Approved March 10, 1983
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY.

The meeting was called to order by Senator Elwaine F. Pomeroy at
Chairperson

10:00 a.m./~~p.m.~~ on February 16, 1983 in room 514-S of the Capitol.

All members ~~were~~ present ~~except:~~ were: Senators Pomeroy, Winter, Burke, Feleciano, Gaar, Gaines, Hein and Werts.

Committee staff present: Mike Heim, Legislative Research Department

Conferees appearing before the committee:

John M. McCabe, Chicago, National Conference of Commissioners on Uniform State Laws.
Jerry Slaughter, Kansas Medical Society
John Wine, Office of Secretary of State
Representative Harold Guldner
Representative David J. Heinemann
Jon Josserand, Office of Secretary of State
Bert Cantwell, Office of Governor

Senate Bill 81 - Uniform Determination of Death Act.

John McCabe appeared before the committee to explain the Uniform Determination of Death Act. A copy of his remarks and a copy of an article written by Mr. McCabe are attached (See Attachments #1, #2). A committee member inquired if there are set standards across the nation that are acceptable medical standards. Mr. McCabe answered they have levels of decision-making in determination of death. They leave it pretty much to the medical profession. They have established national criteria for the determination of death. Another committee member inquired how does the question of medical devices to keep respiratory functions apply to this. Mr. McCabe answered the standard way death has been determined for years, and brain death determination is the other way.

Jerry Slaughter appeared in support of the bill. He submitted a proposed amendment for the committee's consideration (See Attachment #3). Mr. Slaughter explained the proposed amendment to the committee. A committee member inquired if there will be problems with vital organs removed before death has been pronounced. Mr. Slaughter replied, there have been none, it is added protection. In response to Mr. Slaughter's proposed amendment, Mr. McCabe stated it is their opinion those are essentially criteria issues, and they should be left to the medical profession to make the determination. He said there hever has been a determination as this made by someone other than a doctor. He said in time it may be coming that certain technicians can make these determinations. Mr. McCabe said he thought it was not right to put this proposal in the act, because it would put a constraint on the medical profession. Committee discussion with him followed.

Senate Bill 89 - Uniform Law on Notarial Acts.

John McCabe explained the Uniform Law on Notarial Acts (See Attachment #4).

John Wine testified the Secretary of State's office support the bill. He stated it does simplify the notarial law, and it is more clear what their duties are. The chairman explained the notaries public had problems with the uniform bill so that part was deleted by the national conference. A committee member inquired if it deals with the fees. Mr. Wine said it was a separate statute. The committee member inquired what the fee is for being a notary. Mr. Wine answered, it was raised to $10.00 a year.

A committee member inquired of Mr. McCabe if there had been opposition from religious groups with regard to the death act. Mr. McCabe replied, in some cities, yes. He reported there is a mixed reaction from the Catholic church; in some cases have sided with the Right to Life movement but has not been a universal reaction. He stated the Catholic Conferences have supported some of the laws enacted by other states.

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY,

room 514-S, Statehouse, at 10:00 a.m./~~p.m.~~ on February 16, 1983.

House Bill 2056 - Concerning sheriffs; waiver of certain training requirements.

Representative Guldner, the prime sponsor of the bill, explained the bill and the amendment that was made by the House committee. He explained a sheriff in Kearney County who was hired from the police department in Garden City and had the training, but under the law, would have to take the basic academy over again. He found out later there are four other appointed sheriffs in the state who would have to go through the training again. A committee member inquired why it is amended in the manner that it is; why not leave it up to the associate director. Representative Heinemann explained the particular section that sets out law enforcement from others is K.S.A. 74-5608a. He explained the bill needs to be enacted by March or these individuals will have to enter the program in law enforcement training center. Representative Guldner said one of the reasons for doing away with this is that there is extra training for sheriffs other than what the academy training is. In answer to a question from a committee member, Bert Cantwell explained the school has different types of training, the basic training class, and there is a special sheriffs' school. Following committee discussion, Senator Gaines moved to report the bill favorably; Senator Feleciano seconded the motion, and the motion carried.

Senate Bill 7 - Filing of security interests in farm products.

