't just do it for the
Sake of goodwill

For you might just find
That your <u>After Life</u>
Will be condemned to the
Fires of hell

To All House and
Senate Members.
And All on the
H.E.S.S. committee

H.B. 371
I Oppose This Bill

James M. Hunter
452 Evolyn Dr.
North Pole, Alaska
1-907-488-8019
Po. Box 56799
North Pole, Alaska
99705-1799

Alaska State Legislature

FEB 16 1996

Please enter into the record my testimony to the HESS
committee name

committee on HB 371, dated 2/13/96.
bill/subject

I am opposed to HB 371. I have read the Sponsor Statement + HB 371 and am concerned because I do not believe government should be involved in the business of ending life.

Government should protect life. This euthanasia bill was the predicted next step following legalized abortion which I also oppose. We cannot continue to devalue the ~~by~~ lives of those that others deem "unnecessary." I feel it will not stop here, but will move on to include those with disabilities, mental illness or other "unacceptable" differencies. No one has the right to terminate life in this way. Please do not pass this bill.

Signed: Mary L. Hetrick
Testifier

self
Representing (Optional)

1413 HPR Soldotna AK 99669
Address

907-747-3515
Phone No.

ALASKA State House BILL # 370

My Letter is Regards to this.

Elwood Mathews
320 8 W. PT. Rd.
SP 15
SITKA, AK.
99835

I am Completly AGAINST THIS Assisted suicide Debate -

ASSISTING people TO DIE IS Wrong, against GOD'S Law and our Nation -

I would ask all you TO Take a FIRM STand against anything that pertains TO THIS KILLING. I am 80 yrs old, and surely WOULD NOT Care TO Be Euthanized -

AND I Thank you all THAT WILL help DO away WITH THIS PROCEDURE COMPLETLY.

Sincerely:
Elwood Mathews

ALASKA STATE HOUSE BILL #371
my letter is in Regards
to this Bill #371

Louise E. Mathews
3208 Halibut PT. Rd.
S.P. 15
SITKA, Alask
99835
Phone (907) 747-6996

In regards to assisisted Suicide Debate:

I am completely against this in every way. All assisited Suicide legislation is a poor Public Policy which invitably leads to tremendus social pressure on terminally ill People, and to inevitable abuses.

These people who are ill and want assisted Suicide, are really crying for help, to live, not to die - they are depressed because of pain, and life's situations; but it is treatable, controllable, by a Doctor better trained in alleviating pain.

I understand Too, because I have been in pain for 10 yrs. I have been depressed, and felt I wanted to die, but am so thankful there was other help, not assisted Suicide

You have to Believe there is always Hope for Healing, Never Give up - This is a known FACT that Happens many times.

This POLICY WOULD eventually Lead to the KILLING of CHILDren with DISABILITIES, and any person also, PLUS the people of OLD AGE.

The problem is the INCOMPETANT People who are suggesting such a measure In the first PLACE.

I Thank all you FOR acting on this.

Most Sincerely

MRS Louise Mathews

Alaska State Legislature

Please enter into the record my testimony to the HESS committee name

committee on Bill #371 "Rights of the terminally ill" bill/subject dated 2-13-96.

Signed: Teresa J Ware
Testifier

Representing (Optional)

PO Box 2634 (613 OJAST) Sitka
Address

966-2307
Phone No.

9/86 Legislative Information Office

To: HESS
From: Teresa J. Ward

To whom it may concern,
I wish to take this opportunity to make it known that I am very opposed to Alaska State House Bill # 371 entitled "rights of the terminally ill".
It is no persons right to determine the value or worth of another human being. That right is Gods alone. It is not for any of us to determine whether the quality, or the lack thereof, of ones life is sufficient to justify its termination. There are many possitive alternatives to ending one's life when fought with difficulties.
Oftentimes a request for assisted suicide is a cry for help from a hurting individual facing seemingly insurmountable problems. Often the intervention of a qualified counselor can provide the solutions or insights needed to weather the storm - if not quell it altogether.
For those who are terminally ill, it is not uncommon for depression to enter into the picture, causing one to seek the release of suicide. Yet this too, can be treated successfully. I am certainly not unsympathetic, and I realize that pain can be of such intensity during some illnesses, that release

Alaska State Legislature

Please enter into the record my testimony to the Health Education and Social Services committee name committee on AS# 13 III #371 bill/subject, dated 2/13/96.

Signed: Ruth Hunt RUTH HUNT
Testifier

Representing (Optional)

Box 1185 Sitka, Alaska 99835
Address

907-747-6895
Phone No.

