Approved: 14 June 1991
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY.

The meeting was called to order by Chairperson Senator Wint Winter Jr. at

10:05 a.m. on March 20, 1991 in room 514-S of the Capitol.

All members were present except: Senators Moran and Oleen who were excused.

Committee staff present:
Mike Heim, Legislative Research Department
Jerry Donaldson, Legislative Research Department
Gordon Self, Office of Revisor of Statutes
Judy Crapser, Secretary to the Committee

Conferees appearing before the committee:
Bob McDaneld, Board of Emergency Medical Services
Michael B. Press, Johnson County Med-Act
Myra Christopher, Midwest Bioethics Center
Tom Pollan, Sedgwick County EMS, Kansas Association of EMS Administrators and KEMTA
Ted McFarland, Douglas County Department of Emergency Medical Services and Emergency Preparedness
Joan Strickler, Kansas Advocacy and Protective Services, Inc.
Dick Hite, Kansas Bar Association
Jennifer Brandeberry, Pro Choice Action League
John Holmgren, Catholic Health Association of Kansas
Sister Mary Francine, St. Francis Hospital, Topeka
Pat Goodson, Right to Life of Kansas, Inc.
Dr. Bruce Carroll, St. Mary's
Marla Luckert, Kansas Hospital Association
Juanita Carlson, American Civil Liberties Union of Kansas
Alan Weldon, Kansans for Life

Chairman Winter called the meeting to order by opening the hearing for SB 272.

SB 272 - natural death act; pre-hospital do not resuscitate order.
SB 350 - enacting the Uniform Rights of the Terminally Ill Act.

Bob McDaneld, State of Kansas Board of Emergency Medical Services, testified in support of SB 272. (ATTACHMENT 1)

Michael B. Press, Director of Johnson County Med-Act, testified in support of SB 272. (ATTACHMENT 2)

Myra Christopher, Midwest Bioethics Center, Kansas City, testified in support of SB 350 and SB 272. She stated that "heroic" life prolonging efforts are not always appropriate and suggested a change in SB 272 to "qualified patients." Her definition for "qualified" would include patients with terminal restrictions. She continued to say requiring two physicians signatures could be a major problem in rural areas and that "medically appropriate determinants" is a meaningless phrase as it is based on individual values.

Tom Pollan, Sedgwick County EMS, Kansas Association of EMS Administrators and KEMTA, testified in support of SB 272. (ATTACHMENT 3)

Ted McFarland, Director of Douglas County Department of Emergency Medical Services and Emergency Preparedness, testified in support of SB 272. (ATTACHMENT 4) Mr. McFarland presented the Committee with written testimony from Dr. H. Laird Ingham, Douglas County Ambulance Service, in support of SB 272. (ATTACHMENT 5)

Joan Strickler, Kansas Advocacy and Protective Services, Inc., testified on SB 350 and SB 272, offering suggested amendments. (ATTACHMENT 6)

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY,

room 514-S, Statehouse, at 10:05 a.m. on March 20, 1991.

Dick Hite, Kansas Bar Association, testified in support of SB350. He stated the bill was drafted from suggestions of the National Conference of Commissioners on Uniform State Laws. (ATTACHMENT 7) Mr. Hite stated he had not read SB 272 so could not offer an opinion on the bill.

Jennifer Brandeberry, Pro Choice Action League, testified regarding SB 350 and suggested amendments. (ATTACHMENT 8)

John Holmgren, Executive Director of the Catholic Health Association of Kansas, testified in opposition to SB 272 and SB 350. (ATTACHMENT 9)

Sister Mary Francine, Director of Pastoral Care at St. Francis Hospital, Topeka, testified in opposition to SB 272 and SB 350. (ATTACHMENT 10)

Pat Goodson, Right to Life of Kansas, Inc., testified in opposition to SB 272 and SB 350. (ATTACHMENT 11)

Dr. Bruce Carroll, St. Mary's, presented written testimony in opposition to SB 272 and SB 350. (ATTACHMENT 12)

Marla Luckert, Kansas Hospital Association, testified in opposition to SB 272 and SB 350. She stated that they do no oppose the principles involved, but from a technical standpoint.

Juanita Carlson, American Civil Liberties Union of Kansas, testified in opposition to SB 350. (ATTACHMENT 13)

Alan Weldon, Kansans for Life, testified in opposition to SB 272 and SB 350. (ATTACHMENT 14)

Written testimony was submitted by:
Keith Hornberger, Sisters of Charity of Leavenworth Health Services Corporation, in opposition to SB 350 (ATTACHMENT 15);
Keith Landis, Christian Science Committee on Publication for Kansas, requesting an interim study of SB 350 (ATTACHMENT 16);
Marilyn Brandt, Kansans for Improvement of Nursing Homes, Inc., in opposition to SB 272 and SB 350 (ATTACHMENT 17); and
Chip Wheelen, Kansas Medical Society, with their recommendations concerning SB 272. (ATTACHMENT 18)

This concluded the hearings for SB 272 and SB 350.

It was the consensus of the Committee that the issues on the Natural Death Act were too important and complex to address with the short amount of time available.

Senator Gaines moved to recommend SB 272 and SB 350 for an interim study. Senator Martin seconded the motion. The motion carried.

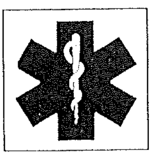
The meeting was adjourned.

Date 20 March 1991

VISITOR SHEET
Senate Judiciary Committee

(Please sign)

Name/Company	Name/Company
Juanita Carlson ACLU	
MICHAEL PRESS	JOHNSON COUNTY MED-ACT
Bob McDaneld	Board of EMS
Chip Wheelen	Kansas Medical Society
Jennifer Brandeberry	Pro Choice Action League
[illegible] Christopher	Midwest Bioethics Center
[illegible] J. Luckert	Goodell, Stratton et al on behalf of Ks Hosp Assn
Sister Mary Francine	St. Francis Hospital & Medical Center, Topeka
Marilyn Bradt	Kansans for Improvement of Nursing Home
John Stuckler	Ks Advocacy & Protective Services
Joan Kiehl	" " " "
James L. [illegible]	" " " "
Pat Goodson	~~RTL~~ Right To Life of KS
BARB REINERT	KS. League of Women Voters
Ted McFarlane	Douglas County EMS + FD
Tom Pollan	SEDGWICK COUNTY EMS
Cleta Renyer	Right to Life of Ks.
Kenda Bartlett	Concerned Women for America of KS
Paul Shelby	OJA
Alan Weldon	Kansans For Life
Kim L. Murphree	Women's Transitional Care Services
[illegible]	KS Dept on Aging
Jeannie Chaney-Martin	Atty-at-Law - Lawrence KS
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
JOHN H Holmgren	Catholic Health Assn
HAROLD RIEHM	KS ASSN OSTEOPATHIC MED
R D Frey	KHA Topeka.



State of Kansas
BOARD OF EMERGENCY MEDICAL SERVICES

109 S.W. 6TH STREET, TOPEKA, KS 66603-3805
(913) 296-7296 *Administration*
(913) 296-7403 *Education & Training*
(913) 296-7299 *Examination & Certification*
(913) 296-7408 *Planning & Regulation*

Bob McDaneld
Administrator

Joan Finney
Governor

DATE: March 19, 1991

TO: Senate Judiciary Committee

FROM: Bob McDaneld

SUBJECT: Testimony in Support of SB 272

The Board of Emergency Medical Services is the state agency which regulates all aspects of pre-hospital emergency medical care. This includes the licensing of ambulance services and the certification of ambulance attendants. The board requested the introduction of SB 272 to resolve a serious liability and ethical problem for ambulance services and personnel.

The problem, although complex, can be simply stated: How can ambulance services and personnel have legal protection when they follow the wishes of the patient and family members to not provide emergency medical care when they are called to a home where a person is dying?

SB 272 provides a solution to this problem. By amending the "Kansas Natural Death Act" to include specific protection for emergency medical services providers, the legal risks for failing to provide care are minimized. The language in SB 272 was developed by Johnson County Med-Act and the Johnson County Medical Society after several years of study.

The Board of Emergency Medical Services introduced this legislation at the request of Johnson County Med-Act. The board strongly supports SB 272 and requests your support.

RM/st

Senate Judiciary Committee
3-20-91
Attachment 1

TESTIMONY OF MICHAEL B. PRESS
DIRECTOR, JOHNSON COUNTY MED-ACT
IN SUPPORT OF S.B. 272

--Paramedics and EMT's in Kansas are frequently confronted by family members of terminally ill patients, who call for help when the patient stops breathing. Quite often, the family desires no resuscitative efforts on the patient's behalf and states that that was the patient's wishes, as well. However, pre-hospital care providers have a duty to act and begin resuscitation, without any clear-cut directives to do otherwise. This upsets family members greatly, causing anguish, unnecessary medical expense, and threats of legal action against EMS systems.

--In order to reduce confusion about patients wishes in the event of cardiac and/or respiratory arrest, these amendments to the Natural Death Act are proposed to allow a recognizable, consistent Do Not Resuscitate (DNR) form to be presented to first-responders and EMS attendants. This will standardize the Pre-hospital DNR Form and eliminate the use of scribbled notes, doctor's prescriptions, and other documents that are intended to express a patient's wishes in the event of cardiorespiratory arrest, but in reality create more confusion and liability for EMS systems. A standard form used throughout the state can be incorporated in educational curricula for training programs, and health care providers can provide them to qualified patients as the need arises.

--We believe that these modifications to the Natural Death Act are consistent with the legislative intent of the original Act, and clarify that intent for pre-hospital care providers and their patients. We also believe that patients, family members, health care providers, and the community at large will be better served by adopting these modifications that clarify the wishes and desires of qualified patients and the actions of emergency services personnel who answer their call for assistance.

Senate Judiciary Committee
3-20-91
Attachment 2

SEDGWICK COUNTY, KANSAS

EMERGENCY MEDICAL SERVICES

OFFICE OF THE DIRECTOR

538 N. MAIN
WICHITA, KANSAS 67203-3754
(316) 383 - 7994

To: Chairperson Winter and Honorable Members of the Senate Judiciary Committee

From:Tom Pollan, Director

Date:March 20, 1991

Re: S.B. 272

Sedgwick County EMS appears in support of S.B. 272 regarding pre-hospital do not resuscitate orders.

Sedgwick County EMS is the largest provider of pre-hospital emergency medical services within Kansas and responds to 1 out of every 5 EMS calls responded to in the State. Sedgwick County responds to over 500 cardiac arrest victims annually and since 1976 has resuscitated 1 out of very 4 victims suffering from cardiac arrest. These numbers don't include the ever increasing incidents we encounter where families have or desire to implement a "do not resuscitate" (DNR) procedure. The families that have followed the Medical Society of Sedgwick County's guidelines and have a valid DNR are relatively easy to work with. But when the family desires a DNR and has failed to receive a proper form, the scene can be extremely difficult for the family and the EMS providers. Conflicts are not uncommon between family and those who are required to provide services, when a valid DNR is not available. By placing DNR's in statute form, you may eliminate some of these conflicts.

One thing that does not seem to be addressed in this bill is what is required to notify an EMS provider that a valid DNR is to be executed. Does it have to be present and read by the EMS provider? Can it be verbally relayed? To eliminate the potential for conflict, Sedgwick County EMS would submit the following to clarify this situation:

> **(New section) "In order for emergency medical services providers to execute a pre-hospital do not resuscitate order for a qualified patient, the pre-hospital do not resuscitate order must be presented to said providers."**

Senate Judiciary Committee
3-20-91
Attachment 3

We recognize that Sec. 2 (c) makes it unlawful to willfully withhold or conceal, but this will place the responsibility of having the DNR with the victim or their guardian, during the time of need.

Nothing in this act will completely stop the difficult situations that EMS providers are placed in when a DNR is desired, but doesn't exist. Only public education by physicians, hospital, EMS providers, and other health care agencies on how to implement this program will eliminate those situations. However, the recognition of DNR's in legislation is necessary to ensure solid legal grounds for such orders. Sedgwick County EMS supports legislative action to legitimize DNR's for the pre-hospital EMS community. As K.S.A. 65-28,101 states, "... adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care" and this bill would allow EMS providers to execute a qualified patient's rights.

Thank you for your consideration of this humane issue.

Should you have any questions, please contact me.

Sincerely,

Tom Pollan
Director

Douglas County

Department of Emergency Medical Services and Emergency Preparedness

Ted McFarlane, Director

REFERENCE SB 272 MARCH 19, 1991

MY NAME IS TED McFARLANE, I AM THE DIRECTOR OF DOUGLAS COUNTY EMS & EP. WE PROVIDE PARAMEDIC LEVEL CARE TO THE CITIZENS OF DOUGLAS COUNTY. I WOULD LIKE TO SPEAK IN SUPPORT OF SENATE BILL 272.

THIS BILL ADDRESSES A REAL PROBLEM FOR PRE-HOSPITAL EMERGENCY MEDICAL PERSONNEL. TODAY THERE IS NO UNIVERSALLY ACCEPTED METHOD OF COMMUNICATING SOMEONE'S DESIRE FOR WITHHOLDING WHAT MOST PEOPLE CONSIDER "HEROIC" MEDICAL CARE MEASURES AT THE TIME OF DEATH. LIVING WILLS DON'T DO IT BECAUSE IT IS IMPOSSIBLE FOR THE EMERGENCY CARE TECHNICIAN TO EVALUATE THE VALIDITY OF A LIVING WILL AT THE TIME OF AN EMERGENCY. SIMPLE PHYSICIAN ORDERS DON'T ACCOMPLISH IT BECAUSE THESE ARE NOT ROUTINELY GIVEN TO PRE-HOSPITAL PERSONNEL. THIS BILL WOULD CREATE A METHOD WHEREBY A PATIENT OR SOMEONE CLOSE TO THE PATIENT COULD REQUEST THAT NO HEROIC MEASURES BE TAKEN AT THE TIME OF DEATH. THIS WILL ALLOW THE PATIENT'S DESIRES TO BE RESPECTED BY THE PRE-HOSPITAL PERSONNEL. AT THE SAME TIME IT WILL REMOVE THE PRE-HOSPITAL PERSONNEL FROM A NO WIN SITUATION WHERE SOMEONE IS DISPLEASED WITH EITHER COURSE OF ACTION THEY MIGHT TAKE.

I URGE YOUR FAVORABLE CONSIDERATION OF SB 272.

