MINUTES

SENATE & ASSEMBLY JOINT COMMITTEE HEARINGS
February 28, 1977
Senate Bill 200 and Assembly Bill 8
8:30 a.m.

Assemblyman present: Chairman Barengo
Mr. Price
Mr. Coulter
Mrs. Wagner
Mr. Sena
Mrs. Hayes
Mr. Ross
Mr. Polish
Mr. Banner

Senators present: Senator Close
Senator Bryan
Senator Ashworth
Senator Foote
Senator Gojack
Senator Sheerin
Senator Dodge

Senator Close brought this meeting to order at 8:30 a.m. for the purposes of hearing testimony on Assembly Bill 8 and Senate Bill 200 which, in summary, permits voluntary cessation of life-sustaining procedures for terminally ill persons.

First to testify on Assembly Bill 8 was Assemblyman Coulter, as the bill's chief sponsor. Attached hereto and marked as Exhibit "A" are Mr. Coulter's remarks in support of A.B. 8. Mr. Coulter went over different sections of the bill for the committees and there were some questions from the committeemen. Senator Bryan asked one question of Mr. Coulter with respect to § 3 of Section 10, as to what would be his thinking of precluding an employee of the health care facility. Mr. Coulter stated that the idea was merely to get a totally disinterested party to come in. Mr. Coulter added that he has requested an amendment for the committees' consideration which would define "death" for the purposes of this bill, as the cessation of brain function. Mrs. Wagner asked Mr. Coulter if he felt that there might be a problem in having a verbal revocation and Mr. Coulter stated that the idea was that if a patient were totally weak and incapable of writing something out, this would give them an added protection; they could just orally state it and anyone near them is obligated to pass that on to the doctor. Senator Dodge, in making reference to the declation having wording similar to a will, asked if Mr. Coulter felt they should put some wording in there to, in fact, determine if a person is mentally competent. Mr. Coulter advised that in New Jersey they set up the committee approach to this and perhaps this method would solve the problem, although, Mr. Coulter did not think this was a good approach. Upon Senator Sheerin's question, Mr. Coulter advised the committees that the difference between A.B. 8 and S.B. 200 is in the retroactive clause at the end that would essentially put into force those persons who have already signed living wills (Section 20 of S.B. 200). Mr. Coulter stated that this bill is generally patterned after the California law, however, one of the major differences is in California you have to wait two (2) weeks after being diagnosed as terminally ill before a directive could go into effect. Senator Bryan made the observation that the thrust of this bill is someone, years before the actual situation may arise, is, in effect, giving a statement of his expression and at the time that he is really needed, he is incapable. Mr. Coulter stated that

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essentially what this does is it sets up a form for a living will, but the living will only actually takes effect once you have been diagnosed as terminally ill by these two physicians and then you re-execute the directive.

Senator William Raggio then testified, as introducer of S.B. 200, before the committees stating that Mr. Coulter did cover everything, however, he wanted to make a few additional remarks. He mentioned that he did not approach this very important issue from a theology standpoint and this bill is carefully tailored not to be a bill which in any way endorses the principle of euthanasia, mercy killing, etc. He stated that anyone who reads anything else into this bill does a real disservice to those individuals who ought to have the right to make this determination for themselves, i.e. the dignity to die. Senator Raggio stated that the bill has only been adopted in California because it is a rather recent concept as to the actual execution of the directive. He did report, however, that there are, at last count, 28 bills in different states that are still pending. New Mexico's bill has passed the Senate. He stated that this bill received his attention because, as an attorney, in the last year, he has had increasing number of requests from people who come into execute an ordinary Will and Testament along with a package of forms designating a directive of Living Wills and he has to advise them that this does not assure them of anything. He must advise them that this has no legal standing, nor can he assure them that the attending physician at the time of need would have to honor it. Therefore, what these bills do is to recognize the right of that inidividual to make that decision for himself. Senator Raggio stated that he asked for a bill patterned after the bill in California and with the exception of the "two week provision", they are the same. He stated that he did not see the need for that provision because they are not looking at this the same as they do a will, in some respects. However, he has no objections to it. He attempted to answer an earlier question from the committee regarding the reason for the differentiation between hospitals and other health care facilities, by stating the reasonining behind California's decision. It was felt that if these were executed in a health care facility other than a hospital that there were varying degrees of professional health and expertise available in the health care facilities and for that reason and to give some added insurance that disinterested, competent witnesses would be available as a witness to the will. Whether or not it has merit or to what degree, Senator Raggio said he would not conjecture. The bill that he introduced has the added feature in the final section of recognizing the validity of those instruments which have been executed before the effective date of this measure. He stated that there are alot of people who have executed such documents. Section 20 under S.B. 200 would recognize the validity of those documents, as well as, those that are executed after the effective date of the bill. He stated that it should be noted that the bill does require a patient's terminal condition as defined, to be certified by two physcians. Senator Raggio said he does not look upon this the same as a will, when you go into court to determine competency or coercion or something of that nature, but, looks upon it as something where if the comatose condition occurs where the declarant were unable to communicate, then if the directive was in existence then a Court matter could be instituted by a family member. Senator Sheerin asked of Senator Raggio if we should go one step further to have a form of specific findings that have to be made by the physician in order to trigger this thing. Senator Raggio stated that he did not think so and further, to remember that this is not some sort of contractual matter, but something that the declarant himself wants to do at the time. In further answer to Senator Sheerin's inquiries, Senator Raggio said he would have no objection with at the time the physician complies with the declaration and makes that determination, then at that point, the circumstances on which he bases that determination would be included. Although, Sen. Raggio added that he could not

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conceive of a physician doing that. Sen. Raggio clarified for Mrs. Hayes the reasoning for this bill, stating that because alot of people are executing these declarations with the belief and understanding, not necessarily going to an attorney, that they are making an effective declaration and there is nothing in our law which does that. Mr. Coulter then added that it would also guarantee that the patient's decision is obeyed, while right now it is all in a sort of "twilight zone" . This just puts the patient back in control again. Senator Raggio stated that at the present time, some physicians might be willing to follow such a directive even with the absence of a statutory authorization, while others might be extremely timid. Senator Dodge asked Sen. Raggio if there should be some sort of language in the bill which recognizes a Will, however expressed, as long as it is a written document. Sen. Raggio stated that he feels that there is a danger in elaborating too much. Upon questioning from Mrs. Hayes regarding page 2, line 31 relating to pregnancy, Sen. Raggio explained his reasoning and Mr. Coulter added that it was put in specifically because of objections from "Right to Life" groups in California. Sen. Sheerin asked with regard to Section 16, page 3, line 33, if we were, perhaps, putting too much of a burden on the physician in this regard. Sen. Raggio advised him that the purposes behind that provision is that, first of all, this is a situation which probably will not arise that often, however, if it did, it is an attempt to recognize the fact that the attending physician has the permissive authority to give weight to the declaration. He stated that the intent is not to make the physician a judge; he said it makes it mandatory that he satisfies himself that there is a declaration in existence. This is not only a protection to the declarant to see that his wishes are fulfilled but it also gives protection to the physician who follows the procedure and complies with the provisions. There followed several questions and discussion from committee members, including a question from Mrs. Hayes expressing concern of whether this will really hold up in Court with regard to insurance claims.

Mrs. Ruth Mc Groarty, Director of Nevada Right to Life Committee, was first to testify in opposition to A.B. 8 and S.B. 200. Attached hereto and marked as Exhibit "B" is her testimony. There were considerable questions and remarks from the committee. Mr. Coulter stated that Mrs. Mc Groarty said that a passage of a bill such as this would lead to confusion and the fact that he disagreed, and feels that it would end a lot of confusion that surrounds the area, as it would put the patient in control of his own situation. Mrs. Mc Groarty attempted to answer Mrs. Hayes previous question with regard to insurance. She stated that she thought of the same thing, that there would be a lot of court cases in the case of a double indemnity situation.

Dr. John Sande, Nevada State Medical Association, Legislative Chairman, then testified on these bills. He gave the committees some history on this, stating that these are essentially patterned after the California Natural Death Act, which became law there as of January 1, 1977. He detailed at length for the committee the medical meaning of "death" and of life sustaining equipment, etc. He stated that the problem is that the physician, in many instances, can take care of the problem himself, but there are times when he cannot, when he might be fearful of taking some action which might result in legal action against him. Therefore, he and the Nevada State Medical Association endorse these bills.

Mrs. Patricia Glynn, active in the Pro-Life Movement and married to a physician in Reno, testified in opposition to this bill and made a few comments, one of which was that the "Living Will" is not really necessary. She asked if it were really possible to construct a living will bill that is not open to abuse. In addition, she posed the question of whether or not we are really placing a terrible temptation on the physician as we are removing all threat of legal suit to the physician. How differently is a physician supposed to treat a

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patient who has a living will from one who does not have one? She stated that she has no answers to these questions, nor does she expect answers from the committeemen, but, to please think about these questions. She further asked about the person who has lost his ability to communicate and has signed this will and has suddenly changed his mind, how will he communicate and who will protect him. She asked if you could legislate compassion and could you legislate prudence.

Upon further question from Senator Sheerin, Dr. Sande then elaborated for the committees the reasoning behind the Nevada State Medical Association's support of these bills.

Ellen Pope of the Nevada Licensed Practical Nurses Association and member of the National Federation of Licensed Practical Nurses, Inc. then testified in support of these bills with a few changes. A copy of her testimony is attached hereto and marked as Exhibit "C", which include their proposed amendments. Senator Sheerin pointed out in A.B. 8, line 48 on page 2, section 4, stating that if you are not terminally ill, section 4 is omitted from the declaration.

Mr. Bob Petroni then testified on the bill, specifying section 10, line 8 through 10 and additionally, § 3, "...An employee of the attending physician or the health and care facility in which the declarant is a patient". He felt that that should be clarified, by stating a professional type of person. There was some questioning and discussion concerning this issue. In addition, he feels that there should be an expert type of committee to advise the physician. He also mentioned that he does think there should be a definition of "death" in the bill.

Bonnie Hickson of the Nevada Nurses Association, presently practicing at Washoe Medical Center, Reno, Nevada then testified in support of these bills. She stated that the nurses throughout the state were polled in regard to these bills and 100% were in support of this type of bill.

Mr. George Hawes, Past President of A.A.R.B., stated that his organization consisting of 160 people at the present time, voted unanimously for a bill of this type.

There being no further business to discuss at this time, Senator Close adjoured the meeting at 10:57 a.m.

Respectfully submitted,

Anne M. Peirce, Assembly Attache

Joint Meeting of the Assembly Committee on Judiciary
Senate Committee on Judiciary

STEVE COULTER —
A.B. 8

On February 28th, the Judiciary Committees of the Senate and Assembly will consider A.B. 8, the natural death act. I am writing you to present an analysis of this much needed legislation and to seek your support.

A.B. 8 fills a current void in the law. It sets up specific circumstances under which a terminally ill patient can elect not to artificially prolong the moment of death. As it now stands, the needs and desires of the dying patient are often overshadowed by other factors such as the personal ethics of the doctor, the caring or lack of caring of the family, or the source of payment for the cost of the medical treatment. The bill establishes a process allowing the dying patient to control his or her final days. The patient makes the decision and I believe that is how it should be.

Traditionally, a person has been considered dead when his vital functions, such as respiration and pulse, have stopped. But advances in medical technology have rendered these traditional indicators inapplicable. As one supporter of the bill has stated, "for many people, the ultimate horror is not death, but being maintained in a medical limbo, strapped to a machine controlled by strangers. Today the terminally ill must not only contend with death, but also the artificially prolonged process of dying."

A.B. 8 is similar to a bill enacted in California last year. It was the culmination of over two years of research, debate and compromise. In it's final form, the bill received wide support from religous and medical groups, civil libertarians and the press. The Nevada bill, like the one in California, contains many safeguards to avoid abuse.

I introduced the bill with the hope of restoring some measure of dignity and personal control over one's own death, when death is inevitable. In this age of expanding medical technology, surely we have the compassion, understanding and desire to allow the terminally ill this most basic right, the right to choose to die naturally.

Sincerely,

STEVE COULTER

EXHIBIT A

From National Catholic Welfare Conference

This is the teaching of the Catholic Church as now proclaimed by the Vicar of Christ. It is a middle course between the pagan theory of euthanasia that would allow a person suffering from a hopeless ailment to be put to death by some direct means and the theory that every possible means must be used to keep a person alive, even when death would be a relief.

This latter theory is actually unchristian for it exaggerates the importance of earthly life.

Christians should always remember that the principal purpose of life on earth is to prepare for eternity. When one has used all ordinary means to preserve his health and life and has made use of the sacraments established by Jesus Christ to insure eternal salvation, there is no reason why he may not abstain from further efforts to lengthen his term of life on earth and calmly accept death with the glad hope of life eternal.

To understand correctly the pronouncements of the Pope one must clearly visualize the particular case with which he was concerned.

The Pontiff certainly was not speaking of a case in which artificial respiration offers some chance of restoring a person to health. In such a case, there is surely an obligation to have recourse to artificial respiration.

Furthermore, the Pope added that even when there seems to be no hope that the patient will survive, the doctor will, for a time, attempt reanimation by artificial means. Sometimes, contrary to all hope, the afflicted person will recover.

But it can happen that even after artificial respiration has been used for several days, the patient's condition remains the same, and it is evident only the artificial respiration is keeping him alive. In fact, he may be so debilitated that one wonders if he is still alive or if it is rather the artificial measures that are producing the appearance of life in his body.

This is the case to which the Pope referred. He proposed the question whether, in such a situation, the doctor has the right and duty to make use of artificial respiration, especially when the members of the patient's family demand that these measures be ended and the sick person allowed to die in peace.

Pope Pius XII explicitly laid down a fundamental principle, commonly accepted in moral theology -- namely, that everyone has an obligation to make use of ordinary means to preserve his life, but usually he is not obliged to use extraordinary means.

The first part of this principle is based on the truth that man has a duty toward himself, toward certain individuals (for example, the members of his family) to live as long as he reasonably can.

The Pope does not explain in detail what is meant by ordinary means, except by saying that they are such as impose no extraordinary burden on the patient or on any other person. Theologians give as examples such means as necessary food, bed-rest and shelter. These must be provided for a patient, no matter how hopeless his case may be.

The Pontiff added that the distinction between ordinary and extraordinary means may depend on circumstances of persons, places, times and culture. The span of life expected from the means would be the determining factor. Thus, several blood transfusions would be an ordinary means of prolonging life (and hence obligatory) if they would cure a young person, but they would be extraordinary if they would only give a few days more life to a dying person.

Usually there is no obligation to use extraordinary means, though one is entitled to make use of them if he wishes. But there is no obligation because they would be too difficult for most persons, and, in addition, excessive attention to health and bodily life and activity would draw a person's attention and efforts away from more important spiritual goals.

When artificial respiration certainly will not help a person to survive but will only keep him alive a little while longer, it need not ordinarily be used. In that case it is an extraordinary means of preserving life, which, according to the general principle enunciated above, is not obligatory.

At the same time the Pope pointed out that the determination whether or not to use extraordinary means of prolonging life belongs primarily to the person himself and, if he is unconscious, to the members of his family. They should make the decision in accordance with what they believe the patient himself would wish. The doctor should follow the wishes of the patient or of his family.

--The preceding is an excerpt from the National Catholic Welfare Conference News Service Report.

THE RIGHT TO DIE
(An Analysis of A.B. 8)

The bill establishes in law a process by which the dying patient may control his or her final days. It gives legal recognition to a written directive by the terminally ill patient, instructing their physician to order the withdrawl or withholding of life sustaining mechanical procedures when they serve no purpose except to artificially delay the moment of death.

1). <u>Putting the Directive into Effect:</u>

A. Section 10 permits any adult to execute a declaration that life sustaining prodecures not be used to artificially prolong the moment of death when death is imminent.

B. The directive must be signed in the presence of two witnesses who cannot be related to the declarent, the attending physician, an employee of the attending physician or health care facility in which the declarent is a patient, or have any claim against any portion of the estate of the declarent (this is a safety mechanism to avoid potential abuse).

C. Section Eight states that a patient must be diagnosed as having a terminal condition by two physicians before the directive can take effect (one must be the patient's personal physician and the other must physicially examine the patient).

D. Section 12 states the directive is void if the patient is in any health care facility other than a hospital unless one of the witnesses is a person designated to witness declarations by the Division of Aging Services (many nursing home patients are in such poor condition, it was felt a representative from the state should be there to protect their interests).

E. The declaration is in effect for five years and must be reaffirmed to remain in effect for a longer period.

II. Revocation:

A. Section 13 states that a declaration may be revoked at any time by the patient either orally or in writing.

B. The doctor must record the verbal revocation and the date and time it was made in the patient's medical record.

III. Liability:

A. Section 15 relieves hospitals, other medical facilities, doctors and staff from criminal liability or charges of unprofessional conduct for carrying out the patient's directive.

B. Section 16 states that failure of a physician to follow the directive of a qualified patient constitute's unprofessional conduct if he or she refuses to make necessary arrangements to transfer the patient to a physician who will follow the directive (to guarantee the patient's wishes are carried out).

IV. The Living Will:

A. Anyone may execute a directive, whether or not they are diagnosed as being terminally ill.

B. However, Section 16 states that if a person executes a declaration before being diagnosed as terminally ill, and they do not re-execute the directive after learning of their condition, the doctor will consider the directive and other factors before taking any action (this is designed as a safeguard for the person who may have executed a will and intended to revoke it but never did before becoming terminally ill, perhaps comatose. Other factors that would be considered would include the feelings of the family).

V. Insurance:

A. The execution of a directive does not constitute suicide (Section 17).

B. The declaration does not restrict, inhibit or impair the sale, procurement or issuance of any insurance policy.

VI. Penalties:

A. It is a misdomeanor to revoke a declaration without a patient's consent (Section 18).

B. A.B. 8 makes it a homicide for a person to forge, or falsify a declaration, or willfully conceal knowledge of a revocation of one.

VII. Other Provisions:

A. No one can be forced to make a declaration for any reason.

B. Section 19 prohibits any act which ends life other than to permit the natural act of dying.(this in an important point--mercy killing or euthanasia is absolutely prohibited. A.B. 8 is a "right to die" bill only in the most limited sense. The conditions under which it can be used are well defined).

STATEMENT OF

Ruth McGroarty, Director
of
Nevada Right to Life Committee

on

AB8 AND SB200

(The Right to Die/Living Will Concept)

February 28, 1977

EXHIBIT B

INTRODUCTION

The Nevada Right to Life Committee, composed of approximately 20,000 members, opposes AB8 and SB200 and urges you to recommend that it "Do Not Pass".

It is our belief that these laws are basically unnecessary and would do more harm than good. At the least, passage would lead to confusion. At worst, it could lead to abuse and a lessening of respect for human life.