SCANNED ITEM

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

To: HESS
From: Teresa J. Ward

To whom it may concern,
I wish to take this opportunity to make it known that I am very opposed to Alaska State House Bill # 371 entitled "rights of the terminally ill".
It is no persons right to determine the value or worth of another human being. That right is Gods alone. It is not for any of us to determine whether the quality, or the lack thereof, of ones life is sufficient to justify its termination. There are many possitive alternatives to ending ones life when fought with difficulties.
Oftentimes a request for assisted suicide is a cry for help from a hurting individual facing seemingly insurmountable problems. Often the intervention of a qualified counselor can provide the solutions or insights needed to weather the storm - if not quell it altogether.
For those who are terminally ill, it is not uncommon for depression to enter into the picture, causing one to seek the release of suicide. Yet this too, can be treated successfully. I am certainly not unsympathetic, and I realize that pain can be of such intensity during some illnesses, that release

through suicide is sought. But again, with the help of modern medicine, pain is controlable. Though there are wide and varied reasons that certain individuals seek assistance in suicide, there are no right reasons for its justification. There are many avenues available for assistance with positive alternatives.

Thank you. Teresa J. Ward

Alaska State Legislature

Please enter into the record my testimony to the Health Education and Social Services
committee name

committee on AS # 13 111 #371 , dated 2/13/96 .
bill/subject

Signed: Ruth Hunt RUTH HUNT
Testifier

Representing (Optional)

Box 1185 Sitka, Alaska 99835
Address

907-747-6895
Phone No.

3/3/96

To Health EDUCATION AND Social services (HSS) Committee
FROM RUTH HUNT - Ruth Hunt
REGARDING
AS HB # 371 ENTITLED - RIGHT OF THE TERMINALLY ILL.
IF A PERSON Request Suicide, ITS A SIGN THAT they need help to Build themselves up NOT to make them Die, their Rights SHOULD be COUSELING, ASSISTANCE AND POSITIVE ALTERNATIVES AS A SOLUTION For the PROBLEM
I WOULD NOT WANT VOLUNTARY - EUTHANASIA AS it Would make so incompete people who DONT KNOW WHAT's RIGHT would have to Die when they REALLY DIDNT WANT to ANYWAY when you PASS these LAW'S YOU ARE MAKING DOCTOR'S KILL - WHEN, THEIR OATH IS TO help people Live To the best of their Ability AND SOME DOCTORS WOULD NOT WANT TO DO IT.
(PSALM 139-16) Your were there while I WAS being formed, in utter seclusion, you saw me before I WAS Born AND Scheduled EACH DAY of my Life Before I begin to Breathe EACH DAY IS Recorded in your Book..
ANYWAY, before A Person get help WITH SUCIDE - IT SHOULD be MANDATORY THAT they KNOW WHAT the BIBLE SAYS About IT.

Ruth Hunt

Alaska State Legislature

Please enter into the record my testimony to the Health Education and Social Services committee name

committee on ASHB #371 bill/subject, dated 2-13-96.

Signed: Carole Henry Carole Henry
Testifier

Representing (Optional)

PO Box 214, Sitka, AK 99835
Address

907. 747-6578
Phone No.

2-13-96

TO: Health Education & Social Services Committee

From: Carole Henry, P.O. Box 214, Sitka, AK 99835
907-747-6578 Carole Henry

Re: ASHB #371
"Rights of the Terminally Ill"

I object to this bill.
My objection is that in considering physician-assisted suicide we are taking lightly the moral command "Thou shalt not kill", Exodus 20:13.

I believe terminally ill patients' rights are for an opportunity to counsel, assistance and positive alternatives to give hope, including -if necessary- treatment for depression, and comfort towards a natural death, for our time on earth is not ordained by man's wisdom but our creator's.

"Thou shalt not kill" speaks of a right to life that no man should interfere with another's "time to die" Ecclesiastes 3:2.

"Search me, O God, and know my heart; test me and know my anxious thoughts. See if there is any offensive way in me, and lead me in the way everlasting."
Psalm 139:23,24

Alaska State Legislature

Please enter into the record my testimony to the HESS COMMITTEE committee name

committee on "RIGHTS OF THE TERMINALLY ILL" bill/subject, dated _____.

AK State House Bill #~~SB~~ 371

I am in opposition to "physician-assisted suicide".

Hess Committee members I oppose House Bill #371 because I ~~have~~ believe that terminally ill patients are crying for help and this is NOT the solution!!

Signed: Norma J. Perkins
Testifier

_____
Representing (Optional)

PO Box 1553 SITKA, AK.
Address

907-747-7476
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House HESS
committee name

committee on HB 371 , dated 2-13-96 .
bill/subject

I ~~am~~ am opposed to passage of bill to permit medical assistance to patient to enable them to die ~~for~~ for whatever reason. The Hippocratic oath should prevent the medical profession doing this. Removal of life support is one thing but assisting a ill patient is not ethical. Drugs to kill pain is one possible alternative

Signed: Linda D. Kaven
Testifier

Representing (Optional)

502 PIERSON ST.
Address

SITKA, AK 99835

Phone No. 747-5509

Alaska State Legislature

Please enter into the record my testimony to the HESS House Bill
committee name

committee on HB 271, dated 2/13/96.
bill/subject

I oppose raising any bill that would claim that an individual has a "right" to die, or one that would condone mercy killings for those terminally ill, or for any other reasons ... on the just conceived child (person) in the womb to the elderly.