Senate Judiciary Committee
3-20-91

Ambulance Service Division
225 Maine Street
Lawrence, Kansas 66044
(913) 843-7777

Emergency Preparedness Division
Judical and Law Enforcement Center
111 East Eleventh
Lawrence, Kansas 66044
(913) 841-7700 Extension 259

Attachment 4

DOUGLAS COUNTY AMBULANCE SERVICE

225 Maine
Lawrence, Kansas 66044
(913) 843-7777

To: Senate Judiciary Committee

Reference: Senate Bill 272

Date: March 20, 1991

I have been the medical director for the Douglas County Ambulance Service for 14 years. My medical specialty is internal medicine. I have reviewed Senate Bill 272 and discussed it with the ambulance service Director Ted McFarlane. I think it is a step forward in dealing with a difficult out of hospital situation. When there is a desire on the part of the terminally ill or aged patient or the patient's family members to allow the patient to die without heroic efforts on his behalf we should honor this desire. This bill would help us do so.

I encourage you to support Senate Bill 272.

Laird Ingham

H. Laird Ingham, M.D.
404 Maine
Lawrence, Ks. 66044

Senate Judiciary Committee
3-20-91
Attachment 5

Kansas Advocacy & Protective Services, Inc.

513 Leavenworth, Manhattan, KS 66502 (913) 776-1541

Kansas City Area
6700 Squibb Rd.
Suite 104
Mission, KS 66202
(913) 236-5207

Wichita Area
255 N. Hydraulic
Wichita, KS 67214
(316) 269-2525

TO: The Senate Committee on Judiciary,
Senator Wint Winter, Jr., Chairperson

FROM: Kansas Advocacy and Protective Services
R.C. Loux, Chairperson

RE: S.B. 350 and S.B. 272

DATE: March 20, 1991

Our staff have reviewed S.B. 350 and S.B. 272 and offer the following observations.

Our primary focus in reviewing these measures comes from the perspective of our role in the Kansas Guardianship Program and our role in providing protection and advocacy for persons with disabilities.

One concern we have is that any resulting legislation not conflict with, what we see, as the intent of the Kansas Law on Guardianship and Conservatorship (K.S.A. 59-3018(g)(3)) which states that a guardian shall not have the power to consent to the withholding of life-saving medical procedures, except in accordance with provisions of the Natural Death Act K.S.A. (65-28,101 et seq.) Currently the Natural Death Act presumes that any declaration has been made by a qualified patient prior to an adjudication of disability at the time when the person had the capacity to give informed consent. To go beyond simply fulfilling the wishes of a ward, as documented at the time the person had the capacity to provide informed consent, to provide for the substituted judgement consent of a guardian, would appear to us to step considerably beyond the original intent of existing law. We urge caution in doing so.

First, we see some differences in the level of intervention involving a do not resuscitate order and an order to withdraw or remove life-sustaining treatment. We suggest that different standards should apply.

Second, we see it as important to recognize the diversity of persons who serve as guardians and why they were selected. A guardian might be the parent of a minor child, the parent, child or close relative of an adjudicated disabled adult, or a guardian may be a person previously a stranger to the individual. In most instances, the persons served through the Kansas Guardianship Program are served by guardians/conservators who were previously unknown to the person who is the ward. Often such a person is appointed when no family members are available to serve or are considered not appropriate to serve.

KAPS has been charged with developing systems of advocacy and protective services in Kansas relevant to the provisions of Sec. 113 of P.L. 94-103, as amended; the Developmental Disabilities Services and Facilities Construction Act, and P.L. 99-319, the Protection and Advocacy for Mentally Ill Individuals Act.

Senate Judiciary Committee
3-20-91
Attachment 6

Individuals served by the Kansas Guardianship Program often were referred, not necessarily because there was no family, but because Social and Rehabilitation Services had determined the family had no interest in the person or the family had abused or exploited the individual.

Third, we believe it important to look at the diversity of persons who have guardians appointed by the court. These persons may be in advanced years or they may be young adults with mental retardation or mental illness diagnoses. It is not impossible for subjective judgements to be made which are based on prejudices that may devalue the life of the person who is impaired.

It is with these things in mind that we suggest the attached amendments to S.B. 350.

We would prefer that the determination of a terminal condition be made by two physicians rather than only the attending physician. This would help shield against the type of situation where a doctor who consults or contracts with a facility (a nursing home for example) who may see the individual client for a brief time every other month, makes such a determination without the check and balance of a second opinion. We see the extra protection as very important.

We suggest that language from S.B. 272 be included in the definitions section which would separate out the do not resuscitate order from the decision to withdraw life sustaining treatment. We suggest there should be one standard for a do not resuscitate order and a higher standard for an order to withdraw life sustaining treatment.

We wish to clarify that when there is a designated attorney-in-fact pursuant to the durable power of attorney act, or where there is a guardian, that the applicable durable power of attorney instrument or relevant court document (in situations involving guardianships) specifically state the authority to make decisions regarding the withholding or withdrawal of life-sustaining treatment.

When there is no declaration, we further suggest that, except in situations involving a do not resuscitate order, consent to the withholding or withdrawal of treatment only be given when authorized by order of the court. We maintain that the benefits of protecting persons who may be socially devalued far outweigh the inconvenience of making a living will or of getting a court order.

Respectfully submitted,

Joan Strickler
Executive Director

JS:jag

Session of 1991

SENATE BILL No. 350

By Committee on Judiciary

2-27

8 AN ACT enacting the uniform rights of the terminally ill act.
9
10 *Be it enacted by the Legislature of the State of Kansas:*
11 Section 1. As used in this act, unless the context otherwise
12 requires:
13 (a) "Attending physician" means the physician who has primary
14 responsibility for the treatment and care of the patient;
15 (b) "declaration" means a writing executed in accordance with
16 the requirements of subsection (a) of section 2; [s] [or (d)]
17 (c) "health care provider" means a person who is licensed, cer-
18 tified or otherwise authorized by the law of this state to administer
19 health care in the ordinary course of business or practice of a
20 profession;
21 (d) "life-sustaining treatment" means any medical procedure or
22 intervention that, when administered to a qualified patient, will serve
23 only to prolong the process of dying;
24 (e) "person" means an individual, corporation, business trust,
25 estate, trust, partnership, association, joint venture, government,
26 governmental subdivision or agency, or any other legal or commercial
27 entity;
28 (f) "physician" means an individual licensed to practice medicine
29 in this state;
30 (g) "qualified patient" means a patient 18 or more years of age
31 who has executed a declaration and who has been determined by [two physicians, one of whom is]
32 the attending physician to be in a terminal condition;

[(h) "resuscitate" or "resuscitation" means the administration of any medically accepted method of cardiopulmonary resuscitation, including, but not limited to, cardiac compression, endotracheal intubation and defibrillation, the purpose of which is to induce cardiac function or respiratory function or both such functions in a patient after such function or functions have ceased.]

33 (h) "state" means a state of the United States, the District of
34 Columbia, the commonwealth of Puerto Rico, or a territory or insular
35 possession subject to the jurisdiction of the United States; and
36 (i) "terminal condition" means an incurable and irreversible con-
37 dition that, without the administration of life-sustaining treatment,
38 will, in the opinion of the attending physician, result in death within
39 a relatively short time.
40 Sec. 2. (a) An individual of sound mind and 18 or more years
41 of age may execute at any time a declaration governing the with-
42 holding or withdrawal of life-sustaining treatment. The declarant may
43 designate another individual of sound mind and 18 or more years

Session of 1991

SENATE BILL No. 350

By Committee on Judiciary

2-27

8 AN ACT enacting the uniform rights of the terminally ill act.
9
10 *Be it enacted by the Legislature of the State of Kansas:*
11 Section 1. As used in this act, unless the context otherwise
12 requires:
13 (a) "Attending physician" means the physician who has primary
14 responsibility for the treatment and care of the patient;
15 (b) "declaration" means a writing executed in accordance with
16 the requirements of subsection (a) of section 2;
17 (c) "health care provider" means a person who is licensed, cer-
18 tified or otherwise authorized by the law of this state to administer
19 health care in the ordinary course of business or practice of a
20 profession;
21 (d) "life-sustaining treatment" means any medical procedure or
22 intervention that, when administered to a qualified patient, will serve
23 only to prolong the process of dying;
24 (e) "person" means an individual, corporation, business trust,
25 estate, trust, partnership, association, joint venture, government,
26 governmental subdivision or agency, or any other legal or commercial
27 entity;
28 (f) "physician" means an individual licensed to practice medicine
29 in this state;
30 (g) "qualified patient" means a patient 18 or more years of age
31 who has executed a declaration and who has been determined by
32 the attending physician to be in a terminal condition;
33 ~~(h)~~ (i) "state" means a state of the United States, the District of
34 Columbia, the commonwealth of Puerto Rico, or a territory or insular
35 possession subject to the jurisdiction of the United States; and
36 ~~(i)~~ (j) "terminal condition" means an incurable and irreversible con-
37 dition that, without the administration of life-sustaining treatment,
38 will, in the opinion of the attending physician, result in death within
39 a relatively short time.
40 Sec. 2. (a) An individual of sound mind and 18 or more years
41 of age may execute at any time a declaration governing the with-
42 holding or withdrawal of life-sustaining treatment. The declarant may
43 designate another individual of sound mind and 18 or more years

1 Witness ____________________
2 Address ____________________
3 Witness ____________________
4 Address ____________________
5 Name and address of designee.
6 Name ____________________
7 Address ____________________
8

9 (d) The designation of an attorney-in-fact pursuant to the durable
10 power of attorney act , or the judicial appointment of an individual
11 guardian , ~~who is~~ [which attorney-in-fact or guardian is specifically] authorized to make decisions regarding the with-
12 holding or withdrawal of life-sustaining treatment, constitutes for
13 purposes of this act a declaration designating another individual to
14 act for the declarant pursuant to subsection (a).
15 (e) A physician or other health care provider who is furnished a
16 copy of the declaration shall make it a part of the declarant's medical
17 record and, if unwilling to comply with the declaration, promptly
18 so advise the declarant and any individual designated to act for the
19 declarant.
20 Sec. 3. A declaration becomes operative when: (a) It is com-
21 municated to the attending physician; and (b) the declarant is de-
22 termined by the attending physician to be in a terminal condition
23 and no longer able to make decisions regarding administration of
24 life-sustaining treatment. When the declaration becomes operative,
25 the attending physician and other health care providers shall act in
26 accordance with its provisions and with the instructions of a designee
27 under subsection (a) of section 2 or comply with the transfer re-
28 quirements of section 8.
29 Sec. 4. (a) A declarant may revoke a declaration at any time and
30 in any manner, without regard to the declarant's mental or physical
31 condition. A revocation is effective upon its communication to the
32 attending physician or other health care provider by the declarant
33 or a witness to the revocation.
34 (b) The attending physician or other health care provider shall
35 make the revocation a part of the declarant's medical record.
36 Sec. 5. Upon determining that a declarant is in a terminal con-
37 dition, the attending physician who knows of a declaration shall
38 record the determination and the terms of the declaration in the
39 declarant's medical record.
40 Sec. 6. (a) A qualified patient may make decisions regarding life-
41 sustaining treatment so long as the patient is able to do so.
42 (b) This act does not affect the responsibility of the attending
43 physician or other health care provider to provide treatment, in-

6-9

1 cluding nutrition and hydration, for a patient's comfort, care or al-
2 leviation of pain.
3 (c) Life-sustaining treatment must not be withheld or withdrawn
4 pursuant to a declaration from an individual known to the attending
5 physician to be pregnant so long as it is probable that the fetus will
6 develop to the point of live birth with continued application of life-
7 sustaining treatment.
8 Sec. 7. (a) ~~If~~ written consent to the withholding or withdrawal
9 of the treatment, witnessed by two individuals, is given to the at-
10 tending physician, the attending physician may withhold or withdraw
11 life-sustaining treatment from an individual ~~who:~~
12 (1) ~~Has~~ been determined by ~~the attending physician~~ to be in a
13 terminal condition and no longer able to make decisions regarding
14 administration of life-sustaining treatment; and
15 (2) ~~has no effective declaration.~~

Except in situations involving resuscitation as defined in Section 1 of this act, if

who has no effective declaration as defined in this act, provided that:

The individual has

two physicians who have personally examined the patient, one of whom shall be the attending physician,

the withholding or withdrawal of life sustaining treatment shall first be authorized by order of the District Court, after notice which shall be given to any spouse, natural guardian, custodian guardian, conservator, and to such other persons or parties as the court shall direct, said notice to be made a reasonable amount of time before the hearing, as the court shall direct.

6-7

(b) In situations involving resuscitation as defined in Section 1 of this act, if written consent to a do not resuscitate order, witnessed by two individuals is given to the attending physician, the attending physician may issue a do not resuscitate order for an individual who has no effective declaration as defined in this act, provided that the individual has been determined by two physicians who have personally examined the individual, one of whom shall be the attending physician, to be in a terminal condition and no longer able to make decisions regarding administration of life sustaining treatment.

16 ~~(b)~~ (c) The authority to consent or to withhold consent under ~~sub-~~
17 section ~~(a)~~ this may be exercised by the following individuals, in order
18 of priority:
(1) The guardian, if one has been appointed;
19 ~~(1)~~ (2) ~~The~~ the spouse of the individual;
20 ~~(2)~~ (3) an adult child of the individual or, if there is more than one
21 adult child, a majority of the adult children who are reasonably
22 available for consultation;
23 ~~(3)~~ (4) the parents of the individual;
24 ~~(4)~~ (5) an adult sibling of the individual or, if there is more than
25 one adult sibling, a majority of the adult siblings who are reasonably
26 available for consultation; or
27 ~~(5)~~ (6) the nearest other adult relative of the individual by blood or
28 adoption who is reasonably available for consultation.
29 ~~(c)~~ (d) If a class entitled to decide whether to consent is not rea-
30 sonably available for consultation and competent to decide, or de-
31 clines to decide, the next class is authorized to decide, but an equal
32 division in a class does not authorize the next class to decide.
33 ~~(d)~~ (e) A decision to grant or withhold consent must be made in
34 good faith. A consent is not valid if it conflicts with the expressed
35 intention of the individual.
36 ~~(e)~~ (f) A decision of the attending physician acting in good faith that
37 a consent is valid or invalid is conclusive.
38 ~~(f)~~ (g) Life-sustaining treatment must not be withheld or withdrawn
39 pursuant to this section from an individual known to the attending
40 physician to be pregnant so long as it is probable that the fetus will
41 develop to the point of live birth with continued application of life-
42 sustaining treatment.
43 Sec. 8. An attending physician or other health care provider who

A Few Facts About

THE UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1985)(1989)

PURPOSE: Providing competent adults the legal framework to implement a declaration or "living will," instructing the attending physician to withhold life-sustaining treatment in the last stages of a terminal illness should they no longer be able to communicate. Now includes optional language that authorizes withdrawal of life-support by a surrogate decision maker.