Jon Josserand presented an amendment to the bill. Following his explanation, a committee member inquired what is the status of feed lot cattle, are they farm products or inventory? A staff member explained it is unclear because in one decision the court held it was a farm product, and another the court held it was inventory. Following committee discussion, Senator Gaines moved to amend the bill by adding the language provided by Jon Josserand of the Secretary of State's office. Senator Winter seconded the motion. Following further committee discussion, the motion carried. Following committee discussion, Senator Winter moved to amend the bill to require the Secretary of State's office to provide telephone information upon request and provide them the authority to charge an appropriate fee for that service; Senator Feleciano seconded the motion and the motion carried. Senator Gaar moved to report the bill favorably as amended; Senator Hein seconded the motion, and the motion carried. Senator Feleciano requested to be recorded as voting "no".

Senator Gaar moved that the mintues of February 10, 1983, be approved; Senator Winter seconded the motion, and the motion carried.

The meeting adjourned.

2-16-83

GUESTS

SENATE JUDICIARY COMMITTEE

NAME	ADDRESS	ORGANIZATION
John M. McCabe	645 N. Mich, Chicago	NCCUSL
Grant Hill	R#1 Plevna	Farm Bureau
Jerry Robinson	R# Buhler	" "
Wayne Yoder	R 1 Hutch	F" B'
Ray Lowe	Rt 4 Hutchinson	F. B.
Eli E. Mishler	Rt 1 Hutchinson	F. B.
Jack + Zola McGonigle	Abbyville, Ks	F. B
Dale & Barbara Snodgrass	Mt. Hope, Ks.	F. B.
Phyl Fitzgerald	3035 Lydia Topeka	Notary Clerk (SoS)
John Neil Jr		Sec of State offc
James Brothers	Topeka	Kans Bar assn
Lynette Lloyd	Concordia	
Julia L. Erickson	"	
Jim Clark	Topeka	KCDAA
David Ream	Mission, Ks	FTC
Gregg Matson	Law	Steineger
Valerie Whitney	Concordia	

2-16-83

#1

UNIFORM DETERMINATION OF DEATH ACT

During the 1970s, 25 states enacted brain death legislation, and three states sanctioned the brain death concept through state Supreme Court decisions. Legislation in 16 states was patterned after four model acts or laws: the Kansas law (1970) (1), Capron and Kass proposal (1972) (2), the American Bar Association model (1975) (3), and the Uniform Brain Death Act (UBDA) of the National Conference of Commissioners on Uniform State Laws (1978) (4). Laws in the other nine states did not follow any particular model (5). Two of the three states with Supreme Court decisions incorporated the language of the Uniform Brain Death Act into their decisions (6).

In December 1979, the House of Delegates of the American Medical Association approved an amended AMA model. Thus, by the end of the 1970s, three national organizations--the ABA, AMA, and NCCUSL--had each supported enactment of brain death legislation in general and had proposed their own model acts.

In 1980, the most significant event in brain death legislation occurred when representatives of the ABA, AMA, and NCCUSL, at a meeting in Chicago

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(1) Kansas, Maryland, New Mexico, Virginia
(2) Alabama, Alaska, Hawaii, Iowa, Louisiana, Michigan, Texas, West Virginia
(3) Montana, Tennessee
(4) Nevada, Wyoming
(5) Arkansas, California, Connecticut, Georgia, Idaho, Illinois, North Carolina, Oklahoma, Oregon
(6) Arizona and Colorado; Massachusetts did not specify any particular model.

Atch. 1

on May 23, drafted the Uniform Determination of Death Act (UDDA). It is anticipated that all three organizations will have formally endorsed this act by early 1981.

The Uniform Determination of Death Act is a simple, concise act with only one section:

> 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. (7)

On July 23, 1980, the Ethics Committee of the American Academy of Neurology endorsed this new act. In a previous editorial discussing the Uniform Brain Death Act (8), the Ethics Committee gave reasons for its support of the UBDA. Except for the inclusion of the heart-lung standard into the UDDA, it is our opinion that these two model acts are essentially identical. Thus, the comments and rationale of the previous editorial apply equally to both acts. We will now review those considerations and relate them specifically to the UDDA (9).

Like the UBDA, the UDDA has as its fundamental purpose the statutory recognition of the concept that the death of the brain

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(7) The Uniform Brain Death Act, adopted by the NCCUSL on August 3, 1978. reads as follows:

> For legal and medical purposes, an individual with irreversible cessation of all functioning of the brain, including the brain stem, is dead. Determinations of death under this act shall be made in accordance with reasonable medical standards.

(8) Uniform Brain Death Act. Neurology 29:417-418, 1979.