We would like to cover three specific areas. First, we will address the specific sections of the bills and attempt to point out flaws and areas subject to misinterpretation. Second, we will examine the impact on the various individuals who would be affected by such laws and the impact on society as well. Last, we will look at where such bills would lead us.

SPECIFIC COMMENTS ON PROVISIONS OF THE BILLS

The attempts to write in specific protection sections point up the inherent weaknesses of this type of legislation. The bill is jerry-built, with various pieces thrown in to attempt to provide protection.

The "Directive to Physicians", defined in Section 11, can be restated to say, in essence, that a person has a "right to die". We disagree. The Constitution and traditions of our land have always enumerated a right to life but not a right to die. If the right to die is declared an inalienable right available to all, it MUST be granted. Thus, by declaring the right to die an inalienable constitutional right, voluntary, involuntary, passive and active euthanasia could become the law of the land. Who then will set the standards, make the decisions on life and death? It is a foregone conclusion that death is imminent from the moment of conception...only the circumstances vary and not even our greatest scientists can predict with absolute accuracy the "time".

AB8 AND SB200 ARE UNNECESSARY

This bill is unsound basically because it is unnecessary. It would give the patients nothing other than what they already have. The patient already has the absolute "legal right" to refuse any medical treatment offered...he can change doctors or hospitals or nursing homes. Because the Living Will is signed in advance of the illness and the treatment, the patient does not give what is normally considered to be informed consent. If there is uncertainity in the medical and legal professions as to the

legalities of terminating the use or application of life-sustaining procedures, why not just require the doctor to discuss it with the patient? Even if the doctor has a Living Will, he would have to discuss it with the patient because the patient would not know all the facts at the time he signed the will. The doctor should then treat the patient as if there were no will. Does not this law place too large a burden upon the individual person when it expects him to predict now the kind of medical care he would like to have sometime in the future under conditions which he does not presently know? If physicians are rendering medical procedures not in the best interests of their patients, then such cases should be reported for prosecution.

In Sec. 6, the definition of "life sustaining" procedures makes no distinction between ordinary and extraordinary measures. A physician may judge that because a patient suffered massive electrical shock, death is imminent regardless of whether or not the ordinary procedure of cardio-pulmonary resuscitation is attempted. Under these bills, he would be prohibited from attempting resuscitation if the victim had signed a declaration. Other examples come readily to mind...such as the ordinary life sustaining procedure of normal care such as intravenous feedings will be eliminated and the patient may die from lack of food and liquids, not from illness or injury. In 1971, doctors at Johns Hopkins University Hospital were refused permission to operate to remove the abdominal obstruction in a newborn infant who was also afflicted with Downs' Syndrome. The parents would not allow the relatively simple procedure which would have allowed the child to digest food. Instead, a sign was hung on its crib which read, "Nothing by Mouth", and the baby starved to death over a fifteen day period. Here again, what appears to be a simple definition is a quicksand upon which cautious men should fear to tred. The safest course for a physician when there is some question whether the patient is terminally ill and qualified under the act would be to withdraw any life sustaining procedures pursuant to the act rather than to attempt to preserve the life of his patient. The physician could be penalized if the patient lives, but not if the patient died.

SEC. 11, paragraph 3 states "If I have been found to be pregnant and that fact is known to my physician, this directive is void during the course of my pregnancy." Right to Life is grateful that the members of the Senate and Assembly still recognize the right to life of the unborn as evidenced by this protective paragraph. One comment, though, wouldn't it be more in keeping legally to request the physician to test for pregnancy rather than HOPE that the fact is known to the physician?

Our deepest concern in SEC 11 deals with the areas of free will, voluntarism and mental competency. The only guarantee that the declarant has executed the document voluntarily, of his own free will and while mentally competent is that he has so stated and two lay witnesses have attested to this belief. There is no requirement that the declarant's mental state IS sound. There is no way of determing whether or not the declarant has been "brainwashed" or pressured into signing.

A key difference between a "Living Will" and normal wills is that once the provisions of the living will are implemented, they are IRREVERSIBLE. While in an unstable state of mind, persons have bequeathed fortunes to their cats. Such wills have later been modified by the courts. Under various forms of duress, persons have executed wills distributing their estates in manners contrary to their true wishes. These, too, have been thrown out.

Although a court could later determine that a "living will" was made by an incompetent person or under coercion, the court would not be able to reverse the damage done. In effect, the "living will" becomes the "final mistake" or a death contract.

SEC. 12...deals with patients in a facility. A facility is defined as any health and care facility other than a hospital which by the wording of this section refers to nursing homes for the aged. If there was NO possibility for abuse, there would be no need for this provision. Here again, the inherent weakness of this bill is manifest. If men of good will, such as the sponsors, sense the danger which this section purports to guard against, is it not logical to presume that there are those who would devise ways to circumvent it? Should not the law be more concerned with improving the well-being and life of our aged and terminally ill?

According to national statistics, taxpayers spend 35 Billion Dollars on drug addicts and alcoholics who are suffering from self-inflicted diseases. Then, why can't we

extend our compassion and financial assistance to those who are soon to die...build a place where they can truly find peace as they prepare themselves for the final journey home. Such places are being built called the Hospices. A Hospice embodies a radically old-fashioned idea that is beginning to catch on in America: that many terminal patients should be allowed to die at home, instead of in the grim, impersonal surroundings of a hospital ward or nursing institution. The Hospice takes the place of those who cannot be cared for in the home with a home-like atmosphere and it helps the patient face the consequences of serious illness with greater courage. It would take the elderly out of the hands of greedy nursing homes where they are kept heavily sedated and kept alive unnecessarily. This "Living Will" would not eliminate these problems...it would simply eliminate lives. Again, we are dealing with the unknown...only God gives life and only God can take it away. When it is one's time to go, our obligations lie in keeping the patient comfortable, administering to his ordinary physical needs and his spiritual needs. I hope that someone here today will introduce a Bill that will give encouragement for the establishment of a facility like the Hospice.

REVOCATION OF A DECLARATION...The paragraphs dealing with revocation of a declaration have flaws which could prove fatal to the declarant.

First, suppose that under Sec. 13, paragraph 1, that the attending physician cannot be reached and that the machinery for withdrawing life support has already been set in motion. What happens then? What are the legal ramifications?

Second, consider a patient who has been paralyzed and is unable to speak or move a finger. All he or she can do is blink, or perhaps not even do that. Suppose that person has a change of heart and is unable to communicate his desire to live. The horrible knowledge that life support will be withdrawn and that you are powerless to stop it is UNTHINKABLE and totally unnecessary.

Third, Sec 13, paragraph 2 in no way prevents a person, who stands to benefit from the declarant's death from hiding knowledge of a revocation until it is too late. If there was not such a possibility, why was this proposed in the bill?

When there is any question as to whether a patient has a terminal illness, these bills tend to favor a finding that the patient is terminally ill and encourage the withholding of life sustaining procedures. A doctor of a hospital acting in accordance with the provisions of the bill who causes a patient to die would not be subject to civil or criminal liability and could nto be charged with unprofessional conduct. Immunity from civil or criminal prosecution or charges of unprofessional conduct is not even contingent upon the physician or health facility acting in good faith. This extraordinary protection is granted when life sustaining procedures are withdrawn or withheld, apparently, irrespective of whether the doctor acts in bad faith or is grossly negligent or whether he would otherwise be in violation of another criminal statute.

The safest course for a physician when there is some question whether the patient is terminally ill and qualified under the act would be to withdraw any life sustaining procedures pursuant to the act rather than to attempt to preserve the life of his patient. The physician could be penalized if the patient lives but not if the patient died. These bills could be a blessing for the physicians...under these bills the doctor would not need malpractice insurance...if he makes a mistake, death was imminent anyway and he is fully protected.

Where could this lead? In some future session will the law be modified to require doctors to directly participate or face possible forfeiture of their licenses. Today, in Sweden, a qualified doctor who does not honor a woman's request for an abortion, is subject to loss of license and a jail term. Will this bill allow us to head in that direction?

Combining Sections 13, 14, 15, 16, we see that those who can bring themselves to pull the plug are in far less jeopardy than those who cannot. If we must bias the bill, should not that bias be toward life? If not, it is the patient who will suffer most. These provisions re-direct the doctor's train of thought from a focus upon what is sound medical judgment to a consideration of the legal ramifications. These sections force a course of action upon physicians. And, this IS wrong. This creates two classes of patients; those who have signed a declaration (whether they remember it later or not) and those who have not signed; thus creating two standards of care.

Section 17..."A rose by any other name would smell as sweet," and the provisions in this section could be considered a suicide pact with the state. But, we just don't call it suicide. Why would this have been inserted if the possibility of someone using this bill as a method of indirect suicide did not occur to the sponsors?

Section 18...provides that a person who obstructs the execution of a valid living will shall be guilty of a misdemeanor. On the other hand, it provides that a person who forges a bogus living will or hides a valid revocation can be prosecuted for murder. It says, in effect, that the person to be killed determines whether or not the act is murder. A single piece of paper makes the difference. And could a later General Assembly reverse the provisions, so that it becomes a felony to obstruct the execution of the document? And then, could it further amend the law so that a falsified document or hidden revocation becomes merely a misdemeanor violation? As we all know, the original "intent" of men of good will in legislatures can very quickly be torn to shreds. We of the Right to Life are very cognizant of this probability when men of good will took away every protection in due process of law from the lives of the unborn right up to the date of birth. When a bill contains any loopholes, it should not be passed.

Here again, the authors have shown their concern about areas that will be difficult, if not impossible, to monitor and enforce. We are talking about LIFE, the ending of it, and must be certain that total protection is provided. As you can readily see, it is totally impossible to provide adequate protection in a "Living Will". The great lengths the authors have gone to to provide protection indicate the broad range of potential abuses which can be committed. Who is to say that some others might have escaped their attention? Can the sponsors guarantee that this first step extended to the easier cases will not later be extended to the hard cases or the first step toward euthanasia?

INCURABLE...First, we must not equate incurability with hopelessness. Diabetes, emphysema, practically all heart diseases, kidney failures, Multiple Sclerosis, Muscular Dystrophy, even the new sexual diseases called herpes simplex type 2 can be included... baldness, flat feet...all incurable but not hopeless. A cancer patient may live 3 months, 3 years or 30 years with his disease, earn a living, raise a family and enjoy life and may or may not require treatment along the way and he may or may not die of this incurable disease. Also, with cancer as with other incurable diseases, there are 509aneous B

remissions, when the disease lies dormant and even rare spontaneous cures. The patient who is told by his doctor that he has 6 months to live but is alive years later is legendary.

Dr. Foye testified to the U. S. Senate that out of hundreds of the incurable cancer patients, he never had one refuse treatment or request that the doctor let him die, even though every patient knew what could be done and couldn't be done and knew what the risks were and knew that he was a free agent and could say stop at any time. If there were the need for a Living Will, a greater percentage of terminal patients would commit suicide but less than 1% do.

EFFECTS ON THE PARTIES INVOLVED

We turn now to the effects of the bill on the people who would come under its provisions. What is the phychological meaning of signing such a living will? We believe it could be a sign of a deep form of pessimism on the part of the declarant. The desire for suicide is present in a large number of people. Would not such a law be a means for transforming desire into reality? And does such a law encourage this type of pessimism? No one knows---yet.

As mentioned earlier, a person's mind can change quickly on subjects far less important than death. We have all said, "If I were in that situation, I'd do thus and such." But none of us can make such a statement with certainty. When actually confronted with death, a person may change his mind by 180 degrees. This bill attempts to provide for that possibility. But death is final, and an attempt will not suffice.

The rights of both physicians and patients would be inhibited by these bills. Dying is complex. This bill presumes that doctors and their patients know more than they really do. Decisions must be made based on the current situation; not what one thought would be the situation. The bill would abridge the right to make judments based upon current knowledge. A doctor may project what course of treatment he will follow, but he does not know for sure. And there is no one who can predict with exactitude when death will occur.

Death is a family affair, in which relatives and loved ones draw close to the afflicted together with their clergyman and physician. This is good. But this bill would cut them off and isolate the patient from their loving council.

Again, we suggest to the sponsors...a Hospice type of case is the humane answer when the patient cannot die naturally at home and with his family. The Hospice includes the family and friends in the last days of the patient's life.

OUR GREATEST CONCERN?

Our greatest concern lies in the fact that AB8 and SB200 were drafted after the Society for the Right to Die, Inc. suggested model bill. In view of this grave importance, we repeat paragraphs three and four of our letter to you...

"We feel it is most important that we acquaint you with the goals of the Pro-Euthanasia groups. Dr. Joseph Fletcher is President of the Euthanasia Society of America. The first action of the board of directors, when he became president, was to select a new name for the society. Out of many submitted, they chose Society for the Right to Die, Inc. because legislators and lawyers had expressed gratitude for receiving material on 'death with dignity' but objected to receiving it from an organization with the word 'euthanasia' in its title...it is all a matter of semantics. "A rose by any other name would smell the same."

To illustrate the thinking of this organization, we quote one of Dr. Joseph Fletcher's famous or should we say infamous sayings... (Columbia Magazine - Sept. 1974)...

"I am impatient with such notions as 'Right to Life'.
Needs have precedence over rights...
I am primarily concerned with human need...both of life and death.
We should drop the classical sanctity-of-life ethic and embrace a quality of life ethic.
We have birth control and birth selection...
THE TIME HAS COME FOR DEATH CONTROL AND DEATH SELECTION."

The words and goals of Dr. Fletcher should leave no doubt in anyone's mind that by changing the name to the Society for the Right to Die, Inc. is the first step toward Euthanasia...an innocent sounding living will the first step, followed by the really hard cases. Already, Mr. Keene who introduced the California Death Bill admitted that it was purposely written narrowly so that it would have a greater chance of passage but that they intended to come back during later sessions to 'clean it up' and take care of the HARDER CASES. As of this writing he has drafted a new bill which he will introduce shortly...its contents are unknown at this time...BUT.......we can guess....it will not adhere to the 'INTENT' of the sponsors.

There have been many euthanasia bills proposed but not passed in the United States. We admit that we are blessed with not having gone as far as some other states. In Wisconsin, a bill was introduced which, if passed into law, would allow any person 7 years of age or older to request another person 14 years of age or older to terminate his life. It is also not without good cause that on November 2, 1973, the Florida Association for Retarded Children and the National Association for Retarded Children passed resolutions condemning Dr. Sacket's proposed bill to 'kill all the mentally incompetent in Florida."

Then, there is the Florida-based American Euthanasis Foundation which urged the White House to permit the distribution of 'living wills' to terminally ill veterans in hospitals of the U. S. Veterans Administration which was rejected by the Veterans Administration. In introducing his bill for the second consecutive year, State Senator Julian L. Lapides, Baltimore, was asked whether the bill would provide a wide-open door for mercy killing in the future. He replied,"Well, not a wide-open door, but maybe it opens it a crack."

In view of the above, we are of the definite opinion that these bills would be the first step toward euthanasia...from the Living Will, to Mercy Killing, to Death Control and Death Selection. Can anyone of the sponsors guarantee that this will not happen? We Nevadans are nervous about these probabilities and feel that we should not join California to be noted as the first nation since Nazi Germany to entertain euthanasia in any form. We would rather have it said of Nevada that "we can take care of our own".

If, in my testimony today, I have asked a lot of questions and failed to answer them, it is because there are no answers. There are some subjects which cannot be codified into law.

I have deliberately refrained from discussing the case of Karen Quinlan, because Miss Quinlan's case does not apply. Even though the prime sponsors of many Living Will bills use her case as the basis for their introduction of such a bill, Miss Quinlan did not sign a living will and would not have qualified under these bills. However, I will interject one comment...The Karen Quinlan case was sadly exploited by Pro-Euthanasia groups...they went to court...pulled the plug BUT she still lives. The final curtain is demanded...she did not die from withholding ordinary care so now what...the next step is frightening but certainly expected...they are now forming guidelines to 'kill' her, which of course will set a precedence for other states.

Finally, I would like to quote briefly to you from the writings of Dr. C. Everett Koop, who is Surgeon-in-Chief at Childlen's Hospital in Philadelphia. Dr. Koop is a Presbyterian. When asked how he feels about the right to die, Dr. Koop responds:

"As a basic principle, keep as many men at as many guns for as long a time as possible; that's how you win the war. I am in the life-saving business and that comes first, but I recognize also that I am in the business of alleviating suffering. I never take a deliberate action with the motive of terminating a patient's life. It is possible that a patient's life might be shortened by some therapeutic measure I employ with the intent of relieving suffering. In some circumstances where I believe that I have sufficient experience and expertise with the life history of a disease process and my patient's response to that disease as well as to his therapy, I might withhold treatment that could be considered extraordinary or heroic in the given circumstance in reference to the quality of life that might be salvaged for a short period of time...Even as I write these words I recognize full well the change for errors in judgment. Because of that, I try to err only on the side of life."

Dr. Koop's advise to legislators is as follows:

If well-meaning legislators, pressured by public opinion rising out of the emotional concern around the Karen Quinlan case or others like it, should push several of the United States to formulate laws concerning the right to die, Pandora's box will have been opened to expose a situation that really has no solution. We are dealing with medicine, with technology, and with law. Basic to the relationship between physician andpatient is the expectation that life is worthy to be lived and that physicians will act on behalf of their patients toward this end, and that if acts of omission or commission lead to an earlier demise of a patient than might orinarily have been expected, these decisions have to remain within the bounds of the expected, compassionate understanding relatiopship between the patient and his doctor and the patient's family and the patient's doctor. The number of examples of this decision-making is legion. It is unthinkable that the law could direct this decision making on the part

of the physician, because to do so would undermine the fundamental principles in all of the great field of health care."

There are no simple solutions. And hard cases made bad law. When the law attempts to address these hard cases, the result is jerry-built documents such as AB8 and SB200 which someone will always want to amend. The law is least able to address these complex questions. They must be left to the best medical judgment of the physician in consultation with the patient, the family, and their clergyman.

On behalf of our members across the State of Nevada, and all other Nevadans, we urge you to recommend that AB8 and SB200 "Do Not Pass".

Thank you for your time and courtesy.

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CARD SHARK — Stockbroker Mike Wilson of Vancouver, Canada, plays championship bridge with his toes. The 25-year-old Wilson was born without arms and one leg. But that doesn't stop him from competing regularly in regional bridge tournaments. "It's kind of a natural thing," Wilson says. "What you learn to do with your hands, I learn to do with my foot." AP photo

being delivered by cesarean section.

These carvings were docu-

TELESCOPE — accepted as being invented in 1608 — is shown being used in ancient Peruvian stone drawing.

contact with a ... far more advanced than any | astronomical techniques.

Doctors Expected Me to Die — But Love for My Family Gave Me The Will to Live

Doctors held little hope for Louis Branco after he developed a deadly form of stomach and bowel cancer. He had to undergo four operations, including a colostomy. "He almost died," said one of his physicians. But Louis, who is now 28 and living in Warren, R.I., had an incredible will to live. He recovered from the disease and now lives a normal life with his wife and son. If you know someone who has triumphed over great odds, write us. We'll award that person $100 if we publish his or her story. Send your letter to: Will to Live, NATIONAL ENQUIRER, Lantana, Fla. 33462.