ORIGIN: Completed by the Uniform Law Commissioners in 1985 and amended in 1989.

ENDORSED BY: The American Bar Association's Section on Real Property, Probate and Trust Law.

STATE ADOPTIONS OF 1985 ACT:

- Alaska
- Arkansas
- Iowa
- Minnesota
- Montana
- North Dakota

STATE ADOPTIONS WITH 1989 AMENDMENTS: Maine

INTRODUCTIONS:

- Arizona
- Massachusetts
- Ohio
- South Dakota

NEED A SPEAKER? These persons are available to provide testimony or give presentations on the Uniform Rights of the Terminally Ill Act:

Randall P. Bezanson
Lexington, Virginia
Reporter

Richard C. Hite
Wichita, Kansas
Chairman

John McCabe
Chicago, Illinois
ULC Legislative Director

For information on arranging a speaker, contact John McCabe or Katie Robinson at 312-915-0195.

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UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989)

The doctor and patient relationship requires some complex decisions these days. As we become more and more able to cure the diseases that disable and kill us, and as medical technology strives to surpass the understanding of even the most sophisticated and learned among us, a curious thing is occurring. We, as a people, are demanding an ever more substantial role in the decisions that affect health, life, and even death. It is as if overwhelming complexity has stiffened the individual resolve of each of us to take control of these momentous decisions.

Decisions about death have become as important as decisions about treatment and cure - so important that the large majority of state legislatures have seen and passed numbers of bills concerning decisions about death. The first wave of legislation that passed through the state legislatures concerned those documents that have become popularly known as "living wills." The second wave has concentrated upon durable or springing powers of attorney for health-care decisions. The plethora of legislation has created some confusion, and the quality of the enacted bills has not always been that good. There is also a distinct lack of uniformity between the states, so that "living wills" or "durable powers of attorney" drafted in one state may not necessarily be valid in another. Since most Americans do not spend all their lives within the boundaries of one state, the lack of uniformity means that many of them will have to keep different documents for different jurisdictions. People who are retired, and who maintain winter and summer residences in different states, are particularly affected by this lack of uniformity.

The Uniform Law Commissioners made an initial effort to estabilsh uniformity with respect to "living wills" in the original Uniform Rights of the Terminally Ill Act in 1985. In 1989, this act has been extensively revised to incorporate the notion of durable power of attorney and to provide a mechanism for obtaining consent when no document that can be called a "living will" or a "durable power of attorney" has ever been executed. It is this act that can establish the needed uniformity between the states.

The fundamental issue is to provide for consent to the maintenance or withdrawal of life-sustaining treatment when a person is in the last stages of a terminal illness, and when that person no longer has the capacity to communicate with the attending physicians. URTIA 1989 offers three alternatives that may be utilized in that situation.

The first is simply a continuation of URTIA 1985, the declaration that is popularly called a "living will." A living will is a written directive to the attending physician, written while a patient has the capacity to consider and decide on treatment, that tells the physician not to continue life-sustaining treatment in the last stages of a terminal illness. URTIA provides a form of general "living will" that can be taken verbatim, but any person can use any language that he or she wishes. To be effective, the declaration does require two witnesses.

If a person does not want to use a living will, but prefers to designate somebody else to make the decision, that kind of declaration becomes available under URTIA 1989, as well. URTIA allows the appointment of a surrogate to make the decision about withdrawing life-sustaining treatment. Again, the statute offers language that anybody can follow, but a person may use his or her own language to accomplish the same end. The declaration appointing a surrogate to make this decision must be witnessed, exactly as a "living will" must be. The designation of a surrogate is exactly the same as the designation of an attorney-in-fact under a durable power of attorney. URTIA establishes that any designation of an attorney-in-fact or of a judicially appointed guardian, is identical with appointing a surrogate decision-maker, and suffices as a declaration appointing one.

The third alternative is available if a person has not written either a "living will" or a declaration appointing a surrogate. The alternative is available to family members who may be faced with the decision when a person suffering a terminal illness is already incapacitated and in the last stages of that terminal illness. Key family members may give consent to withdraw treatment in such circumstances, in a witnessed writing. Only certain family members may give such consent, and only in a specific order of priority. An individual's spouse has the first priority. If there is no spouse, the next person able to consent is an adult child, or a majority of adult children available for consultation. If there are no children, an individual's parents are next able to consent. Siblings constitute the next class, and if nobody in any of these classes of family members is available, the nearest adult relative by blood or adoption available for consultation, has the power to consent.

These three options are available under URTIA. There are significant conditions for them to be selected, however. First, there must be a "terminal condition", which is defined an "an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time." Second, the declarations authorized in URTIA reach only to the administration of "life-sustaining" treatment. This is defined as "any medical procedure or intervention that, when

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administered to a qualified patient, will serve only to prolong the process of dying." These are the only conditions which make any of these declarations operative.

An operative declaration is binding upon a physician when it is communicated to the physician. If a physician objects to withdrawal of treatment, URTIA requires the patient to be transferred into the care of a physician who will honor the declaration. A physician who follows a declaration in good faith is absolved from any liability for following it.

Two situations permit a physician to refuse to follow a declaration to withdraw treatment. The declaration of a pregnant woman cannot be given force and effect if there is a probability or development of the fetus "to the point of live birth." The second situation involves the comfort care of the patient or the alleviation of pain. The physician continues to treat for these purposes even if the dying process is prolonged.

Any declaration under URTIA may be revoked "at any time and in any manner by which the declarant is able to communicate an intent to revoke, without regard to mental or physical condition."

Nutrition and Hydration in the Uniform Rights of the Terminally Ill Act

Questions have been raised about the administration of food and water to terminally ill patients under the Uniform Rights of the Terminally Ill Act (URTIA (1985)(1989)). Here are some facts about the Act and in particular how "nutrition and hydration" are treated.

The Act not only authorizes a written declaration, popularly called a "living will," but it has been revised to add the appointment of a proxy or surrogate as an alternative to the living will provisions. The revision also authorizes a patient's close relatives to consent to withdrawal of life–sustaining treatment in the absence of any form of prior instructions, so long as such decisions do not conflict with known and expressed intentions of the patient.

The patient, through a living will, or the patient's surrogate, can instruct physicians or others providing medical service to withhold life–sustaining procedures when an individual reaches the very last stages of a terminal illness. A life–sustaining procedure is any treatment that only prolongs the dying process. The instructions become effective when the individual is not competent enough to make his or her own health care decisions.

Life–sustaining treatment as defined by URTIA does not specifically exclude the giving of food and water. (A number of current state acts exclude "nutrition and hydration" so they cannot be classified as life-sustaining procedures.) Although URTIA does not specifically provide for such an exclusion, it allows food and water to be given (or any other treatment or therapy) "for comfort care or alleviation of pain." In most circumstances, food and water would be administered because it would be "necessary" for the comfort care of the patient.

It should also be noted that a person making a declaration can precisely specify what he or she wants to happen in writing. For example, if the declaration requires food and water, then the physician must give food and water even if its sole function is prolonging the dying process.

What must happen before the issue of food and water comes into the decision–making process?

> **1. A patient must have a written, witnessed declaration, or the patient's surrogate must instruct that life–sustaining procedures be withheld in the final stages of terminal illness.**
>
> **2. The patient making the declaration, must be, in fact, terminally ill.**
>
> **3. The patient must not be able to make his or her own treatment decisions.**
>
> **4. Death must be expected in a very short time.**
>
> **5. Food and water must truly be a life–sustaining procedure without benefit to the comfort care of the patient.**

The question of food and water, then, as a life–sustaining procedure is one for the professional judgment of the physician, whose professional standards should govern any decision. To withhold treatment when it benefits the patient either for cure or comfort care, violates the standards of the medical profession.

Nothing in this Act authorizes the starvation and dehydration of extremely handicapped infants, or of elderly people both in and out of institutions. The context of this Act simply does not threaten vulnerable people, and it cannot be interpreted in that manner.

ProChoice Action League ★ P.O. Box 3622, Wichita, KS 67201 ★ 316-681-2121

Dedicated★Determined★Decisive

MEMBERS OF THE SENATE JUDICIARY COMMITTEE

FROM: Jenifer Brandeberry, Pro Choice Action League

REGARDING: S.B. 350

DATE: March 20, 1991

Pro Choice Action League is concerned with S.B. 350, section 3(c), lines 4,5,6 and 7, and recommend that these lines be struck from the bill.

The very essence of a living will is freedom of choice. To construct a bill that denies this most basic freedom is totally inappropriate.

I would like to share with you two recent court cases. Although these two court cases are not exactly on point, they illustrate potential problems that section 3(c) of S.B. 350 could cause.

On April 26, 1990 the District of Columbia's highest court ruled in a 7-1 decision that "A pregnant patient's decision to refuse medical treatment is almost always paramount, even when survival of a fetus is at stake." The court stated "We hold that in virtually all cases the question of what is to be done is to be decided by the patient -- the pregnant women -- on behalf of herself and the fetus." This cases involved 27 year old Angela Carder, a terminally ill cancer patient, pregnant with a 26- week -old fetus. The District of Columbia's Superior court found it unclear what the heavily sedated Carder wanted done with the fetus and told George Washington University Hospital to perform an emergency Cesarean section. The premature infant died 2 1/2 hours after the surgery; her mother died two days later. The Cesarean section was listed as a contributing cause of Carder's death.

The second case involves Martin and Nancy Klein. Nancy Klein was comatose after a car accident in February of 1989. Nancy Klein was pregnant. Martin Klein was forced to go all the way to the United States Supreme Court in order for doctors to perform an abortion which was determined by both Nancy's physicians and her husband to be a life saving procedure. Martin Klein is currently suing two anti-abortion activists that tried to stop him from obtaining the life saving procedure for his wife.

Both of these cases illustrate the potential problems which could arise from the language written in section 3(c), lines 4,5,6 and

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7 of S.B. 350. Pro Choice Action League would recommend that the committee either insert on page 2, line 26 of the bill a statement which would read...

"The above shall be considered null and void if I am found to be pregnant."...

or should enact the language from the previous statute 65-28,103 found in section (a) stating "The declaration of a qualified patient diagnosed as pregnant by the attending physician shall have no effect during the course of the qualified patient's pregnancy."

We appreciate your consideration in this matter. Thank you.

TESTIMONY RE: SB 272

SENATE JUDICIARY COMMITTEE

SENATOR WINT WINTER, JR., CHAIR

MARCH 21, 1991

I am John Holmgren, Executive Director of the Catholic Health Association of Kansas, an association of Catholic hospitals and nursing homes in Kansas, and an interest and concern over the ethics of health care. Such concerns include concerns over death and the dying. Our Association supported the 1989 Durable Power of Attorney Act which passed the Legislature as HB 2009.

As we understand it, the EMS Service in Johnson County and the Johnson County Medical Society believe that the Kansas Natural Death Act needs to be amended to provide for those pre-hospital situations where family members at nursing homes and hospices insist that cardiac resuscitation should not be given to an elderly, terminally ill patient because they a) either don't want the patient to die at the nursing site, or b) truly believe that the patient does not want resuscitation, and may have expressed that wish, by completing a Durable Power of Attorney form. This dilemma we do appreciate. Our hospitals have very

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good relationships with what we believe to be a very fine EMS system, statewide. This places the EMS Technicians in a serious dilemma, to be asked not to resuscitate when the patient is gasping for breath or looks like he or she will have a stoppage of the heart, - because ethically and legally, the EMS unit has an obligation to resuscitate, whether at the patient's nursing home or in transport to the hospital.

Our concern is with the language or intent of the bill. We feel it is confusing at best. We believe it should be studied further. We offer the following reasons:

1.) "Medically appropriate" according to the bill amendment, provides pre-existence in a patient of a terminal illness or physical deterioration typical of and accompanied by advanced age. What is advanced age? Is it 45 yrs or 91 yrs?

2.) Today it is understood that the majority of patients who are in this situation at a nursing home or hospice, do not have a Durable Power of Attorney or Living Will. The proposed so-called Pre-Hospital DNR Request Form probably will not be found at most nursing homes also following the passage of this bill. What makes us believe otherwise? If the Administrator of the nursing home follows a policy of ensuring that the patient and relatives know about the

Durable Power of Attorney or Living Will mechanism, then this would more likely cover these situations with the nursing home patient, if a document is signed. (Cite the new Social Security amendment.)

3.) We are concerned that the DNR Request Form may be completed by those not willing to approve appropriate care, nutrition and hydration, to a relative, for reasons that may not be humane. In most cases, the Pre-Hospital Do Not Resuscitate form may be a valid procedure, and to some degree, an ethical procedure relating to a relative's wish for a dying patient to have a decent quality of life in their last hours. But this bill will not insure against those few who, for personal reasons, do not wish their dying relative to be resuscitated - perhaps, pre-maturely.

4.) Since the advent of the Nancy Cruzan case, death and dying has become a matter of community/hospital/nursing home ethics, because the right of the patient to die comfortably and under his or her agreed upon circumstance, has become a community standard. This bill may not address a "community standard" in the absence of a controlled medically ethical environment. For example, all private hospitals today are required to develop, maintain, and monitor a hospital Ethics Committee of

physicians, nurses and administrators to ensure that patients are treated in an ethical manner, especially the terminally ill.

Perhaps the development of protocols, procedures and standards relating to this issue, as developed locally by each provider with the EMS service, would be the answer. This would tend to be less of a fragmented approach because it would apply to all providers transferring or transporting patients in a terminal condition to the hospital and not the nursing home or hospice alone. There is an increased emphasis on home health care, for example, with an increased number of terminally ill who will be living in their homes. Shall we amend the law again later for this custodial group not in an institution? They are transported by the EMS in a pre-hospital mode.

The present proposal while undoubtedly well intended for good purpose introduces ambiguity and confusion and is extraordinarily vulnerable to abuse. For the reasons given we urge that this measure not be adopted at this time.

Thank you for your courtesy and interest. We appreciate your concern. We share that concern but the subject is complex and needs further study. We also believe we have a law that answers this need, the Kansas Durable Power of Attorney Act.