(9) Activities which led to the drafting of the UDDA and its progress thus far among the involved organizations, as well as the role of the AAN, are covered in the newsletter section of this journal (p.).

is equivalent to the death of the person. The UBDA did not expressly include the heart-lung standard for three interrelated reasons: (1) the heart-lung standard had been accepted by common law; (2) the need was for statutory recognition of the brain standard; and (3) the act should be as simple and brief as possible to address the specific need. While this line of thinking was reasonable, it became apparent that a one-standard death law was not entirely satisfactory. When death legislation only specified the brain standard, without including the heart-lung standard, legislators and others questioned whether there might not be other standards besides these two. And, if there were not, was there any harm in incorporating both standards into the same piece of legislation? There was also a concern that, by adding a phrase allowing for other means of determining death without expressly mentioning what these were, the door would be open for the eventual addition of neocortical death as a third alternative means for determining death. The promulgation and acceptance of a two-standard law would be sufficiently comprehensive and make it clear that, in fact and in law, there were only two standards for a determination of human death.

Both acts, then, accomplish the same objective: to state as simply and concisely as possible that a person is dead when he has sustained either a cardiorespiratory or neurological death. By identifying both standards, the UDDA is more specific in preventing the use of other means of determining death, such as irreversible cessation of all functions of the neocortex.

The UDDA, by not referring to transplantation in any manner, applies uniformly to all persons under any circumstances which require a

determination of death. One of the most serious errors in legislation has been to amend the definition of brain death to the Uniform Anatomical Gift Act (10).

As in the acts and laws previously discussed (Kansas, Capron and Kass, ABA, UBDA, and AMA), a determination of death under the UDDA is mandatory, not permissive. The UDDA reads "An individual...is dead," not "An individual...may be considered dead." Permissive brain death statutes will only create confusion (11). One simply cannot be dead for some purposes and not for others. One of the most fundamental distinctions between determining death (cardiorespiratory or neurological) and allowing to die (as in the persistent vegetative state) is that a declaration of death is obligatory, while a decision to allow to die is permissive.

Drafters of recent model acts have become increasingly aware of the confusion that exists in the minds of many between whole brain death and the persistent vegetative state. To minimize this confusion, recent legislation has shown a trend toward being more explicit in defining the whole brain death concept, even to the point of redundancy. Illustrating this explicitness and redundancy, the UDDA defines brain death as the "irreversible cessation of <u>all functions of the entire brain, including the brain stem</u>." (Emphasis added.) Drafting committees have spent considerable amounts of time discussing the exact terminology used to define the brain death concept. Such phrases as "the functions of the entire brain" or "all functions of the brain" would have been sufficiently inclusive, but the drafters of the UDDA, like others before

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(10) Connecticut, Illinois, West Virginia
(11) Connecticut, Georgia, Oregon

them, decided to be as clear and complete as possible, and to leave no room for doubt as to their intentions. The rationale underlying this explicit definition is important. Such redundancy will not harm legislation, will not be restrictive on the medical criteria developed by the medical profession, and is another means of educating the public on the issues involved in decisions related to the severely brain damaged. A more complex and, in many ways, more significant dilemma awaits our resolution in the future--the appropriate management of patients in a persistent vegetative state and other related syndromes of severe, irreversible brain damage. By clearly distinguishing between issues of determining death and allowing to die, brain death statutes are an important initial step toward dealing with cases of less than complete destruction of the brain.

While it recognizes two definite standards for determining death, the UDDA is silent on the specific criteria and procedures used by physicians to determine that the brain has died. Under this act, physicians are free to use whatever criteria and confirmatory tests are indicated, providing it has been determined that all functions of the brain have permanently ceased (functions of the brain at a clinical level, not at cellular, biochemical, or electrical levels) and that the criteria used are consistent with accepted medical standards. One of the major concerns of the medical profession is that brain death laws would specify definite criteria. This act does not specify criteria, the time of death, the relationship between death and transplantation, or other issues related to the pronouncement of brain death. It does not prevent physicians from using appropriate confirmatory tests, nor does it preclude changes in medical standards with further advances in medical diagnosis and therapy.

This act does not include any sections on liability, as did the most recent version of the AMA model act. Sections providing for immunity for physicians or others who act in compliance with the statute are unnecessary. No liability will accrue if a physician acts reasonably and in accordance with accepted standards of medical practice. Liability provisions only unduly emphasize the medical malpractice issue at the expense of other, equally important, issues of public policy at stake in the entire question of whether a person is alive or dead.

In conclusion, the Uniform Determination of Death Act (UDDA), recently formulated by representatives of the American Bar Association, American Medical Association, and National Conference of Commissioners on Uniform State Laws, represents an important step forward in the ten year history of brain death legislation. The Ethics Committee enthusiastically supports this act and suggests that members of the AAN become familiar with the language and meaning of the act. It is hoped that neurologists will agree to provide testimony in legislative hearings and act in other ways to promote education on the issues surrounding the brain death concept.