By LOUIS BRANCO

I was 24 when doctors first told me I had cancer. They expected me to die, but I knew I was going to live.

I couldn't die.

My young wife and infant son needed me. I didn't want little Louis to go through life without his father.

That was over four years ago. I've had four operations since then. I had to wear a rubber bag to do the work of my bowels after a colostomy. But I survived.

I'm going back to work and my wife Cindy wants me to finish high school, too.

I was born in Portugal and moved to America when I was 11. I loved the healthy outdoor life, working as a gardener and landscaper. I guess that's one reason the shock was so great when I got the awful news late in 1971.

stomach and bowels. Doctors had to remove my spleen. I was in surgery 8½ hours and remained in intensive care for a month.

I had reticular cell sarcoma — a deadly form of cancer. The doctors thought I was a terminal case.

I guess that's when I felt the lowest.

But Cindy would come to visit me and tell me about tiny Louis, and I knew I had to get well.

"I'm not going to let it kill me," I told my wife. "I will live."

TV TRIVIA QUIZ

[Hu]man Vegetable Re[co]vers Because Mo[th]er Refused To Pull The Plug

Carol Rogman, of Union, Ill., is a pretty housewife and mother today instead of a "human vegetable," because her mother refused to "pull the plug."

"I've put in for a miracle," Mrs. Valentine Dusold told the doctor after a car crash 10 years ago had left her daughter in a coma as deep as the one which envelops Karen Quinlan, the New Jersey girl whose parents were recently denied permission to let her die.

So, every morning, Mrs. Dusold entered her daughter's room with a cheery greeting, just as though Carol, who was given a five percent chance to live, could hear and understand every word.

"Hi, dear, gee, you look pretty today," she'd say, because someone had told her that even when a person is in a coma, the subconscious mind remains awake.

One day, Carol's older brother was waving a small flashlight in front of her eyes, as he often did, to test her. Suddenly, her eyes followed the beam, the first sign of life in four months.

'I can do anything I set my mind to.'

It was only a start. Carol remained in a semi-coma for five months more before she was transferred to a rehabilitation hospital in Chicago.

"She had to relearn everything," Mrs. Dusold told MIDNIGHT. "Talking, even sitting up in a wheelchair."

But the therapists were impressed by Carol's determination, and they were resolved that she should return to as normal a life as possible.

Nonetheless, there was plenty of heartache along the way. Sometimes Carol would try to eat and miss her mouth with the spoon.

Her memory was so poor that hospital workers had to post signs in her room to remind her what time to wash, dress, go to occupational therapy and so on.

She learned her lessons well, though, and now she can do practically anything, even earn a college degree. She's the mother of a 20-month-old son, but even he isn't too much for her.

Her left arm remains paralyzed and she has a slight speech impediment, but she bristles at the word "handicapped."

"It's not as good as a normal one, but it's better than none at all," she says of her arm. "I don't consider myself handicapped. I can do anything I set my mind to."

Carol's husband, Larry, is a quiet 31-year-old man who works as a steel insulator. He had lived down the street and tried to date her when they were both students in high school and pretty Carol was the class belle.

She was engaged to another man when the accident happened, but he eventually gave up on her. Larry never did. He came to see her every day throughout her long convalescence. They were married in 1972.

"I couldn't have made it without Larry," Carol says.

But with her courage and determination, you have to wonder.

"I've gotten more blessings since the accident than you'd ever believe," she said. "Nothing has gone against me since then.

"It's brought me to a fuller realization of what life is and how to enjoy it more by getting every thing out of it I can."

10 YEARS AGO Carol was given a five percent chance of living. Today she's a happy mother and housewife.

5a Aug

Comatose Girl, 22, Revives

BELOIT, Wis. (UPI) — Judith Steuck, 22, emerged Saturday from a 53-day coma induced by accidentally inhaling carbon monoxide and told her parents, "I remember this day."

That she spoke at all was remarkable, her mother, Mrs. Eugene Steuck, said.

"She was telling us she was finally okay. She's talking a lot and the doctors are very excited," Mrs. Steuck said.

Mrs. Steuck said she believes Judy is able to speak so quickly because she majored in communicative disorders at the University of Wisconsin-Madison.

"With her graduating in communications, you could tell she was remembering what she had learned the first time she talked," Mrs. Steuck said.

Mrs. Steuck said Judy can speak of things her mother told her while she was unconscious.

"We've continued to talk to her throughout the coma, hoping she'd hear us," she said.

Following her spring graduation, Judy traveled to Europe for further studies in communications and was visiting friends in Madrid last Dec. 17 when the accident happened, her mother said.

She was staying in a Madrid youth hostel and had borrowed a space heater from the hostel manager. The woman told Judy it should be used only a half hour and that she would come in and turn it off, Mrs. Steuck said.

But the woman "got involved watching TV" and didn't return until the next day, and by that time Judy was in a coma. She was taken to a local hospital and was flown home four days later, Mrs. Steuck said.

Right to Life News

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VOL. 2 NO. 1 P.O. Box 73, Clovis, CA 93612 (209) 291-4958 JANUARY, 1974

25 YEARS OF JAPAN ABORTIONS MAY FORCE KILLING OF ELDERLY

"Easy abortion has been a bad experience for us," says Professor T.S. Ueno of Tokyo's Nihon University.

In a story in the November issue of Medical World News, the Professor tells of the pressure for euthanasia because of 25 years of abortion in Japan.

Speaking to the Nineth Congress of the International Academy of Legal and Social Medicine, in Rome, Professor Ueno, said that "Mōral life has become disorderly It is an age of free sex, and the life of the unborn is not respected. We can now say the (abortion) law is a bad one."

Professor Uemo pointed out that because of 25 years of abortion (the law was passed in 1948), Japan now has 14 million people over 65 among its population of 108 million In the next 30 years the over 65 population is expected to reach [illegible] million, of a total of 130 million Japanese.

Because this means too many old people for the young to support, he predicts strong pressure for euthanasia.

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Doctors Gave Him Only Hours to Live, but . . .

Family's Love, Faith & Prayers Help Boy Recover After 70 Days in Coma

"Doctor, doctor!" screamed Nadine Sadowsky. "He can hear me! He understands! My brother is coming out of the coma!"

Doctors and nurses came running to see 14-year-old Lewis Sadowsky emerge from 70 days of unconsciousness after an auto crash. Doctors had given him only hours to live when he was first brought to the hospital.

For week after week after the accident on April 22, the boy's parents, friends and rabbi had been praying for a miracle. "We talked to him through his coma as though he could hear us," said Lewis' mother, Mrs. Rita Sadowsky.

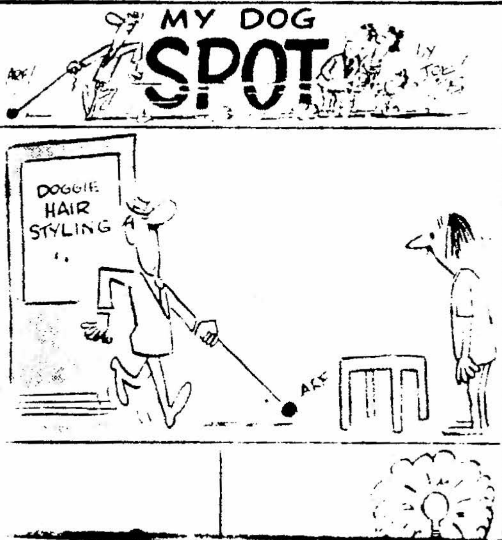
She refused to accept the possibility that he might not re-

By NEAL TRAVIS

surgery, Lewis was in far worse shape.

"When he was admitted we thought he had less than four

QUIRER: "The faith of the Sadowsky family was so ... that it rubbed off on all of the staff in the hospital. It was a miracle to see what happened."



After 15 Years of Agony . .

Courageous Teenage Girl Wins Against One of World's Rarest Di...

. . . She's the Only Person With T... To Survive Beyond 6 Months, Says...

... were terrifying moments when I'd wake up ... the hospital ... excruciating pain ... through ... pain I thought ... never stop.

... all these kind doctors down ... I had to prove to myself and everyone ... lead a normal ...

These are the ... words ... courageous girl who has ... one of the world's rarest diseases ... and

... several ... Mommy, It ... stop hurtin...

Baby Pacemaker Costs Killin...

By EDNA CLOYD
Copley News Service

LOS ANGELES — Alisa Dixon, seven pounds, nine ounces, begins life with a burden that outweighs her.

Her doctor and hospital bills total ...00.

The infant daughter of Bonnie and ... Dixon of suburban San Pedro is one of the youngest persons in medical history to have a pacemaker, according ...

pediatric ward at the San Pedro and Peninsula Hospital was giving out an alarming message.

It registered only 30 to 40 beats a minute on the unborn baby.

A Cesarean section was performed by Dr. Gary Krieger. After delivery, the heart was barely beating. Dr. Richard Wittner, pediatric cardiologist, was called in.

Immediately, a heart catheterization was performed on the tiny girl.

What the doctors and technicians saw was not good. "The small heart was blocked, had two holes in it and the arteries were reversed," says the baby's father.

A pacemaker was the only thing to keep it beating.

A temporary pacemaker was used until the hospital could have the correct infant ...

When the ... from the ... implant he ... responds to tender, lov... family is swathed in anxi...

They know there are m... ahead. "One will have to b... six months to a year," sa... father.

According to the doct... three more surgeries will ha...

LAS VEGAS SUN — Sunday, November 16, 1975

Paradox Of The Aged: Burdening The Young

...ERT P. STUDER
...ey News Service

SACRAMENTO — The ... too often is tragically

the same the elderly grow to be too much of a burden for the young folks at home, busy building their own ...

... with proper care.

... home ... them ... to care for ... elderly ...

Most of ... to die

... with Health Department ... "It's really no ... that there are a lot of ... in the nursing home business for purely monetary purposes. As it is now, ... operator makes ... by ... an ambulatory pa... ...

Money is also saved ...

Original document is of poor quality

Fr[illegible], Aug[illegible] 1976 — Las Vegas Review-Journal

Iron lung does housewife's breathing

Original document is of poor quality

Tuesday, October 14, 1975—Las Vegas Review-Journal

Hospital turns off boy's life without parents' okay

FRESNO, Calif. (AP) -- The parents of a youth who died after his life-support system was shut off say they did not give doctors permission to unhook a respirator that kept their son alive for 18 days after his brain was destroyed through medical error.

Mr. and Mrs. Pete Uribes said they did not know how their 19-year-old son, Sammy, died until they read in the newspapers that the hospital had disconnected the respirator that had kept him breathing.

In a report filed Sept. 11 by Valley Medical Center's chief resident surgeon, Dr. Michael Freeman, the hospital said [illegible] brain had died and that the couple agreed the respirator should be shut off.

The hospital said the mistake made by the anesthetist, who has since been fired, was "contributory" to Sammy's death.

George Carter, attorney for the Uribes, said the couple "never consented to taking him off (the respirator). They were told that the hospital had decided after a [illegible]

[illegible] legal right to do so.

In Sammy Uribes' case, the parents say they did not ask doctors to let their son die.

Sammy was taken to the hospital on Aug. 15 for treatment of a stab wound in the abdomen. It was when surgeons were trying to repair his punctured stomach that the mistake was made by the anesthetist.

He was placed on a mechanical [illegible]

found out, not from the hospital but through the newspapers, how their son died.

"It's a unique situation when it's the hospital's negligence that causes the boy to be in the position he's in, then they make the decision to take him off the respirator."

Lauren Bowytz, associate administrator at the hospital, declined to comment on the case, [illegible]

patient's life, even if parents give their consent, Carter said. And in Sammy's case, his parents could not have made such a decision for him because he was not a minor, Carter said.

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Fashion Eyeland Optical
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in the Tropicana Plaza

8B —Las Vegas Review-Journal— [illegible]y, Oct[illegible] 9, 197[illegible]

Medical miracles pose question of definition of deat[h]

The Washington Post

WASHINGTON — She was dead when she was wheeled into the admission area of the Maryland Institute of Emergency Medicine — the Shock Trauma [illegible]

says, between deciding not to turn on a respirator and deciding to turn one off.

The Jesuit father and others like him note that [illegible] desperately ill patient's [illegible]

obviously would have decided against turning on the respirator.

Doctors, patients and families have been making such determinations [illegible]

the patient is either senile or comatose and cannot participate in the decision-making process.

Under those circumstances, the physician [illegible] the relatives [illegible]

always been a private, if not secret, affair.

Because Karen Ann Quinlan's physicians and parents could not reach a decision [illegible]

Whatever the decision, it is one that will haunt us for years to come. For if the court decides that the family has the right to turn off the respirator, and if that [illegible]

Jersey attorney general has warned, open the door to mercy killing. Such a court ruling, clearly, necessitates the passage of stringent laws regarding the [illegible]

If, on the other hand [illegible] decides against the fa[illegible] Karen Ann Quinlan is [illegible] to "live," our hospital[illegible] ing homes [illegible]

A Story of Courage

New Doctor Is First Blind Person to Graduate From a Medical School in 100 Years

By DEN[illegible] D'ANTONIO

"[illegible] is a disability — but it doesn't have to be a handicap," said David Hartman, the first American in a century to start and complete his medical studies while totally blind.

"I believe I'm living proof of that. And I hope in some small way I've pointed the way for other men and women who've lost their vision — shown them nothing's impossible."

For 27-year-old Hartman, [illegible]

I'd have to get a friend to read them to me. It got me down after a while."

Down, perhaps — but far from out.

Temple's gamble and Hartman's fierce determination to succeed paid off — he's now a qualified doctor. Declared [illegible]

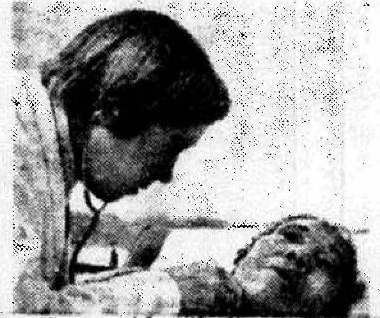
man studied anatomy by touch alone, helped deliver a baby, and even performed a successful tracheotomy on a dog.

Once, during an anatomy class he achieved a small but significant victory that went a long way toward boosting his confidence.

tor, but what's equally important when you're blind is to know that other people believe in you, too."

Hartman paused and reflected for a moment. "You have to have a sense of humor to counteract some people's prejudice — those who see me as blind first and as a person second," Hartman explained.

"I remember once at a [illegible]



"I understand," he said, "that you bring along a chaplain to pray for the team. I wonder if I could meet him to interview him for my paper."

"I'm sure that could be arranged," replied the pleasant young man, "but which one do you want, the offensive or the defensive chaplain?"

— Parts Pups

He Used to Dream of Suicide, Now He Earns $35,000 a Year . . .

Paralyzed Polio Victim Runs State Agency That Once Told Him He Was Too Crippled to Be Helped

By DON HORINE

Fourteen-year-old Ed Roberts lay in his hospital bed . . . his mind methodically devising a way to kill himself.

The young athlete — his body ravaged by polio — lay helpless, paralyzed from the neck down.

The cruel disease that left the boy so hopelessly crippled had left him only a slow, agonizing means of suicide — he would starve himself to death.

Today — 23 years later — Roberts earns $35,000 a year as the director of the California Dept. of Rehabilita- [illegible]

spends his nights in an iron lung and part of his days on a respirator. "There was a time when I felt worthless as a person. Now I feel exactly the opposite. I care a lot about myself."

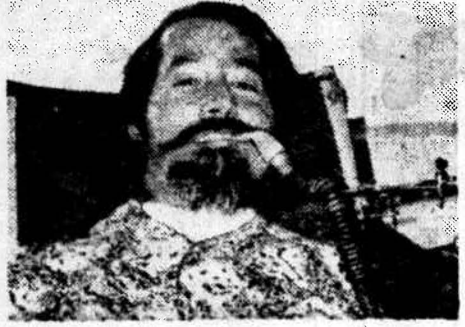
How did this paralyzed man make the incredible leap from potential suicide to "Super-Crip"? His is a unique, inspiring story.

"Until I got polio, I didn't really [illegible]

ma. So I stopped eating. I starved myself almost to death."

But then two things changed Roberts' outlook. "First my mother began giving me an occasional kick in the butt," he recalled. "She wasn't hostile, but she encouraged me to stop feeling sorry for myself.

"The other thing was that my special duty nurse left, and there was no [illegible]



New 'Nerve Pacemaker' Lets Crippled Multiple Sclerosis Victims Walk, Talk and Even Dance Again

Victims of crippling multiple sclerosis are being given the power to walk, talk, live normally and even dance again — with an amazing new "nerve pacemaker" implanted in their bodies.

[illegible] Column [illegible] — the [illegible]

Mrs. Green was struck down at age 24 by the dread MS and wound up in a wheelchair.

"My legs and hands felt as if they were dead," she told The ENQUIRER. "I lost my voice — I couldn't even talk properly — and my handwriting got so bad the bank wouldn't take a check from me. My face also started [illegible]

my left eye. I was told there was no cure and that I'd never walk right again. One doctor said I could expect to live only another year or so."

Then, last February, she was given a neuropacemaker at St. Vincent's Medical Center in Jacksonville.

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Ann Landers

Answers Your Questions

Address all correspondence to P.O. Box 1400, Elgin, Illinois 60120.

Dear Ann Landers: "Amen" to the reader who signed her letter "A Relative." I go to see my elderly mother at least once a week and after each visit I am depressed. Fortunately I have an understanding husband who goes with me. I could never make it alone.

It's impossible to carry on an intelligent conversation because Mother is so deaf. So we sit for what seems like an eternity and listen to her crazy chatter.

She is crippled with arthritis, otherwise is in excellent health for 88. Mother made a complete recovery from a breast removal a few years ago but she still insists "there's a lump."

She is very comfortable in a large, well-run nursing home with excellent care. Many people there are a lot worse off than she is, but she's never satisfied. All she does is complain.

It's so sad to see those old folks sitting around waiting for the next meal. They have nothing to look forward to. Some of them don't even know what day it is. I sometimes wonder if it's right to keep these people alive. I pray a lot. — Also A Relative

Dear Also: Of course it's "right" to keep them alive. The alternative is murder.

I receive dozens of letters from people who work in nursing homes. They ask me why the relatives of these old folks don't come to visit them. Loneliness is the worst part of it, I'm told. If only the sons, daughters, grandchildren, someone — ANYONE — would drop in for half-an-hour, it would make such a difference. Those old folks, as you say, have nothing to do but [illegible] and wait for the next [illegible]. I have a [illegible] insist you want more responsibility, but you can't even do what is required of you in school. You are a terrible time-waster. You have no goals. You've lost your initiative. You can't stop "sailing" long enough to see that you have become a dreamer instead of an achiever.