Signed: Helen Kansen
Testifier

Representing (Optional)

502 Pherson St. Sitka, AK
Address

907-747-5509
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on 371 , dated 2-13-96 .
bill/subject

Signed: Deborah Copeland
Testifier

Deborah Copeland
Representing (Optional)

613 OTA Street SITKA, AK 99835
Address

907-747-6412
Phone No.

Health Education and Social Services January 13, 1996

To whom it may Concern,

I am writing this letter in regards of Bill 371. I am against the act of assisting Suicide. I Strongly feel that no matter what a person is going through there are other actions to be taken than a life! I also feel if this Bill is legalized it will be altered for other purposes which lead to death. Example - the Netherlands now use assisting Suicide for non-voluntary euthanasia for Children born with disabilities mental illness, permanent disability and old age. I hope this time the United States can learn by other Countries mistakes. We can always go forward but never back.

Thank-you
A Concern Citizen
Deborah Copeland

Deborah Copeland
613 DJN Street
Sitka, Alaska 99835

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on State House Bill #371 , dated 2/13/96 .
Physician assisted suicide bill/subject

Signed: Stephanie A Vieira
Testifier

Stephanie Vieira
Representing (Optional)

611 Birch St.
Address

7473698
Phone No.

Feb 13, 1996

Health Education and Social Services

To Whom it may concern:

I oppose Alaska State House Bill #371, physician assisted suicide. I believe our Supreme Creator is the giver of life and it is not responsible policy for man to determine when a life is no longer valuable. Also the argument about mercy killing because of severe pain can no longer be valid since there has been great strides on controlling pain through modern medicine and doctors that are trained in alleviating pain.

Overall, this kind of irresponsible legislation opens up a can of worms and would lead to abuses such as we have seen happening in Holland. They now have legalized nonvoluntary euthanasia with such abuses as killing people with various disabilities and even old age.

I strongly urge you to support all life and oppose Bill #371. Thank You.

Stephanie S. Veeira
614 Biorka St.
Sitka AK 99835

Alaska State Legislature

Please enter into the record my testimony to the House HESS
committee name

committee on HB 371, dated 2-13-96.
bill/subject

I oppose this bill because we do not have the right to decide when someone should live or die - only God, our Creator, has this right. We all are equal in God's eyes no matter what our condition is. I urge you to oppose the passage of HB 371.

Signed: Dorothy M Johnson
Testifier

self
Representing (Optional)

Box 3
Address

747-8579
Phone No.

2-13-96

Health Education and Social Services Committee

I am writing in regards to Alaska State House Bill # 371 entitled "Rights of the Terminally Ill."

I am a Registered nurse in Sitka. I am very opposed to Physician-assisted suicide. The very idea is incompatible with the saving of life. To assist in the saving of life is what the healing professions are about. I feel to assist in the taking of a life is contrary to all a Physician is taught. Please do not open the Door to suicide.

Nancy W. McManagle, 706 Monastery St # A
Sitka
747-3067

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on HB #371 , dated 2-13-96 .
bill/subject

I oppose HB # 371 for the following reasons:

1. The State should never involve itself in legislating the taking of lives of citizens.
2. Physicians are trained to heal - Not to kill. This bill goes against the very fabric of the Hippocratic Oath
3. There are very effective pain killers available. Suicide is the very extreme solution to pain and it is not reversible.
4. How will the the many problems associated with this bill be addressed? How will families be notified? What about counseling? Are suffering people going to feel a responsibility to die rather than burden others.

Signed: LaVerne Y Johnson
Testifier

Representing (Optional)

110 Finn Alley Sitka, Alaska
Address

907 747-8368
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on House Bill 371, dated 3 Feb 96.
bill/subject

Please reject this Bill. If passed it further potentially legalizes Murder. As a Mental Health professional and a Christian I abhor such legislature.

Signed: Leslie Forsth RNC, MSN
Testifier

Self
Representing (Optional)

PO Box 415
Address

Sitka, Ak 99835 (907) 747-0588
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on House bill #371, dated Feb 13 1996.
bill/subject

I vote NO to bill # 371

Signed: Ellen George
Testifier

Representing (Optional)

Address

907 9/64 2627
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on HB 371, dated 2-13-96.
bill/subject

In the Netherlands, legalizing voluntary assisted suicide for those with terminal illness has spread to include nonvoluntary euthanasia for children born with disabilities.

Half the killings in the Netherlands are now nonvoluntary, and the problems for which death is now the legal "solution" include such things as mental illness, permanent disability, and even simple old age

Signed: Anita Wright
Testifier

Self
Representing (Optional)

P.O. Box 2392 Sitka, AK 99835
Address

907-747-5074
Phone No.