Sincerely,

John H. Holmgren
Executive Director

ST. FRANCIS HOSPITAL AND MEDICAL CENTER

COMMENTS ON SENATE BILL NO. 272 AND NO. 350

Sister Mary Francine, Director Pastoral Care
St. Francis Hospital and Medical Center, Topeka, KS

NO. 272 AMENDING KS. NATURAL DEATH ACT

There is a perception among many health care providers and the public that there is a direct connection between a Living Will and a do-not-resuscitate decision. This is not correct. Associating these separate issues in one Natural Death Act, reinforces this error and compounds the confusion.

Is a legal statute necessary to spell out procedures for a do-not-resuscitate protocol? Can this be accomplished more appropriately by procedures written and approved by the proper authority? I suggest that this bill is unnecessary.

NO. 350, THE UNIFORM RIGHTS OF THE TERMINALLY ILL ACT.

S.B. 350 might have looked good in the early '80s, but it appears out-of-date and unnecessary at this time. It combines a health care power of attorney and the natural death act in one document. It is inadequate on both scores. Especially so, since Kansas currently has statutes that are more comprehensive for each of these issues.

The definition of "terminal condition" clouds, rather than clears, the basis of medical judgment of this condition. Sec. 2 (a) and (c) introduce power of attorney and fail to make the power "durable". The powers of a guardian in Sec. 2 (d), contradict Kansas law.

Sec. 6 (b) addresses treatment for a patient's comfort, care or alleviation of pain. There are many comfort therapies yet SB 350 names only one, "nutrition and hydration". Will this be interpreted to mean these are always needed for comfort and should therefore be required? This is a false conclusion.

The entire Sec. 7 is problematic; (a) applies the living will principle to a person who has not executed a Declaration; and (b) names individuals who can act for the patient without reference to the KS Durable Power of Attorney for Health Care Decisions. There are other editing problems in this section.

Senate Bill 350 tries to fix something that isn't broken for the sake of "uniformity".

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RIGHT TO LIFE
OF KANSAS, INC.
Crosby Place Mall
717 S. Kansas Ave. Topeka, Ks. 66603 (913) 233-8601

March 20, 1991

Chairman, members of the committee in 1979 we spoke in opposition to the current natural death act. We warned that living wills were only the first step - the foot in the door for euthanasia and soon there would be attempts to expand the legislation. The bills we oppose today, SB 272 and 350 are just the latest of such attempts.

Some supporters would argue these are not euthanasia measures. Hemlock News the newsleter of the Washington State euthanasia society recommends attempting to change state "Living Will" legislation to incorporate the following; expand the definition of terminal condition to include persistent vegetative state; to specify that tube feeding and fluids are life sustaining procedures and may be withdrawn; They want the Living Wills to apply to everyone, not just those who have signed them and finally they point to the long painful starvation death of Nancy Cruzan and suggest that it would be more humane, efficient, and less costly to simply give a lethal injection to kill the patient

The bills before you accomplish at least one of those goals and we believe open the door at least for another. We are all familiar with the step at a time approach to legislation. If legislation accompishes the goals of the euthanasia society, even if at a step at a time, it is immaterial what we call it.

Part of SB 350 appears to be a duplication of existing law but does not repeal the existing statute. If the bar association will forgive an observation from a housewife - that is not the only instance of poor drafting in this bill. Section 7 expands the living will declaration to permit virtually any relative in an order of descending priorities to make that decision for an incapacitated person who has not signed a will. These are people who would ordinarily be consulted in normal circumstances. What is the need for this kind of legislation. It creates the potential for abuse? The current law states that adult persons have a fundamental right to control decisions regarding their treatment and the living will is a means to give them that right, but that is so much rhetoric if we are now going to expand the law to permit others to make these decision. If a person is incapacitated someone else is going to make the decisions for them anyway. Besides a persons state of mind changes with the condition. We often hear of someone who has jumped off a bridge in a suicide attempt. Often when interviewed they will say that between the bridge and the water they changed their mind. The will to live changes with the condition. Living wills and pre hospitalization DNR requests are open to abuse and color the treatment one recieves in the direction of letting people die.

Section 7 (5) (c) states that if the members of a class of persons authorized to consent or withhold consent for an incapacitated person are not available the decision falls to the next class of persons but if that class is equally divided there is a stalemate and the bill provides no means of resolving that stalemate.

Section 6 (b) appears on the surface to be a prohibition of the withdrawal of food and water but if the language is examined carefully we are not sure that it does that. Whether this is poor drafting or clever drafting would depend on the intention. Nevertheless the terms nutrition and hydration are equated with the term treatment. Food and water are not treatments. When you ate breakfast this morning you were not taking a treatment. We only consider food and water as treatment when we want someone

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to die, whose quality of live we no longer value, such as Nancy Cruzan or baby Doe in Indiana.

Section 6 (b) states this act does not affect the responsibility of the attending physician to provide food and water. What if a court determines that physicians do not have such a responsibility, or if a patient executes a form that is either explicit or ambiguous about food and water? Is the physician then relieved of the "responsibility and could he then withhold food and water. If the intent is to not authorize the withholding of food and water the language should do more than simply relieve the physician of responsibility.

Another change from current law is that SB 350 allows one physician to make the determination of terminal condition. Presently I believe, two physicians must make that determination.

SB 272 is another dangerous expansion of current law. It authorizes a pre-hospitalization DNR order. It would permit DNR orders in a discriminatory manner solely on the basis of age. According to the bill in order for a DNR order to be medically appropriate a young person must be terminally ill. For an older person a determination that DNR is medically appropriated is based soley on age.

This is a blank check. You wouldn't go to a used car dealer and give him a statement that you would buy any car at any price that was appropriate. You would specify at least some conditions. S272 sets only "physical deterioration" as to when a DNR is appropriate.

We are told that EMS personel are concerned about liability if they do not comply with a DNR order but if they have been called to a nursing home for instance to give emergency treatment that is what they should give. It is the physicians responsibility to determine the appropriateness of a DNR order in consultation with the patient and the family on a case by case basis. That is what he is trained for. There is no need for legislation which would open the door to abuse. Has any EMS or other health care provider ever been successfully sued for following doctors orders. There is no need for this legislation. If the objective is to protect everyone from a lawsuit why don't we just outlaw lawsuits. The best protection from lawsuits is still and always will be ethical behavior.

Finally both S 272 and 350 place an inappropriate burden on a physician to follow directives which may be against his ethical and moral judgement. The hippocratic oath is no longer taken by doctors. Some doctors have become technicians of death, rather than healers. Let us not force ethical physicians out of practice by enacting laws that force them to violate their own moral and ethical judgements.

Respectfully submitted - Pat Goodson, RTLK

What's All the Fuss about Tube Feeding?

Here's what's really at stake in the debate over feeding seriously ill people

By RITA L. MARKER

We've been hearing a lot lately about the feeding of seriously ill, disabled and "comatose" people.

The relatives of some of these unfortunate people insist on their right to direct that food and water be withheld from them. This view receives support from some medical people and even some religious leaders.

Others passionately resist these claims. They say that giving food to the hungry and water to the thirsty is a requirement of basic human decency.

The debate is raging across the country - not only in the legislatures and courts, but also in hospitals and nursing homes. Decisions are being made every day to stop giving food and water to patients.

What's really at stake here? Is tube feeding artificial and "extraordinary"? Where is all of this leading? And what can be done about it?

I hear these questions often as I speak to groups across the country. Here are some of the questions I answer most frequently.

Q. Why prolong the lives of people in a persistent vegetative state (PVS) or coma? Wouldn't it be better to let them die a peaceful death?

A. First, let's look at what is meant by PVS and coma. News accounts often confuse the two terms, sometimes using them interchangeably. They're not the same. PVS is a term used to describe someone who is awake but unaware. The person has no apparent ability to understand or respond. Coma, on the other hand, is a sleeplike state from which the person cannot be wakened. Often these terms are used inaccurately.

For example, Nancy Cruzan of Missouri, who was the subject of a recent U.S. Supreme Court ruling, has been described in the press as being comatose. Yet nurses who care for her testified that sometimes she smiles when they tell her stories, weeps when visitors leave, and appears to make attempts to form words.

It's true that if food and water are taken away from someone in a coma or persistent vegetative state, that person can't say he's hungry or thirsty. And if he's really in such a condition - rather than misdiagnosed - he won't even understand what's happening. He'll simply feel thirst and hunger until he dies.

Removing his food and water isn't "letting him die." It's making him die. Nor is this type of death "putting him out of his misery," as some would say. Instead, it's putting him into misery - the misery of dying in an excruciating manner. How could dying of thirst possibly be considered a peaceful death?

Q. I know the church says euthanasia is wrong, but is taking away tube feeding the same as euthanasia?

A. Yes. Taking away food and water, no matter how they are provided, is wrong if the purpose of doing so is to cause death. The "Vatican Declaration on Euthanasia," issued in 1980, was very clear in stating that actions or omissions intended to hasten death are considered euthanasia.

Testimony in the Cruzan case made this intent very clear. In that case, a physician was asked if there would be any attempt to spoon-feed Nancy Cruzan if the court granted her parents' request to stop tube feeding. He responded that, in such situations, no attempt is made to do any sort of spoon-feeding, because it "would be totally inconsistent" with what is wanted. Death is what is wanted. Death is the intended outcome.

Q. Does this mean that food and water must always be provided to every patient?

A. No. There are situations where giving food and water would be futile or excessively burdensome. For example, a patient who is very close to death may be in such a condition that fluids would cause a great deal of discomfort or may not be assimilated by his body. Food may not be digested as the body begins "shutting down" during the dying process.

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Th comes a time, when a person is truly imminently dying (within 24 to 48 hours, not weeks or months) that a simple wiping of the brow and moistening the lips with ice chips may be all that need be done. No one is saying that food and fluids should be forced on such a person. This would be burdensome and futile.

But the current debate doesn't center around "burdensome treatment." It focuses on people who are a "burden."

The real question is, "Do we continue to feed the disabled, the demented, the abandoned, and the unwanted who are not dying, or do we end their lives by the universally effective measures of stopping food and water?

Removing food and water because the person is considered burdensome or "better off dead" is a way of killing the person - directly, intentionally and cruelly.

Q. We're not required to use "extraordinary means" to prolong life. Isn't tube feeding just one of these extarordinary means of keeping people alive with new and expensive medical technology?

A. Tube feeding is neither new nor expensive. It's been in use for almost 100 years. Two articles, published in the 1896 "Transactions of the Kentucky Medical Society," described the ease with which feeding by gastrostomy tube (g-tube) was being accomplished at that time.

The food placed in a feeding tube is not expensive. A full day's supply generally averages about $8. Nor is it exotic? Next time you're shopping in your neighborhood supermarket, pick up a can of Ensure in the liquid diet food section. Pick any flavor. It comes in chocolate, strawberry or vanilla. Read the label on the back and you'll find that you can drink it as a fully balanced meal or that it can be used for tube feeding. If it's a quick meal for you and me, how can it be "extraordinary medical treatment" when it's placed in a feeding tube?

Tube feeding isn't as rare as some may think. A 1987 governmental report found that at least 848,100 people per year receive food by means of a tube in hospitals, nursing homes, or their own homes.

Q. When someone can't swallow, isn't it better to stop artificial means to prolong life?

A. No. Some who receive nourishment by tube do so because they can't swallow, but this doesn't affect their ability to hold c jobs or, for that matter, to take unaccompanied vacations to faraway places.

In most cases, however, those who are tube fed are dependent on others for much or all of their care. In long-term care facilities, people who can't chew or swallw if spoon-fed are often placed on tube feeding for the convenience of caregivers. After months of tube feeding, the ability to swallow can become atrophied. Ironically, this then presents the opportunity or excuse to remove food and water, because it is provided by "artificial means."

Q. Isn't insertion of a g-tube a very risky surgical procedure?

A. No, it isn't. In fact, a case that took place a few years ago indicates that the degree of risk may depend very much on the social status of the patient involved.

Ninety-two-year-old Mary Hier had lived in mental hospitals for more than half of her life. She thought she was the Queen of England. She wasn't terminally ill, but because of a throat problem she had received food by means of a g-tube for more than 10 years.

When that tube became dislodged, the health facility asked permission from her court-appointed guardian to reinsert the tube. He refused, and the case went to court. The court, agreeing with the guardian, said that implanting the tube was a "highly intrusive and highly risky procedure."

Mary Hier's case got into a Boston newspaper. The paper reported on a similar case at about the same time. The article reported on a 94-year-old woman who was doing well following "minor surgery to correct a nutritional problem." The surgery was performed on an outpatient basis under local anesthesia.

The woman's name? Rose Kennedy.

The minor surgery? Insertion of a g-tube.

For Mary Hier - elderly, demented, and without family - the same surgery was described as "highly invasive and highly risky." For Rose Kennedy - mother of a President and U.S. Senators - it was a "minor medical procedure."

Draw your own conclusions about degree of risk.

Fortunately for Mary Hier, last minute intervention by Massachussetts physician Joseph Stanton and attorney Robert Ledoux resulted in her g-tube being reinserted. And, at last report, Mary Hier continued to live comfortably and happy - still signing her name "Mary Hier, Queen of England."

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TESTIMONY - KANSAS SENATE JUDICIARY COMMITTEE - MARCH 20, 1991

IN OPPOSITION TO SB 272 AND SB 350

Dr. Bruce Carroll, M. D., St. Mary's, Kansas

Mr. Chairman, members of the committee, I am a practicing physician in St. Mary's, Kansas. I would like to call to the committee's attention some of the provisions of Senate Bills 272 and 350 which I as a physician find troubling.

With regard to the definition of an attending physician; sometimes it is difficult to know who the attending physician really is. Some criticaly ill patients will have a cardiologist, pulmonologist, maybe a surgeon and a neurologist. Who is the attending physician and who is the consultant? I have seen some difficult situations in this exact scenario. Also the attending physician may not be the same physician who signed the pre-hospital DNR order.

In SB 272 the definition of medically appropriate is open ended. It would seem to include any patient of advanced age regardless of the severity of that persons illness. DNR is appropriate for those patients who are gravely ill or moderately ill at advanced age and in whom CPR would effect only a temporary restoration to a prior condition that is already grim. But prudence and caution must be applied. I am doubtful that any statutory language could satisfactorily spell out those terms. They need to be decided on a case by case basis.

Section 6 (b) of SB 350 equates nutrition and hydration with the term "treatment". They are not. They are basic necessities of all life, not a treatment - even if parenteral.

Section 2 (a) of SB 272 and Sec 10 (a) provide no latitude for a physician to object on moral grounds. The physician must either comply, wash his hands of the matter by transferring the patient, or be considered guilty of a misdemeanor or unprofessional conduct. In other words if the physician acts contrary to his moral and ethical standards he is "unprofessional", even a criminal. I cannot agree with that.