Perhaps life is easier when you coast along—no struggle, no ambition, no chance to fail because you never try anything.

I used to be where you are today but I got off that treadmill and back to living again. It only cost me $1. I sent for an Ann Landers booklet, "Straight Dope On Drugs." It was then that I began to see things "crystal clear."

It was the smartest dollar I ever spent in my life. Why don't you do the same? — Born Again In Michigan

Dear Born: Thank you for the testimonial. I'm glad my booklet helped. If anyone wants it, just send $1 to P.O. Box 1400, Elgin, Illinois 60120 and enclose a self-addressed envelope with 20 cents postage.

Dear Ann Landers: Please tell "Crystal Clear" that two years ago I was where he is today. Reading his letter brought back some vivid memories.

I was into pot very heavy and I was convinced it was sharpening my senses, making me more aware of the beauty of art, nature, music, sex, enhancing my hearing and my taste buds. Baloney, horse manure, and balderdash, Buster.

Dope only removes you FROM reality. It doesn't improve one damned thing. The paintings are the same, the music is no better, the pizza is the identical stuff that was put in front of you before you lit up, and sex — well, if you can hack it it's OK, but it actually unlit the fire.

ANN LANDERS

Answers Your Questions

Dear Ann Landers: I was struck by the poignancy of the poem by R. B. Richards, Palos Verdes [illegible], Calif., "Pardon Me Doctor But May I Leave."

The old gentleman had buried his wife, most of his friends were gone, his children were grown and on their own, his work was done, he was tired and sick — very sick — and he asked the doctor to take away all those tubes and machines and let him go in peace. That plea was one I hope will make an impact on doctors everywhere.

I have another poem, which I hope you will print.

Put Out The Flame

"I do not fear death, physician,
As much as I fear the indignity
Of hideous deterioration."
Thus Euthanasia's [illegible] spoke openly.
"Kind doctor, when that certain time arrives,
When I am not productive anymore,
Or cannot add to my fellows' lives
Or with excruciating pain am sore —
Then I beseech thee in God's holy name,
Perform thy greater Hippocratic role
The hour unknown to me, put out the flame
Within my body and release my soul
To take its journey to that Reservoir
Where all departed souls and angels are." — Boston Globe Reader

Dear Reader: Sorry, but there's a big difference between keeping a terminally ill person alive through extraordinary measures, and "putting out the flame."

To "put out the flame" suggests to me at least, that something be done to end a life. I am not in favor of this. The old gentleman who pleads, "Let me die," is asking that the flame be permitted to go out, but to PUT

Blind for 61 Years—Then an Accidental Bump Restores Man's Sight

"I can see! I can see!" shouted Carl Allen, throwing his arms around his startled wife. "You're even lovelier than I'd pictured."

It was too much for Mrs. Eileen Allen to comprehend all at once — her husband had never gazed upon her face in all the years of their marriage.

"Then it hit me," Mrs. Allen [illegible] and excited, prepared for it all to disappear ... but it didn't. I wanted to cry out, 'I can see,' but I just sat there for 11 hours. I wanted to be sure my sight wouldn't fade before I told Eileen."

Just before midnight, Mrs. [illegible]er. "We laughed and cried, dancing around the kitchen."

Allen was examined by Dr. Thomas Barnett, an ophthalmic specialist, who said: "His left eye is improving all the time and there's little doubt he has regained permanent

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It was too much for Mrs. Eileen Allen to comprehend all at once — her husband had never gazed upon her face in all the years of their marriage.

"Then it hit me," Mrs. Allen recalled to The ENQUIRER. "Carl could see after almost a lifetime of blindness!"

The incredible recovery — and excited, prepared for it all to disappear . . . but it didn't. I wanted to cry out, 'I can see,' but I just sat there for 11 hours. I wanted to be sure my sight wouldn't fade before I told Eileen."

Just before midnight, Mrs. Allen was making tea in the kitchen when her husband rushed in, hugged her and shouted that he could see.

"It was such a thrill to be er. "We laughed and cried, dancing around the kitchen."

Allen was examined by Dr. Thomas Barnett, an ophthalmic specialist, who said: "His left eye is improving all the time and there's little doubt he has regained permanent sight in it. I'm astonished."

Dr. Cahill, who had treated Allen in 1959, expressed delight over the recovery. "This is the closest I've ever come

Little Town With a Big Heart Raises $45,000 to Save Teenager's Life

"I knew I was dying — and I so badly wanted to live. I just didn't know where to turn for help."

With those words, teenager Alice Demick recalled her plight last August when she needed money for a costly operation to save her life.

By JOE WEST

And she's alive today because she lives in Freeburg, Ill. — the town with a heart.

There are only 2,500 people in this tiny manufacturing community near East St. Louis — but they dug deep into their pockets and raised $45,000 to finance the bone marrow transplant 17-year-old Alice so desperately needed.

Her eyes misting with tears, Alice told The ENQUIRER: "I always thought that perhaps some of the peo- volved. I'm really proud of the way the entire town got behind Alice and reached into their hearts for her. Even the people who couldn't afford to give a lot of money got involved in some way."

Polly Mead, Alice's high school English teacher and one of the key people in the fund-raising effort, agreed:

"Contributions ranged from 98 cents a little boy took from his piggy bank

GRATEFUL Alice Demick (front row, center) with sister Rita (front left), teacher Polly Mead (front right) and other townspeople.

Doctors Said He'd Never Walk Again but, 7 Months Later, Courageous Youth Steps Across Stage to Get His Diploma

By MALCOLM BALFOUR

There was a hush at the high school graduation ceremonies when the principal called the name of the last graduate: "David McNamara!"

do you know what the pain means? It means your body is starting to work again."

Mrs. McNamara, widow of a Boston police detective, had given up her job as technologist in a local hospital while she stayed with the critically

ever lift my head. I just lay in the hospital bed for 12 weeks. They had to flip me over every two hours for two weeks, around the clock. I was dead weight. And the pain was unbelievable."

New Jersey RTL expresses concerns about Quinlan ruling

After carefully studying the March 31, 1976 New Jersey Supreme Court's decision in the Quinlan case, the New Jersey Right to Life Committee (NJRTLC) has come to the conclusion that the decision is moral and sound, but "several of the justifications cited by the Justices have ominous overtones when studied in depth."

In a statement released recently, the group expressed concern for "the Court's reference to 'cognitive' and 'sapient' as qualitative criteria for a human life." They fear that this criteria "has effectively opened the door to future reinterpretation, so as to be applicable in subsequent cases."

The committee statement continued: "'Cognitive' means to know, to recognize, or remember. Could not this interpretation of the Court then include large segments of the retarded, the mentally ill, and the senile? Could these persons not be considered as incapable of a 'cognitive' existence?

"'Sapient' means wise and in the words of . McCarthy DeMere, chairman of the American Bar Association's law and medicine committee, this would automatically eliminate most of the human race.' Certainly, at the very least, this wording of the Court sets a rather capricious and arbitrary criteria for just who is worthy of continuing their life."

The right to life group also expressed concern over a recent report (Vol. 2, No. 2, May, '76) by the Euthanasia Educational Council. The report stated: "The decision (Quinlan) . . . goes a long way toward setting a strong precedent for future treatment of the 'irreversible, terminal pain-ridden patient' and particularly the incompetent patient." The New Jersey Attorney General also said that the N. J. Supreme Court decision could, indeed, include the exclusion of food and or antibiotics as "life sustaining."

The committee report concluded: "We uphold the philosophy of every human life being of worth and would remind the public that the concept of utilizing death as a solution to life's problems. . . . 'began with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. (Dr. Alexandria, "Medicine Under the Nazis," **Private Practice Mag.**, Dec. '75).

"We, the New Jersey Right to Life Committee, fear that, in reality, this is the precedent set by the New Jersey Supreme Court in its landmark decision of March 31, 1976."

Doctor suggests that "human-looking forms" be mercifully put to death

An article in the **New England Journal of Medicine**, (Vol. 294, No. 15), written by John Lachs, a Ph.D. from Vanderbilt University, calls for beings that are only "human looking shapes" and "treated as though they were human, in spite of the fact that they lack the least vestige of human behavior intelligence or feeling," to be "mercifully put to death."

Lachs continuously calls children born with hydrocephalia (water-heads) and unconscious or ailing patients with little hope of recovery, "non-persons." Since these people are "non-persons," he writes that it is not necessary to treat them as humans, but instead treat them humanely, like one would treat an animal.

Lachs also says: "I believe that moral decisions invariably involve persons, and the only persons involved in such situations as the one I have just described (an infant born with hydrocephalia) are the physicians, nurses, parents and siblings of the patient. The child itself (and to make the point more forcefully, I should not even call it a 'child') is not a person, and the fundamental error of our ways consists in thinking that it is one."

In the article, Lachs maintains that these "human-looking forms" that he calls "non-persons" are treated on the basis of our eyes and not our heads. He says that emotions will not let people treat these human-looking forms as anything but human.

"The fundamental error our senses and emotions cause is to demand that we treat everyone who looks and used to act like a human being as though he continued to be human to the last," writes Lachs.

Lachs says he realizes some of the dangers connected with allowing euthanasia and recognizes that, if physicians or nurses are permitted to put anyone to death, the practice may quickly develop into a habit. "It is perhaps better to bear the cost of thousands of non-persons indefinitely sustained," he writes, if the alternative is to face a growing, gnawing habit on the part of those who should save lives to take them instead, in the name of mercy."

He asks whether euthanasia would be just and uniform or if the indigent, drug addicts and prostitutes would be disposed of before the stalwart and well-to-do members of the community.

But despite these dangers, Lachs concludes: "This system would indubitably mean the termination of life for some. But the system, if rightly conceived, would not condone murder. For those humanely put to death would not be human beings, only human forms."

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'I Can't Go Around Worrying About Dying . . . I'm Too Busy Living'

. . . Says Brave 12-Year-Old Girl With Cancer

managed to make life a little more beautiful for everyone around her."

Paris lost her right leg to cancer five years ago and has undergone seven major operations since. Yet she has bounced back every time, amazing her doctors and inspiring [illegible]

"With [illegible] you think it has to be [illegible] the human body

you know it she's back out on her motorcycle or going off with the other kids to go ice skating.

"She just doesn't let her illness or the loss of a leg stop her."

Pete Bokavich agrees. "She's got more

hard one to her I heard a really loud 'thunk.'

"You know what that great little kid was doing?" Bokavich laughed. "She was knocking those balls down with her artificial leg so they couldn't get by her.

"I'm the coach and I'm the one who's supposed to be inspiring these kids. But

but the summers kept coming and Paris still in there plugging away.

"I've never seen anyone like her befo[re] — and I don't expect to ever again."

At her home in Hayward, near San Fra[n]cisco, Paris' mom talked about her daught[er]

"She's so alive! She infects everyo[ne] around her with her enthusiasm and co[ur]age. We don't talk death too much, but

Ann Landers

Answers Your Questions

Address all correspondence to P.O. Box 1400, Elgin, Illinois 60120.

Dear Ann Landers: I'm a teenager who never thought the day would come when I would be writing "Dear Ann" but it has. Maybe I can help some of your readers who had the same problem I suffered with for years.

My brother is brain-damaged. Until today, I was very impatient with him because he got more attention from my folks than I did. Last night my father explained to me for the first time exactly what is wrong with my brother. He told me how hard he has to ...k to do simple, ordinary ...gs and how much progress ...as made in the last few years. I know now how frustrating life must be for him and I respect him very much for the way he is trying to cope with his handicap.

Now I see him through different eyes. I love him and admire his courage. Please pass this on, Ann. — JB

Dear JB: What a beautiful letter! It's too bad your father didn't talk to you a few years ago. You would have been wiser sooner and your brother's life as well as yours would have been easier. Thank you for writing.

Dear Ann Landers: I was widowed four months when I met Alex. He was recovering from a broken romance that had lasted for seven years.

Alex has been married for 20 years but to a woman he doesn't care for. He tells me he loves me very much and would like to marry me, but he ...t want to upset his wife ...ildren.

I thought I was getting away with sneaking Alex in and out of my bedroom for the last ... months. We would arrive ... my 13-year-old d... ...Helen, went to ...

Well, Helen saw Alex leave this morning and I thought I would die. She informed me that the neighbors told her what was going on but she didn't believe them. Seeing him with her own eyes was quite a shock.

Now Helen is begging me to move to another city because she is ashamed to face her friends. Money is no problem, Ann. I can live comfortably anyplace. The trouble is — I love Alex and believe he will marry me if I just give him time. Please advise. — In A Quandary

Dear Quan: The other dame gave him seven years and he didn't marry HER. I can't improve on your daughter's advice. I hope you take it — and the sooner the better.

Dear Ann Landers: Will you please tell your readers that just because a person hardly ever smiles or laughs it doesn't mean he is a sourpuss?

I'm a young man who, unfortunately, was not blessed with a happy face. But it's the only face I have and I can't force myself to put on another one. I am sick to death of people coming up to me and saying, "Why don't you smile? You look so glum."

I know several people who laugh a great deal and I'll bet most of it is put on. I don't want to be one of them.

It's too bad I wasn't ble... with a cheerful look and ...py smile, but I am wh... and I wish peopl... assume I'm an o... suggestion... Penns...

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First Person Without Hands Licensed as A Truck Driver in California

...te a semi if you've lost an arm, leg, hand or foot.

"I didn't give up. I talked to the department director and convinced him to let me take the class-one truck driver road test after I went through truck driving school."

Bill Fisk, a state motor vehicles official, told The ENQUIRER: "With any amputee, the decision is up to the department.

"De Ford was incredible. He came in here with a 13-gear semi and scored about 10 points more than the average first-time trucker.

"You have to hand it to a man like De Ford. There's nobody without both hands ... California driving trucks."

De Ford had scored 97 out of a possible 100. "I would've scored 100," he said, "except I was so nervous that I gave him a right-hand turn signal when the tester asked me to show him a left-hand turn signal."

COURAGEOUS Richard De Ford, seen in cab of his semi, scored amazing 97% in his first truck driver road test.

A Poor Gamble

Finally, at bedtime, when Barbara said, "I'm all worn out," little Diane shot back: "I'm not — because I'm NEWER!"

— Catholic Quote

...er Gives His Heart, Time and Money Helping the Handicapped

...elp to the helpless, comfort to those in distress, giving all you've got to total strangers without any thought of reward — that's what being a Good Samaritan is all about. Good Samaritans are people who sacrifice their time, their energy and often their money to help others — people like Philip Hayes of Scarborough, Ontario, Canada. We believe these people deserve recognition — and that's why we've established The ENQUIRER Good Samaritan Award. If you know of such a person, please write us and give us all the details. If we publish a sto... your Good Samaritan, he or she will receive $50 and a Certificate of Recognition. Include your name, address and phone number when you write to: Good Samaritan, NATIONAL ENQUIRER, Lantana, Fla. 33462.

ENQUIRER GOOD SAMARITAN

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International 3-Man Team Develops . . .

Inexpensive Treatment for Thousands of Kidney Disease Victims in Poor Nations

A simple, inexpensive new treatment for deadly uremia promises hope for countless thousands of kidney disease victims in poor nations [illegible]

mia has been tested on 62 patients in Taiwan and Northern Ireland so far. And Dr. Phillips reported: "I am satisfied it is an alternative to the kidney machine, which is terribly

must build up that will lead to diarrhea. It may sound horrible to some, but it might save thousands of lives around the world."

Said Dr. Eli Friedman [illegible]

Dad Whose Sight Is Restored After 31 Years Tells of...

The Thrill of Seeing My 4 Children for the First Time

Doctors slowly, carefully peeled back the bandages from William Renstrom's eyes — and suddenly, in one dramatic moment, a world he hadn't seen for 31 years came alive for him again.

A rush of light, shapes and colors flooded his field of vision. "I could see again — it was wonderful, marvelous," Renstrom told The ENQUIRER. "God had granted me a touch of heaven in advance.

"What a thrill it was to see my children and grandchildren for the first time! I never dreamed I would ever see them, or my lovely wife again.

"I guess I just stared at them for 15 or 20 minutes, drinking in their features and crying tears of joy," Renstrom said, his voice growing husky at the memory.

"I had not dared to dream this would ever happen. 'Here is a true miracle,' I thought, as I gazed upon their lovely faces."

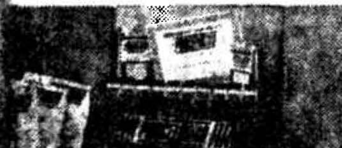
GOOD TO SEE YOU! William Renstrom looks lovingly at his wife, Ruby. He had seen her only a few times before he was blinded by a land mine explosion in World War 2, then came home to marry her.

Renstrom, 51, had seen his wife, Ruby, only a few times before he went into the Army in World War 2. They were married when he came home from the war — blinded by a land mine explosion in France. He had never seen his four grown children, Charles, 26; Bruce, 23; Scott, 21, and Lorraine, 19.

Then last summer an eye doctor told Renstrom, of Murfreesboro, Tenn., there was hope that an operation could restore the sight of his left eye. In September the operation was performed — and it [illegible]

dark hair and sparkling blue eyes. I just pulled her close to me and held her tightly. 'You're even more beautiful then I remembered,' I finally whispered to her."

Renstrom, a solo singer with the evangelistic program of Dr. Bill Rice in Murfreesboro, said: "I thank God for what He has done. Being able to see again is a miracle. It's hard



ENQUIRER Investigation of Greedy Nursing Homes Reveals . . .

Scandal of Old People Being Bought and Sold

Elderly Americans are callously being bought and sold in "one huge meat market" by unscrupulous nursing homes which make their money from human misery. And taxpayers are footing the bill.

In a shocking nationwide scandal known as "headhunting" and "bodyselling," some nursing homes pay from $100 to $250 per patient so they can collect the patients' financial benefits and Medicaid payments, reveal incensed experts who are investigating nursing homes.

And once these helpless old people are sold, they're often kept as virtual prisoners just so the nursing homes can collect payments on them.

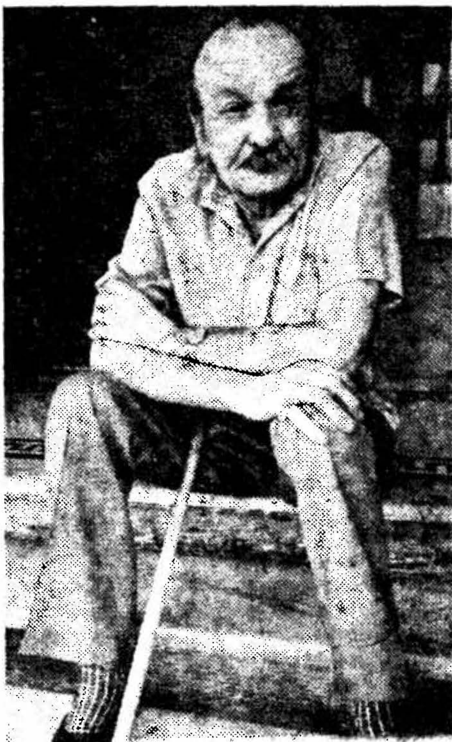
Prime sources for the body sellers are other nursing homes, hospitals and even, in one startling case, the courts.