9/86 Legislative Information Office

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on House Bill # 371, dated 2/13/96.
bill/subject

I Vote 'No' to this Bill - this may lead to more than "terminally ill" suicides

Signed: Rhonda Holloway
Testifier

Representing (Optional)

P.O. BX 8812, Sitka AK
Address

907-747-6896
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on House Bill 10.371 dated February 13, 1997
bill/subject

I wish to strongly protest any bill/proposal/law which would legalize "assisted suicide" as I stand firm that no man or woman is permitted to take another man/woman or child's life. This country's health care pay system is not appropriately set up to adequately monitor or assure nonabuse of such a policy. Furthermore, who would be deemed capable of making these decisions when a Power-of-Attorney was in play? How would euthanasia of select "nondesirables" be prevented?

Regardless of any of these issues, the taking of another's life for any reason is not permitted under God's law, and I would not submit to such a law.

Signed: Dawn L Dill, R.N.
Testifier

Nurse
Representing (Optional)

P.O. Box 735, Sitka 99835
Address

(907) 747-1010
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on Bill #371 , dated 2-13-96 .
bill/subject

I, vote NO, to house bill
371.
NO one has The Right
TO Kill, OR Take The life
OF ANY one.

Signed: Ronald E Davis
Testifier

Representing (Optional)

~~Add~~ PO Box 11 - SITKA, AK
Address

907-747-6746
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on H. House bill #371, dated Feb 14, 1996.
bill/subject

I vote "NO" to bill # 371.

Signed: Darlene L. McClenahan
Testifier

Representing (Optional)

P.O. Box 2416 Sitka, Alaska 99835
Address

907 747-3424
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS committee name

committee on Bill #371 bill/subject, dated 2/13/96.

I vote No to the Hess Bill. People do not have the right to take a life regardless of the circumstances.

Signed: Evelyn Reed
Testifier

Representing (Optional)

2002 HPR #B Sitka Ak 99835
Address

907-747-5058
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the Hess Committee
committee name

committee on HB371, dated 2/13/96.
bill/subject

My greatest fear on this issue is that the person involved will not always be the one who decides his or her own fate.

Signed: Mary Hackett
Testifier

Representing (Optional)

Address

Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on HB 371 , dated Feb 13, 1996 .
bill/subject

Please see attached

Signed: Clifford L Duncan
Testifier

Self
Representing (Optional)

340 H.P.R. Utqiagvik AK 99923
Address

946-2365
Phone No.

In regards to H.B. 371

Thank you for receiving my testimony today. I have thoroughly read this bill and the accompanying sponsor statement, and I can only come to the conclusion that this would be extremely detrimental to our great state, and to fellow Alaskans. I am in the health care profession, and though I usually am in on the rehabilitative part of someone's life, recently I have assisted in the dying process of a woman with two young children. She was dying of cancer, which had progressed rather rapidly. There was hospice in attendence, a constant flow of supportive people around her. She had discussed final plans, drawn up a will, and also discussed pain relief. She was thoroughly in control of her death experience. She did NOT, however seek to rush the process or seek to end her life before the appointed time. Life is a process. There is an established process for birth, life, and death. There are definate stages to the death process, they are letting go of this world, and it is a tremendously spiritual experience.I have a friend who's long-lost father came to visit, only to discover that he was dying. Through this experience, they were able to repair a torn relationship, and he was able to die in peace. It was a time of restoration, and she found a sister that she never knew she had; they're great friends today. If this man had opted for this law, none of this would have occurred.

In the accompanying sponsor statement, the authors cite anacdotal stories of patients dying in pain and suffering. If your loved one is in pain, you need to consult with your doctor. If he/she refuses to prescribe adaquate pain relief you need to find another doctor. The hospice movement was begun under these circumstances, but they do not subscribe to suicide. The goals are education to the client and family, assistance and support throughout, and supportive after care. The often touted example of Sweeden as the model of assisted suicide belies the current backlash. From the altruistic idealogy has come elders afraid to go to the hospital for fear of being expected to die, for their care costs too much. Others are coerced into premature death by family members, who see them as a burden. The slippery slope described in this bill is exactly similar to the laws in Sweeden.

Further, this bill would make the state the arbiter and promoter of death. Though this bill uses semantics to rename suicide, this is exactly what it describes. It also turns the medical doctors into acting agents for death, instead of being the healing profession of the Hyppocratic oath. Also, the clause regarding pregnant women's inability to aquire terminal medication would be prohibited. If this state can't protect unborn children from abortion through 9

months of pregnancy under a privacy clause, how do you propose to protect them from this bill?

