Approved March 28, 1983
Date

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY.

The meeting was called to order by Representative Bob Frey at
Chairperson

3:30 ~~a.m.~~/p.m. on March 21, 1983 in room 526-S of the Capitol.

All members were present except:

Representatives Justice and Peterson were excused.

Committee staff present:
Mark Burghart, Legislative Research Department
Mike Heim, Legislative Research Department
Mary Ann Torrence, Revisor of Statutes Office
Nedra Spingler, Secretary

Conferees appearing before the committee:
Senator Elwaine Pomeroy
John McCabe, Attorney, National Conference of Commissioners on Unified State Laws, Chicago
Jerry Slaughter, Kansas Medical Society
Gerald Goodell, Kansas Savings and Loan League
Marjorie Van Buren, Office of the Judicial Administrator
Professor John Kuether, Washburn School of Law

Minutes of the meetings of March 15, 16, and 17, 1983, were approved.

SB 81 - An act relating to determination of death.

Senator Pomeroy, sponsor, said Kansas was the first state to adopt the determination of death act in 1969. Because of changes in medical techniques and developments from studies conducted, the commissioners (representing all 50 states) of the National Conference of Commissioners on Uniform State Laws have upgraded the act. SB 81 would enact the uniform determination of death act as recommended by the commissioners. Senator Pomeroy gave a background of the function and makeup of this commission.

John McCabe, legal counsel for the commissioners, explained the new uniform determination of death act, using Attachment No. 1. It clarifies responsibilities of physicians and eliminates barriers to the modern practice of medicine. There was discussion regarding the use of life-saving machines and when death was determined when they are used. Mr. McCabe said the commissioners saw no reason for a distinction being made between clinical and legal death determination.

Jerry Slaughter offered an amendment to SB 81 (Attachment No. 2) which would provide that death be determined by a licensed physician or surgeon. He noted the amendments the Medical Society offered to the Senate committee which would, in cases of organ donors, require that a person be pronounced dead before organs are removed. The Medical Society will not offer this amendment again because of recent Supreme Court opinions, making it unnecessary. Mr. Slaughter was requested to furnish a copy of the amendment to the Committee. Senator Pomeroy had no objection to this amendment if wording was changed which would not inhibit living persons from donating organs.

SB 91 - An act relating to executions and redemption of real property.

The Chairman noted a similar bill, HB 2302, had been passed out of Committee.

Senator Pomeroy supported SB 91 which was requested by the Judicial Council.

Gerald Goodell supported the bill and said it would correct current problems in existing law relating to how mortgages are foreclosed. Pages 6 and 7 contain the main substance of the bill. The principal change in the law is explained in Attachment No. 3. He noted the confusion to and many different methods used by courts. The bill would illeviate this and reduce costs.

Marjorie Van Buren pointed out the bill is the same as HB 2302, now in the Senate Judiciary Committee. The Chairman said he would make a determination with that committee as to which bill should be enacted. Representative Knopp moved to report SB 91 favorable for passage, seconded by Representative Douville. Motion carried.

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY,

room 526-S, Statehouse, at 3:30 ~~XXX~~ a.m./p.m. on March 21, 1983.

SB 90 - An act relating to probate of wills.

Senator Pomeroy said the bill was requested by the Judicial Council.

Professor John Kuether, a member of the Judicial Council committee requesting the bill, explained its intent which would codify current practice in Kansas of not entering probate of out-of-state wills until a need arises in title changes to real estate. He gave examples of cases in Kansas as the result of out-of-state wills.

Representative Knopp moved to report SB 90 favorable for passage, to be placed on the Consent Calendar, seconded by Representative Ediger. Motion carried.

SB 370 - An act relating to venue and actions for divorce.

Staff said the bill brings the venue statute into conformity with action adopted in the divorce code in 1982. A need for use of a respondent petition being in the bill was noted.

SB 318 - An act relating to victim impact statement.

Amendments to the bill (Attachment No.4) were distributed but not discussed due to a motion made by Representative Miller, seconded by Representative Wagnon, to table the bill. Motion carried.

The meeting was adjourned at 4:45 p.m.

by John M. McCabe

The New Determination of Death Act

The new act clarifies the responsibilities of physicians and eliminates barriers to the modern practice of medicine.

WHEN the American Bar Association House of Delegates approved the Uniform Determination of Death Act last February, the action marked the end of an unusual development in statutory language that produced the uniform act. The House regularly considers uniform acts promulgated by the National Conference of Commissioners on Uniform State Laws, but this particular act was unusual because it represented a co-operative effort of the A.B.A., the commissioners, and the American Medical Association.