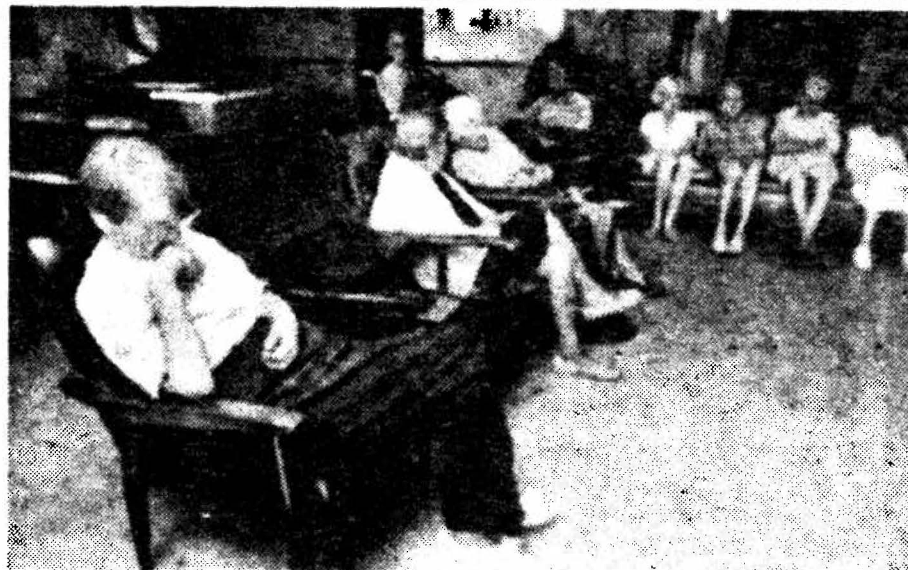
An ENQUIRER probe into this well-hidden scandal brought these incredible facts to light:

- At an auction held by a large New York nursing home going out of business, patients were sold to other nursing homes for the highest bids.
- A California man misrepresented himself to the courts as a member of an alcoholic rehabilitation group to get custody of arrested elderly drunks — then sold them off to nursing homes for $125 each.
- A New York rabbi sold patients to nursing homes for $150 to $200 a head, hiding his payoff under the guise of "religious counseling fees."

"We have touched only the tip of the iceberg in this problem — many thousands of these old people are being sold each year into substandard homes for the aged!" said Val Halamandaris, associate counsel for the U.S. Senate's Special Committee on Aging. "Time and time again we have heard this from informants in the nursing home business. But it's really hard to pin down.

"The problem lies mainly in the bad homes, the ones that can't get patients any other way. They starve their patients, feed them for less than $1 a day . . .





PATIENTS relax at a nursing home — photo is out of focus to conceal their identity. At some homes they are fed on less than $1 a day, and sometimes even beaten, reveals investigator.

group of X-ray technicians. So will doctors."

Sales usually occur when a patient is moved from a hospital or another nursing home, Halamandaris said, adding that both the state and federal governments have the responsibility to stop these human auctions because of the public money involved.

Dr. Jack Weinberg, director of the Illinois State Psychiatric Institute, was indirectly offered $100 a head by a nursing home bounty hunter when he had the job of moving more than 7,000 elderly from state hospitals.

"A nursing home representative ask . . .

tients and couldn't find a nursing home with an empty bed, he'd just drop the men off on Skid Row."

Weldon has since been convicted of selling six people to a nursing home under a California statute that makes it a crime to receive money for referring patients to medical institutions, Cast-

Val Halamandaris
"Thousands of old people are sold into homes for aged each year."

...ientists Working on Project Say . . .

New Device Will Enable People to Control Machines Merely by Moving Their Eyes

...rsity, said: "This is a dramatic breakthrough. It's the first time a computer has been hooked directly to a person's brain.

"The potential for such a hookup is incredible. The day of the bionic man — with immense strength and mobility — may soon be at hand."

With this device, people is-[illegible] ...ing their eyes. The eyes flash a signal to the brain — where electrodes attached to the scalp pick up the resulting electroencephalograph (EEG) signals and relay them to a computer.

The computer then draws on its memory to follow the directional order.

In experiments at UCLA, subjects successfully used [illegible]

Experts Say It's a Problem Throughout U.S. . . .

Handicapped Children Forced to Live in Hospitals Where They Were Brought for Treatment by Parents—Then Abandoned

Seven-year-old Tony has lived at New York's Kings County Hospital since he was 2 years old . . . he has no place else to go.

The adorable redhead with several teeth missing suffers from psychomotor retardation and epilepsy . . . but mostly he suffers because his mother has abandoned him in a hospital when he would be far better off at home. Tony has no friends, few toys, no concept of what a normal, loving home is like.

He is only one of a number of children throughout the U.S. — no one seems to know how many — for whom hospital wards have become home . . . even though the children could be treated at home.

"He was brought here for epilepsy. His mother refused to take him back because she felt she couldn't handle him," [illegible] him and now he thinks every female he sees is his mother. The hospital has done everything possible for him — but it's not the same as home."

Tony is one of three children currently at Kings County Hospital known as "Boarder Babies," according to Director of Social Services Beverly Sa[illegible]ders. "They have been here for years. But they don't need to be here — in fact they shouldn't be here.

"Almost any municipal h[illegible]

...ber her turning to the Presi-... dent once and saying in mock | ... Kennedys. He recalled for The

— JAN GOODWIN

Incurable Disease Linked to 'New Sexual Morality' Is Sweeping U.S.

. . . Leading Doctors Warn

An incurable disease, linked by doctors to "the new sexual morality," is sweeping the country in near-epidemic fashion.

Called herpes simplex type 2, it already has infected an estimated quarter of a million Americans, and some estimates go much higher.

Affecting the genitals with blisters that often are extremely painful, the disease can lead to serious complications.

"If herpes attacks the eye it can cause blindness, and if it inflames the central nervous system it can lead to brain damage. This is because meningitis or encephalitis sets in and in these cases is often fatal," said specialist Dr. James Louis Pipkin.

An official of the Center for Disease Control in Atlanta, said: "The most commonly estimated figure for the number of people now suffering from herpes simplex type 2 is 250,000, but I believe that is just the tip of the iceberg."

[illegible] type 2 was identified only six years [illegible]. It is spread by sexual in[illegible] as a venereal disease. [illegible] call it 'the venereal disease of the new morality.' It is closely allied to herpes type 1, a viral infection that frequently shows up in the familiar and far less serious cold sore on the lip or mouth.

"As sexual promiscuity has become more and more widespread, so herpes 2 virus has taken bigger and bigger hold," said Dr. Pipkin, clinical professor of dermatology and syphilology at the University of Texas.

"I have noticed an incredible increase in the number of people suffering from it, and in the last five years it seems to have grown 50 times over."

Once caught, the virus lurks in the system and can erupt again and again. No remedy for it is available in this country, but Dr. Pipkin said: "Doctors in Germany have been using a drug called Lupidon G, which completely destroys the virus. The Food and Drug Administration (of the U.S.) is now testing the drug, but that could take another three or four years. By that time, I dread to think how far the virus will have spread."

Dr. Paul Wiesner, chief of operational research in the Venereal Disease Control Division of the Atlanta center, described other dangers of the virus. "It is possible for a woman to have herpes for years without knowing it, because the blisters usually erupt within the mouth of the womb.

"If a woman is pregnant when she contracts venereal herpes, there is a very good chance that the virus will be passed on to the baby." Doctors say that for infants who are infected in this way, the disease can be fatal.

"The chance of a miscarriage is also increased if the mother has venereal herpes," said Dr. Wiesner.

Doctors are now studying possible links between venereal herpes and cervical cancer, leading many sufferers of the viral infection to undergo what one official called "a cancer hysteria."

Dr. Nicholas Fiumara, chief epidemiologist for the state of Massachusetts, told The ENQUIRER: "Herpes 2 and the hysteria over this infection are reaching fantastic proportions. People who have contracted this venereal infection are terrified they're going to develop cancer."

Dr. Andre Nahmais of Emory University, who first identified the herpes 2 virus, said: "People have had the hell scared out of them. I must say emphatically that the herpes 2 infection has not been proven as a cause of cancer."

— DAVID KLEIN

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Peggy Lee: After 14 Years, I'm Free of the Agony of My 'Iron Lung'

"I'm lucky to be alive today," confessed Peggy Lee.

With that dramatic statement, the glamorous singer revealed for the first time that she's won her painful 14-year fight for the breath of life — and she's no longer tied to her respirator machine.

"It was extremely traumatic for me," said Peggy, relaxing between shows in her dressing room at the Flamingo Hilton Hotel in Las Vegas. "My image is one of softness, femininity, glamour I didn't want my audiences to think of a cold metal machine keeping me alive.

"So I did everything in my power to keep stories of my 'iron lung' out of the press. It was a very lonely thing — bearing my secret."

Peggy's battle for life began in 1961 She suffered a serious attack of double pneumonia and pleurisy, which caused extensive lung damage. From that time until a few months ago, her only hope for survival was a machine.

"It's called the Bennett Positive Pressure Respirator — and every day I had to take four or five treatments," said Peggy. "The sessions were long and painful. Cascades of steam were pumped into my lungs. The steam was composed of air enriched by pure oxygen, and it cleared the deadly congestion accumulated in my lungs.

"Without the treatment, I would have died from lack of

SINGER Peggy Lee would have died without treatment from respirator.

an ailment. After every treatment I'd suffer severe coughing spells Occasionally I'd end up in the hospital again.

"I became so dependent on the machine — which fits into a small trunk — that I bought another one just in case the first one broke down. Both machines went with me everywhere. I called them Charlie 1 and Charlie 2, because they didn't seem so formidable with people's names."

Strangely enough, Peggy learned her ordeal was over when she injured her head in a bathroom fall. "As I was being examined for that, the doctors gave me a thorough checkup — and told me my lungs were so improved I didn't need Charlie anymore."

NEVADA LICENSED PRACTICAL NURSES ASSOCIATION

member of

NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.

Feb.28, 1977

Re: AB 8
SB 200

Committees on Judiciary

Mr Chairman
&
Members of the Committees

I am Ellen Pope. I live at 1298 Lovelock Hwy, Fallon, Nv. I am the Chairman of the Legislative Committee of the Nevada LPN Association.

Prior to the introduction of AB 8 and SB 200, my Association went on record as supporting a "Right to Die" bill.

Several colleagues and I have read AB 8 and SB 200 and believe that the language of the bill requires that a person be in a terminal condition before he can execute the declaration.

The question in our minds is: If this bill becomes law and if I were to write a declaration today and if I should be in an auto accident on the way home next week resulting in head injuries to myself that leaves me in a coma; or if I should have a cerebral vascular accident; or if anything should happen that I would suddenly cease breathing for long enough that I would sustain brain damage so that I could continue to live but be a "vegetable"-- will the language of the bill be interrupted to direct that life sustaining procedures be withheld or withdrawn?

We know that we are not lawyers but we feel that the language is not clear enough. It seems to us that the patient must be terminal at the time of the writing of the declaration because of Sec. 11 subsection 4 of the declaration which reads "I have been diagnosed as having a terminal condition.".

The changes we would recommend are minimal and we ask for your consideration of them.

Using SB 200. See Section 10 line 5.

Change to read: "withholding or withdrawal of life-sustaining produres from him when, OR IF, he________________

 EXHIBIT C

And in the declaration itself:
SB 200. Section 11 subsection 4 lines 33, 34 and 35 should be deleted.

As nurses we have found that the conscious ~~pa~~ terminal patient can and often does refuse treatment or procedures that only results in the prolonging of their agony.

And we like Section 20 of SB 200 that isn't found in AB 8.

Thank you for taking these thoughts into consideration. We are fearful that the bill as now written leaves too much to individual interruption. Please make it more clear.

Ellen Pope
Ellen Pope LPN
Registration #77-380
Nevada Licensed Practical Nurses Association
1298 Lovelock Hwy
Fallon, Nevada 89406

GUEST LIST

NAME (Please print)	REPRESENTING	WISH TO SPEAK Yes	WISH TO SPEAK No
John P. Sande, MD	Nev. State Med. Assn	X	
Richard G. Pugh	Nev. State Med. Assn		X
Ellen Pope	Nev LPN Assn	X	~~X~~ man
Ruth McGroarty	Right To Life		X
Ann M Hilke	Nev Nurses Assoc	X	
Bonnie Hickson	Nev Nurses Assoc	X	
John McSweeney	Div for Aging		X

ASSEMBLYMAN
CLARK COUNTY DISTRICT NO. 5
723 SOUTH THIRD STREET, SUITE 202
LAS VEGAS, NEVADA 89101

MEMBER
ENVIRONMENT AND PUBLIC RESOURCES
HEALTH AND WELFARE
JUDICIARY

Nevada Legislature

FIFTY-NINTH SESSION

February 24, 1977

ANALYSIS AND RECOMMENDATION CONCERNING AB 8

Comparison with California Natural Death Act

I. CONCLUSION

It is recommended that AB 8, known as the right to die bill, be adopted providing that certain amendments are made. Basically further protections which exist in the California law need to be added. Additional protections which were not enacted in California should be considered.

II. THE CALIFORNIA NATURAL DEATH ACT

The history of California's Natural Death Act begins in 1974. [Cited as Division 7, Part 1, Chapter 3.9, (commencing with Section 7185) of the California Health and Safety Code and hereinafter sometimes referred to as the Natural Death Act, the California Act, or the Act.] California Assemblyman Barry Keene, chairman of the California Assembly Committee on Health, introduced a bill in the 1974 session of the legislature which proposed that every person should have the right to die without prolongation of life by extraordinary medical procedures. However, this 1974 bill (AB 4444) failed to become law. In September of 1976, Governor Brown signed into law a far more detailed bill (AB 3060 - the California Natural Death Act) authored by Mr. Keene. The primary difference between the 1974 bill (AB 4444) and the 1976 Act (The Natural Death Act) was the additional safeguards which were included in the 1976 Act.

A major safeguard of the Act is a requirement mandating that the signing of the directive to physicians must be witnessed by two people not related to the patient, his doctor or the hospital. Witnesses also may not have any claim on the prospective estate of the patient. For nursing home patients, one of the witnesses must be a "patient advocate or ombudsman"[1] designated by the State Department of Aging. The California Act states that, "The intent... is to recognize that some patients in skilled nursing facilities may be so insulated from a voluntary decision-making role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of willfully and voluntarily executing a directive."[2] Other major safeguards included in the Act are as follows: (1) a directive (as defined in Section 7187, subsection (b) of the Natural Death Act) is valid for up to five years but

may be revoked at any time, either orally or in writing;[3] (2) the Act specifically forbids mercy killings, and recognizes that excepting the action by which a doctor permits the natural process of dying is not mercy killing;[4] (3) two doctors must certify that the patient's illness if terminal before the patient's directive can be carried out;[5] (4) life insurers are prevented from requiring anyone to sign a directive in order to obtain coverage and are further barred from denying policies or benefits to people who do sign directives.[6]

III. NEVADA ASSEMBLY BILL EIGHT: HOW IT DIFFERS FROM THE CALIFORNIA NATURAL DEATH ACT

AB 8 and the California Natural Death Act are very similar in form and content. However, there are a number of major differences between the two.

The first major difference between the California Natural Death Act and AB 8 may be found in Section 7187, Subsection (c) of the California Act and in Section 6 of AB 8. The California Act states in Section 7187(c) that a "'life-sustaining procedure' means any mecical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. 'Life-sustaining procedure' shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain" (emphasis added). The corresponding section of AB 8 (Section 6) is worded substantially the same, except for the lack of the emphasis words which are not included in Section 6 of AB 8. This difference takes on the utmost importance when we examine California Assemblyman Keene's discussion of Section 7187(c) of the then (September 13, 1976) proposed Natural Death Act in a letter to California Governor Brown. Assemblyman Keene writes, "No provision is more essential to AB 3060 (the Natural Death Act) than the definition of life-sustaining procedure [Section 7187(c)]. The definition is intended to reflect the contemporary medical, legal, bioethical, and theological literature which states that the scope of life-sustaining is dependent upon the purpose for which the procedure is utilized. The definition in AB 3060 obligates the physician to review the patient's condition to determine whether the procedure is being utilized solely to artificially prolong the patient's death and whether the patient, in the reasonable judgment of the physician, will die irrespective of the intervention of such procedures."[7] There is a need for a complete definition.

The second major difference is found in Section 7188 (part 4 of the directive to physicians) and in Section 7191, subsection (b) of the California Natural Death Act. The California Act

requires that the directive to physicians shall be conclusively presumed to be the directions of the patient if he was a qualified patient at least 14 days prior to executing the directive.[8] AB 8 has no such fourteen day inclusion.

The third major difference is found in Section 7188 (part 5 of the directive to physicians) of the California Natural Death Act. Although both the California Act and AB 8 set forth the provision that the directive to physicians be effective for a period of five years [see Section 14 of AB 8 and, in the California Act, see both Section 7188 (part 5 of the directive to physicians) and Section 7189.5] only the California Act includes this important provision in the directive to physicians.

The fourth major difference between AB 8 and the California Natural Death Act is found in Section 7191, subsection (a) of the California Act. The latter part of Section 7191(a) states that "the attending physician shall determine that the directive complies with Section 7188, and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the desires of the qualified patient" (emphasis added). If we refer to AB 8, we find that the above underlined portion of Section 7191(a) of the California Act is not included anywhere in the bill (especially see Section 17, subsection 1 of AB 8).

The fifth major difference between AB 8 and the California Act is found in Section 7191, subsection (b) of the California Act and Section 16, subsection 2 of AB 8. Notice that Section 7191(b) of the California Act specifically exempts a physician or licensed health professional acting under the direction of a physician, from criminal liability for failing to effectuate the directive. It also exempts a physician from civil liability for failing to effectuate the directive unless he refuses to make necessary arrangements, or fails to take necessary steps, to effect the transfer of the patient to another physician who will effectuate the directive (in which case the physician in question is guilty of unprofessional conduct).[9] The latter part of Section 16, subsection 2 of AB 8 states only that, "A failure by a physician to follow the directions of a qualified patient constitutes unprofessional conduct if he refuses to make necessary arrangements to transfer the patient to a physician who will follow the directions of the patient." Notice that AB 8 does not directly address the question of the attending physician's criminal and/or civil liability, as does the California Act.

The sixth major difference between the California Act and AB 8 is similar to the fifth difference and may be found in Section 7191(c) of the California Act and in Section 16, subsection 3 of AB 8. Section 7191(c) of the California Act states (in regard to a declarant who has become a qualified patient subsequent to

executing the directive, and who has not subsequently re-executed the directive) that, "No physician, and no licensed health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision." The corresponding section of AB 8 (Section 16, subsection 3) makes no reference to the criminal and/or civil liability of the physician.