The clause regarding the patient's request for suicide medication prevents their family from knowing. This cuts the patient off from the very support system that desires to help and assist them at such a time. This "Lone Ranger" approach to death is not dignified. Who is then left with the responsibility to care for the body, make final arrangements, or CLEAN UP? I find this incredibly selfish and isolating, which is the exact opposite to what the death experience shouild be. There are hospice services available, some incredibly devoted and supportive people who's only goal is to make this difficult time better for the patient and his family. Alaska isn't on the cutting edge of medicine regarding the use of pharmacological agents in terminal patient care. There are centers in the Lower 48 that have made great strides in this area.

In conclusion, I believe that there are better ways of treating terminally ill patients. True dignity involves a supportive environment to allow a natural process to progress, and not to hasten death for convenience.

Thank you for your time.

Martha Devereaux
3404 H.P.R.
Sitka, AK 99835

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on HB 371 (bill/subject), dated 2/13/96.

Pain is controllable. Modern medicine has the ability to control pain. A person who seeks to kill him/her self to avoid pain does NOT need legalized assisted suicide but a doctor better trained in alleviating pain.

Who makes sure the lethal dose doesn't get into the wrong persons hands?

I oppose HB 371.

Signed: Mary A Lattis
Testifier

self
Representing (Optional)

405 Iverstovia
Address

907 747 5624
Phone No.

To: HESS committee
From: Kathy Newman, Sitka
Re: Alaska State House Bill #371
Date: 2/13/96

This testimony is in opposition to House Bill #371, "rights of the terminally ill". First of all I feel that it is wrong to take the life of another for any reason. Secondly, in so many cases people who desire to commit suicide change their minds later and are thankful that they did not or that someone else intervened to show them other options. Third, with so many medical advances many things, including pain, are able to be treated in ways that were previously unknown. We should be involved in giving terminally ill patients the best possible help in living their life to the fullest, not giving them a quick 'way out'. Fourth, and this is the most scary to me, if we give this so called 'right' to those who choose to end their life it opens the door to taking the life of many who have not chosen this route but they are unable to speak up for themselves. In that case then assisted suicide has turned into murder. I strongly urge you to do everything in your power to work for the defeat of this bill. Thank you for your consideration.

Kathy Newman
613 Ojas St.
Sitka, AK 99835

Alaska State Legislature

Please enter into the record my testimony to the HESS / STATE AFFAIRS committee name

committee on HB - 371 bill/subject, dated 02-13-96.

Signed: Teri Lundy
Testifier

Representing (Optional)

P.O. BOX 2975 SITKA AK 99835
Address

747-8138
Phone No.

HB
#371

Teri Lundy
P.O. Box 2975
Sitka AK 99835
907-747-8138

* What is 'DNR identification?
* Is this going to become a mandatory form that needs to be filled out and signed while being registered into a Pioneers' Home? or in a hospital before major surgery? or an AIDS Pt. entering a Hospice? or for a Pt. who may be a risk for stroke?...do you know if the Living Will is a mandatory document now?
* What is the medication or medications that will be used by the for Physician Assisted Suicide?

Sec. 2. AS 18.12 is amended by adding a new section to read:
Sec. 18.12.005 FINDINGS; PURPOSE
(a) The legislature finds that the people of the state have a fundamental right to make their own 'end-of-life' decisions.
The right should include (What are the other choices? Suicide by hanging? Suicide using a firearm? Suicide by using a self detonating device? Suicide by cutting one's wrists?) the ability to make a conscious and informed choice to enlist the assistance of the medical profession in prescribing medication that will make death as humane and dignified as possible. (Humane and dignified? The proper term is euthanasia .. a physician assisted suicide...like putting an old or sick animal down.)

Sec. 3. AS 18.12 is amended by adding a new section to read:
Sec. 18.12.015 REQUEST FOR MEDICATION TO ENDS ONE'S LIFE IN A HUMANE AND DIGNIFIED MANNER... go down to last sentence in a.) 'The request for medication shall be signed by the requester and witnessed by two adults who at the time of witnessing

1.) are not related to the requester by blood, marriage or adoption;
2.) are not entitled to a portion of the estate of the requester under a will or by operation of the law;
3.) do not have a creditor's claim against the requester and do not anticipate making a claim against the estate of the requester; and
4.) are not the requester's attending physician, an employee of the attending physician, a health care provider, or an employee of a health care provider.

Since there is an option for the requester to NOT notify next if kin of their decision, or may not have next of kin to notify...WHO ARE THESE PEOPLE THAT ARE GIVEN THE AUTHORITY TO WITNESS, SIGN, AND THEN REQUIRED TO GIVE THEIR RESIDENCE ADDRESS?

Continuing on in this same section, line 18 of REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER...
Why does one have to be over 18 years of age to do this?

The last part of the second paragraph, line 29 "...I ask my attending physician to prescribe medication that I can use to end my life in a humane and dignified manner." This sentence pushes responsibility on the physician to write the prescription...thus he becomes the messenger of Death. He gets the medication for the Pt. He becomes Dr. Death.

Sec. 3 goes on to read, line 9 "I understand that I have the right to rescind this request for medication at any time." At any time? And, further down this document states, line 13 "I make this request for medication voluntarily and without reservation, and I accept full *moral* responsibility for my actions." What the heck does this mean?