For the Ethics Committee of the American Academy of Neurology,

Ronald E. Cranford, M.D., Chairman
Richard Beresford, M.D., J.D.
John J. Caronna, M.D.
John P. Conomy, M.D.
Paul M. Hardy, M.D.

2-16-82 #2

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

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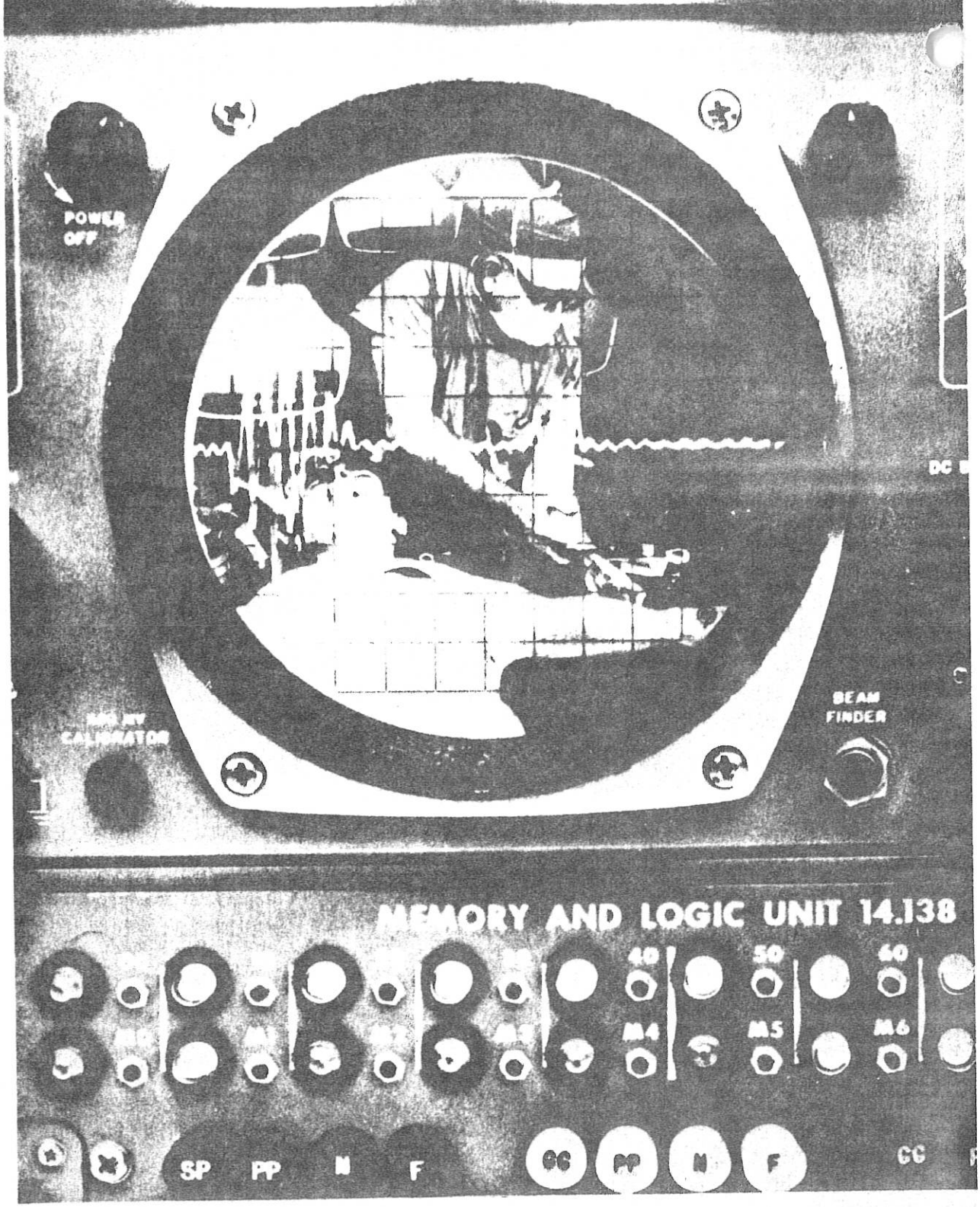

need for a properly drafted act for the determination of death. A series of cases has come from the courts, the first, *Massachusetts* v. *Golston*, 366 N.E. 2d 744, decided by the Supreme Judicial Court of Massachusetts in 1977, and the most recent, *In re Welfare of Bowman*, 617 P. 2d 731, decided 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

cases 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 cr[illegible] these tests are made and remade a[illegible]ast 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 sharpenod 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.)