The seventh major difference between the California Act and AB 8 may be found in Section 7191, subsection (c) of the California Act and in Section 16, subsection 3 of AB 8. The California Act states in Section 7191(c) (in regard to a declarant who has become a qualified patient subsequent to executing the directive, and who has not subsequently re-executed the directive that, "The attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding or withdrawal of life-sustaining procedures and may consider other factors, such as information from the affected family or the nature of the patient's illness, injury or disease, in determining whether the totality of circumstances known to the attending physician justify effectuating the directive" (emphasis added). The corresponding section of AB 8 (Section 16, subsection 3) makes reference to "other factors" (page 3, line 47) but does not attempt to give examples of these factors.

The eighth major difference between the California Natural Death and AB 8 may be found in Section 7194 of the California Act and Section 18, subsection 2 of AB 8. The California Act states where justified or excused by law, falsifies or forges the directive of of another..." (emphasis added). The corresponding section of AB 8 (Section 18, subsection 2) omits the above underlined provision of the California Act.

The final major difference between the California Act and AB 8 may be found in Section 7195 of the California Act and Section 19 of AB 8. The California Act specifically states in Section 7195 that, "Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing..." The corresponding section of AB 8 (Section 19) omits such a specific rejection of mercy killing.

IV. THE PROS AND CONS OF THE NATURAL DEATH ACT

Since AB 8 is modeled on the California Act, it may encounter some of the same criticisms.

A major fear voiced by critics of California's Natural Death Act is that the Act may provide a license for doctors to kill the aged, the weak, and the poor by way of the doctor being able to coerce or persuade patients to sign directives and thereby authorize the termination of life-sustaining procedures. Memories of "the calculated euthanasia policy employed by Nazi Germany against cripples, mental incompetents, epileptics, the elderly and others

held to be socially undesirable"[10] are evoked by this criticism. Although few people draw a direct parallel between the euthanasia policy of Hitler's Germany and California's Natural Death Act, "voluntary death might be even more insidious (than the euthanasia policy of Germany in the 1930's) - (in that it would represent) democracy's use of a civil liberty to encourage what it cannot do by fiat."[11] As Dr. Alvin I. Goldfarb of Mount Sinai Hospital told a Right to Die symposium sponsored by the Group for the Advancement of Psychiatry, "The current preoccupation with death is a sign of ultraconservatism and authoritarianism..."[12] He added that a danger of this preoccupation is that "controlling forces within the establishment may decide for the living that their lives are considred of little value, that they may be killed or allowed to die at government whim."[13]

Supporters of the California Natural Death Act reject the notion that it could encourage euthanasia of weak and unprotected patients. These supporters argue that a person would have to suppose a conspiracy of physicians to come up with this idea. Supporters also point to the numerous safeguards contained in the Natural Death Act (see appendix for a listing of these safeguards) which they contend will reduce abuse of this Act to a bare minimum. Advocates further believe that the Natural Death Act could not, under any circumstance, be construed as an initial step on the road to euthanasia due to the contention, as enunciated here by the Reverend Richard McCormick of Georgetown's Kennedy Center for Bioethics, that, "There is a moral difference between killing and allowing to die. When you cease extraordinary effort, it is the disease that kills, not the withdrawal."[14]

Doctor Jerome Lockner, Director of the California State Department of Health, became a critic of the California Natural Death Act soon after AB 3060 (the Natural Death Act) went to Governor Brown for signing. The reason that Dr. Lockner is a critic of the Act and, in fact, urges complete revision of the Act is because he believes that the right to decline medical treatment should be as broadly available as possible.[15] He believes that by so narrowly defining the conditions under which a physician can withdraw treatment without fear of liability, the Natural Death Act may have implied that doctors are liable for ending treatment of patients who, although in terminal condition and requesting that they be allowed to die naturally, have failed to draw up a directive to physicians, as specified in the Natural Death Act. Within the medical profession, it is a fairly widespread practice for physicians, usually with the concurrence of the patient and his family, to allow death to come naturally to the terminally ill patient by way of withholding or withdrawing life-sistaining procedures.[16] "'You have a patient with a brain tumor, in coma, and there's just no chance for her,' notes a New York neurologist. 'If she stops breathing, we don't put her on the respirator.' In a case like Karen's (Karen Ann Quinlan) doctors might keep the respirator going, but not order the use of antibiotics if she developed

pneumonia or some other infection."[17] Another example of this practice is given by the head nurse of the surgical-intensive-care unit at New York City's Bellevue Hospital. She says that Bellevue's chief resident will oftentimes place the letters "DNR" meaning "do not resuscitate." However, she goes on to state that this coding is not always allowed.[18]

Supporters of California's Natural Death Act "recognize the validity and difficult nature of Lockner's objection."[19] These supporters further recognize that the Act does not address such difficult cases as that of the terminally ill patient who has not signed a formal directive to physicians and yet requests that he be allowed to die naturally.[20] However, advocates of the Natural Death Act are able to partially counter Dr. Lockner's argument by pointing to Section 7193 of the Act. Section 7193, then, "is a legal recogniation that AB 3060 (the California Natural Death Act) shall not preempt the judicially created and protected right to refuse health care, including life-sustaining procedures by a competent adult. As such, it permits a patient to use any other legal means to order a physician to withdraw life-sustaining procedures. Assuming that the decision in the Quinlan case would be considered as good law in California, the bill would recognize a decision of a court to order a guardianship for the family to order the physician to withdraw life-sustaining procudures."[21]

Critics of the Natural Death Act have also taken notice of the fact that nowhere does the Act define "imminent death," a critical prerequisite which, according to the directive to physicians contained in the Natural Death Act, must be met before life-sustaining procedures can be withheld or withdrawn [the undefined "imminent death" may be found in Section 7187(c) and in Section 7188 (directive to physicians, part 1) of the California Natural Death Act]. "Imminent death" is also not defined in Nevada AB 8 (the undefined "imminent death" may be found in Section 6, line 16 and in Section 11, line 25 of AB 8).

Another criticism of the Natural Death Act concerns the fact that a physician cannot always be certain that a patient will not recover from what originally seemed to be a terminal condition.[22] This leads to the conclusion that when a physician, acting under the legal requirements and safeguards of the Natural Death Act, withholds or withdraws life-sustaining procedures, he is in fact eliminating a "terminally" ill patient's slight choice of miraculous recovery.

> Dr. Robert Glaser, president of the Kaiser Family Foundation in Palo Alto, California, recalls a 70 year-old man with multiple myeloma, an incurable malignancy of the bone marrow, who seemed to be going progressively downhill. Physicians at a large medical center decided to administer only painkillers and to keep the patient comfortable during

his last days. They also transferred him to a hospital nearer his home. But there a new doctor took over and decided to try another course of drug therapy to treat the myeloma. As a result, the patient went into partial remission and he enjoyed another four years of relatively active life. Doctors agree that the patient who is told that he has six months to live but is alive six years later is almost a cliche.[23]

In relation to the above case history, a bothersome question arises as to what the fate of this man would have been if he had been able to sign a legal directive to physicians under the present California Natural Death Act. Melvin D. Levine, M.D., who is Director of the Medical Out-Patient Department at the Children's Hospital Center in Boston, and Clinical Coordinator for the Harvard Interfaculty Program in Medical Ethics has stated: "There is no certainty in prognostication. One out of five thousand 'hopeless' patients may go on to lead a normal life. The physician does not invoke rare events as criteria for decision making. Nevertheless, reports of 'miraculous cures' may intensify one's moral discomfort during disconnection" (of artificial life-sustaining procedures).[24]

The supporters of the California Natural Death Act probably recognize the above problem of uncertainty in prognostication. It is this recognition that led to the requirement in the Act that two physicians must diagnose the presence of a terminal condition in a patient before that patient can be termed a "qualified patient".

Although numerous religious groups in California are in support of the California Natural Death Act,[25] organized religion, as a whole, remains mute, neither supporting or criticizing the Act. However, Catholic and Jewish positions have been voiced regarding the general ethics surrounding the prolongation of life.

The Catholic position is as follows: "Positive euthanasia - taking action to hasten death - is against Catholic ethical teaching. As to whether to intervene and prolong the dying process, the response hinges on use of extraordinary means according to norms set by Pope Pius XII."[26] The norms referred to in the above quotation were set forth in 1957 in a statement made by Pope Pius XII. In 1957 the Pope stated that, "normally one is held only to use ordinary means according to the circumstances of persons, places, times, and cultures, that is to say, means that do not involve any great burden for one's self or another."[27]

The Jewish position is similar to the Catholic position. In regards to the living will (an extra legal forerunner to the directive to physicians contained in the California Natural Death Act), the Jewish view is as follows: "It (the living will) is not 'euthanasia' - or mercy killing! There is a clear distinction between actively killing a person and 'allowing him to die.'

According to Jewish law, when a person suffers irreversible brain damage and can no longer recite a 'bracha' - a blessing to praise God - or perform a 'mitzvah' - an act to help his fellow man - he is considered a 'vegetable', and there is nothing to 'save'. It is thus an act of compassion to spare the family the suffering, anguish and expense of artifically prolonging the breathing and heartbeat when death is inevitable."[28] No official position has yet been taken by any Protestant denomination as a whole, although numerous individual Protestant churches have officially voiced support of AB 3060 (the California Natural Death Act).[29]

V. PUBLIC ACCEPTANCE OF THE CALIFORNIA NATURAL DEATH ACT

Although the accuracy of polls and statistics can be questioned, the fact remains that polls and statistics are useful as rough guides to public sentiment.

Polls directed at measuring the public's acceptance of the California Natural Death Act have not, as of yet, been made due to the fact that the Act did not take effect until January 1, 1977. However, several polls have been taken in years past that relate in a direct way to the provisions contained in the Natural Death Act. Among these is a 1975 poll limited to California. This poll "found that 63 percent (of those surveyed) believed that an incurably ill patient should have the right to ask for and receive medication that would end his or her life, and 87 percent (of those surveyed) thought that an incurably ill patient should have the right to refuse life-prolonging medication."[30] In an admittedly unscientific poll conducted by the San Francisco Examiner, 96 percent of those participating in the poll answered "yes" to the following question: "Does a terminally ill person have the right to die?" Four percent of those participating in the poll answered "no" to the above question.[31] A more scientific poll conducted in early November of 1975 by the William Hamilton organization asked the following question: "Suppose a person is in the hospital and, according to all medical evidence, is dying and cannot be cured or saved. Do you feel that it would be right to simply let that person die or should every effort be made to keep them alive?" This question was asked in 982 households randomly selected throughout the nation. Fifty-nine percent of those surveyed said that it would be right to let such a person die versus thirty percent who said that every effort should be made to keep such a person alive.[32] Further evidence of possible public acceptance of natural death acts such as California's is found in the fact that, according to the Society for the Right to Die and the Euthanasia Educational Council, more than 500,000 people had (as of the summer of 1976) requested that one of these two groups send them a living will[33] (the living will is an extralegal document similar in function to the directive to physicians found in the California Natural Death Act).

THE CALIFORNIA NATURAL DEATH ACT AND NEVADA ASSEMBLY BILL EIGHT

I. RECOMMENDATION

In conclusion, AB 8 is not a routine piece of legislation. If passed, this legislation will directly affect the way in which many terminally ill Nevadans will die. It is for this reason that every facet of AB 8 deserves the careful attention of every legislator.

My recommendation is that AB 8 become law. However, this recommendation is premised upon the addition of the following amendments to AB 8:

(1) inclusion in AB 8 of an adequate definition of "imminent death" (the undefined "imminent death" may be found on page 1, line 16 and on page 2, line 25 of AB 8);

(2) on page 1, line 14, after "which", strike out: "sustains, restores, or supplants" and add: "utilizes mechanical or other artificial means to sustain, restore, or supplant";

(3) on page 1, line 15, after "to", insert "artificially";

(4) inclusion in the directive to physicians (Section 11 of AB 8) of a part five, to read substantially as follows: "This directive shall have no force or effect five years from the date of execution unless sooner revoked.";

(5) inclusion in AB 8 of a safeguard similar in meaning and function to the following safeguard (see underlining) found in the California Natural Death Act [Section 7191(b)]: "If the declarant was a qualified patient <u>at least 14 days prior to executing</u> or <u>re-executing</u> the <u>directive</u>, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures";

(6) inclusion in AB 8 of a safeguard similar in meaning and function to the following safeguard (see underlining) found in the California Natural Death Act [latter part of Section 7191(a)]: "the attending physician shall determine that the directive complies with Section 7188, and, <u>if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the desires of the qualified patient</u>";

(7) on page 3, line 38, after "patient", insert: "No hospital, facility, physician, or person working under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision";

(8) inclusion in Section 16, subsection 3 of AB 8 of examples of "other factors" (see page 3, line 47 of AB 8) which may be considered by the attending physician in determining whether the circumstances warrant following the directions contained in the directive to physicians (examples of these "other factors" to be considered might include such things as information from the affected family, or the nature of the patient's illness, injury or disease);

(9) on page 3, line 48, after "directions", insert: "No hospital, facility, physician, or person working under the direction of a physician, shall be criminally or civilly liable for failing to efectuate the directive of the qualified patient pursuant to this subdivision";

(10) inclusion in AB 8 of a section similar in meaning and function to Section 7193 of the California Natural Death Act;

(11) inclusion in Section 19 of AB 8 of a specific rejection of mercy killing;

(12) finally, during the course of the public hearing, other safeguards may be raised. This new venture into an important but unconventional area must be done on a responsible and conservative level. Better a too limited law than one which creates unforeseen negative results.

Prepared for and under the direction of Assemblyman Ian Ross by University Legislative Intern, Jon McCreary

FOOTNOTES

[1] California Natural Death Act, Section 7188.5.

[2] California Natural Death Act, Section 7188.5.

[3] California Natural Death Act, Section 7189.5.

[4] California Natural Death Act, Section 7195.

[5] California Natural Death Act, Section 7187, subsection (e).

[6] California Natural Death Act, Section 7192, subsection (b) and subsection (c).

[7] The quotation is from page three of a five-page enclosure sent with the letter. A copy of the letter and the enclosure may be obtained in the library of the Legislative Counsel Bureau.

[8] The quotation is from page four of an eleven-page document compiled by the California Senate Committee on Judiciary. A copy of the document may be obtained in the library of the Legislative Counsel Bureau.

[9] Please see footnote eight.

[10] Matt Clark et al., "A Right To Die?" Newsweek, 3 November 1975, p. 59.

[11] David Dempsey, "The Living Will and the Will to Live," The New York Times Magazine, 23 June 1975, p. 24.

[12] Dempsey, p. 22 and p. 24.

[13] Dempsey, p. 24.

[14] Matt Clark et al., p. 59.

[15] Michael Garland, "Politics, Legislation, and Natural Death," The Hastings Center Report, October 1976, p. 6.

[16] Matt Clark et al., p. 67.

[17] Matt Clark et al., p. 67.

[18] Lawrence Mosher, "When There is NO Hope . . . Why Prolong Life?" The National Observer, 4 March 1972, p. 1.

[19] Garland, p. 6.

[20] Garland, p. 6.

[21] The quotation is from page five of a five-page enclosure sent with a letter dated September 13, 1976, from Barry Keene to Governor Brown of California. A copy of the letter and enclosure may be obtained in the library of the Legislative Counsel Bureau.

[22] Matt Clark et al., p. 68.

[23] Matt Clark et al., p. 68.

[24] Melvin D. Levine, M.D., "Disconnection: The Clinician's View," The Hastings Center Report, February 1976, p. 11.

[25] For a listing of Californian religious groups which support A.B. 3060 (the Natural Death Act), please consult material provided by the California Assembly Committee on Health. This material may be obtained in the library of the Legislative Counsel Bureau.

[26] Robert Veatch, Ph.D., Edward Wakin, "Death and Dying," U.S. Catholic, April 1972, p. 12.

[27] Veatch, Wakin, p. 11.

[28] Abigail Van Buren, "The Living Will," Nevada State Journal, 26 February 1976, section 1, p. 6, column 1. (With aid from Rabbi Bernard S. Raskas, Temple Aaron of St. Paul, Minnesota.)

[29] Please see footnote 25.

[30] Virginia G. Cook, Ralph I. Marcelli, "Legislating Death," State Government, Summer 1976, p. 134.

[31] The results of this poll may be found on page 31 of the final edition of the April 26, 1976, San Francisco Examiner.

[32] Roy Branson, Kenneth Casebeer, "Obscuring the Role of the Physician," The Hastings Center Report, February 1976, p. 9

[33] Cook, Marcelli, p. 133.

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Several dossiers concerning the California Natural Death Act were also used in the preparation of this paper. These dossiers are available in the library of the Legislative Counsel Bureau.

1976

e, as proposed to be added by As-
on of the Legislature, is amended to

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l Procedure is amended to read:

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Regular Session of the Legislature

l renumbering the heading of Divi-
Elections Code shall only become
-76 Regular Session of the Legisla-

that each section of this bill which
roposed to be amended or added to
herein, shall only become operative
bill amends or adds such provision

Section 1400 of the Elections Code,
ill No. 2606 and Assembly Bill No.

Assembly Bill No. 3467 of the
e Bill No. 1392 of the 1975–76

In text are indicated by underline

Regular Session of the Legislature are both chaptered and this bill is also chaptered, and is chaptered last, that the provisions of both AB 3467 and SB 1392 be given effect and incorporated in Article 2 (commencing with Section 5200) of Chapter 4 of Division 4 of the Elections Code in the form set forth in Section 6.7 of this bill. Thus, if both AB 3467 and SB 1372 are chaptered, Article 2 (commencing with Section 5200) of Chapter 4 of Division 4 of the Elections Code, as proposed to be added by Assembly Bill No. 3467, is repealed, as set forth in Section 6.6 of this bill, and Sections 5200 and 5200.1 of the Elections Code, as proposed to be amended by SB 1392, are likewise repealed, as set forth in, respectively, Sections 6.8 and 6.9 of this bill.

Therefore, if this bill is chaptered last, and AB 3467 and SB 1392 are also chaptered, Sections 6.6 to 6.9, inclusive, of this bill shall become operative. In the event that AB 3467 or SB 1392, or both, are not chaptered, Sections 6.6 to 6.9, inclusive, of this bill shall not become operative.

SEC. 33. Section 14 of this bill amending Section 14005 of the Elections Code, shall not become operative if Assembly Bill No. 3683 is chaptered before this bill and AB 3683 amends Section 14005 of the Elections Code.

SEC. 34. Sections 19.2, 19.4, and 19.5 of this act, amending Sections 20021, 20300, and 20330 of the Elections Code, respectively, shall only become operative if Assembly Bill No. 3683 is also chaptered.