SEC. 6 - WHAT IS THE DEFINITION OF A "VIABLE FETUS" WHAT ARE THE GUIDELINES?

Line 18 STATEMENT OF WITNESSES
1.) is personally known to me or has provided proof of identity; (what forms of identification?)
3.) appears to be of sound mind and not under duress, fraud, or undue influence; (How can the person NOT be under duress if he or she is dying of leukemia, pneumonia. And, what about AIDS...dementia may be involved here, and/or extreme duress when one sees what is coming on down the line for them. And cancer patients...if the person is in and out under the effects of medication...how can they think clearly? And, who makes the decisions for terminally ill children? I believe there is a broad area for abuse here, regardless of the so-called guidelines and carefully worded documents.)
g.) The attending physician shall ask the patient to notify the next of kin of the request for medication. A patient who declines or is unable to notify next of kin may not have the request for medication denied for that reason. (is this because the Pt. is circumstantially not able to notify next of kin or because the Pt. is physically..and what if the Pt. wants to terminate the procedure to commit suicide and is unable to coherently make this known? (see Sec.10 AS18.12.060, (a))

Sec. 18.12.055 ~~How and why should the~~ WHO WILL MONITOR Department of Social Services AS THEY review records maintained under this chapter. Who gives this department their authorization and license to issue appropriate regulations to facilitate collecting information regarding compliance with this chapter? Isn't the health care, hospice, hospital, or physician capable of taking care of this? Unless, their only purpose is as stated in the following paragraph (b) in order to prepare and make available to the public annual statistical reports of complied information on physician assisted suicide. How will the Department of Social Services "police", so to speak, the authenticity and evaluation of paperwork generated from the legalization of Physician assisted suicide?

Sec. 10 AS 18.12.060 (a) is amended to read:
(a) In the absence of actual notice of the revocation of declaration, request for medication, or do not resuscitate order, as applicable, the following, while acting in accordance with the do not resuscitate protocol adopted under AS 18.12.035 or with the other requirements of this chapter, are not subject to civil or criminal liability or guilty of unprofessional conduct;
etc.
Do you foresee complete safeguards and accurate, up-to-date, unquestionable documentation to verify that Pt. is or is not willing to proceed with Physician Assisted Suicide?

Sec. 18.12.070 is amended to read:
Sec. 18.12.070 PENALTIES (a) going down to line #25"...effective or after transfer should have occurred and may be liable to the patient and to the heirs of the patient for a civil penalty not to exceed $1000 plus the actual costs associated with the failure to comply with the order, declaration, or request of medication and this shall be the exclusive remedy at law for damages.
Why are the "heirs" suddenly so important 'after the fact'? This document needs to be airtight so that there is no chance of this ever happening, and if it does, nobody gets paid anything. No law suits, no liability, nothing.
(b) Why? Why all the hand waving and bogus civil liability to the other person and to the heirs of the other person? Why should it matter? (The life isn't that important to begin with.) It is up to the attending physician and Pt. to make sure that something like this does not happen in the first place.

Sec. 13 AS 18.12.070 is amended to read:
(c), (d), (e) and (f)why or how could this happen? This must be an airtight document that cannot be changed or altered in any way. There has to be a 'dual-control' system to prevent this from ever happening.

Sec. 14 AS 18.12.080 (a) is amended to read:
line 19 "...Death resulting from medication prescribed under a request for medication in accordance with this chapter does not, for any purpose, including civil or criminal liability, constitute a suicide or homicide if the medication is self-administered by the person who made the request for medication and the person who made the request for medication controlled the time, place, and manner of death."

Sec. 15 AS 18.12.080 (b) line 27 "...or a request of medication under AS 18.12.015 does not effect in any manner the sale, procurement, or issuance of a policy of life insurance, nor does it modify the terms of an existing policy of life insurance. A policy of life insurance is not legally impaired or *invalidated* in any manner by the withholding or withdrawal of life-sustaining procedures form an insured qualified Pt...etc." Why is this different from suicide in general? Can you tell me if it is a general policy of insurance companies not to honor life insurance policies for clients who die from self-inflicted gun shot wounds, hanging, or pill overdose and the like? What makes Physician Assisted Suicide different? How can you guarantee this life insurance policy will be honored after the Physician Assisted Suicide of the Pt.?

Sec. 18 AS 18.12.090 is amended to read:
Sec 18.12.090 RECOGNITION OF DECLARATIONS, REQUESTS FOR MEDICATION AND ORDERS EXECUTED OR ISSUED FROM OTHER STATES.
A declaration, request for life-ending medication, do not resuscitate order, or DBR identification executed, issued, or authorized in another state or a territory or possession of the United States in compliance with the law of that jurisdiction is effective for purposes of this chapter.
I believe that this presents a broad definition that fails to provide a fail-safe measure in controlling and preventing the fraudulent use of Physician Assisted Suicide documentation in patients that move to Alaska from another state. Again, what are your guidelines in identifying authentic paperwork that qualifies the patient for Physician Assisted Suicide? Who decides what forms are acceptable and what forms are not?