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Attachment 12

The withdrawal of treatment is a positive action which may be under certain circumstances morally wrong, as may be the withholding of treatment. I oppose the concept of giving a "blanket" authorization to the withdrawal or withholding of treatment. Again, the physician is given no discretion to object on moral grounds.

God is the giver of life; we shall live how long He wills us to live. We must be careful and prudent - both physicians and the state - not to take His role. DNR's and "Living Wills" do have their place in our modern world as does withholding and withdrawing treatment under certain special circumstances. We must be careful not to be too broad or too eager to apply this, lest we be euthanistic.

I urge the committee to vote against these bills. Thank you.

TESTIMONY BY AMERICAN CIVIL LIBERTIES UNION OF KANSAS
Senate Judiciary Committee
Senate Bill 350
March 20, 1991

I am speaking today for the American Civil Liberties Union in regard to Senate Bill 350, the Uniform Rights of the Terminally Ill Act. We have several concerns regarding this bill which we want to bring to the attention of the Committee.

First, I want to emphasize that the ACLU believes in the right to control your own body. This includes the right to withhold or refuse medical or life-sustaining treatment. The ACLU was a major participant in the Nancy Cruzan case. But we believe Senate Bill 350 has some problems that must be worked out before it can be a positive step forward for Kansans with terminal conditions.

The Uniform Act that this bill is based on was written prior to the Supreme Court decision on the Cruzan case. We believe this Act must be scrutinized in light of Cruzan, and amended accordingly. We are not prepared today to make that kind of analysis since we believe there are other problems with this bill.

Senate Bill 350 does not, as written, repeal the Natural Death Act which is presently part of the Kansas statutes. It is unclear how these two Acts would co-exist. Further, the cross-references to the durable power of attorney act and guardian statutes on page 3, line 9-14 are very confusing. Under existing Kansas law, a guardian is not empowered to make decisions to withhold medical treatment.

There is even a larger problem in the language on page 4, lines 3-7 and 38-42. The bill states that in certain circumstances the declaration of a pregnant woman will not be given effect. We believe that the language as it stands in the bill is too restrictive. There was more appropriate language in the 1985 version of the Uniform Rights of the Terminally Ill Act. In that version, the paragraph dealing with pregnancy began with the phrase: "Unless the declaration otherwise provides. . .". This language does not restrict the rights of a pregnant woman with a terminal condition.

We applaud the Committee for holding a hearing on this bill, and for attempting to clarify the rights of those with terminal conditions. We hope the Committee will move carefully in light of Cruzan to make sure that whatever is enacted doesn't further confuse existing law, but truly helps people have control over their destiny.

Senate Judiciary Committee
3-20-91
Attachment 13

Suite 5
3202 W. 13th Street
Wichita, Kansas 67203

Senate Judiciary Committee
Testimony on S. 272 and S. 350
March 20, 1991

I am Alan Weldon from Wichita, and I'm here representing Kansans For Life, the state affiliate of the National Right To Life Committee. I appreciate your giving me the opportunity to speak against passage of S. 272, an amendment to the natural death act, and S. 350, the uniform rights of the terminally ill act.

Of these two bills, Kansans For Life has greater problems with the latter, S. 350. Time doesn't permit my going through this bill with you this morning. So I have made copies of an analysis of the model bill drafted in Minneapolis in 1985. This analysis will give you the basis for our dissent, and you can read it at your leisure.

In the time I have this morning, I want to mention the section which is common to both bills. This is Section 4 in S. 272, and Section 7 in S. 350. These two sections expand the number of persons authorized to sign the declaration to refuse or withhold medical treatment. The effect of these sections is to make it easier for health care personnel to dispatch human beings who are ill.

We are aware of the "bottom line" approach to managing patient care. A major portion of the health care dollar is involved in assisting the dying. If third party payers pick up all these expenses, the health care costs affecting all Americans will rise, complicating the affordability of adequate health care in this country. For example, the cost of dying from AIDS or cancer can be astronomical. If third party payers only pick up part of this cost, then health care providers can be forced into a financial crunch. So the "bottom line" approach looks at ways to reduce the cost associated with these seriously ill patients, or in other words, find ways to keep them from consuming these costly services over an extended period of time.

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Attachment 14

Health care is a very emotional thing; we all want the best care for ourselves and our loved ones. For the dying, it is a very personal thing. It is something each of us will face by ourselves. In 1979, the Kansas legislature passed a living will law which allows the patient the right to refuse treatment. Then in 1989, the legislature passed the durable power of attorney law which allows the patient the right to name a third party to make health care decisions for him. These laws are in effect in Kansas today.

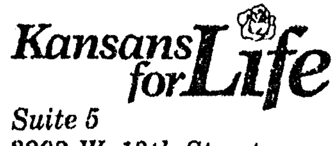
Now you are asked to take another major step in allowing someone other than the terminally ill patient to make the decision to withhold life-supporting medical treatment. With the living will and the durable power of attorney, the patient already has the right to make such a declaration. Late last year, the U.S. Congress adopted a measure requiring hospitals and nursing homes to inform patients of their rights under state law.

Now for the patient who did not wish to make such a declaration, you are asked to give this right to someone other than the patient. We, human beings, often allow pressures from the real world to influence our decision for what is best for the patient. For example, it's possible the spouse may want free of his or her terminally ill mate, or not wish to see him or her exhaust their life's savings. Other relatives may wish to cut short the dying process for fear it might eat into a possible inheritance.

The state's interest should be in conserving life, not in fostering death. The law used to make the presumption to treat when the patient's wishes are not explicitly known. Let's not turn this around to a presumption for death, which is where the expansion of the authorization for withholding life support systems is headed.

The patient already has the rights he needs in Kansas. We don't need new laws to terminate the defenseless. So I ask you to vote "no."

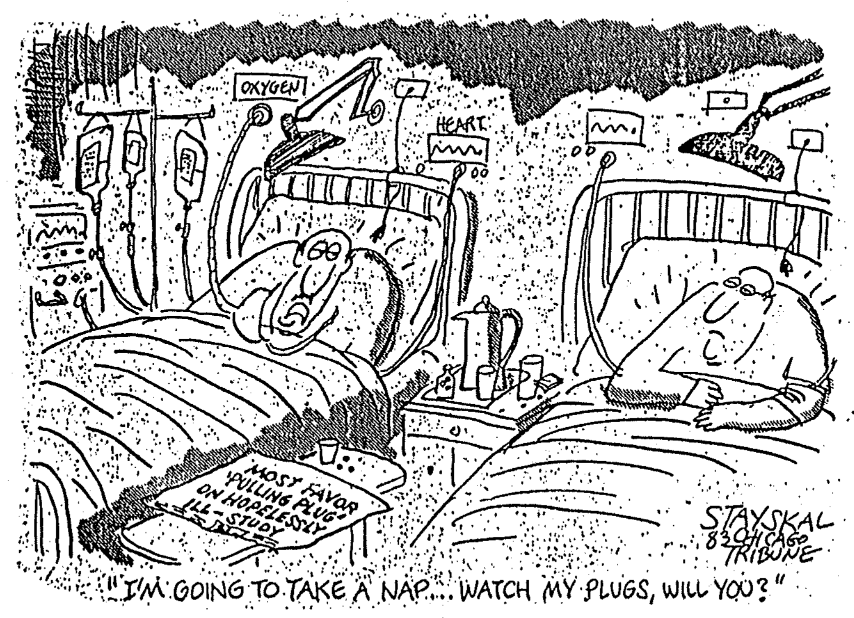
For further information, please contact the KFL lobbyist Valerie Joens at 233-8676, or the KFL office 1-316-945-9291.



Suite 5
3202 W. 13th Street
Wichita, Kansas 67203

The attached analysis of the Uniform Rights of the Terminally Ill Act was prepared from the draft of the National Conference on Uniform State Laws in August of 1985. The current proposed statute, S. 350, makes allowances for the durable power of attorney law passed in 1989, and adds a new section, Section 7, for those patients who have no effective declaration.

The criticisms contained in this analysis still apply to S. 350. (1991)



"I'M GOING TO TAKE A NAP.... WATCH MY PLUGS, WILL YOU?"

UNIFORM RIGHTS OF THE TERMINALLY ILL ACT

AN ANALYSIS

41-4-7-9

by Rita L. Marker

On August 8, 1985, the National Conference of Commissioners on Uniform State Laws, meeting in its 94th year in Minneapolis, Minnesota, approved the Uniform Rights of the Terminally Ill Act which will now be promulgated as an Act of the conference and submitted to the various states for consideration.

Floor debate on the Uniform Rights of the Terminally Ill Act took place on August 3, 4 and 7, 1985. It was during this debate that the intent of the Act and the ways in which the Act will be interpreted became apparent.

The following analysis of the approved Act is based on tape recordings made of the floor debate. Numbers in parentheses refer to the pages of the typewritten transcription of the tape recordings.

With the exception of three persons who were given privileges of the floor, (Ronald Cranford, M.D., representing the American Society of Law and Medicine, and Rodney Haughton and John Lombard, both representing the American Bar Association) only commissioners were allowed to speak during the floor debate. The following analysis, with the exception of italicized portions, is based upon the NCCUSL floor debate.

Italicized portions of the analysis are based upon private discussions with commissioners and others in attendance as observers at the conference.

UNIFORM RIGHTS OF THE TERMINALLY ILL ACT

SECTION 1. DEFINITIONS.

In this [Act]:

(1) "Attending physician" means the physician who has primary responsibility for the treatment and care of the patient.

(2) "Declaration" means a writing executed in accordance with the requirements of Section 2(a).

(3) "Health-care provider" means a person who is licensed, certified, or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

(4) "Life-sustaining treatment" means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process.

(5) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, government, governmental subdivision or agency, or any other legal entity.

(6) "Physician" means an individual [licensed to practice medicine in this State].

(7) "Qualified patient" means a patient [18] years of age or older who has executed a declaration and who has been determined by the attending physician to be in a terminal condition.

(8) "State" means a state, territory, possession, or commonwealth of the United States and the District of Columbia.

(9) "Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.

ANALYSIS

Although a person signing a declaration generally perceives the "attending physician," subsection (1), to be one individual in whose care the patient has been, in actuality, the "attending physician" may be someone who has never before cared for the patient and has no knowledge of the patient's wishes — other than the fact that the patient has signed a declaration.

It is possible that, throughout the course of a day, a hospitalized patient may have as many as three "attending physicians," any one of whom may make the determination that the patient is in a terminal condition, thus putting the declaration into effect. (11-1, 11-2)

"Life-sustaining treatment," subsection (4), is commonly thought of as that treatment involving the use of advanced technological equipment, carrying with its use the image of a patient attached to tubes, machines, etc. For this reason, the average person, signing a declaration will not be aware that "life-sustaining treatment" also means manually provided food and fluids. (11-22, 11-25, 30, 31)

Attempts to clarify the meaning by adding the words "including nutrition and hydration" to the definition of "life-sustaining treatment" failed. An attempt to define only artificially administered food and fluids as "medical treatment" also failed. (11-24)

The inclusion of manually provided feeding (spoon feeding) in the definition of "life-sustaining treatment" could very

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easily result in the withholding of nourishment from Alzheimers' patients. This withholding of nourishment from such patients was suggested as a possibility by Jerome Marmorstein, M.D. in a March 27, 1985 article in Medical Tribune.

Among the "life-sustaining treatments" which may be withdrawn in accordance with this Act are those medications, treatments or procedures upon which the qualified patient was dependent before developing a terminal condition. This would, for example, allow the withholding of insulin from the diabetic cancer patient who has been determined to be in a terminal condition. (49)

The determination making one a "qualified patient," subsection (7), is made by only one physician. No second, concurring opinion is required.

As defined in subsection (9), " 'Terminal condition' means an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time."

Symptoms of an incurable condition may be reversible (as in diabetes). However, the language incurable or irreversible leads to confusion.

Although the Drafting Committee contended that the selection of "or" was to differentiate between diseases and conditions such as those arising from shock or trauma, the explanations given seemed to confirm the problem with the use of the word "or" rather than "and." Attempts to change the definition to read an "incurable and irreversible condition" were unsuccessful. (11-21)

No clarification is given to the meaning of a "relatively short time," as used in subsection (9). Its meaning will be left to the individual physician who will not be bound by specified time limitations. The patient need not be in the final stages of a terminal illness and death need not be imminent. A "relatively short time" could vary from physician to physician and could mean days, weeks, months or longer. (11-7)

Once the determination has been made that the patient is in a terminal condition, the declaration is to be put into effect, allowing the withholding or withdrawal of such "medical treatments" as food and fluids, insulin, etc. thus assuring that death occurs in a "relatively short time." Rather than allowing a natural death to occur as a result of the terminal illness, a deliberately intended death will be hastened by means of the omission of the "medical treatment." (11-13, 11-14, 28)

SECTION 2. DECLARATION RELATING TO USE OF LIFE-SUSTAINING TREATMENT.

(a) Any individual of sound mind and [18] years of age or older may at any time execute a declaration governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the declarant, or another at the declarant's direction, and witnessed by 2 individuals.

(b) A declaration may, but need not, be in the following form:

DECLARATION

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and if I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the [__________ Uniform Rights of the Terminally Act], to withhold or withdraw treatment that only prolongs the dying process and is not necessary to my comfort or to alleviate pain.

Signed this __________ day of __________, __________.

Signature __________

Address __________

The declarant voluntarily signed this writing in my presence.

Witness __________
Address __________

Witness __________
Address __________

(c) A physician or other health-care provider who is provided a copy of the declaration shall make it a part of the declarant's medical record and, if unwilling to comply with its provisions, promptly so advise the declarant.

ANALYSIS

According to subsection (a), the declaration must be witnessed by two individuals but no qualifications or restrictions are placed upon who may serve as witnesses. A witness may be an individual totally unknown to the declarant or may be a spouse, relative or attending physician. Individuals, who have or are affiliated with those who have a financial interest in withdrawal of life-sustaining treatment may also serve as witnesses.

The declaration's suggested form, subsection (b), need not be the form used by the declarant but, since a suggested form is easily read and signed, it is expected to be, by far, more widely used than any individualized declaration.