SEC. 35. Section 20.4 of this act, amending Section 22032 of the Elections Code, shall only become operative if Assembly Bill 2606 is also chaptered.

SEC. 36. Section 20.11 of this act, amending Section 23557 of the Elections Code, shall only become operative if Assembly Bill No. 3684 is also chaptered.

Approved and filed Sept. 30, 1976.

NATURAL DEATH ACT

CHAPTER 1439

ASSEMBLY BILL NO. 3060

An act to add Chapter 3.9 (commencing with Section 7185) to Part 1 of Division 7 of the Health and Safety Code, relating to medical care.

LEGISLATIVE COUNSEL'S DIGEST

No existing statute prescribes a procedure whereby a person may provide in advance for the withholding or withdrawal of medical care in the event the person should suffer a terminal illness or mortal injury.

This bill would expressly authorize the withholding or withdrawal of life-sustaining procedures, as defined, from adult patients afflicted with a terminal condition, as defined, where the patient has executed a directive in the form and manner prescribed by the bill. Such a directive would generally be effective for 5 years from the date of execution unless sooner revoked in a specified manner. This bill would relieve physicians, licensed health professionals acting under the direction of a physician, and health facilities from civil liability, and would relieve physicians and licensed health professionals acting under the direction of a physician from criminal prosecution or charges of unprofessional conduct, for withholding

deletions by asterisks * * *

or withdrawing life-sustaining procedures in accordance with the provisions of the bill.

The bill would provide that such a withholding or withdrawal of life-sustaining procedures shall not constitute a suicide nor impair or invalidate life insurance, and the bill would specify that the making of such a directive shall not restrict, inhibit, or impair the sale, procurement, or issuance of life insurance or modify existing life insurance. The bill would provide that health insurance carriers, as prescribed, could not require execution of a directive as a condition for being insured for, or receiving, health care services.

The bill would make it a misdemeanor to willfully conceal, cancel, deface, obliterate, or damage the directive of another without the declarant's consent. Any person, not justified or excused by law, who falsifies or forges the directive of another or willfully conceals or withholds personal knowledge of a prescribed revocation with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant and thereby causes life-sustaining procedures to be withheld or withdrawn, and death to thereby be hastened, would be subject to prosecution for unlawful homicide.

This bill would also provide that, notwithstanding Section 2231 of the Revenue and Taxation Code, there shall be no reimbursement nor appropriation made by this bill for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Chapter 3.9 (commencing with Section 7185) is added to Part 1 of Division 7 of the Health and Safety Code, to read:

CHAPTER 3.9. NATURAL DEATH ACT

7185.

This act shall be known and may be cited as the Natural Death Act.

7186.

The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

The Legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The Legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

7187.

The following definitions shall govern the construction of this chapter:

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

(b) "Directive" means a written docume in accordance with the requirements of S the directive, shall be made part of the pat

(c) "Life-sustaining procedure" means which utilizes mechanical or other artific a vital function, which, when applied to artificially prolong the moment of death tending physician, death is imminent whe "Life-sustaining procedure" shall not inc the performance of any medical procedur

(d) "Physician" means a physician and Quality Assurance or the Board of Osteop:

(e) "Qualified patient" means a patien afflicted with a terminal condition by tw tending physician, who have personally ex

(f) "Terminal condition" means an inc or illness, which, regardless of the appli within reasonable medical judgment, pr life-sustaining procedures serve only to tient.

7188.

Any adult person may execute a direct of life-sustaining procedures in a termin by the declarant in the presence of tw blood or marriage and who would not the declarant upon his decease under a then existing or, at the time of the di In addition, a witness to a directive shal of the attending physician or a health or any person who has a claim against upon his decease at the time of the exe be in the following form:

DIRECTIVE

Directive made this ________ day of

I ______________, being of sound m my desire that my life shall not be ar set forth below, do hereby declare:

1. If at any time I should have an to be a terminal condition by two phy taining procedures would serve only to and where my physician determines th sustaining procedures are utilized, I withdrawn, and that I be permitted to

2. In the absence of my ability to sustaining procedures, it is my intenti family and physician(s) as the final e or surgical treatment and accept the co

3. If I have been diagnosed as pre sician, this directive shall have no f nancy.

4. I have been diagnosed and noti condition by ______________, M.D., wh phone number is ______________. I u sician's name and address, it shall be dition when I made out this directive.

lures in accordance with the

a withholding or withdrawal
: constitute a suicide nor im-
l the bill would specify that
not restrict, inhibit, or impair
life insurance or modify ex-
provide that health insurance
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meanor to willfully conceal,
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:t *follows:*
h Section 7185) is added to Part 1
o read:

AL DEATH ACT

s the Natural Death Act.

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be withheld or withdrawn.

hich patients have a right to expect,
of the State of California shall recog-
ritten directive instructing his physi-
procedures in the event of a terminal

onstruction of this chapter:
l elected by, or assigned to, the
ment and care of the patient.

(b) "Directive" means a written document voluntarily executed by the declarant in accordance with the requirements of Section 7188. The directive, or a copy of the directive, shall be made part of the patient's medical records.

(c) "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

(d) "Physician" means a physician and surgeon licensed by the Board of Medical Quality Assurance or the Board of Osteopathic Examiners.

(e) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient.

(f) "Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient.

7188.

Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The directive shall be signed by the declarant in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

Directive made this ________ day of ________ (month, year).

I ______________, being of sound mind, willfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

4. I have been diagnosed and notified at least 14 days ago as having a terminal condition by ______________, M.D., whose address is ______________, and whose telephone number is ______________. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

5. This directive shall have no force or effect five years from the date filled in above.

6. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed ________________________

City, County and State of Residence ____

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness ________________________

Witness ________________________

7188.5.

A directive shall have no force or effect if the declarant is a patient in a skilled nursing facility as defined in subdivision (c) of Section 1250 at the time the directive is executed unless one of the two witnesses to the directive is a patient advocate or ombudsman as may be designated by the State Department of Aging for this purpose pursuant to any other applicable provision of law. The patient advocate or ombudsman shall have the same qualifications as a witness under Section 7188.

The intent of this section is to recognize that some patients in skilled nursing facilities may be so insulated from a voluntary decisionmaking role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of willfully and voluntarily executing a directive.

7189.

(a) A directive may be revoked at any time by the declarant, without regard to his mental state or competency, by any of the following methods:

(1) By being canceled, defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his presence and by his direction.

(2) By a written revocation of the declarant expressing his intent to revoke, signed and dated by the declarant. Such revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time and date when he received notification of the written revocation.

(3) By a verbal expression by the declarant of his intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when he received notification of the revocation.

(b) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

7189.5.

A directive shall be effective for five years from the date of execution thereof unless sooner revoked in a manner prescribed in Section 7189. Nothing in this chapter shall be construed to prevent a declarant from reexecuting a directive at any time in accordance with the formalities of Section 7188, including reexecution subsequent to a diagnosis of a terminal condition. If the declarant has executed more than one directive, such time shall be determined from the date of execution of the last directive known to the attending physician. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders him or her able to communicate with the attending physician.

7190.

No physician or health facility which, ments of this chapter, causes the withhol cedures from a qualified patient, shall be licensed health professional, acting unde ticipates in the withholding or withdraw ance with the provisions of this chapter physician, or licensed health professional who participates in the withholding or in accordance with the provisions of this act or of unprofessional conduct.

7191.

(a) Prior to effecting a withholding or from a qualified patient pursuant to the determine that the directive complies wit tally competent, that the directive and all to be undertaken are in accord with the d

(b) If the declarant was a qualified pa or reexecuting the directive, the directiv revoked, to be the directions of the pat drawal of life-sustaining procedures. N fessional acting under the direction of a liable for failing to effectuate the directiv subdivision. A failure by a physician to tient pursuant to this division shall cons sician refuses to make the necessary arr steps, to effect the transfer of the qualifi effectuate the directive of the qualified pat

(c) If the declarant becomes a qualifie rective, and has not subsequently reexecu may give weight to the directive as evid the withholding or withdrawal of life-sust factors, such as information from the affe illness, injury, or disease, in determinin known to the attending physician justify and no licensed health professional acting be criminally or civilly liable for failing t patient pursuant to this subdivision.

7192.

(a) The withholding or withdrawal of li patient in accordance with the provision pose, constitute a suicide.

(b) The making of a directive pursuant or impair in any manner the sale, procu insurance, nor shall it be deemed to modi insurance. No policy of life insurance sh any manner by the withholding or withd an insured qualified patient, notwithstan trary.

(c) No physician, health facility, or otl service plan, insurer issuing disability i benefit plan, or nonprofit hospital service a directive as a condition for being insure

7193.

Nothing in this chapter shall impair or sibility which any person may have to effe sustaining procedures in any lawful mann chapter are cumulative.

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re and I am emotionally and men-

Signed ____________

and I believe him or her to be of

Witness ____________
Witness ____________

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r able to communicate with

7190.

No physician or health facility which, acting in accordance with the requirements of this chapter, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom. No licensed health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be subject to any civil liability. No physician, or licensed health professional acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be guilty of any criminal act or of unprofessional conduct.

7191.

(a) Prior to effecting a withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the directive, the attending physician shall determine that the directive complies with Section 7188, and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the desires of the qualified patient.

(b) If the declarant was a qualified patient at least 14 days prior to executing or reexecuting the directive, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. No physician, and no licensed health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision. A failure by a physician to effectuate the directive of a qualified patient pursuant to this division shall constitute unprofessional conduct if the physician refuses to make the necessary arrangements, or fails to take the necessary steps, to effect the transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient.

(c) If the declarant becomes a qualified patient subsequent to executing the directive, and has not subsequently reexecuted the directive, the attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding or withdrawal of life-sustaining procedures and may consider other factors, such as information from the affected family or the nature of the patient's illness, injury, or disease, in determining whether the totality of circumstances known to the attending physician justify effectuating the directive. No physician, and no licensed health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision.

7192.

(a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide.

(b) The making of a directive pursuant to Section 7188 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

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

7193.

Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative.

7194.

Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarant's consent shall be guilty of a misdemeanor. Any person who, except where justified or excused by law, falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 7189, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for unlawful homicide as provided in Chapter 1 (commencing with Section 187) of Title 8 of Part 1 of the Penal Code.

7195.

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter.

SEC. 2. If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

SEC. 3. Notwithstanding Section 2231 of the Revenue and Taxation Code, there shall be no reimbursement pursuant to this section nor shall there be any appropriation made by this act because the Legislature recognizes that during any legislative session a variety of changes to laws relating to crimes and infractions may cause both increased and decreased costs to local government entities and school districts which, in the aggregate, do not result in significant identifiable cost changes.

Approved and filed Sept. 30, 1976.

PARKS AND COASTAL MANAGEMENT—APPROPRIATION

CHAPTER 1440

ASSEMBLY BILL NO. 400

An act to amend Sections 5051, 5052, 5053, 30304.5 as added by Assembly Bill No. 2948, 30334 as added by Senate Bill No. 1277 and amended by Assembly Bill No. 2948, and 30502.5, as added by Assembly Bill No. 2948, of, and to add Section 30608 to, the Public Resources Code, relating to public resources, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

(A) Under existing law funds in the Bagley Conservation Fund are available for beach, park, and land acquisition programs and coastline planning and development of recreational facilities which do not require continuous funding.

This bill would appropriate $31,276,508 from the General Fund for transfer to the Bagley Conservation Fund. Such funds in the Bagley Conservation Fund would be appropriated for the following purposes:

(1) Support of the agency designated by statute to assume responsibility for coastal zone management after January 1, 1977.

(2) Land acquisition
tion at various beaches
Land that is situated in
quired subject to the req
the county an agreement
such land. Further, au
grant moneys received b
and Water Conservation
at El Matador and El P
geles. In this connectic
2995 of the current sessi
thereby from a requirer
moneys to meet a speci
Matador Beach and wou
funding such acquisition
AB 2995 and this bill) sh

(3) Capital outlay
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and middle-income popu
most suitable for provid
ber of such persons. Th
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and recreation areas, in
subject to the requireme
having jurisdiction over
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or any regional coastal
under the California Co
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Act of 1976 to, in releva

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view of local coastal
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area shall be recomme
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ASSEMBLY BILL NO. 8—ASSEMBLYMEN COULTER, POLISH, GOMES, ROBINSON, GOODMAN, BENNETT, WAGNER, JEFFREY, HOWARD, MURPHY, KISSAM, PRICE, WESTALL, VERGIELS, KOSINSKI AND MOODY

JANUARY 17, 1977

Referred to Committee on Judiciary

SUMMARY—Permits voluntary cessation of life-sustaining procedures for terminally ill persons. (BDR 40-580)
FISCAL NOTE: Local Government Impact: No.
State or Industrial Insurance Impact: No.

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to health and care facilities; providing for election by terminally ill persons of cessation of life-sustaining procedures; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

1 SECTION 1. Chapter 449 of NRS is hereby amended by adding
2 thereto the provisions set forth as sections 2 to 19, inclusive, of this act.
3 SEC. 2. *As used in sections 2 to 18, inclusive, of this act, unless the*
4 *context otherwise requires, the words and terms defined in sections 3 to 9,*
5 *inclusive, have the meanings ascribed to them in those sections.*
6 SEC. 3. *"Attending physician" means the physician, selected by or*
7 *assigned to a patient, who has primary responsibility for the treatment and*
8 *care of the patient.*
9 SEC. 4. *"Declaration" means a written document executed by an*
10 *adult person.*
11 SEC. 5. *"Facility" means any health and care facility other than a*
12 *hospital.*
13 SEC. 6. *"Life-sustaining procedure" means a medical procedure*
14 *which sustains, restores or supplants a vital function and which, when*
15 *applied to a patient, serves only to prolong the moment of death in cases*
16 *where, in the judgment of the attending physician, death is imminent*
17 *whether or not the procedure is used. The term does not include medica-*
18 *tion or procedures necessary to alleviate pain.*
19 SEC. 7. *"Physician" means any person licensed to practice medicine*
20 *or osteopathy.*
21 SEC. 8. *"Qualified patient" means a person who has been diagnosed*
22 *and certified in writing to be afflicted with a terminal condition by two*

1 *physicians, one of whom is the attending physician, who have personally*
2 *examined the person.*
3 SEC. 9. *"Terminal condition" means an incurable condition which is*
4 *such that the application of life-sustaining procedures serves only to post-*
5 *pone the moment of death.*
6 SEC. 10. *Any adult person may execute a declaration ordering the*
7 *withholding or withdrawal of life-sustaining procedures from him when*
8 *he is in a terminal condition. The person shall execute the declaration*
9 *in the same manner in which a will is executed, except that a witness*
10 *may not be:*
11 *1. Related to the declarant by blood or marriage.*
12 *2. The attending physician.*
13 *3. An employee of the attending physician or the health and care*
14 *facility in which the declarant is a patient.*
15 *4. A person who has a claim against any portion of the estate of the*
16 *declarant.*
17 SEC. 11. *The declaration shall be in substantially the following form:*
18 *DIRECTIVE TO PHYSICIANS*
19 *Date* ....
20 *I,* ...., *being of sound mind, intentionally*
21 *and voluntarily declare:*
22 *1. If at any time I should have an incurable injury, disease or illness*
23 *certified by two physicians to be terminal, where the application of life-*
24 *sustaining procedures would serve only to prolong the moment of my*
25 *death, and where my physician determines that my death is imminent*
26 *whether or not life-sustaining procedures are utilized, I direct that these*
27 *procedures be withheld or withdrawn, and that I be permitted to die*
28 *naturally.*
29 *2. In the absence of ability to give directions regarding the use of*
30 *life-sustaining procedures, it is my intention that this directive be hon-*
31 *ored by my family and physicians as the final expression of my legal right*
32 *to refuse medical or surgical treatment and to accept the consequences*
33 *of my refusal.*
34 *3. If I have been found to be pregnant, and that fact is known to my*
35 *physician, this directive is void during the course of my pregnancy.*
36 *4. I have been diagnosed as having a terminal condition and notified*
37 *by* ...., *(M.D.) (D.O.), whose address is* ....,
38 *and whose telephone number is* ....
39 *I understand the full import of this directive, and I am emotionally and*
40 *mentally competent to execute it.*
41 *Signed*......................................
42 *City, County and State of Residence*......................................
43 *The declarant has been personally known to me and I believe*..................
44 ....*to be of sound mind.*
45 *Witness*......................................
46 *Witness*......................................
47 *Section 3 of the declaration form should be omitted for male declar-*
48 *ants, and section 4 should be omitted if it is not applicable.*
49 *The executed declaration shall be placed in the medical record of the*
50 *declarant and a notation made of its presence and the time and date of*

1 *its execution. A notation of the circumstances, time and date of removal*
2 *of a declaration shall be entered in the medical record if the declaration*
3 *is removed for any reason.*
4 SEC. 12. *A declaration is void if the declarant is a patient in a facility*
5 *at the time the declaration is executed, unless one of the witnesses is a per-*
6 *son designated to witness declarations by the aging services division of the*
7 *department of human resources and is otherwise qualified to witness the*
8 *declaration.*
9 SEC. 13. *1. A declaration may be revoked at any time by the declar-*
10 *ant in the same way in which a will may be revoked, or by a verbal expres-*
11 *sion of intent to revoke. A verbal revocation is effective upon*
12 *communication to the attending physician by the declarant or another per-*
13 *son communicating it on behalf of the declarant. The attending physician*
14 *shall record the verbal revocation and the date and time at which he*
15 *received it in the medical record of the declarant.*
16 *2. No person is liable in a civil or criminal action for failure to act*
17 *upon a revocation of a declaration unless the person had actual knowledge*
18 *of the revocation.*
19 SEC. 14. *1. Except as provided in subsection 2, a declaration is effec-*
20 *tive for 5 years from the date of execution unless sooner revoked. A*
21 *declarant may reexecute his directive at any time, including a time after*
22 *diagnosis of a terminal condition. If more than one directive has been exe-*
23 *cuted, each is effective for 5 years.*
24 *2. If the declarant becomes comatose or is rendered incapable of*
25 *communicating with the attending physician, the directive remains in*
26 *effect throughout the disability.*
27 SEC. 15. *No hospital, facility, physician or person working under the*
28 *direction of a physician who causes the withholding or withdrawal of*
29 *life-sustaining procedures from a qualified patient is subject to criminal*
30 *or civil liability or to a charge of unprofessional conduct or malpractice*
31 *as a result of an action taken in accordance with sections 10 to 18, inclu-*
32 *sive, of this act.*
33 SEC. 16. *1. The attending physician shall determine that a declara-*
34 *tion has been lawfully executed and remains in effect before taking any*
35 *action to withhold or withdraw life-sustaining procedures from a patient.*
36 *2. If the patient became a qualified patient before the execution of*
37 *his declaration, the declaration is conclusively presumed to be the direc-*
38 *tions of the patient. A failure by a physician to follow the directions of*
39 *a qualified patient constitutes unprofessional conduct if he refuses to*
40 *make necessary arrangements to transfer the patient to a physician who*
41 *will follow the directions of the patient.*
42 *3. If the declarant has become a qualified patient since executing*
43 *the declaration and has not reexecuted the declaration under conditions*
44 *set forth in subsection 2, the attending physician may give weight to the*
45 *declaration as evidence of the patient's directions regarding the with-*
46 *drawal or withholding of life-sustaining procedures, and may consider*
47 *other factors in determining whether the circumstances warrant following*
48 *the directions.*
49 SEC. 17. *1. A person does not commit suicide by executing a decla-*
50 *ration.*