The evolution of "definition of death," "brain death," and "determination of death" statutes began with the Kansas adoption of a definition of death in 1970. The evolution of language continued with an improved and simplified definition suggested by Alexander Morgan Capron and Leon R. Kass in *121 University of Pennsylvania Law Review* 87 (1972). In 1975 the A.B.A.'s Law and Medicine Committee proposed a resolution containing yet another "definition of death." The House of Delegates approved that resolution, stimulating the Uniform Law Commissioners to consider the topic for a uniform act. In 1979 they produced the Uniform Brain Death Act, and the A.M.A. also published a Model Definition of Death Act. In all, 29 states have adopted one or the other of these drafts.

All these drafts permit "brain death" determinations to be made on an equal footing with common law, cardiorespiratory determinations of death. Brain death determinations are not different in kind from common law, cardiorespiratory determinations. They merely represent a change in diagnostic techniques. But the common law reliance on cessation of cardiac and respiratory functions creates a dilemma when the cardiorespiratory system is sustained beyond the death of the brain by life-saving apparatus that is available in most hospitals. Can death be legally determined? Since these acts all serve the same policy and certain concepts have become common currency between them, the proliferation of "model" and "uniform" acts seemed likely to confuse, rather than solve, the fundamental problem.

In May, 1980, representatives of the A.B.A., A.M.A., and U.L.C. met to seek agreement on a common uniform act. Professor Capron, co-author of the Capron and Kass model and now executive director of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, participated in the meeting. An agreed text was settled on, and the representatives turned to their organizations to obtain approval. U.L.C. adopted the new Uniform Determination of Death Act to replace the Uniform Brain Death Act in August, 1980. The A.M.A. approved it in October, 1980. The A.B.A. acted on the recommendation of its Law and Medicine Committee at its 1981 midyear meeting. On July 9 of this year the president's commission endorsed the uniform act and joined the three organizations in urging its adoption by the states.

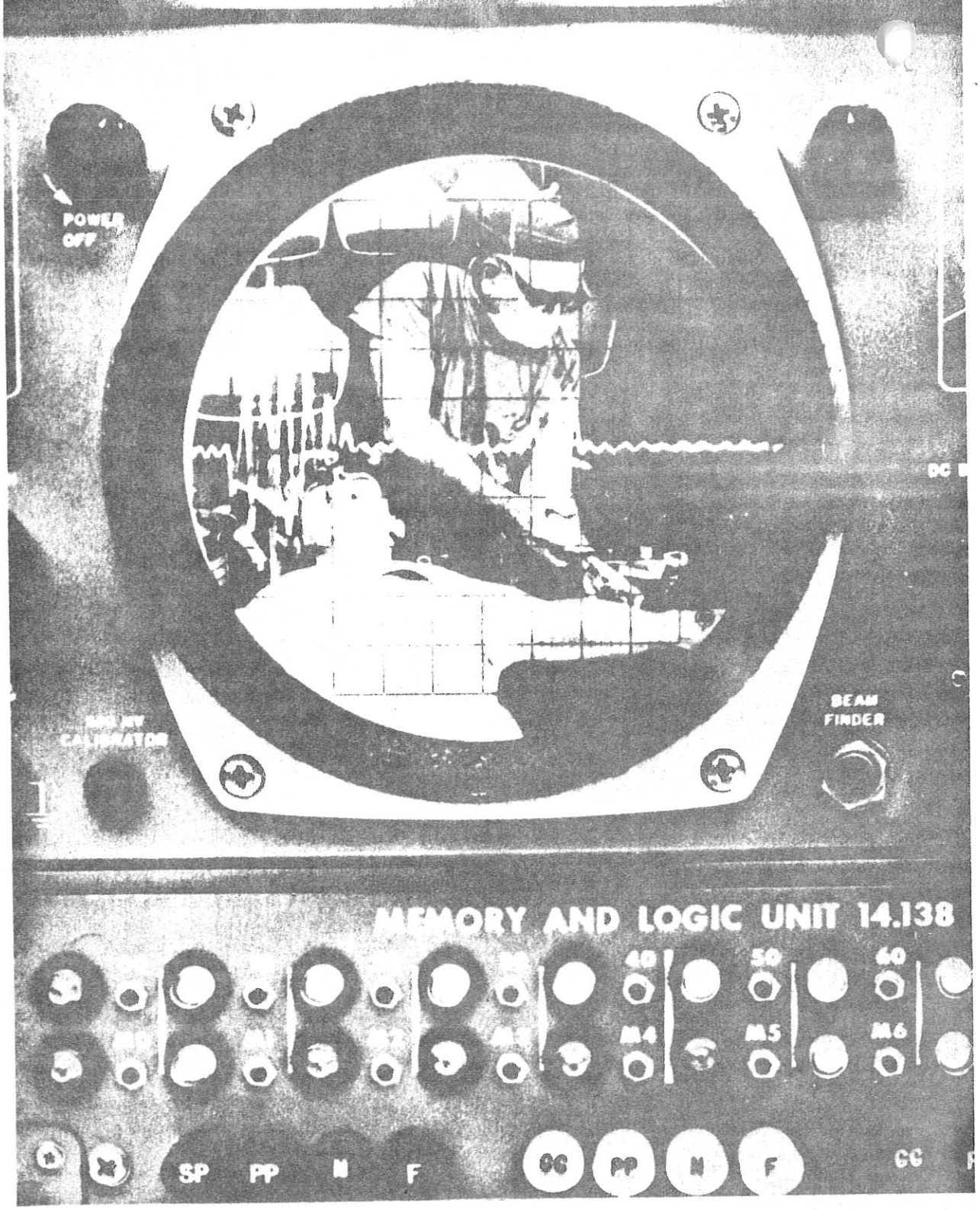
The evolution of the law and the agreement of the organizations follow medical advances in technology and diagnostic techniques designed to save, not terminate, lives. For example, 20 years ago a victim of cardiac arrest suffered outside a hospital had virtually no chance of survival. Today up to one of five survives and returns to a normal life. Technology is the key — respirators, intubation, and cardiorespiratory resuscitation. In acute emergencies, such as cardiac arrest or severe head injury, medical teams concentrate on stabilizing cardiorespiratory functions as part of the life-saving process. The near miracles these procedures work often astound laymen.