2-16-83

#3

Proposed amendment of the Kansas Medical Society
February 16, 1983

SENATE BILL No. 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 by a physician in accordance with accepted medical standards.

Sec. 2. Death is to be pronounced before any vital organ is removed for purposes of transplantation.

Sec. ~~2~~ 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.

Sec. ~~3~~ 4. Short Title. This act may be cited as the uniform determination of death act.

Sec. ~~4~~ 5. K.S.A. 1982 Supp. 77-202 is hereby repealed.

Sec. ~~5~~ 6. This act shall take effect and be in force from and after its publication in the statute book.

Atch. 3

77-202. Definition of death. A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused, directly or indirectly, these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless; and, in this event, death will have occurred at the time these functions ceased; or

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function; and if based on ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before artificial means of supporting respiratory and circulatory function are terminated and before any vital organ is removed for purposes of transplantation.

These alternative definitions of death are to be utilized for all purposes in this state, including the trials of civil and criminal cases, any laws to the contrary notwithstanding.

History: L. 1970, ch. 378, § 1; July 1.

Cross References to Related Sections:

Murder and other crimes resulting in death, see ch. 21, art. 34.

Use of dead bodies by medical school, see ch. 65, art. 9.

Use of dead bodies by schools for teaching embalming, see 65-1706.

Uniform anatomical gift act, see ch. 65, art. 32.

Law Review and Bar Journal References:

Mentioned in an article on the Uniform Anatomical Gift Act as clearing up the uncertainty in the Act due to the omission of a definition as found in this section, Glee S. Smith, Jr. and Glee S. Smith III, 19 K.L.R. 569, 574 (1971).

2-16-83

#4

UNIFORM LAW ON NOTARIAL ACTS

The National Conference of Commissioners on Uniform State Laws (ULC) adopted the first Uniform Acknowledgments Act in 1892, the year, not coincidentally, of its first conference. It has been perfectly clear, right from the beginning of the uniform laws movement, that uniformity in the means, recognition, and form of acknowledgment makes great sense. What is valid and recognized in California as a true signature ought to be valid and recognized in Maine, as well.

Over time, the ULC has reviewed the Acknowledgments Act. Revisions took place in 1939, 1942, 1949 and 1960. In addition, the ULC added the Uniform Foreign Acknowledgments Act in 1914, and replaced it with the Uniform Recognition of Acknowledgments Act in 1968. These latter Acts were meant to improve the interstate and international recognition of acknowledgments. In 1982, the ULC has combined the Uniform Acknowledgment Act and the Uniform Recognition of Acknowledgments Act into the single Uniform Law on Notarial Acts.

The new Law is somewhat broader than the prior Acts. Its scope includes those acts called "notarial acts" or "any act that a notary public of this State is authorized to perform, and includes taking an acknowledgment, administering an oath or affirmation, taking a verification upon oath or affirmation, witnessing or attesting a signature, certifying or attesting a copy, and noting a protest of a negotiable instrument." The old Acknowledgment Act dealt only with the less inclusive "acknowledgment," which is the signator's verified statement of his proper capacity to execute the acknowledged instrument. The Recognition of Acknowledgments Act recognized "notarial acts," but more restrictively. The new Law simply recognizes that the responsibility of the official in all cases is the verification of the true signature and, in all instances, that every verification should be valid everywhere under the terms of this Uniform Law.

Atch. 4

It is the problem of recognition between states, between states and the federal government, and between nations that this Uniform Law principally addresses. Section 4 of the new Uniform Law on Notarial Acts states the basic rule: Any notarial act performed by a notarial officer in another state "has the same effect under the law of this State as if performed by a notarial officer of this State." Section 5 accords the same treatment to notarial acts of federal officers. Notarial acts committed in another nation, also, have the same stature as notarial acts committed in the home state, under Section 6. In all cases, the signature of the notarial officer is prima facie evidence that it is genuine.

The new Uniform Law also breaks ground in the simplification of notarial acts. Section 8 offers short forms for the commission of all notarial acts. These forms are clear, concise and inclusive. And the use of Section 8 forms meets all of the certificate requirements to which notarial officers will be subject.

In this reconsideration and combination of the two earlier Uniform Acts, the ULC has further improved signature verification and its recognition. Improved practices should be the inevitable result.