1 *2. The execution of a declaration does not restrict, inhibit or impair*
2 *the sale, procurement or issuance of any policy of insurance, nor shall*
3 *it be deemed to modify any term of an existing policy of insurance. No*
4 *policy of life insurance is impaired or invalidated in whole or in part by*
5 *the withholding or withdrawal of life-sustaining procedures from an*
6 *insured person, regardless of any term of the policy.*
7 *3. No person may require another to execute a declaration as a con-*
8 *dition for being insured for or receiving health care services.*
9 SEC. 18. *1. Any person who willfully conceals, cancels, defaces, oblit-*
10 *erates or damages the declaration of another without the consent of the*
11 *declarant is guilty of a misdemeanor.*
12 *2. Any person who falsifies or forges a document purporting to be*
13 *the declaration of another, or who willfully conceals or withholds personal*
14 *knowledge of a revocation, with the intent to cause a withholding or*
15 *withdrawal of life-sustaining procedures contrary to the wishes of the*
16 *declarant and thereby directly causes life-sustaining procedures to be*
17 *withheld or withdrawn and death to be hastened is guilty of murder.*
18 SEC. 19. *Nothing in sections 10 to 18, inclusive, of this act permits*
19 *any affirmative or deliberate act or omission which ends life other than*
20 *to permit the natural process of dying.*

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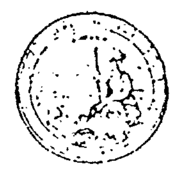

Assembly Committee on Health

STATE CAPITOL
445-1770

BARRY KEENE
CHAIRMAN

SAFEGUARDS IN AB 3060 -- THE NATURAL DEATH ACT

I. SAFEGUARDS in Executing the Directive:

A. Only an adult person may execute a directive. (Section 7188)

B. The directive must be in the form set forth in the bill. (Section 7188)

C. The directive must be signed and dated by the declarant. (Section 7188)

D. The directive must be witnessed by two persons not related by blood, or entitled to the estate of the declarant (at the time the directive is executed), or the attending physician, or an employee of the attending physician or health facility in which the declarant is a patient at the time which the directive is executed. (Section 7188)

E. Any person forging a directive with the intent to cause the withdrawal of life-sustaining procedures and thus causing the death of a person is subject to prosecution for criminal homicide (murder, manslaughter). (Section 7194)

F. Health providers or insurance companies are prohibited from conditioning health care services on the execution of a directive. (Section 7192(c))

II. SAFEGUARDS in Revoking the Directive:

A. The declarant can revoke the directive at any time without regard to mental state by physically destroying the document, by written revocation, or by oral revocation. (Section 7189)

B. Any person can communicate the revocation to the attending physician on behalf of the patient. (Section 7189)

C. The directive remains in effect, unless revoked, for a

LEGISLATIVE COUNSEL BUREAU

maximum of five years and must be re-executed in accordance with the formalities to remain effective. (Section 7189.5)

D. Any person willfully concealing a revocation with the intent to cause the withdrawal of life-sustaining procedures and thus causing the death of a person is subject to prosecution for criminal homicide. (Section 7194)

III. <u>SAFEGUARDS</u> <u>in</u> <u>Effectuating</u> <u>the</u> <u>Directive</u>:

A. The bill specifically prohibits any affirmative act to end life other than to permit the natural process of dying as provided in AB 3060. (Section 7195)

B. The bill specifically prohibits mercy killing. (Section 7195)

C. The declarant must have a terminal condition as that term is defined in the bill. (Section 7187(f))

D. The declarant must be certified as a qualified patient by two physicians, one of whom must be the attending physician, who have personally examined the patient. (Section 7187(e))

E. The life-sustaining procedures can be withdrawn when they serve <u>only</u> to artificially prolong the moment of death and where death is imminent. (Section 7187(c))

F. Before effectuating the directive, the physician must determine that the directive complies with the statutory requirements and if the patient is competent, that the proposed treatment is in accord with the desires of the qualified patient. (Section 7191 (a))

G. If the patient was not terminally ill when the directive was executed, the physician may consider other factors in determining whether the totality of circumstances justifying effectuating the directive. There would be no civil or criminal liability if the physician chose not to effectuate the directive (Section 7191(c))

ing a goal which is *inherently inconsistent*: a procedure for death which *both* (1) provides ample safeguards against abuse and mistake, and (2) is 'quick' and 'easy' in operation. Professor Williams meets the problem with more than bitter comments about the tactics of the opposition. He makes a brave try to break through the dilemma:

> [T]he reformers might be well advised, in their next proposal, to abandon all their cumbrous safeguards and to do as their opponents wish, giving the medical practitioner a wide discretion and trusting to his good sense.
>
> [T]he essence of the bill would then be simple. It would provide that no medical practitioner should be guilty of an offence in respect of an act done intentionally to accelerate the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character. Under this formula 'it would be for the physician, if charged, to show that the patient was seriously ill, but for the prosecution to prove that the physician acted from some motive other than the humanitarian one allowed to him by law.[19]

Evidently, the presumption is that the general practitioner is a sufficient buffer between the patient and the restless spouse, or overwrought or overreaching relative, as well as a depository of enough general scientific know-how and enough information about current research developments and trends, to assure a minimum of error in diagnosis and anticipation of new measures of relief. Whether or not the general practitioner will accept the responsibility Williams would confer on him is itself a problem of major proportions.[20] Putting that question aside, the soundness of the underlying premises of Williams's 'legislative suggestion' will be examined in the course of the discussion of various aspects of the euthanasia problem.

B. THE 'CHOICE'

Under current proposals to establish legal machinery, elaborate or otherwise, for the administration of a quick and easy death, it is not enough that those authorized to pass on the question decide

that the patient, in effect, is 'better off dead'. The patient must concur in this opinion. Much of the appeal in the current proposal lies in this so-called 'voluntary' attribute.

But is the adult patient really in a position to concur?[21] Is he truly able to make euthanasia a 'voluntary' act? There is a good deal to be said, is there not, for Dr Frohman's pithy comment that the 'voluntary' plan is supposed to be carried out 'only if the victim is both sane and crazed by pain'.[22]

By hypothesis, voluntary euthanasia is not to be resorted to until narcotics have long since been administered and the patient has developed a tolerance to them. *When*, then, does the patient make the choice? While heavily drugged?[23] Or is narcotic relief to be withdrawn for the time of decision? But if heavy dosage no longer deadens pain, indeed, no longer makes it bearable, how overwhelming is it when whatever relief narcotics offer is taken away too?

'Hypersensitivity to pain after analgesia has worn off is nearly always noted'.[24] Moreover, 'the mental side-effects of narcotics, unfortunately for anyone wishing to suspend them temporarily without unduly tormenting the patient, appear to outlast the analgesic effect' and 'by many hours'.[25] The situation is further complicated by the fact that 'a person in terminal stages of cancer who had been given morphine steadily for a matter of weeks would certainly be dependent upon it physically and would probably be addicted to it and react with the addict's response'.[26]

The narcotics problem aside, Dr Benjamin Miller, who probably has personally experienced more pain than any other commentator on the euthanasia scene, observes:

> Anyone who has been severely ill knows how distorted his judgment became during the worst moments of the illness. Pain and the toxic effect of disease, or the violent reaction to certain surgical procedures may change our capacity for rational and courageous thought.[27]

Undoubtedly, some euthanasia candidates will have their lucid moments. How they are to be distinguished from fellow-sufferers who do not, or how these instances are to be distinguished from others when the patient is exercising an irrational judgment, is not an easy matter. Particularly is this so under Williams's propos-

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al, where no specially qualified persons, psychiatrically trained or otherwise, are to assist in the process.

Assuming, for purposes of argument, that the occasion when a euthanasia candidate possesses a sufficiently clear mind can be ascertained and that a request for euthanasia is then made, there remain other problems. The mind of the pain-racked may occasionally be clear, but is it not also likely to be uncertain and variable? This point was pressed hard by the great physician, Lord Horder, in the House of Lords debates:

> During the morning depression he [the patient] will be found to favour the application under this Bill, later in the day he will think quite differently, or will have forgotten all about it. The mental clarity with which noble Lords who present this Bill are able to think and to speak must not be thought to have any counterpart in the alternating moods and confused judgments of the sick man.[28]

The concept of 'voluntary' in voluntary euthanasia would have a great deal more substance to it if, as is the case with voluntary admission statutes for the mentally ill, the patient retained the right to reverse the process within a specified number of days after he gives written notice of his desire to do so—but unfortunately this cannot be. The choice here, of course, is an irrevocable one.

The likelihood of confusion, distortion or vacillation would appear to be serious drawbacks to any voluntary plan. Moreover, Williams's proposal is particularly vulnerable in this regard, since as he admits, by eliminating the fairly elaborate procedure of the American and British Societies' plans, he also eliminates a time period which would furnish substantial evidence of the patient's settled intention to avail himself of euthanasia.[29] But if Williams does not always choose to slug it out, he can box neatly and parry gingerly:

> [T]he problem can be exaggerated. Every law has to face difficulties in application, and these difficulties are not a conclusive argument against a law if it has a beneficial operation. The measure here proposed is designed to meet the situation where the patient's consent to euthanasia is clear and incontrovertible. The physician, conscious of the need to protect himself against malicious accusations, can devise his own safeguards appropriate to the circumstances; he would normally be well advised to get the patient's consent in writing, just as is now the practice before operations. Sometimes the patient's consent will be particularly clear because he will have expressed a desire for ultimate euthanasia while he is still clear-headed and before he comes to be racked by pain; if the expression of desire is never revoked, but rather is reaffirmed under the pain, there is the best possible proof of full consent. If, on the other hand, there is no such settled frame of mind, and if the physician chooses to administer euthanasia when the patient's mind is in a variable state, he will be walking in the margin of the law and may find himself unprotected.[30]

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If consent is given at a time when the patient's condition has so degenerated that he has become a fit candidate for euthanasia, when, if ever, will it be 'clear and incontrovertible'? Is the suggested alternative of consent in advance a satisfactory solution? Can such a consent be deemed an informed one? Is this much different from holding a man to a prior statement of intent that if such and such an employment opportunity would present itself he would accept it, or if such and such a young woman were to come along he would marry her? Need one marshal authority for the proposition that many an 'iffy' inclination is disregarded when the actual facts are at hand?

Professor Williams states that where a pre-pain desire for 'ultimate euthanasia' is 'reaffirmed' under pain, 'there is the best possible proof of full consent'. Perhaps. But what if it is alternately renounced and reaffirmed under pain? What if it is neither affirmed or renounced? What if it is only renounced? Will a physician be free to go ahead on the ground that the prior desire was 'rational', but the present desire 'irrational'? Under Williams's plan, will not the physician frequently 'be walking in the margin of the law'—just as he is now? Do we really accomplish much more under this proposal than to put the euthanasia principle on the books?

Even if the patient's choice could be said to be 'clear and incontrovertible', do not other difficulties remain? Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think

others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act? Will not some feel an obligation to have themselves 'eliminated' in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?

It would not be surprising for the gravely ill person to seek to inquire of those close to him whether he should avail himself of the legal alternative of euthanasia. Certainly, he is likely to wonder about their attitude in the matter. It is quite possible, is it not, that he will not exactly be gratified by any inclination on their part—however noble their motives may be in fact—that he resort to the new procedure? At this stage, the patient-family relationship may well be a good deal less than it ought to be.

And what of the relatives? If their views will not always influence the patient, will they not at least influence the attending physician? Will a physician assume the risks to his reputation, if not his pocketbook, by administering the *coup de grâce* over the objection—however irrational—of a close relative. Do not the relatives, then, also have a 'choice'? Is not the decision on their part to do nothing and say nothing *itself* a 'choice'? In many families there will be some, will there not, who will consider a stand against euthanasia the only proof of love, devotion and gratitude for past events? What of the stress and strife if close relatives differ over the desirability of euthanatizing the patient?

At such a time, members of the family are not likely to be in the best state of mind, either, to make this kind of decision. Financial stress and conscious or unconscious competition for the family's estate aside,

> The chronic illness and persistent pain in terminal carcinoma may place strong and excessive stresses upon the family's emotional ties with the patient. The family members who have strong emotional attachment to start with are most likely to take the patient's fears, pains and fate personally. Panic often strikes them. Whatever guilt feelings they may have toward the patient emerge to plague them.
>
> If the patient is maintained at home, many frustrations and

> physical demands may be imposed on the family by the advanced illness. There may develop extreme weakness, incontinence and bad odors. The pressure of caring for the individual under these circumstances is likely to arouse a resentment and, in turn, guilt feelings on the part of those who have to do the nursing.[31]

Nor should it be overlooked that while Professor Williams would remove the various procedural steps and personnel contemplated in the British and American Bills and bank his all on the 'good sense' of the general practitioner, no man is immune to the fear, anxieties and frustrations engendered by the apparently helpless, hopeless patient. Not even the general practitioner:

> Working with a patient suffering from a malignancy causes special problems for the physician. First of all, the patient with a malignancy is most likely to engender anxiety concerning death, even in the doctor. And at the same time, this type of patient constitutes a serious threat or frustration to medical ambition. As a result, a doctor may react more emotionally and less objectively than in any other area of medical practice. . . . His deep concern may make him more pessimistic than is necessary. As a result of the feeling of frustration in his wish to help, the doctor may have moments of annoyance with the patient. He may even feel almost inclined to want to avoid this type of patient.[32]

Putting aside the problem of whether the good sense of the general practitioner warrants dispensing with other personnel, there still remain the problems posed by *any* voluntary euthanasia programme: the aforementioned considerable pressures on the patient and his family. Are these the kind of pressures we want to inflict on any person, let alone a very sick person? Are these the kind of pressures we want to impose on any family, let alone an emotionally shattered family? And if so, why are they not also proper considerations for the crippled, the paralyzed, the quadruple amputee, the iron-lung occupant and their families?

Might it not be said of the existing ban on euthanasia, as Professor Herbert Wechsler has said of the criminal law in another connection:

> It also operates, and perhaps more significantly, at anterior

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stages in the patterns of conduct, the dark shadow of organized disapproval eliminating from the ambit of consideration alternatives that might otherwise present themselves in the final competition of choice.[33]

C. THE 'HOPELESSLY INCURABLE' PATIENT AND THE FALLIBLE DOCTOR

Professor Williams notes as 'standard argument' the plea that 'no sufferer from an apparently fatal illness should be deprived of his life because there is always the possibility that the diagnosis is wrong, or else that some remarkable cure will be discovered in time'.[34] But he does not reach the issue until he has already dismissed it with this prefatory remark:

> It has been noticed before in this work that writers who object to a practice for theological reasons frequently try to support their condemnation on medical grounds. With euthanasia this is difficult, but the effort is made.[35]

Does not Williams, while he pleads that euthanasia be not theologically prejudged, at the same time invite the inference that non-theological objections to euthanasia are simply camouflage?

It is no doubt true that many theological opponents employ medical arguments as well, but it is also true that the doctor who has probably most forcefully advanced medical objections to euthanasia of the so-called incurables, Cornell University's world-renowned Foster Kennedy, a former President of the Euthanasia Society of America, *advocates* euthanasia in other areas where error in diagnosis and prospect of new relief or cures are much reduced—that is, for the 'congenitally unfit'.[36] In large part for the same reasons, Great Britain's Dr A. Leslie Banks, then Principal Medical Officer of the Ministry of Health, maintained that a better case could be made for the destruction of congenital idiots and those in the final stages of dementia, particularly senile dementia, than could be made for the doing away of the pain-stricken incurable.[37] Surely, such opponents of voluntary euthanasia cannot be accused of wrapping theological objections in medical dressing!

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Until the Euthanasia Societies of Great Britain and America had been organized and a party decision reached, shall we say, to advocate euthanasia only for incurables on their request, Dr Abraham L. Wolbarst, one of the most ardent supporters of the movement, was less troubled about putting away 'insane or defective people [who] have suffered mental incapacity and tortures of the mind for many years' than he was about the 'incurables'.[38] He recognized the 'difficulty involved in the decision as to incurability' as one of the 'doubtful aspects of euthanasia': 'Doctors are only human beings, with few if any supermen among them. They make honest mistakes, like other men, because of the limitations of the human mind.'[39]

He noted further that 'it goes without saying that, in recently developed cases with a possibility of cure, euthanasia should not even be considered', that 'the law might establish a limit of, say, ten years in which there is a chance of the patient's recovery'.[40]

Dr Benjamin Miller is another who is unlikely to harbour an ulterior theological motive. His interest is more personal. He himself was left to die the death of a 'hopeless' tuberculosis victim, only to discover that he was suffering from a rare malady which affects the lungs in much the same manner but seldom kills. Five years and sixteen hospitalizations later, Dr Miller dramatized his point by recalling the last diagnostic clinic of the brilliant Richard Cabot, on the occasion of his official retirement:

> He was given the case records [complete medical histories and results of careful examinations] of two patients and asked to diagnose their illnesses. . . . The patients had died and only the hospital pathologist knew the exact diagnosis beyond doubt, for he had seen the descriptions of the postmortem findings. Dr Cabot, usually very accurate in his diagnosis, that day missed both.
>
> The chief pathologist who had selected the cases was a wise person. He had purposely chosen two of the most deceptive to remind the medical students and young physicians that even at the end of a long and rich experience one of the greatest diagnosticians of our time was still not infallible.[41]

Richard Cabot was the John W. Davis, the John Lord O'Brian, of his profession. When one reads the account of his last clinic,

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SECRETARY

February 18, 1977

The Nevada State Legislature
Committee on Judiciary
c/o The Hon. Steven A. Coulter
P.O. Box 13877
Reno, Nevada 89507

Re: Assembly Bill No. 8

Dear Committee Members:

The Democratic Party of Nevada wishes to go on record in support of Assembly Bill No. 8 "permitting voluntary cessation of life-sustaining procedures for terminally ill persons."

Page two of Section3 of the State Democratic Party Platform states "That the Nevada State Legislature make lawful the 'living will' concept which legalizes the individual's will to choose between continuation or termination of medical treatment in cases where life is prolonged by artificial and extraordinary means."

The Democratic Party is looking forward to the passage of this bill.

Thank you for your kind consideration.

Respectfully submitted,

Didi Carson
DIDI CARSON
State Chairwoman

DC:jsd