Medical teams concentrate on life. It is ironic that their life-saving technology and efforts refocus attention on death and its determination. Sometimes the medical arsenal of respirators and supporting devices maintains heartbeat and respiration in patients who suffer complete, irreversible brain damage. When a medical team works to stabilize cardiorespiratory functions, it does not have the time to ascertain the extent of brain damage. If the brain damage is not total and irreversible, the team succeeds in keeping the patient alive. If the brain has irreversibly and totally ceased to function, death must be the final and inevitable diagnosis. Death has occurred, although the intricate machinery attached to the patient continues to circulate blood and maintain respiration. While the patient is dead, without some extension of the common law, it is uncertain that death legally can be determined.

But if death has occurred, won't cardiorespiratory functions fail eventually? Yes, they will, but the interim period presents potentially difficult problems. These functions may last for some time, up to 30 days in certain cases. Some persons suffering brain death are potential organ donors. Fresh organs are essential to the preservation of other lives. Cardiorespiratory support systems can sustain the heart and lungs beyond the time when deterioration makes organs unusable. Brain death determinations are essential if organs are to be available for others. Again, the decision for death is, ironically, connected to decisions for life.

The longer the machinery is used, the greater the costs to family, insurers, or, if all else fails, the taxpayers. Hospital costs are enormous. Each day a brain death victim is retained unnecessarily on cardiorespiratory support, the costs mount. In addition, machinery used on a person who has suffered irreversible and total brain death cannot be used to save other lives. Not only do costs mount, but hospital resources are stretched unnecessarily. For each of these reasons, legislation permitting brain death determinations has become essential.

Current case law also points to the



need for a properly drafted act for the determination of death. A series of cases has come from the courts, the first, *Massachusetts* v. *Golston*, 366 N.E. 2d 744, decided by the Supreme Judicial Court of Massachusetts in 1977, and the most recent, *In re Welfare of Bowman*, 617 P. 2d 731, decided in 1980 by the Supreme Court of Washington. In all these cases determinations of death by brain death criteria were incorporated into the common law in advance of legislative enactment. In two cases—*Arizona* v. *Fierro*, 603 P. 2d 74 (1979), and *Lovato* v. *District Court*, 601 P. 2d 1072 (Colo. 1979)—the Uniform Brain Death Act was incorporated into the common law. In *Bowman* it was the Uniform Determination of Death Act.

Lovato and *Bowman* involved child abuse that ripened into homicide. *Golston* was a beating homicide, and in *Fierro* a shooting resulted in death. The child abuse cases seem particularly pathetic. Apparently it is common for the victims of child abuse to be brought in for emergency treatment, comatose and suffering from severe head injuries. The head of a young child is particularly fragile. Despite all the work of the responding medical team, brain death takes place. It is a sad scenario.