Since most signers of a declaration will receive copies of the form through such sources as doctors' offices, hospitals, nursing homes or the Society for the Right to Die at the suggestion of "Dear Abby" or Ann Landers, it's doubtful that the signers will have a copy of the "Uniform Rights of the Terminally Ill Act." The suggested form of the declaration usually will be the only portion of the Act which the declarant will see. (55)

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UNIFORM ACT

(cont. from page 6)

As a result:

1. *The declarant may regard a "relatively short time" as meaning hours or days. He/she will not know that the attending physician's judgement of a "relatively short time" may be entirely different.*

2. *The declarant may perceive "my attending physician" as the family physician with whom a dialogue about the declaration's conditions has taken place. He/she may not know that the "attending physician" who places the declaration into effect may be a complete stranger.*

3. *The declarant may understand, "if I am no longer able to make decisions regarding my medical treatment," to mean a comatose state. He/she may not be aware that the attending physician could consider a mild, permanent impairment of competence as an indication of one's being "no longer able to make treatment decisions."*

   The approved Act uses the more acceptable "no longer able" rather than "unable" — which could refer to a temporary inability — as contained in early drafts. However, nowhere in the Act is there any objective criteria for determining the meaning of "no longer able." The judgement of this will be left entirely to the subjective determinations of the attending physician who could, possibly, make such a judgement of "no longer able to make decisions" based on assumptions of senility for persons over a certain age, etc.

4. *The declarant may interpret "treatment that only prolongs the dying process" to mean advanced technological procedures. The declarant may be unaware that he/she is directing the withholding or withdrawal of food and fluids or the withdrawal of medications upon which he/she is now dependent.*

Because the Act allows for individualized declarations, virtually any directive could be made by the declarant, including the directive that a revocation is not to be honored if the revocation is made at a time when the declarant is incompetent. (128, 129, 130)

A declarant could also direct that all food and fluids, even those which would be provided for comfort care or to alleviate pain, as specified in Section 5, subsection (b), be withheld and that massive doses of painkillers be provided to prevent any pain associated with the removal of food and fluids. (80, 81)

Witnesses are to attest to the declarant's having signed voluntarily but there is no requirement that the individuals witness the declarant's understanding of the declaration.

SECTION 3. REVOCATION OF DECLARATION.

(a) A declaration may be revoked at any time and in any manner by the declarant without regard to mental or physical condition. A revocation is effective upon communication to the attending physician or other health-care provider by the declarant or by another who witnessed the revocation.

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

ANALYSIS

According to subsection (a) a declaration may be revoked at any time, however, a declaration stating that a revocation is not to be honored, if made when the declarant is incompetent, is allowable under the Act.

One of the most likely times for revocation of a declaration is at such time as the declaration is ready to go into effect. There is, however, no requirement that the attending physician inform the conscious declarant that he/she has been determined to be in a "terminal condition" and that, therefore, life-sustaining medical treatment is to be withdrawn or withheld. (70, 71, 132, 133)

It is entirely possible that an elderly person may enter a hospital for what is assumed to be a treatable condition. While there, an incurable or irreversible condition may be diagnosed.

If, in the opinion of an attending physician, the patient is "no longer able" to make decisions regarding his/her medical treatment, life-sustaining medical treatment could be withdrawn. The patient need never have been informed that the determination of a "terminal condition" was made.

While revocation of a declaration is possible, there are no provisions for invalidation of a declaration — even if the physician believes the declaration was made involuntarily or because of undue influence. (67)

SECTION 4. RECORDING DETERMINATION OF TERMINAL CONDITION AND DECLARATION.

Upon determining the declarant is in a terminal condition, the attending physician who knows of a declaration shall record the determination and the terms of the declaration in the declarant's medical record.

ANALYSIS

The recording of a declaration does not require placing the actual declaration or a copy of the declaration in the declarant's medical record. The attending physician need not have seen the declaration before recording its existence in the medical record. The existence of the declaration and terms contained in it may be transmitted to the physician by phone. There are no requirements that phone transmission of a declaration be verified. (131, 132, 133, 134, 135, 136, 149)

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(cont. from page 7)

Since the patient need neither be informed that the declaration has been placed in the record, nor informed that he/she has been determined to be in a terminal condition, the patient does not have the opportunity to advise the attending physician or other health-care provider if the phone transmission of the declaration's existence was mistaken. (132, 133, 134, 135, 136)

SECTION 5. TREATMENT OF QUALIFIED PATIENTS

(a) A qualified patient has the right to make decisions regarding life-sustaining treatment as long as the patient is able to do so.

(b) A declaration becomes operative when (1) the declaration is communicated to the attending physician and (2) the declarant is determined by the attending physician to be in a terminal condition and no longer able to make decisions regarding administration of life-sustaining treatment. When the declaration becomes operative, the attending physician and other health-care providers shall act in accordance with its provisions or comply with the transfer provisions of Section 6.

(c) This [Act] does not affect the responsibility of the attending physician or other health-care provider to provide treatment, including nutrition and hydration, for comfort care or alleviation of pain.

(d) Unless the declaration otherwise provides, the declaration of a qualified patient known to the attending physician to be pregnant shall be given no force or effect as long as it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.

ANALYSIS

According to subsection (a), a "patient has the right to make decisions regarding life-sustaining treatment as long as the patient is able to do so." (Emphasis added.) This seems to imply that the patient loses this right at some point. The patient, however, does not lose this right, but is only unable to exercise it. (75)

This reference to having the right to make decisions only so long as one is able seems to contradict the patient's right to revoke a declaration. Recognition of the right should always remain — even when an individual is unable to exercise that right.

Subsection (b) embodies the operative portion of the Act. According to this subsection:

1. The declaration becomes operative when it is communicated to the attending physician. This communication of a declaration's existence may be verbal (for example, by telephone) and does not require that the attending physician actually see a copy or verify the existence of the declaration. (131, 132, 137, 148, 149, 150)

2. In this subsection, the compulsory nature of the declaration's directives is apparent — "... physician and other health-care providers shall act in accordance with its provisions . . . " (Emphasis added.)

   Although a late draft had been amended to state that the attending physician and other health-care providers "shall act in accordance with its provisions, insofar as they are consistent with reasonable medical standards", the reference to "reasonable medical standards" was deleted to enable a declarant to issue a directive according to his/her wishes. This deletion makes it mandatory that the physician carry out any request of the declarant or transfer the declarant's care. (Emphasis added.) (76)

3. The declaration becomes operative upon communication to the attending physician and upon determination that a terminal condition exists. The declaration becomes operative without the declarant's knowledge that such is the case. (132, 133, 134, 145)

4. While subsection (b) implies that a physician or health-care provider need not transfer care of a patient until the declaration becomes operative, this implication is inaccurate. Section 6 requires the physician or health-care provider who is unwilling to comply with the Act to transfer the patient's care at the time the existence of the declaration becomes known to the physician or health-care provider. (172, 173)

Substantial changes were made in Section 5, prior to final approval of the Act. Draft copies of the Act had referred to comfort care and alleviation of pain, stating in subsection (b), that such care was not prohibited. In the approved Act, comfort care and alleviation of pain (dealt with in the approved Act in subsection (c)) receive a more positive emphasis.

Subsection (c) clearly states that the Act recognizes the responsibility of physicians and other health-care providers to provide comfort care and alleviation of pain. However, it is allowable, under the Act, to provide massive amounts of painkiller, making comfort care — which includes such "treatments" as turning the patient and providing food and fluids — unnecessary. (80, 81, 11-22)

Within the context of subsection (c), comfort and care and alleviation of pain do not apply to the truly comatose patient. (79b)

While drafts of the Act carried a

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pregnancy exclusion stating that a declaration would not become effective if the qualified patient was known to be pregnant and if it was probable that the baby could be born alive, the approved Act explicitly provides that a declarant may indicate that the declaration take effect even if the qualified patient is pregnant. The declaration would take effect at any stage of pregnancy.

The provisions in the approved Act go far beyond the U.S. Supreme Court's Roe v. Wade decision since the Act enables a woman to choose death for her unborn child in the third trimester even though this bears no relationship to enhancing, maintaining or restoring the health of the mother. (78, 143, 144, 145)

In accord with the Drafting Committee's verification that virtually any portion of the Act could be affected by the declarant's "providing otherwise" in the declaration, it is likely that the words "unless the declaration otherwise provides" in subsection (d) are superfluous. (128, 129, 130)

In the event that a declarant does not specify that the declaration take effect during pregnancy, it is still possible that such could occur. As approved, subsection (d) provides that the declaration take effect unless it is probable that the baby be born alive. A declarant, who may never have opted for abortion, may have her life-sustaining treatment withdrawn or withheld — thus ending the life of her unborn child — if in the opinion of the attending physician, it is not probable that the child would be born alive.

No objective criteria, based on trimesters or months of gestation, is given to determine if it is probable that a live birth could occur. The decision is left to the individual attending physician. (78)

SECTION 6. TRANSFER OF PATIENTS.

An attending physician or other health-care provider who is unwilling to comply with this [Act] shall as promptly as practicable take all reasonable steps to transfer care of the declarant to another physician or health-care provider.

ANALYSIS

Although Section 2, subsection (c) seems to imply that the physician or health-care provider who is unwilling to comply with a declaration need only inform the declarant and, although Section 5, subsection (b) appears to indicate that the transfer of a patient's care is to take place when the declaration becomes effective, the section dealing specifically with the transfer of patients, Section 6, mandates that the transfer take place at such time as the physician or health-care provider is made aware of the declaration's existence. (172, 173)

In accordance with Section 6, a physician or health-care provider is required to transfer care of a patient — even a patient whose declaration may not foreseeably become operative for twenty years — if the physician or health-care provider would be unwilling to comply with the Act or the terms of the declaration. (173)

This requirement of prompt transfer was recognized as posing great difficulty in one-physician towns but was never-the-less retained as part of the Act. An attempt to amend Section 6 to provide that transfer be required "once a declaration becomes operative" failed. (173)

The requirements of Section 6 will possibly create grave problems for health-care facilities whose policies preclude compliance with portions of the Act or with specific directives contained in an individual's declaration.

This requirement may make it necessary for such health-care facilities to transfer even those patients who are not likely for months — or even years — to be in a condition which would cause the declaration to be put into effect.

A transfer requirement is not the same as a conscience clause. The requirements to carry out the Act, comply with the declaration, or transfer the patient, also present unique problems for health professionals who are not physicians.

A nurse, employed in a health-care facility that has no policies which would preclude compliance with the Act will, under the Act, be placed in a difficult position.

If the attending physician is willing to comply with the Act and all necessary steps have been taken to put the declaration into effect, the nurse is not in a position to transfer the patient if he/she is unwilling to carry out the provisions of the Act.

SECTION 7. IMMUNITIES.

(a) In the absence of knowledge of the revocation of a declaration, a person is not subject to civil or criminal liability or discipline for unprofessional conduct for carrying out the declaration pursuant to the requirements of this [Act].

(b) A physician or other health-care provider, whose actions under this [Act] are in accord with reasonable medical standards, is not subject to criminal or civil liability or discipline for unprofessional conduct.

SECTION 8. PENALTIES.

(a) A physician or other health-care provider who willfully fails to transfer in accordance with Section 6 is guilty of [a class ________ misdemeanor].

(b) A physician who willfully fails to record the determination of terminal condition in accordance with Section 4 is guilty of [a class ________ misdemeanor].

(c) An individual who willfully conceals, cancels, defaces, or obliterates the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another is guilty of [a class ________ misdemeanor].

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(cont. from page 9)

(d) An individual who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 3, is guilty of [a class _______ misdemeanor].

(e) Any person who requires or prohibits the execution of a declaration as a condition for being insured for, or receiving, health-care services shall be guilty of [a class _______ misdemeanor].

(f) Any person who coerces or fraudulently induces another to execute a declaration under this [Act] shall be guilty of [a class _______ misdemeanor].

(g) The sanctions provided in this section do not displace any sanction applicable under other law.

ANALYSIS

Physicians who fail to transfer patients and physicians who fail to record determinations of terminal conditions are subject to penalties. Other penalties which would seem to have been appropriately included in Section 8 were omitted or failed to receive necessary support for inclusion in Section 8. (99)

No penalty exists for a physician or other health-care provider who fails to honor a revocation. (99)

No penalty exists for a physician or other health-care provider who fails to record a revocation in accordance with Section 3, subsection (b).

No penalty exists for a physician or health-care provider who fails to provide comfort care or alleviation of pain in accordance with Section 5, subsection (c). (99)

The penalty associated with requiring or prohibiting the execution of a declaration (subsection (e)) and the penalty for coercing or fraudulently inducing one to execute a declaration (subsection (f)) were added after considerable debate related to an attempt to delete Section 9, subsection (c). (166, 167)

SECTION 9. GENERAL PROVISIONS.

(a) Death resulting from the withholding or withdrawal of life-sustaining treatment pursuant to a declaration and in accordance with this [Act] does not constitute, for any purpose, a suicide or homicide.

(b) The making of a declaration pursuant to Section 2 does not affect in any manner the sale, procurement, or issuance of any policy of life insurance or annuity, nor does it affect, impair, or modify the terms of an existing policy of life insurance or annuity. A policy of life insurance or annuity is not legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining treatment from an insured qualified patient, notwithstanding any term to the contrary.

(c) A person may not prohibit or require the execution of a declaration as a condition for being insured for, or receiving, health-care services.

(d) This [Act] creates no presumption concerning the intention of an individual who has revoked or has not executed a declaration with respect to the use, withholding, or withdrawal of life-sustaining treatment in the event of a terminal condition.

(e) This [Act] does not affect the right of a patient to make decisions regarding use of life-sustaining treatment so long as the patient is able to do so, or impair or supersede any right or responsibility that any person has to effect the withholding or withdrawal of medical care.

(f) Nothing in this [Act] shall require any physician or other health-care provider to take any action contrary to reasonable medical standards.

(g) This [Act] does not condone, authorize, or approve mercy-killing or euthanasia.

ANALYSIS

An attempt was made by the Drafting Committee to delete subsection (c) in its entirety. Reasons given by the committee included:

1. In certain circumstances, there might be a reduction in insurance premiums for those who have executed a declaration, therefore, insurance companies should be allowed to require a person to sign a declaration before receiving the reduced rates. (162)
2. Certain health-care providers — hospices, in particular — condition their services on such an agreement. (163)

The Drafting Committee explained that subsection (c) was too broad a statement of public policy; its broad applications could have a serious impact and, therefore, it should be eliminated. (163)

After considerable discussion, the committee of the whole voted to restore subsection (c). (160, 161, 162, 163, 164, 166)

The strong attempt by the Drafting Committee to strike subsection (c) on the final day of floor debate should be viewed as an indication of ways in which this Act may be further amended after initial passage in the various states.