In closing, I am not pleased with the drafting of HB 371 nor with it's presentation to the public. What a shame it is that our legislative body would entertain leading us over such a precarious, and unpredictable direction. No matter how much time you men and women deliberate, calculate, and carefully discuss the wording in this document, it will always be the State of Alaska merging with the Nation's preoccupation with death, and the celebrated fixation with Kevorkian's audacious and brash Physician Assisted Suicide movement.

You are misleading the public that elected you in good faith and trusted you to (among other things) represent, and initiate the passing of laws that protect the innocent, defend the weak and ill, and champion for the very old.

As for self-administered suicide in a "Humane and dignified manner"?
This is a thinly veiled plan under seductive wording that is meant to placate and negate the reality that we all must face...Death...and what you are saying is, "if we must die, then let it be on our terms." The only requirements needed for one requesting Physician Assisted Suicide are being over 18, having a documented terminal illness, at least one consulting physician, and the willingness to self-administer the drug that will take one's life. What a cowards way out.

To quote Mr. Woodman from Sitka's local paper Thursday 02/08, "Suicide is the taking of a life when there are options. This Bill is not about ending life. This bill is about ending death." Who does he think he is fooling? He goes on to say opponents argue for what they feel is morally right without considering the suffering and economic hardships placed on terminally ill patients and their families." *Economic hardships*? These two words should definitely alert even the most apathetic.

Does Mr. Woodman he believe himself to be the only one to have suffered physically, or lost a loved one to cancer or AIDS? Is the emperor wearing new clothes?

And the State of Alaska once again becomes the follower, instead of the leader.

I say no to Physician Assisted Suicide. I say no to HB 371.

Teri Lundy

P.S. WHAT ABOUT PUTTING THIS MUCH ENERGY INTO HOSPICE CARE "AND" PROPERLY TRAINING PHYSICIANS TO USE PAIN MEDICATION THERAPY.

IF A PT. IS SUFFERING - CHANGE THE DOCTOR!

Alaska State Legislature

Please enter into the record my testimony to the HESS / State Affairs committee name

committee on HB 371 bill/subject, dated Feb 13, 1996.

I am a daughter of a woman diagnosed with senility dementia and the niece of 3 Alhzheimer victims. Their lives cause pressures and difficulties for all of us around them, but their value and our interactions are precious. I would be distressed to live in ~~our~~ a state that would shorten their lives and the obvious progression from willing to unwilling participation. I am strongly opposed to this Bill

Signed: Carolyn Oien
Testifier

Self
Representing (Optional)

2414 HPR, Sitka
Address

907-747-6737
Phone No.

Frederick J. Hillman, MD (Ret.)
1685 Stanton Avenue, Anchorage, AK 99508-5034
Tel: (907) 562-7161

FEB 15 1996

TESTIMONY TO THE HESS COMMITTEE REGARDING HB 371
Teleconference at Anchorage, 2-13-1996

My name is Fred Hillman. I am a retired physician.

At the time of the American Revolution some of the colonial patriots were Anglican, some Roman Catholic, Protestant, some Quaker, some Jewish, some deist. In founding this nation the Founding Fathers from these various sects made it clear that their new constitutional nation would be not only *non-sectarian*, but indeed *secular*. They debated the matter, and in the end they wrote the Constitution to include neither the word *God* nor the word *Christ*. In no sense can this country be called a Christian one. The ensuing two centuries of religious liberty that we have enjoyed have shown the wisdom of their decision.

Now we find that some church leaders are using religious arguments to prevent passage of a law that has *nothing* to do with religion. HB 371 is a bill that does *not* infringe on the religious rights of *anyone*. On the other hand, spokespeople for some churches would like to impose their own narrow religious views on everyone. Their religious arguments concerning a purely *non*-religious bill directly contravene the First Amendment of the Bill of Rights, and they mock our two hundred year history of separation of church and state..

HB 371 is entirely *voluntary* and *permissive*. It *allows* an individual to escape needless suffering, *if* the person chooses. It does *not* require action by anyone. It is *not* about killing. It is about one's own personal decision about whether to continue to endure one's own needless suffering. It contains safeguards to prevent such a decision being made in haste, or without thought, or under pressure, or for financial reasons. It concerns a decision that I well may want to make for myself someday.

As a long-time church-member, I do *not* attempt to force my religious views on other people, and I deeply resent the attempts of people from other sects, basing their arguments on *their* peculiar religious views, to stand in the way of a law that may benefit me, my friends and the countless people in the future who may suffer needlessly during their final illness.

I humbly suggest to the Committee that you strike from the record *any* testimony against HB 371 that is based on religious argument.