The child abuse and adult homicide

Photograph courtesy of UPI

ises share the question of what happens legally when a medical determination of brain death is made. Will the medical decision somehow become a defense in any prosecution of the assailants for criminal charges arising from the death? In all these cases, the courts have refused to obscure the criminal law and to permit a gratuitous defense to develop from brain death determinations. All the courts have authorized determinations of death based on brain death criteria.

But another loose end remains to be considered. An ironic effect of technology and the advances in medical science is the ambiguity raised between life and death. That the distinction is less sure than in the more primitive past is exemplified by the distinction between total and irreversible brain death and the "persistent vegetative state." In the former all functions of the total brain cease irreversibly. The persistent vegetative state involves loss of substantial function in the cerebral cortex, to the extent that autonomous functions continue. Permanent coma follows. Technology saves people in this state as it would not have in earlier times. The question of life in this state is one that likely will be addressed in coming decades. The outcome of the debate cannot be forecast at this time, but its existence is certain. The Karen Ann Quinlan case in recent history marks a kind of beginning for this debate because Karen Ann Quinlan remains in a "persistent vegetative state" to this time. The court proceedings surrounding her individual plight did not concern brain death but whether her support systems could be terminated even though her brain was not wholly and irreversibly destroyed.

The Uniform Determination of Death Act sharpens the distinction between life and death. There is general and near universal agreement that death takes place when the brain totally and irreversibly ceases to function. The act makes the clearest distinction that now can be made between life and death and separates it from the debates sure to follow over life and death in contexts such as that of the "persistent vegetative state." If the distinction is not clearly made now, policy decisions of the future will be confused and muddled. To encourage future confusion is to invite potential disaster in what will be very critical public decisions.

The Uniform Determination of Death Act is short and simple: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."

It establishes the standard under which physicians may make determinations of death. Section 1, part (1), incorporates the common law determination by cessation of cardiorespiratory functions. This language simply states the long accepted standard. Section 1, part (2), incorporates brain death determinations. Section 1, part (2), is carefully framed, however, to emphasize the totality of the brain death concept. It refers to "all functions of the entire brain." Section 1 is complete with a general reference to "accepted medical standards."

The act serves medicine as a life-saving and life-preserving profession

It is important to emphasize that the Determination of Death Act sets the standard. It does not establish medical criteria for determination of death. That is left to the medical profession. Capron and Kass, in their seminal article cited earlier, postulated four conceptual levels for a possible definition incorporating brain death: (1) the basic concept or idea; (2) general physiological standards; (3) operational criteria; and (4) specific tests or procedures. The law can respond best at (2); (1) is for theologians and philosophers; (3) and (4) are for the medical profession. The Uniform Determination of Death Act operates at level (2). The other levels are important but cannot be addressed by statute.

In creating the act, however, the drafters had to be particularly assured that the technology and diagnostic techniques were satisfactory at levels (3) and (4). Specific criteria for conclusively diagnosing brain death have been developed. Criteria used in the United States are derivations of the so-called Harvard criteria, established by an ad hoc committee of the Harvard Medical School and published in 1968. The essential tests for brain functions are relatively simple. Key stimuli are applied to check awareness and responsiveness. The respirator is turned off for regular, short intervals to see if the patient will breathe spontaneously. The patient is tested for specific reflexes. Under the Harvard criteria t tests are made and remade at least 24 hours later than the first tests. The patient's medical record is searched, and evidence of drug use that can simulate brain death is sought. If the attending physicians are uncertain about drug use, the patient receives continued treatment beyond the 24-hour period until they are assured that loss of brain functions is not drug induced. The careful application of all these tests establishes whether brain death has occurred while the lungs and heart continue to be supported artificially.

The diagnosis may be confirmed by electroencephalography and more recently by C.A.T. scans (computerized axial tomography), where available, and by certain radioisotope tests. The technology and criteria continue to be sharpened as time goes on. Because better technology is expected, it is important not to incorporate criteria into the statutes. To do so raises the possibility that a statute will require outdated criteria after better criteria are developed. In any case, the drafters were satisfied with the current state of criteria. They are adequate, and they will only improve.

The Uniform Determination of Death Act is meant only to permit the limited extension of diagnostic techniques made possible because of the enormous achievements in medical science to which we have all become accustomed. There are a number of topics it does not address. It does not deal with individual liability of physicians who make death determinations. It does not deal with living wills, death with dignity, euthanasia, rules concerning death certificates, maintaining life support beyond brain death in cases of pregnant women or of organ donors, and protection for a dead body. These are topics well beyond the scope of this act.