Using the rationale that requirement of a declaration will benefit those who wish to sign declarations since it could enable such persons to pay decreased insurance premiums, it is quite likely that

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onomic impact will be applied to those on government assistance as well and, therefore, could possibly lead to mandatory declarations prior to receiving health-care benefits paid for through government assistance.

Subsection (g) states that this Act "does not condone, authorize, or approve mercy-killing or euthanasia." The only purpose of this subsection is to ensure passage of the Act. No legal effect is intended for this subsection. (103)

SECTION 10. PRESUMPTION OF VALIDITY OF DECLARATION.

A physician or other health-care provider may presume, in the absence of knowledge to the contrary, that a declaration complies with this [Act] and is valid.

ANALYSIS

Declarants may tailor the language of a declaration as they so wish, with the expectation that a physician is to carry out the declaration. The physician need not verify that the declaration is in compliance with the Act but can presume it to be so in the absence of actual knowledge to the contrary. (171-172)

It is allowable, under the Act, to direct the withholding of virtually any treatment. Since the declaration need not be in the form contained in Section 2, subsection (b), and, since the physician or health-care provider need not actually see the declaration or a copy of the declaration, the possibility exists that a physician or health-care provider could be informed by telephone of a declaration, even one with somewhat bizarre directives and, in compliance with Section 10, presume that the declaration complies with the Act and is valid.

SECTION 11. RECOGNITION OF DECLARATION EXECUTED IN ANOTHER STATE.

A declaration executed in another state in compliance with the law of that state or this state is validly executed for the purposes of this [Act].

ANALYSIS

Individual states may amend the uniform Act prior to passage. For example, one state may exclude nutrition and hydration from the definition of "life-sustaining treatment."

Recognition of the declaration, executed in such a state, may result in the withholding of nutrition and hydration from a resident of that state if his/her declaration becomes effective in a state which defines nutrition and hydration as life-sustaining treatment.

Since it is highly likely that the suggested form of the declaration, contained in Section 2, subsection (b), will be widely used, the interpretation of the meaning of the declaration will vary from state to state.

There would be significant confusion as to which state's definitions should be followed in placing a declaration into effect. However, the physician or health-care provider would not be compelled to verify the meaning of the declaration as it relates to the state in which it was executed.

"Safeguards" in the form of amendments, passed on a state by state basis, would be virtually meaningless if the declaration were to go into effect in a differing state which does not have the same safeguards as that state in which a declaration was signed.

SECTION 12. EFFECT OF PRIOR DECLARATIONS.

An instrument executed before the effective date of the [Act] that substantially complies with Section 2(a) shall be given effect pursuant to the provisions of the [Act].

ANALYSIS

Persons who have signed declarations prior to the effective date of t. Act, if passed, will have signed such declarations under laws which vary significantly with the Act.

Currently existing "living will" acts often incorporate various provisions which are not present in the uniform Act. The declaration itself, under these currently existing acts, will be in compliance with Section 2(a) of the uniform Act since virtually any declaration made by someone 18 years of age or older and signed voluntarily in the presence of two witnesses complies with the Act.

But, for example, the earlier declaration may have been signed with the understanding that it would not go into effect unless death was "imminent." Under the new Act the effectiveness would occur if death were expected within a "relatively short time."

All safeguards which existed in prior legislation and at the time of the signing of the declaration would be removed, leaving the previously signed declaration to be interpreted under the newly passed Act.

SECTION 13. SEVERABILITY.

If any provision of this [Act] or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this [Act] which can be given effect without the invalid provision or application, and to this end the provisions of the [Act] are severable.

SECTION 14. TIME OF TAKING EFFECT.

This [Act] takes effect on ______.

SECTION 15. 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

(Continued on page 12)

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UNIFORM ACT *(cont. from page 11)*

the subject of this [Act] among states enacting it.

SECTION 16. SHORT TITLE.

This [Act] may be cited as the Uniform Rights of the Terminally Ill Act.

SECTION 17. REPEAL.

The following acts and parts of acts are repealed:

(1)

(2)

(3)

ANALYSIS

Although the title of this Act refers to the "rights" (plural) of the terminally ill, the only "right" stressed is the "right to death."

Virtually all aspects of this Act focus upon carrying out this "right." There is no conscience exception made for health-care providers who wish no involvement in facilitating the qualified patient's death. In some cases, the mandatory transfer provision could require the health-care provider to make, in effect, a euthanasia referral.

In a society faced with the need to extend more compassionate care to the elderly, the handicapped and the terminally ill, isn't it possible that we could be willing to promote humane, loving care rather than death as a solution to human needs? ☐

UNIFORM STATE LAWS — WHAT ARE THEY?

Uniform State Laws are the handiwork of the National Conference of Commissioners on Uniform State Laws (NCCUSL), an organization which is little known to the general public but highly influential in legislative circles.

The purpose of such uniform laws is to prevent problems which arise from differences in state laws — differences which create specific interstate and national problems.

Since its formation with only seven member states in 1892, the NCCUSL has drafted and approved more than two hundred and twenty-five acts ranging from those which would eliminate jurisdictional child custody disputes to laws which address the legalities of electronic transfer of stock ownership. (The Uniform Anatomical Gifts Act and the Uniform Commercial Code are among the better known laws drafted by the NCCUSL.)

Today the NCCUSL has more than 300 members — called Uniform Law Commissioners — representing every state, the District of Columbia and Puerto Rico. Generally appointed by the governors of each state, Commissioners are practicing attorneys, judges, law school deans and professors. Funding for the organization's $700,000 annual budget comes from states with the fee based upon population size. This year the range in states' payments was from $4,000 to $50,000.

Proposals for uniform laws generally come from Commissioners or from the American Bar Association but can be suggested by outside organizations. If the NCCUSL decides to take up a particular topic, a special committee is formed to draft an act. Tentative drafts are then submitted to the Commissioners at their annual meeting, with a requirement that any act must be considered at two annual meetings prior to passage.

All uniform acts are discussed section by section, amended and commented upon prior to presentation for a vote by states. Voting on an act is done on a one vote per state basis with the majority of commissioners from each state deciding the vote for the state. If commissioners from any state are deadlocked, the state abstains in the voting on the particular act under consideration.

Once an act is approved, Commissioners of the NCCUSL are obligated to return to their respective states and work for adoption of the act. For this reason, persons who have concerns or questions about uniform legislation should continue to contact their state's commissioners as well as state legislators who will ultimately decide whether the legislation will be adopted as state law. ☐

The NCCUSL's "Uniform Rights of the Terminally Ill Act" was approved by a vote of 37-10. The following lists the vote by state:

YES

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Indiana
Iowa
Kansas
Maine
Massachusetts
Montana
New Hampshire
New Jersey
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Puerto Rico
Rhode Island
South Carolina
Tennessee
Texas
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

NO

Connecticut
Illinois
Louisiana
Minnesota
Mississippi
Nebraska
Nevada
Pennsylvania
South Dakota
Utah

ABSTAIN or NOT PRESENT

Kentucky
Maryland
Michigan
Missouri
New Mexico

14- 11/11

TESTIMONY RE: SB 350

SENATE JUDICIARY COMMITTEE

SENATOR WINT WINTER, JR., CHAIRPERSON

MARCH 21, 1991

Thank you for the opportunity to comment and provide testimony on Senate Bill No. 350, enacting the Uniform Rights of the Terminally Ill act.

The Sisters of Charity of Leavenworth Health Services Corporation operate eight hospitals in five states, two of these in Kansas--St. John Hospital in Leavenworth, and St. Francis Hospital and Medical Center in Topeka. The Health Services Corporation also sponsors clinics for the medically indigent and is interested both in the care of our patients and assisting patients in terminally ill state.

Although we're sure Senate Bill No. 350 attempts to address questions raised by its proponents, we really are not aware of a practical need to enact such legislation. With the legal mechanisms in place we have not experienced a major problem in our hospitals. The bill makes no reference to the current Kansas Natural Death Act nor to

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the Durable Power of Attorney for medical decision making.

We do have some difficulty with certain inclusions in the proposed legislation:

Section 2(b) includes a declaration for withholding or withdrawing of treatment. The declaration states that "If I should have an incurable and irreversible condition that..will in the opinion of my attending physician, cause my death "within a relatively short time, etc." We do not know what a "relatively" short time is. A "relatively short time" can be much longer for an 8 or 10 year old or much shorter for someone who is 90 or 95 years old. Such wording could cause confusion and we believe this wording should be eliminated. Such decisions are best made individually between the patient and the attending physician.

Section 6(b) of the proposed act states that "this act does not affect the responsibility of the attending physician or other health care provider to provide treatment, including nutrition and hydration, for a patient's comfort, care or alleviation of pain." Why is it necessary to spell out nutrition and hydration in this proposed legislation? By itemizing care for a patient's comfort, care or alleviation of pain is this "creating" the responsibility to do so?

Also, your attention is invited to the Budget Reconciliation Act of 1990, which included amendments to the Social Security Act, specifically Title 18, Medicare. This amendment requires that all hospitals and nursing homes present to all Medicare patients, at admission, a Durable Power of Attorney form and an explanation. This is so the patient being admitted is aware that he or she has a choice of treatment modalities which may be more or less heroic or strenuous than desired. This would be especially true in the case of a heart attack of a 93 year old patient who would wish not to have his or her chest thumped under a dramatic CPR procedure. This Social Security protocol needs to be studied to see if the State of Kansas complies with a the form of a Durable Power of Attorney mechanism required by Medicare under the present Kansas Durable Power of Attorney law. Perhaps this in not the time to publish another type and kind of Durable Power of Attorney in either SB 350 or SB 272, amending the Kansas Natural Death Act.

We Thank you for the opportunity to comment on this proposed legislation. We would recommend additional study of the necessity for and specific wording and intent in an interim session before proceeding with enactment.

Sincerely,

Keith D. Hornberger

Senior Vice President, Operations

Christian Science Committee on Publication For Kansas

820 Quincy Suite K
Topeka, Kansas 66612

Office Phone
913/233-7483

To: Senate Committee on Judiciary

Re: Senate Bill No. 350

It is requested that the following wording be added to this bill:

> "Nothing in this act shall be construed to prohibit or interfere with an individual's right or request expressed in the declaration to rely upon or to be provided by his attorney in fact with spiritual treatment through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment."

This language would clarify that those who desire spiritual treatment in lieu of medical care could still choose that form of treatment.

Possibly the amendment could be added in section 2 as new subsection (b) on page 2, line 5, or as new subsection (f) on page 3, line 20.

There appear to be other problems in the construction of the bill. As drafted, it refers to an attorney-in-fact designated pursuant to the durable power of attorney act or a court appointed guardian, but no mention is made of an agent designated pursuant to a durable power of attorney for health care decisions.

If this act is to replace the natural death act, references to that act in the statutes relating to the durable power of attorney for health care decisions will need to be amended.

It is quite late in the session to begin work on a bill of this nature which can have very serious impact on those who choose to use its provisions or those of related laws. The wiser course seems to be to allow the bill to lie over until next year or, perhaps, to request interim study of this bill and related issues.

Keith R. Landis
Committee on Publication
for Kansas

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KINH Kansans for Improvement of Nursing Homes, Inc.
913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

TESTIMONY PRESENTED TO
THE SENATE JUDICIARY COMMITTEE
CONCERNING THE UNIFORM RIGHTS OF THE TERMINALLY ILL ACT
AND THE KANSAS NATURAL DEATH ACT
SB 350 and SB 272

March 20, 1991

Mr. Chairman and Members of the Committee:

It will be my purpose today to review SB 350, the Uniform Rights of the Terminally Ill, with a consumer's eye and with the desire that, whatever the fate of this particular bill, we will continue to have a "consumer friendly" document by which we can all declare our desires and intentions for the final days of our lives. The Kansas Natural Death Act has been in place now for some time. We have no reason to believe it is not understood and used in its present form.

First, some very general observations. SB 350 appears to contain all the necessary ingredients and safeguards and, philosophically, it is in tune with the current Kansas Natural Death Act. The declaration form is somewhat simpler than the Natural Death Act, but appears to contain all essential language. Simplicity is a virtue if the document is to be useful to all consumers, some of whom cannot or prefer not to seek the services of an attorney.

While some definitions are necessarily vague, such as "within a relatively short time", room for judgement will always be necessary in a document of this nature. The addition of a definition of "terminal condition" is helpful.

Provision for designation of another individual to make decisions governing withholding or withdrawal of life-sustaining procedures is of value. However, this can also be done under the Durable Power of Attorney for Health Care Decisions, which has broad application not only to life-sustaining procedures, but also to decisions which must be made long before the terminus of life.

It is useful to include the ordered list of persons who may be authorized to give or withhold consent in the absence of a declaration. Because of this additional provision, we might tend to favor enactment of SB 350. However, there are some provisions that trouble us enough that we could not give our endorsement to SB 350 in its present form.

Sec. 2(d) does not appear to fit with the terminology of current Kansas law. The Durable Power of Attorney for Health Care Decisions refers to the "agent" rather than to the "attorney in fact"; we recommend that the terminology be consistent throughout related statutes, and prefer "agent", as simpler and easier for the layperson to understand. Also in Sec. 2(d) reference should be made to "the durable power of attorney for health care decisions act" rather than just to "the durable power of attorney".

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More troubling in that same section is the language concerning guardianship which says, "...the judicial appointment of an individual guardian, who is authorized to make decisions regarding the withholding or withdrawal of life-sustaining treatment, constitutes for purposes of this act a declaration designating another individual to act for the declarant pursuant to subsection (a)." The Kansas guardianship act permits that kind of decision-making on behalf of a ward only if the ward has made a declaration under the Natural Death Act. The wording of SB 350 suggests that a guardian always has that power or perhaps that the power may be delegated by the court in the letters of guardianship. We believe that if authority to decide upon life-sustaining measures were to be given a guardian it would require a change in the Kansas guardianship statutes. We are not entirely convinced that the guardian should have that authority in every instance.

We also see a problem in Sec. 4(a), "A declarant may revoke a declaration at any time and in any manner, without regard to the declarant's mental or physical condition. A revocation is effective upon its communication to the attending physician or other health care provider by the declarant or a witness to the revocation." This section gives rise to the potential for much confusion and misinterpretation.

Persons nearing the end of life often drift in and out of competence. What constitutes a revocation "in any manner"? A mumbled word? A gesture? If the declarant has, by someone's judgement, revoked the declaration while incompetent, must he go through the whole procedure of filling out the declaration and having it witnessed again, in order to reinstate the declaration when he regains competence? That would appear to give more weight to decisions made when incompentent, than when competent.