Frederick J. Hillman

Frederick J. Hillman, MD (Ret.)

Kristina Johannes

Testimony on House Bill No. 371

Nationwide View:

There are two basic worldviews. that God exists and that God doesn't exist. If God exists, then people have certain inalienable rights, if God doesn't exist, then "the mighty might makes right."

Americans are very fortunate that our country was founded on the first one, God exists. Because of this, America is not a secular nation, but an interfaith nation. This recognition of a Creator had, and continues to have, a great impact on our country. We recognize that there are limits to what we can do to ourselves or to others. We are always in search of what is "right" in a particular situation, we attempt to know what the Creator wants. We believe that there is an objective right and a wrong.

Therefore it is entirely appropriate within the framework of our form of government to consider the morality of a proposed bill. In fact the question must always be asked of every piece of proposed legislation; is it consistent with the recognition that we are the created not the Creator? If we fail to do this, then we are acting against the very nature of our foundation as a nation, we are being unAmerican.

We failed to do this with the issue of slavery, and we reaped the tragic results. We failed to do this with the issue of abortion, and we continue to reap the tragic results. We cannot afford to continue in this way. The self-destruction we have incurred is all around us, our nation is literally falling down around us. But we can turn it around. We must turn again to the tradition of being one nation under God. We must search for what is right, what the Creator wants, in every situation.

I maintain that if we clearly examine this bill, we will conclude that it is not what the Creator wants. Our Declaration of Independence states

that the Creator gives the right to life, the right to liberty and the right to the pursuit of happiness; not the right over life, the right over liberty, or the right over the pursuit of happiness. No one of us can take his or her own life or that of another. Only the Creator gives and the Creator takes away. This bill places the individual into the role of the Creator. It is not within the nature of being "the created" to take away the life of one whom we did not create, even our own self. I urge you to oppose this bill and any bills that attempt to put the creature into the role of the Creator.

Let us rather affirm life as a great gift from the Creator and strive to individually and corporately help those who find themselves in difficult situations. Attempted suicide has always been recognized as an anguished cry for help. Let us hear that cry more clearly and respond with the love we have been given by our Creator.

STATE OF ALASKA

LEGISLATIVE AFFAIRS AGENCY

DIVISION OF PUBLIC SERVICES

DATE: 2/13/96

Please accept the enclosed original(s) of written testimony for the House HESS teleconference hearing that was scheduled on 2/13/96 at 3pm.
(stapled to cover sheet)

A copy of this testimony was transmitted to your committee via fax on 2/13/96.

All other testimony (not stapled to cover sheet) was not faxed, as it was received after noon. It is being transmitted by mail only.

Thank you,

LEGISLATIVE AFFAIRS AGENCY
Sitka Legislative Office
210 Lake Street
Sitka, Alaska 99835
747-6276

Alaska State Legislature

Please enter into the record my testimony to the House Health, Education and Social Services committee
committee name

committee on House Bill No. 371, dated February 13, 1996.
bill/subject

See attatched

Signed: Geneva Cadiean
Testifier

Representing (Optional)

712 Monastery Street, Sitka, Ak
Address

(907) 747-2634
Phone No.

9/86 Legislative Information Office

February 13, 1996

Dear Sirs:

Thank you for allowing this opportunity to be heard concerning the pending House Bill No. 371.

I strongly **disagree** with the rewording of the law as proposed in House Bill No. 371.

Historically, America, as well as other countries, has forged ahead in finding cures for diseases and treatment for medical problems previously thought to be incurable or insolvable. These cures and solutions were not discovered overnight. True there were those who suffered and died before the cure was found. However, there is hope for those who now live and are helped. A prime example of a medical tragedy turned to success because of the unceasing research and care of desperate and concerned parents is the story of Lorenzo's Oil. But, what if the parents had given up? What if they had taken an easy way out of the situation? This scenario concerns a child rather than an adult. None-the-less, the principle is the same.

Historically, if there is an "easy" answer to a difficult situation, man will tend to seek that route. Cortez understood this principle. Therefore he burnt his ships after reaching Mexico, thus leaving his men no option but to fight to win.

Historically, to enter the field of medicine was to enter the battle against disease, pain, physical disabilities, and death. In some civilizations of the past a physician was even killed if a patient died while under his care . The kingdom of Chimore (1000 to 1466 A.D.), had such a policy. It is interesting to note how skilled their doctors were. How then can we now call death an answer to pain and suffering? Is it not just an easy out to difficult situations, situations for which medicine may be on the verge of conquering?

Based on the above information, I strongly **disagree** with the rewording of our Alaska statute to include the right to use medicine for the purpose of causing death.

Alaska State Legislature

Please enter into the record my testimony to the House Health, Education and Social Services
committee name

committee on House Bill # 371 , dated Feb 13, 1996 .
bill/subject

see attached

Signed: _____ W. Corduan
Testifier

Representing (Optional)

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