With its limited scope, the Uniform Determination of Death Act clarifies the responsibility of physicians and eliminates barriers to the modern practice of medicine. It serves medicine as a life-saving and life-preserving profession. It would be unconscionable for matters of life and death to be treated differently in different jurisdictions. Therefore, it is hoped that the Uniform Determination of Death Act will achieve uniformity between the states without undue delay. *Journal*

(John M. McCabe is legislative director of the National Conference of Commissioners on Uniform State Laws.)

Proposed amendment of the Kansas Medical Society
March 21, 1983

ATTACHMENT # 2

SB 81

AN ACT concerning death; enacting the uniform determination of death act; repealing K.S.A. 1982 Supp. 77-202.

Be it enacted by the Legislature of the State of Kansas:

Section 1. Determination of Death. An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. ~~A determination of death must be made in accordance with accepted medical standards.~~

Section 2. A determination of death must be made in accordance with accepted medical standards by a person licensed to practice medicine and surgery.

Section 3. Uniformity of Construction and Application. This act shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this act among states enacting it.

Section 4. Short Title. This act may be cited as the uniform determination of death act.

Section 5. K.S.A. 1982 Supp. 77-202 is hereby repealed.

Section 6. This act shall take effect and be in force from and after its publication in the statute book.

KANSAS SAVINGS & LOAN LEAGUE

JAMES R. TURNER
PRESIDENT

ATTACHMENT # 3

SUITE 612 • 700 KANSAS AVE. • TOPEKA, KANSAS 66603 • PHONE (913) 232-8215

March 21, 1983

TO: HOUSE JUDICIARY COMMITTEE

FROM: KANSAS SAVINGS AND LOAN LEAGUE

RE: SENATE BILL NO. 91

The Kansas Savings and Loan League appreciates the opportunity to appear before the House Judiciary Committee on Senate Bill No. 91.

A similar bill was sponsored by the Kansas Savings and Loan League during the 1982 session and referred to the Judicial Council for further study. This bill amends K.S.A. 1982 Supp. 60-2414. The principal change is found in sub-paragraph (1) relating to second sales by junior creditors. As amended, all junior creditors who file after the foreclosure petition is filed are barred from a second sale even th ough they are not joined as a party. This will eliminate the former need to check title twice to be certain all junior creditors are joined who filed after the petition was filed and before the Journal Entry of Judgment. This will effectively reverse the recent Kansas Supreme Court Decision: McGraw v. Premium Finance Co. of Mo. 7 Kan. App. 2d 32 (637 P2d 472 (1981)).

G.L.G.

GLG:bw

ATTACHMENT # 4

As Amended by Senate Committee

Session of 1983

SENATE BILL No. 318

By Committee on Judiciary

2-18

AN ACT concerning crimes and punishments; relating to presentence investigation reports; amending K.S.A. 21-4604 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 21-4604 is hereby amended to read as follows: 21-4604. (1) Whenever a defendant is convicted of a misdemeanor, the court before whom the conviction is had may request a presentence investigation by a ~~probation~~ officer. Whenever a defendant is convicted of a felony, the court shall require that a presentence investigation be conducted by a ~~probation~~ officer or in accordance with K.S.A. 21-4603 *and amendments thereto*, unless the court finds that adequate and current information is available in a previous presentence investigation report or from other sources.

court services

(2) Whenever an investigation is requested, the ~~probation~~ officer shall promptly inquire into the circumstances of the offense~~; the attitude of the complainant or victim, and of the victim's immediate family, where possible, in cases of homicide;~~ and the criminal record, social history, and present condition of the defendant. Except where specifically prohibited by law, all local governmental and state agencies shall furnish to the officer conducting the presentence investigation such records as such officer may request. If ordered by the court, the presentence investigation shall include a physical and mental examination of the defendant.

To the extent practical, the court services officer shall send a form for making a victim impact statement to the victim or, in the case of incapacity or death of the victim, to the victim's spouse or a member of the victim's immediate family.

(3) Presentence investigation reports shall be in the form and contain the information prescribed by rule of the supreme court~~;~~ and. *In addition, each report* shall contain ~~such a verified crime~~

~~*victim impact statement assessing the financial, social, psychological and medical impact of the crime upon the victim voluntarily submitted by the victim or, in the case of homicide, by the victim's immediate family*~~ *and any* other information ~~as may be~~ prescribed by the district court.

(4) The judicial administrator of the courts shall confer and consult with the secretary of corrections when considering changes or revisions in the form and content of presentence investigation reports so that the reports will be in such form and contain such information as will be of assistance to the secretary in exercising or performing the secretary's functions, powers and duties.

Sec. 2. K.S.A. 21-4604 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

In addition, if the victim impact statement form is completed and returned to the court services officer, the statement shall be attached to the report.