The language of revocation in the Durable Power of Attorney for Health Care Decisions requires that the power "shall be revoked by an instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out another manner of revocation, if desired", while the current Natural Death Act provides that, "A declaration may be revoked at any time by the declarant by any of the following methods: (1) By being obliterated, burnt, torn, or otherwise destroyed or defaced in a manner indicating intention to cancel; (2) by a written revocation of the declaration signed and dated by the declarant or person acting at the direction of the declarant; or (3) by a verbal expression of the intent to revoke the declaration, in the presence of a witness eighteen years of age or older who signs and dates a writing confirming that such expression of intent was made." Both provide for some latitude in the method of revocation but are less open to misjudgement and misinterpretation than "in any manner".

Sec. 4(a) is a serious stumbling block for KINH. Without some change in its provisions we would oppose SB 350. In any case, we believe there should be extensive deliberation before any change is made to the Kansas Natural Death Act.

While uniformity may be a desirable goal, it should not come at the expense of statute crafted specifically to Kansas needs and wishes if we find the uniform act does not fit us well.

SB 272 also concerns the Natural Death Act. We understand that emergency medical services providers and hospital and nursing home personnel would like to have everything tidily set out, protecting both the patient and health care personnel with regard to do not resuscitate orders. However, the language dealing so exhaustively with DNR orders seems to bring unnecessary clutter and confusion to the Natural Death Act to little advantage. There are other ways of dealing with the problem through protocols and procedures. KINH opposes SB 272.

Marilyn Bradt
Legislative Coordinator

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

March 20, 1991

TO: Senate Judiciary Committee

FROM: Kansas Medical Society *Chip Wheelen*

SUBJECT: Senate Bill 272; Amendments to the Natural Death Act

Thank you for this opportunity to express the concerns of the Kansas Medical Society about the provisions of SB 272. The concept of "Do Not Resuscitate" (DNR) is a very sensitive issue because it affects one of the fundamental principles of medicine; that of preserving and sustaining life. On the other hand, another basic tenant of medical practice is to alleviate suffering whenever possible.

We do have some serious reservations about both the need for SB 272 in the first place, and secondly about the focus and wording of the bill. It is our understanding that nothing in current law prohibits a DNR order being completed by a patient, the patient's guardian, or a durable power of attorney for health care decisions. Furthermore, we are not aware of any case law that would raise questions about the liability exposure of health care providers who honor a DNR order. We must also question whether passage of SB 272 would indeed motivate significant numbers of people to file DNR statements.

Our greatest concern relates to whether or not passage of SB 272 would create a presumption that a DNR document must be signed and on file in order for a physician or other health care provider to honor the DNR wishes of the patient, the patient's guardian, or a durable power of attorney for health care. What if members of a family consult with the attending physician of a permanently incapacitated patient who is suffering immeasurably, and agree not to resuscitate in the event of a cardiac or pulmonary arrest. Would the physician then be guilty of malpractice for honoring the wishes of the family, and would the family members be guilty of manslaughter for doing what they believed to be the most humane decision?

Aside from the more theoretical questions related to SB 272, the bill appears to have a number of technical problems as well. The language used to amend the Natural Death Act would appear to make the protections of new section 6 apply only in nursing home situations or in route from the nursing home to the hospital.

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The protections from criminal and civil liability would appear not to apply in the private home of the patient or the patient's relatives, nor to the emergency room or hospital environment. If indeed the concept of a formal DNR statement is good public policy, why should it not apply at all locations? The bill also contains a number of technical problems arising because of new definitions of terms that have been previously used in the Natural Death Act assuming the common meaning of those terms. By redefining such terms as "patient" or "health care provider," we must then reinterpret the entire Natural Death Act. Because of these concerns, we have outlined some suggested amendments for your consideration in a balloon which is attached to this statement.

We respectfully suggest that the Committee consider taking one of four actions in the following order of choice:

1. No action at all,
2. recommend the subject for interim study by the Joint Committee on Health Care Decisions,
3. recommend that SB 272 not be passed, or
4. adopt the KMS amendments before recommending passage of the bill.

Thank you for considering our concerns.

CW/cb

Attachment

SENATE BILL No. 272

By Committee on Local Government

2-21

8 AN ACT concerning the natural death act; amending K.S.A. 65-
9 28,102, 65-28,107 and 65-28,108 and repealing the existing
10 sections.
11
12 *Be it enacted by the Legislature of the State of Kansas:*
13 Section 1. K.S.A. 65-28,102 is hereby amended to read as fol-
14 lows: 65-28,102. As used in this act:
15 (a) "Attending physician" means the physician selected by, or
16 assigned to, the patient who has primary responsibility for the treat-
17 ment and care of the patient.
18 (b) "Declaration" means a witnessed document in writing, vol-
19 untarily executed by the declarant in accordance with the require-
20 ments of K.S.A. 65-28,103, *and amendments thereto.*
21 (c) "Life-sustaining procedure" means any medical procedure or
22 intervention which, when applied to a qualified patient, would serve
23 only to prolong the dying process and where, in the judgment of
24 the attending physician, death will occur whether or not such pro-
25 cedure or intervention is utilized. "Life-sustaining procedure" shall
26 not include the administration of medication or the performance of
27 any medical procedure deemed necessary to provide comfort care
28 or to alleviate pain.
29 (d) "Physician" means a person licensed to practice medicine and
30 surgery by the state board of healing arts.
31 (e) "Qualified patient" means a patient who has executed a dec-
32 laration in accordance with this act and who has been diagnosed and
33 certified in writing to be afflicted with ~~a~~ terminal condition by two
34 physicians who have personally examined the patient, one of whom
35 shall be the attending physician.
36 *(f)* ~~"Patient"~~ *means a* ~~person~~ *who has executed a* ~~pre-hospital~~ *do*
37 *not resuscitate order, or on whose behalf a person authorized by*
38 *this act has executed a* ~~pre-hospital~~ *do not resuscitate order.*
39 *(g) "Resuscitate" or "resuscitation" means the administration of*
40 *any medically accepted method of cardiopulmonary resuscitation,*
41 *including, but not limited to, cardiac compression, endotracheal in-*
42 *tubation and defibrillation, the purpose of which is to induce cardiac*
43 *function or respiratory function or both such functions in a patient*

an incurable

"DNR-patient"

qualified patient

1 *after such function or functions have ceased.*
2 ~~(h) "Medically appropriate" means the preexistence in a patient~~
3 ~~of a terminal illness or physical deterioration typical of and accom-~~
4 ~~panied by advanced age.~~
5 (h) ~~(i)~~ ~~"Pre-hospital~~ *do not resuscitate order" means a document* "Do
6 *executed in accordance with the requirements of section 4.*
7 (i) ~~(j)~~ *"Emergency medical services provider" means those personnel*
8 *as defined in K.S.A. 1990 Supp. 65-6112, and amendments thereto,*
9 *or an emergency medical service, as defined in K.S.A. 1990 Supp.*
10 *65-6112, and amendments thereto.*
11 (j) ~~(k)~~ *"Health care provider" means any health care provider as*
12 *defined in K.S.A. 65-2891, and amendments thereto*~~, who is regularly~~
13 ~~employed by a state-licensed nursing home or hospice in which a~~
14 ~~person to whom a pre-hospital do not resuscitate order applies is a~~
15 ~~patient~~.
16 Sec. 2. K.S.A. 65-28,107 is hereby amended to read as follows:
17 65-28,107. (a) An attending physician who refuses to comply with
18 the declaration of a qualified patient pursuant to this act shall effect
19 the transfer of the qualified patient to another physician. Failure of
20 an attending physician to comply with the declaration of a qualified
21 patient and to effect the transfer of the qualified patient shall con-
22 stitute unprofessional conduct as defined in K.S.A. 65-2837, *and*
23 *amendments thereto*.
24 (b) Any person who willfully conceals, cancels, defaces, obliter-
25 ates or damages the declaration *or the* ~~pre-hospital~~ *do not resuscitate*
26 *order* of another without such declarant's consent or who falsifies or
27 forges a revocation of the declaration *or the* ~~pre-hospital~~ *do not*
28 *resuscitate order* of another shall be guilty of a class A misdemeanor.
29 (c) Any person who falsifies or forges the declaration *or the* ~~pre-~~
30 ~~hospital~~ *do not resuscitate order* of another, or willfully conceals or
31 withholds personal knowledge of the revocation of a declaration *or*
32 *the* ~~pre-hospital~~ *do not resuscitate order*, with the intent to cause
33 a withholding or withdrawal of life-sustaining procedures contrary to
34 the wishes of the declarant, and thereby, because of such act, directly
35 causes life-sustaining procedures to be withheld or withdrawn and
36 death to be hastened, shall be guilty of a class E felony.
37 Sec. 3. K.S.A. 65-28,108 is hereby amended to read as follows:
38 65-28,108. (a) The withholding or withdrawal of life-sustaining pro-
39 cedures from a qualified patient in accordance with the provisions
40 of this act shall not, for any purpose, constitute a suicide and shall
41 not constitute the crime of assisting suicide as defined ~~by~~ *in* K.S.A.
42 21-3406, *and amendments thereto*.
43 (b) The making of a declaration pursuant to K.S.A. 65-28,103,

3-18-91

1 *and amendments thereto, or a* ~~*pre-hospital*~~ *do not resuscitate order*
2 *pursuant to section 4* shall not affect in any manner the sale, pro-
3 curement, or issuance of any policy of life insurance, nor shall it be
4 deemed to modify the terms of an existing policy of life insurance.
5 No policy of life insurance shall be legally impaired or invalidated
6 in any manner by the withholding or withdrawal of life-sustaining
7 procedures from an insured qualified patient, notwithstanding any
8 term of the policy to the contrary.
9 (c) No physician, medical care facility, or other health care prov-
10 ider, and no health care service plan, health maintenance organi-
11 zation, insurer issuing disability insurance, self-insured employee
12 welfare benefit plan, nonprofit medical service corporation or mutual
13 nonprofit hospital service corporation shall require any person to
14 execute a declaration *or a* ~~*pre-hospital*~~ *do not resuscitate order* as
15 a condition for being insured for, or receiving, health care services.
16 (d) Nothing in this act shall impair or supersede any legal right
17 or legal responsibility which any person may have to effect the
18 withholding or withdrawal of life-sustaining procedures in any lawful
19 manner. In such respect the provisions of this act are cumulative.
20 (e) This act shall create no presumption concerning the intention
21 of an individual who has not executed a declaration *or a* ~~*pre-hospital*~~
22 *do not resuscitate order* to consent to the use or withholding of life-
23 sustaining procedures in the event of a terminal condition.
24 New Sec. 4. (a) A ~~pre-hospital~~ do not resuscitate order may be
25 executed by an adult person or on behalf of any minor child or
26 incapacitated adult person by any of the following persons, in order
27 of priority stated, when persons in prior classes are not available:
28 (1) The spouse;
29 (2) an adult son or daughter;
30 (3) either parent;
31 (4) an adult sibling; ~~or~~
32 (5) a court-appointed guardian~~.~~ ; or
(6) a durable power of attorney for health care decisions.
33 Such order directing that in the event of acute cardiac or respiratory
34 arrest of a patient, no cardiopulmonary resuscitation will be initiated.
35 (b) The ~~pre-hospital~~ do not resuscitate order executed pursuant
36 to this act shall be:
37 (1) In writing;
38 (2) signed by the patient, or, if the patient is incapacitated or a
39 minor child, by a person authorized to execute the order by sub-
40 section (a);
41 (3) dated;
42 (4) signed in the presence of one or more witnesses at least 18
43 years of age; and

1 (5) signed by the patient's attending physician, who shall certify
2 that the ~~order is medically appropriate~~ and that the order is doc-
3 umented in the patient's permanent medical record.
4 (c) The ~~pre-hospital~~ do not resuscitate order authorized by this
5 act shall specifically state that the order will not prevent the patient
6 from obtaining other appropriate emergency medical care by any
7 health care provider or emergency medical service provider.
8 (d) The order shall be substantially in the following form:
9 ~~PRE-HOSPITAL~~ DNR REQUEST FORM
10 *An Advanced Request to Limit the Scope of Emergency Medical Care*
11 I, ________________(name), request limited emergency care as herein described.
12 I understand DNR means that if my heart stops beating or if I stop breathing, no
13 medical procedure to restart breathing or heart functioning will be instituted.
14 I understand this decision will *not* prevent me from obtaining other emergency
15 medical care by ~~prehospital~~ care providers and/or medical care directed by a physician
16 prior to my death.
17 I understand I may revoke this directive at any time.
18 I give permission for this information to be given to the ~~pre-hospital~~ care providers,
19 ~~doctors, nurses, or other health personnel~~ as necessary to implement this directive.
20 I hereby agree to the "Do Not Resuscitate" (DNR) order.
21 ______________________________ ________________
22 Patient/Guardian Signature Date
23 ______________________________ ________________
24 Witness Date
25 REVOCATION PROVISION
26 I hereby revoke the above declaration.
27 ______________________________ ________________
28 Signature Date
29 I AFFIRM THIS DIRECTIVE IS THE EXPRESSED WISH OF THE PATIENT/
30 PATIENT'S GUARDIAN, ~~IS MEDICALLY APPROPRIATE,~~ AND IS DOCU-
31 MENTED IN THE PATIENT'S PERMANENT MEDICAL RECORD.
32 In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation
33 will be initiated.
34 ______________________________ ________________
35 Physician's Signature Date
36 ______________ ______________________________
37 Address Facility or Agency Name
38 THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR
39 ALTERED IN ANY WAY.
40 New Sec. 5. A ~~pre-hospital~~ do not resuscitate order may be
41 revoked at any time by the patient or by the person who executed
42 the order as authorized by section 4, in the manner set forth in
43 K.S.A. 65-28,104, and amendments thereto.

patient is afflicted with an incurable, terminal illness or physical deterioration that substantially diminishes the patient's quality of life

emergency medical service providers or health

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1 New Sec. 6. In the event of a ~~patient's~~ acute cardiac or respi- DNR-patient's
2 ratory arrest, no health care provider or emergency medical services
3 provider who in good faith causes or participates in the withholding
4 or withdrawing of cardiopulmonary resuscitation pursuant to a ~~pre-~~
5 ~~hospital~~ do not resuscitate order in accordance with this act, as a
6 result thereof, shall be subject to criminal or civil liability or be
7 found to have committed an act of unprofessional conduct.
8 Sec. 7. K.S.A. 65-28,102, 65-28,107 and 65-28,108 are hereby
9 repealed.
10 Sec. 8. This act shall take effect and be in force from and after
11 its publication in the statute book.